No. S241431

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

JANICE JARMAN,
Plaintiff and Appellant,

v.

HCR MANORCARE, INC., *et al.*,
Defendants and Appellants,

Court of Appeal of the State of California, Fourth Appellate District
Division Three, Civil No. G051086
Superior Court of the State of California, County of Riverside
Case No. RIC 10007764
Hon. Phrasel Shelton and Hon. John Vineyard

AMICI CURIAE AARP, AARP FOUNDATION, CENTER FOR MEDICARE ADVOCACY, CONSUMER ATTORNEYS OF CALIFORNIA, JUSTICE IN AGING, THE LONG TERM CARE COMMUNITY COALITION, THE NATIONAL CONSUMER VOICE FOR QUALITY LONG-TERM CARE, and THE NATIONAL UNION OF HEALTHCARE WORKERS' MOTION FOR JUDICIAL NOTICE

Matthew Borden
(SBN: 214323)
Adam Shapiro
(SBN: 267429)
BRAUNHAGEY & BORDEN LLP
351 California St.,10th Fl.
San Francisco, CA 94104
Tel.: (415) 599-0210
Fax: (415) 276-1808
borden@braunhagey.com
Attorneys for Amici Curiae

William Alvarado Rivera
(SBN: 178190)
AARP FOUNDATION
601 E Street, NW
Washington, D.C. 20049
Tel.: (202) 434-6291
Fax: (202) 434-6424
warivera@aarp.org

W. Timothy Needham
(SBN: 96542)
JANSSEN MALLOY LLP
P.O. Drawer 1288
Eureka, CA 95503
Tel.: (707) 445-2071
Fax: (707) 445-8305
tneedham@janssenlaw.com

No. S241431

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

JANICE JARMAN,
Plaintiff and Appellant,

v.

HCR MANORCARE, INC., *et al.*,
Defendants and Appellants,

Court of Appeal of the State of California, Fourth Appellate District
Division Three, Civil No. G051086
Superior Court of the State of California, County of Riverside
Case No. RIC 10007764
Hon. Phrasel Shelton and Hon. John Vineyard

AMICI CURIAE AARP, AARP FOUNDATION, CENTER FOR MEDICARE ADVOCACY, CONSUMER ATTORNEYS OF CALIFORNIA, JUSTICE IN AGING, THE LONG TERM CARE COMMUNITY COALITION, THE NATIONAL CONSUMER VOICE FOR QUALITY LONG-TERM CARE, and THE NATIONAL UNION OF HEALTHCARE WORKERS' MOTION FOR JUDICIAL NOTICE

Matthew Borden
(SBN: 214323)
Adam Shapiro
(SBN: 267429)
BRAUNHAGEY & BORDEN LLP
351 California St.,10th Fl.
San Francisco, CA 94104
Tel.: (415) 599-0210
Fax: (415) 276-1808
borden@braunhagey.com
Attorneys for Amici Curiae

William Alvarado Rivera
(SBN: 178190)
AARP FOUNDATION
601 E Street, NW
Washington, D.C. 20049
Tel.: (202) 434-6291
Fax: (202) 434-6424
warivera@aarp.org

W. Timothy Needham
(SBN: 96542)
JANSSEN MALLOY LLP
P.O. Drawer 1288
Eureka, CA 95503
Tel.: (707) 445-2071
Fax: (707) 445-8305
tneedham@janssenlaw.com

MOTION FOR JUDICIAL NOTICE

Pursuant to California Rules of Court, rule 8.252(a), and California Evidence Code section 451, subdivision (a); section 452, subdivisions (b), (c), (h); and section 459, *Amici Curiae* AARP, AARP Foundation, Center For Medicare Advocacy, Consumer Attorneys Of California, Justice In Aging, The Long Term Care Community Coalition, The National Consumer Voice For Quality Long-Term Care, And The National Union Of Healthcare Workers move this Court for an order taking judicial notice of the following materials:

Legislative History of Health & Safety Code Section 1430(b)

Exhibit 1(a): Assembly Bill 2791 (Berg – 2004), Chapter 270, Statutes of 2004.

Exhibit 1(b): Senate Bill No. 1930 (Petris). Amended 08/02/82.

Exhibit 1(c): Aon Risk Consultants, Inc. *Long Term Care, General Liability and Professional Liability, 2004 Actuarial Analysis.*

Exhibit 1(d): Continued: Aon Risk Consultants, Inc. *Long Term Care, General Liability and Professional Liability, 2004 Actuarial Analysis.*

Exhibit 2: Third Amended Complaint for Violations of Patient's Rights, California Health and Safety Code § 1430(b); Unlawful Business Practices, California Business & Professions Code §§ 17200, *et seq.*; Declaratory Relief, *Gloria Single et al. v. Cathedral Pioneer Church Homes II et al.,* Case No.: 34-2017-00220058-CU-NP-GDS (Sacramento Supr. Ct.).

Exhibit 3: Order re Motion for Preliminary Approval of Class Action Settlement, *Levine v. Ventura Convalescent Hospital, et al.,* Case No. 56-2011-00406713-CU-AT-VTA (Ventura Supr. Ct.).

Legislative History of Amendments to Health & Safety Code Section 1430(b)

Exhibit 4(a): Legislative History of California Health & Safety Code § 1430, *As Amended By* Statutes of 1982, Chapter 1455, § 1, Senate Bill 1930 – Petris, Part 1.

Exhibit 4(b): Legislative History of California Health & Safety Code § 1430, *As Amended By* Statutes of 1982, Chapter 1455, § 1, Senate Bill 1930 – Petris, Part 2.

MEMORANDUM OF POINTS AND AUTHORITIES

Amici Curiae AARP, AARP Foundation, Center For Medicare Advocacy, Consumer Attorneys Of California, Justice In Aging, The Long Term Care Community Coalition, The National Consumer Voice For Quality Long-Term Care, And The National Union Of Healthcare Workers request that the Court take judicial notice of the attached materials, described in the Notice, pursuant to Evidence Code section 451, subdivision (a); section 452, subdivisions (b), (c), (h); and section 459, and California Rules of Court, rule 8.252(a).

All of the materials of which judicial notice is requested are pertinent to arguments in the Brief of *Amici Curiae* submitted concurrently herewith regarding the interpretation of Health & Safety Code section 1430, subdivision (b). The legislative materials are relevant because this case present a question of statutory interpretation. The other court records for which judicial notice are sought were not presented to the trial court, but are relevant to show the interests of the *amici* as well as the manner in which Health & Safety Code section 1430, subdivision (b) may be used to improve the lives of seniors.

Legislative Materials:

Judicial notice of Exhibits 1 and 4 is appropriate as they are legislative history materials. Evidence Code section 451, subdivision (a)

requires a court to take judicial notice of "[t]he . . . public statutory law of this state . . . ." Evidence Code section 452, subdivision (b) allows a court to take judicial notice of "[r]egulations and legislative enactments issued by or under the authority of . . . any public entity in the United States." Evidence Code section 452, subdivision (c) allows a court to take judicial notice of "[o]fficial acts of the legislative . . . departments of . . . any state of the United States." Evidence Code Section 452, subdivision (h) allows a court to take judicial notice of "[f]acts and propositions that are not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy." (See also Evid. Code, § 459 (setting forth procedure for requesting that a court take judicial notice); Cal. R. Ct. 8.252, subd. (a) (setting forth procedure for requesting that the Court of Appeal take judicial notice).)

Legislative histories of California statutes, including compilations by Legislative Intent Service, are commonly the subjects of judicial notice by California courts. (See *People v. Sanchez* (2001) 24 Cal. 4th 983, 992, fn. 4; *Grubb & Ellis Co. v. Bello* (1993) 19 Cal.App.4th 231, 240-241; *Estate of Thomas* (2004) 124 Cal.App.4th 711, 723, fn.3.) It is also proper to take judicial notice of failed legislation that would have amended an existing statute. (See *Joannou v. City of Rancho Palos Verdes* (2013) 219 Cal. App. 4th 746, 760-61; *Jutzi v. County of Los Angeles* (1987) 196 Cal. App. 3d 637, 648.)

Court Records:

Judicial notice of Exhibits 2 and 3 is appropriate as these materials are court records and Exhibit 3 is an order of a Superior Court. Pursuant to Evidence Code section 451, judicial notice "shall" be taken of the decisional . . . law of this state and the United States." And under Evidence Code section 452, the Court may take judicial notice of the "[r]ecords (1) of

any court of this state or (2) any court of record of the United States or of any state of the United States."

Amici Curiae AARP, AARP Foundation, Center For Medicare Advocacy, Consumer Attorneys Of California, Justice In Aging, The Long Term Care Community Coalition, The National Consumer Voice For Quality Long-Term Care, And The National Union Of Healthcare Workers respectfully request that the Court grant this motion and take judicial notice of the attached materials.

Dated: October 18, 2018

Respectfully Submitted,

BRAUNHAGEY & BORDEN LLP

By: _____
Matthew Borden

Attorneys for Amici Curiae

PROPOSED ORDER

For good cause shown, the request for judicial notice by *Amici Curiae* AARP, AARP Foundation, Center For Medicare Advocacy, Consumer Attorneys Of California, Justice In Aging, The Long Term Care Community Coalition, The National Consumer Voice For Quality Long-Term Care, And The National Union Of Healthcare Workers is hereby granted.

Dated:

_____

Honorable Chief Justice
Tani G. Cantil-Sakauye

PROOF OF SERVICE

I, Katie Kushnir, declare:

I am over the age of 18 years and not a party to this action. My business address is BraunHagey & Borden LLP; 351 California Street, 10th Floor; San Francisco, CA 94104 which is located in the county where the service described below occurred.

On October 18, 2018, I deposited the following document(s):

***AMICI CURIAE* AARP, AARP FOUNDATION, CENTER FOR MEDICARE ADVOCACY, CONSUMER ATTORNEYS OF CALIFORNIA, JUSTICE IN AGING, THE LONG TERM CARE COMMUNITY COALITION, THE NATIONAL CONSUMER VOICE FOR QUALITY LONG-TERM CARE, and THE NATIONAL UNION OF HEALTHCARE WORKERS' MOTION FOR JUDICIAL NOTICE**

for deposit in the United States Postal Service in a sealed envelope, with postage fully prepaid, addressed to:

Anthony C. Lanzone
Anna Cronk
Lanzone Morgan, LLP
5001 Airport Plaza Drive, Suite 210
Long Beach, CA 90815
Counsel for Plaintiff and Appellant Janice Jarman and John L. Jarman

John Patrick Petrullo
Caroline J. Wu
Petrullo LLP
222 North Sepulveda Boulevard, Suite 806
El Segundo, CA 90245
Counsel for Defendants and Respondents HCR ManorCare, Inc. and Manor Care of Hemet CA, LLC

Jay-Allen Eisen
Jay-Allen Eisen Law Corporation
c/o Downey Brand LLP
621 Capitol Mall, 18th Floor
Sacramento, CA 95814
Counsel for Plaintiff and Appellant Janice Jarman

Joanna S. McCallum
Barry S. Landsberg
Manatt, Phelps & Phillips, LLP
11355 West Olympic Boulevard
Los Angeles, CA 90064
Counsel for Defendants and Respondents HCR ManorCare, Inc.

and Manor Care of Hemet CA, LLC

Wendy York
The York Law Corporation
1111 Exposition Boulevard
Building 500
Sacramento, CA 95815
Publication/Depublication Requestor

CLERK
California Court of Appeal
Fourth Appellate District
Division 3
601 W. Santa Ana Blvd.
Santa Ana, CA 92701
Court of Appeal Case No.
G051086

CLERK
Riverside County Superior Court
4050 Main Street
Riverside, CA 92501
Superior Court Case No.
RIC100007764

I certify and declare under penalty of perjury that the foregoing is true and correct.

Katie Kushnir

EXHIBIT 1A

EXHIBIT 3A

LEGISLATIVE
INTENT SERVICE, INC.

712 Main Street, Suite 200, Woodland, CA 95695
(800) 666-1917 • Fax (530) 668-5866 • www.legintent.com

LEGISLATIVE HISTORY REPORT AND ANALYSIS

Re: **Assembly Bill 2791 (Berg – 2004)**
Chapter 270, Statutes of 2004

Our File No.: 0826250

The legislative history of the above-referenced bill is documented by materials itemized in one declaration.

To comprehend quickly the presentation and order of the documents and obtain important information on our research policies and procedures and request for judicial notice, please visit our web site at www.legintent.com and click on the links "Points and Authorities" and "Research Aids and Policies."

ASSEMBLY BILL 2791 (BERG – 2004)
CHAPTER 270, STATUTES OF 2004

As enacted Assembly Bill 2791 amended Health and Safety Code sections 1337.1 and 1430 only. (See Exhibit #1d) As introduced, Assembly Bill 2791 was a "spot bill." (See Exhibit #1a) A "spot bill" is a measure introduced with minor, nonsubstantive proposals to serve as an empty vehicle for placement of a more substantive legislative proposal later in session; meanwhile it holds as a bill properly introduced to meet legislative time frames for the introduction of bills. As introduced, Assembly Bill 2791 proposed a non-substantive change to Welfare and Institutions Code section 14132 only. (Id.) The first amendment dated April 1, 2004 proposed to amend Health and Safety Code section 1430 only. (See Exhibit #1b) The one subsequent amendment added the provision to amend Health and Safety Code section 1337.1. (See Exhibit #1c)

Assembly Bill 2791 was assigned to the Assembly Committee on Health and the Senate Committee on Health and Human Services where policy issues raised by the bill were considered. (See Exhibits #3 and #7) The fiscal ramifications of the bill were considered by the Assembly Committee on Appropriations and the Senate Committee on Appropriations. (See Exhibits #2 and #5) Two amendments were made to Assembly Bill 2791. (See Exhibits #1b, #1c, and #2) Subsequent to legislative approval, Governor Arnold Schwarzenegger signed the bill on August 23, 2004, and it was recorded by the Secretary of State as Chapter 270 of the Statutes of 2004. (See Exhibits #1d and #2)

The Third Reading analysis prepared by the Office of Senate Floor Analyses provides the following digest of Assembly Bill 2791 as it was last amended on May 11, 2004:

> DIGEST: This bill requires the approved training program of a skilled nursing facility (SNF) and an intermediate care facility (ICF) to include instruction on preventing, recognizing, and reporting residents' rights violations as part of the current training and instruction required under existing law.
> (See Exhibit #9, page 1)

The analysis of the Senate Health and Human Services Committee mentions the purpose of the bill as amended on May 11, 2004 follows:

> According to the author, the intent of this bill is to ensure that nursing home residents' rights are not violated. He believes that in addition to residents knowing their rights, more importantly, the people who care for them must know how to uphold them.
> (See Exhibit #7, page 2)

Prior to the May 11th amendment to Assembly Bill 2791 the purpose of the bill was discussed in the analysis of the Assembly Committee on Health stating:

> According to the author, this bill is necessary because, despite numerous deficiencies reported by the Department of Health Services every year and thousands of unresolved complaints received by the Ombudsman, SNF residents have not exercised their private right of action under current law which limits a nursing home's liability to $500. The author states that current law intended to provide a specific mechanism for an individual resident to enforce his or her rights through a private right of action. However, the author believes that the intent of that law remains unfulfilled for a variety of reasons. First, current residents may fear reprisal if they sue the facility because the home or facility controls every aspect of a resident's daily life. Second, residents' rights cases can be complicated and attorneys will not take cases that involve many hours of work, if the time spent on the case greatly exceeds the maximum damage award of $500. Finally, the damage award may not reflect the extent of the violation. The author notes that the State is facing severe health care cost pressures that are likely to continue and that the number of seniors in California is expected to double in the next 15 years. With such cost and demographic pressures, the author believes that state functions such as licensing and certification of health facilities may suffer, and it thus becomes more important than ever to ensure that residents' rights be respected and enforced.
> (See Exhibit #3, pages 1 and 2)

This version of the bill was opposed by the California Association of Health Facilities, California Association of Homes and Services for the Aging,

California Healthcare Association, Crestwood Behavioral Health, Inc., and 658 individuals. (See #3, page 3) The file materials contain the letters from the sponsor, the California Senior Legislature, regarding the legislation as well as those from parties opposing the proposed changes. (See for example, Exhibits #4, #6 and #8) These materials document the consideration given the proposal while in the Legislature and provide insight into amendments taken to the initial proposal. They provide an insight into the negotiations that resulted in the final version of Assembly Bill 2791.

Health and Safety Code Section 1430

The provision to amend Health and Safety Code section 1430 was in Assembly Bill 2791 as of the April 1, 2004 amendment. (See Exhibit #1b) At this time the section was amended to increase the civil liability from $500 to $5000 and other minor changes to the section. (Id. at pages 2 and 3) The one subsequent amendment to the bill which occurred on May 11, 2004 deleted the $5000 and replaced it with the original $500. (See Exhibit #1c, page 4)

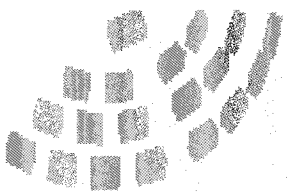
The Background Worksheet found in the bill file of the Assembly Committee on Health mentions that there were two other bills that proposed unsuccessfully to increase the civil penalty from $500. (See Exhibit #4, document AP-49) Please let us know if you wish research on these bills.

The language you are investigating may be affected by bills, pending or enacted, in the current legislative session. *We do not ordinarily review for current session bills, but will do so upon request.*

Any analysis provided in this report is based upon the nature and extent of your request to us, as well as a brief review of the enclosed documents. As such, it must be considered tentative in nature. A more conclusive statement of the impact of the legislative history in your case would be dependent upon a complete understanding of all of the factual issues involved and the applicable legal principles.

We appreciate the opportunity to provide this assistance and hope that these efforts will be of value to you.

Prepared by: FILOMENA M. YEROSHEK, Attorney at Law/ddw; File no.: 0826250
W:\worldox\WDOCS\WORKPROD\03608\07635\00092424.DOC



LEGISLATIVE
INTENT SERVICE, INC.

712 Main Street, Suite 200, Woodland, CA 95695
(800) 666-1917 • Fax (530) 668-5866 • www.legintent.com

DECLARATION OF FILOMENA M. YEROSHEK

I, Filomena M. Yeroshek, declare:

I am an attorney licensed to practice before the courts of the State of California, State Bar No. 125625, and am employed by Legislative Intent Service, Inc. a company specializing in researching the history and intent of legislation.

Under my direction and the direction of other attorneys on staff, the research staff of Legislative Intent Service, Inc. undertook to locate and obtain all documents relevant to the enactment of Assembly Bill 2791 of 2004. Assembly Bill 2791 was approved by the Legislature and was enacted as Chapter 270 of the Statutes of 2004.

The following list identifies all documents obtained by the staff of Legislative Intent Service, Inc. on Assembly Bill 2791 of 2004. All listed documents have been forwarded with this Declaration except as otherwise noted in this Declaration. All documents gathered by Legislative Intent Service, Inc. and all copies forwarded with this Declaration are true and correct copies of the originals located by Legislative Intent Service, Inc. In compiling this collection, the staff of Legislative Intent Service, Inc. operated under directions to locate and obtain all available material on the bill.

ASSEMBLY BILL 2791 OF 2004:

1. All versions of Assembly Bill 2791 (Berg-2004);
2. Procedural history of Assembly Bill 2791 from the September 2, 2004 Assembly Recess History;
3. Analysis of Assembly Bill 2791 prepared for the Assembly Committee on Health;
4. Material from the legislative bill file of the Assembly Committee on Health on Assembly Bill 2791;
5. Analysis of Assembly Bill 2791 prepared for the Assembly Committee on Appropriations;
6. Material from the legislative bill file of the Assembly Republican Caucus on Assembly Bill 2791;
7. Analysis of Assembly Bill 2791 prepared for the Senate Committee on Health and Human Services;

8. Material from the legislative bill file of the Senate Committee on Health and Human Services on Assembly Bill 2791;
9. Third Reading analysis of Assembly Bill 2791 prepared by the Office of Senate Floor Analyses;
10. Material from the legislative bill file of the Office of Senate Floor Analyses on Assembly Bill 2791;
11. Post-enrollment documents regarding Assembly Bill 2791 - (Governor Schwarzenegger's legislative files are under restricted access and are not available to the public.).

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 26th day of February, 2008 at Woodland, California.

Filomena M. Yeroshek

FILOMENA M. YEROSHEK

W:\worldox\WDOCS\ABLYBILL\ab\2791\00092436.DOC

CALIFORNIA LEGISLATURE—2003–04 REGULAR SESSION

ASSEMBLY BILL No. 2791

Introduced by Assembly Member Berg

February 20, 2004

An act to amend Section 14132 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 2791, as introduced, Berg. Medi-Cal.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and other low-income persons. Existing law contains a schedule of covered Medi-Cal benefits.

This bill would make a technical, nonsubstantive change to that provision.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 14132 of the Welfare and Institutions Code is amended to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology,

acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy and occupational therapy, are covered subject to utilization controls.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for the developmentally disabled are covered subject to utilization controls.

(d) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and X-ray services are covered, subject to utilization controls. Nothing in this subdivision shall be construed to require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable X-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The

utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated, is covered subject to utilization controls. When there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

(*l*) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Family planning services are covered, subject to utilization controls.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, other prophylaxis treatment for children 17 years of age and under, are covered.

(2) All dental hygiene services provided by a registered dental hygienist in alternative practice pursuant to Sections 1768 and 1770 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article.

(2) All providers enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, "in-home medical care service" includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

As used in this subdivision, in-home medical care services, include, but are not limited to:

(1) Level of care and cost of care evaluations.

(2) Expenses, directly attributable to home care activities, for materials.

(3) Physician fees for home visits.

(4) Expenses directly attributable to home care activities for shelter and modification to shelter.

(5) Expenses directly attributable to additional costs of special diets, including tube feeding.

(6) Medically related personal services.

(7) Home nursing education.

(8) Emergency maintenance repair.

(9) Home health agency personnel benefits which permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(11) Emergency and nonemergency medical transportation.

(12) Medical supplies.

(13) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(14) Utility use directly attributable to the requirements of home care activities which are in addition to normal utility use.

(15) Special drugs and medications.

(16) Home health agency supervision of visiting staff which is medically necessary, but not included in the home health agency rate.

(17) Therapy services.

(18) Household appliances and household utensil costs directly attributable to home care activities.

(19) Modification of medical equipment for home use.

(20) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(21) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

Beneficiaries receiving in-home medical care services are entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and

applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services may be covered to the extent that federal financial participation is available for those services under waivers granted in accordance with Section 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) ~~Hospice service which is~~ Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services ~~which~~ *that* are authorized and reimbursable under this chapter, and services ~~which~~ *that* are not reimbursable

under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for beneficiaries with a diagnosis of AIDS or ARC, who require intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to individual beneficiaries in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible beneficiaries. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department, a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program.

(2) The department shall seek a waiver for a program to provide comprehensive clinical family planning services as described in paragraph (8). The program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. The services shall be provided under the program only if the

waiver is approved by the federal Centers for Medicare and Medicaid Services in accordance with Section 1396n of Title 42 of the United States Code and only to the extent that federal financial participation is available for the services.

(3) Solely for the purposes of the waiver and notwithstanding any other provision of law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other provision of law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, without taking regulatory action, the provisions of the waiver after its approval by the federal Health Care Financing Administration and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) In the event that the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) is no longer cost-effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical

family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, "comprehensive clinical family planning services" means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration approved contraceptive drugs, devices,

and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(ab) Purchase of prescribed enteral formulae is covered, subject to the Medi-Cal list of enteral formulae and utilization controls.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

O

AMENDED IN ASSEMBLY APRIL 1, 2004

CALIFORNIA LEGISLATURE—2003–04 REGULAR SESSION

ASSEMBLY BILL No. 2791

Introduced by Assembly Member ~~Berg~~ *Simitian*

February 20, 2004

~~An act to amend Section 14132 of the Welfare and Institutions Code, relating to Medi-Cal.~~ *An act to amend Section 1430 of the Health and Safety Code, relating to health facilities.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2791, as amended, ~~Berg~~ *Simitian.* ~~Medi-Cal~~ *Skilled nursing and intermediate care facilities: liability.*

~~Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and other low-income persons. Existing law contains a schedule of covered Medi-Cal benefits.~~

~~This bill would make a technical, nonsubstantive change to that provision.~~

Existing law authorizes a resident or patient of a skilled nursing facility or intermediate care facility to bring a civil action against the licensee of a facility that violates any rights of the resident or patient as set forth in the Patients Bill of Rights. Existing law provides that the licensee is liable for up to $500, and for costs and attorney fees, and may be enjoined from permitting the violation to continue.

This bill would increase the licensee's liability to $5,000.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

98

The people of the State of California do enact as follows:

~~SECTION 1. Section 14132 of the Welfare and Institutions~~
SECTION 1. Section 1430 of the Health and Safety Code is amended to read:

1430. (a) Except where the state department has taken action and the violations have been corrected to its satisfaction, ~~any~~ *a* licensee who commits a class "A" or "B" violation may be enjoined from permitting the violation to continue or may be sued for civil damages within a court of competent jurisdiction. ~~Such actions~~ *An action* for injunction or civil damages, or both, may be prosecuted by the Attorney General in the name of the people of the State of California upon his or her own complaint or upon the complaint of ~~any~~ *a* board, officer, person, corporation, or association, or by ~~any~~ *a* person acting for the interests of itself, its members, or the general public. The amount of civil damages ~~which~~ *that* may be recovered in an action brought pursuant to this section ~~shall~~ *may* not exceed the maximum amount of civil penalties ~~which~~ *that* could be assessed on account of the violation or violations.

(b) A *current or former* resident or patient of a skilled nursing facility, as defined in subdivision (c) of Section 1250, or intermediate care ~~facilities~~ *facility*, as defined in subdivision (d) of Section 1250, may bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights in Section 72527 of Title 22 of the California ~~Administrative~~ Code *of Regulations, or any other right provided for by federal or state law or regulation*. The suit shall be brought in a court of competent jurisdiction. The licensee shall be liable for the acts of the licensee's employees. The licensee shall be liable for up to five ~~hundred~~ *thousand* dollars ~~($500)~~ *($5,000)*, and for costs and attorney fees, and may be enjoined from permitting the violation to continue. An agreement by a resident or patient of a skilled nursing facility or intermediate care facility to waive his or her rights to sue pursuant to this subdivision shall be void as contrary to public policy.

(c) The remedies specified in this section shall be in addition to any other remedy provided by law.

All matter omitted in this version of the bill appears in the bill as introduced in the Assembly, February 20, 2004. (JR 11)

O

AMENDED IN ASSEMBLY MAY 11, 2004

AMENDED IN ASSEMBLY APRIL 1, 2004

CALIFORNIA LEGISLATURE—2003–04 REGULAR SESSION

ASSEMBLY BILL No. 2791

Introduced by Assembly Member Simitian

February 20, 2004

An act to amend ~~Section~~ *Sections 1337.1 and* 1430 of the Health and Safety Code, relating to health facilities.

LEGISLATIVE COUNSEL'S DIGEST

AB 2791, as amended, Simitian. Skilled nursing and intermediate care facilities: ~~liability~~ *training*.

Existing law requires a skilled nursing and intermediate care facility to adopt an approved training program that meets standards established by the State Department of Health Services.

Existing law requires that 6 hours of the precertification classroom training focus on preventing, recognizing, and reporting resident abuse. Existing law requires that 4 hours of continuing education and in-service training for certified nursing assistants address preventing, recognizing, and reporting resident abuse. Violation of these requirements is a crime under existing law.

This bill would additionally require one hour of precertification classroom training addressing the prevention, recognition, and reporting of residents' rights violations. This bill would provide that the continuing education and in-service training for certified nursing assistants includes instruction on preventing, recognizing, and

97

reporting residents' rights violations. By changing the definition of a crime, this bill would impose a state-mandated local program.

Existing law authorizes a resident or patient of a skilled nursing facility or intermediate care facility to bring a civil action against the licensee of a facility that violates any rights of the resident or patient as set forth in the Patients Bill of Rights. Existing law provides that the licensee is liable for up to $500, and for costs and attorney fees, and may be enjoined from permitting the violation to continue.

~~This bill would increase the licensee's liability to $5,000.~~

This bill would make technical, nonsubstantive changes to that provision.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

SECTION 1. *Section 1337.1 of the Health and Safety Code is amended to read:*

1337.1. A skilled nursing or intermediate care facility shall adopt an approved training program that meets standards established by the state department. The approved training program shall consist of at least the following:

(a) An orientation program to be given to newly employed nurse assistants prior to providing direct patient care in skilled nursing or intermediate care facilities.

(b) (1) A precertification training program consisting of at least 60 classroom hours of training on basic nursing skills, patient safety and rights, the social and psychological problems of patients, and resident abuse prevention, recognition, and reporting pursuant to subdivision (e). The 60 classroom hours of training may be conducted within a skilled nursing or intermediate care facility or in an educational institution.

(2) In addition to the 60 classroom hours of training required under paragraph (1), the precertification training program shall

consist of at least 100 hours of supervised and on-the-job training clinical practice. The 100 hours may consist of normal employment as a nurse assistant under the supervision of either the director of nurse training or a licensed nurse qualified to provide nurse assistant training who has no other assigned duties while providing the training.

(3) At least two hours of the 60 hours of classroom training and at least four hours of the 100 hours of the supervised clinical training shall address the special needs of persons with developmental and mental disorders, including mental retardation, Alzheimer's disease, cerebral palsy, epilepsy, dementia, Parkinson's disease, and mental illness.

(4) In a precertification training program subject to this subdivision, credit shall be given for the training received in an approved precertification training program adopted by another skilled nursing or intermediate care facility.

(5) This subdivision shall not apply to a skilled nursing or intermediate care facility that demonstrates to the state department that it employs only nurse assistants with a valid certification.

(c) Continuing in-service training to assure continuing competency in existing and new nursing skills.

(d) Each facility shall consider including training regarding the characteristics and method of assessment and treatment of acquired immune deficiency syndrome (AIDS).

(e) (1) The approved training program shall include, within the 60 hours of classroom training, a minimum of six hours of instruction on preventing, recognizing, and reporting instances of resident abuse utilizing those courses developed pursuant to Section 13823.93 of the Penal Code, *and a minimum of one hour of instruction on preventing, recognizing, and reporting residents' rights violations.*

(2) A minimum of four hours of instruction on preventing, recognizing, and reporting instances of resident abuse, *including instruction on preventing, recognizing, and reporting residents' rights violations,* shall be included within the total minimum hours of continuing education or in-service training required and in effect for certified nursing assistants.

SEC. 2. Section 1430 of the Health and Safety Code is amended to read:

1430. (a) Except where the state department has taken action and the violations have been corrected to its satisfaction, a licensee who commits a class "A" or "B" violation may be enjoined from permitting the violation to continue or may be sued for civil damages within a court of competent jurisdiction. An action for injunction or civil damages, or both, may be prosecuted by the Attorney General in the name of the people of the State of California upon his or her own complaint or upon the complaint of a board, officer, person, corporation, or association, or by a person acting for the interests of itself, its members, or the general public. The amount of civil damages that may be recovered in an action brought pursuant to this section may not exceed the maximum amount of civil penalties that could be assessed on account of the violation or violations.

(b) A current or former resident or patient of a skilled nursing facility, as defined in subdivision (c) of Section 1250, or intermediate carefacility, as defined in subdivision (d) of Section 1250, may bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights in Section 72527 of Title 22 of the California Code of Regulations, or any other right provided for by federal or state law or regulation. The suit shall be brought in a court of competent jurisdiction. The licensee shall be liable for the acts of the licensee's employees. The licensee shall be liable for up to five ~~thousand dollars ($5,000),~~ *hundred dollars ($500),* and for costs and attorney fees, and may be enjoined from permitting the violation to continue. An agreement by a resident or patient of a skilled nursing facility or intermediate care facility to waive his or her rights to sue pursuant to this subdivision shall be void as contrary to public policy.

(c) The remedies specified in this section shall be in addition to any other remedy provided by law.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within

the meaning of Section 6 of Article XIII B of the California Constitution.

O

Assembly Bill No. 2791

CHAPTER 270

An act to amend Sections 1337.1 and 1430 of the Health and Safety Code, relating to health facilities.

[Approved by Governor August 23, 2004. Filed with Secretary of State August 23, 2004.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2791, Simitian. Skilled nursing and intermediate care facilities: training.

Existing law requires a skilled nursing and intermediate care facility to adopt an approved training program that meets standards established by the State Department of Health Services.

Existing law requires that 6 hours of the precertification classroom training focus on preventing, recognizing, and reporting resident abuse. Existing law requires that 4 hours of continuing education and in-service training for certified nursing assistants address preventing, recognizing, and reporting resident abuse. Violation of these requirements is a crime under existing law.

This bill would additionally require one hour of precertification classroom training addressing the prevention, recognition, and reporting of residents' rights violations. This bill would provide that the continuing education and in-service training for certified nursing assistants includes instruction on preventing, recognizing, and reporting residents' rights violations. By changing the definition of a crime, this bill would impose a state-mandated local program.

Existing law authorizes a resident or patient of a skilled nursing facility or intermediate care facility to bring a civil action against the licensee of a facility that violates any rights of the resident or patient as set forth in the Patients Bill of Rights. Existing law provides that the licensee is liable for up to $500, and for costs and attorney's fees, and may be enjoined from permitting the violation to continue.

This bill would make technical, nonsubstantive changes to that provision.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1337.1 of the Health and Safety Code is amended to read:

1337.1. A skilled nursing or intermediate care facility shall adopt an approved training program that meets standards established by the state department. The approved training program shall consist of at least the following:

(a) An orientation program to be given to newly employed nurse assistants prior to providing direct patient care in skilled nursing or intermediate care facilities.

(b) (1) A precertification training program consisting of at least 60 classroom hours of training on basic nursing skills, patient safety and rights, the social and psychological problems of patients, and resident abuse prevention, recognition, and reporting pursuant to subdivision (e). The 60 classroom hours of training may be conducted within a skilled nursing or intermediate care facility or in an educational institution.

(2) In addition to the 60 classroom hours of training required under paragraph (1), the precertification training program shall consist of at least 100 hours of supervised and on-the-job training clinical practice. The 100 hours may consist of normal employment as a nurse assistant under the supervision of either the director of nurse training or a licensed nurse qualified to provide nurse assistant training who has no other assigned duties while providing the training.

(3) At least two hours of the 60 hours of classroom training and at least four hours of the 100 hours of the supervised clinical training shall address the special needs of persons with developmental and mental disorders, including mental retardation, Alzheimer's disease, cerebral palsy, epilepsy, dementia, Parkinson's disease, and mental illness.

(4) In a precertification training program subject to this subdivision, credit shall be given for the training received in an approved precertification training program adopted by another skilled nursing or intermediate care facility.

(5) This subdivision shall not apply to a skilled nursing or intermediate care facility that demonstrates to the state department that it employs only nurse assistants with a valid certification.

(c) Continuing in-service training to assure continuing competency in existing and new nursing skills.

(d) Each facility shall consider including training regarding the characteristics and method of assessment and treatment of acquired immune deficiency syndrome (AIDS).

(e) (1) The approved training program shall include, within the 60 hours of classroom training, a minimum of six hours of instruction on

preventing, recognizing, and reporting instances of resident abuse utilizing those courses developed pursuant to Section 13823.93 of the Penal Code, and a minimum of one hour of instruction on preventing, recognizing, and reporting residents' rights violations.

(2) A minimum of four hours of instruction on preventing, recognizing, and reporting instances of resident abuse, including instruction on preventing, recognizing, and reporting residents' rights violations, shall be included within the total minimum hours of continuing education or in-service training required and in effect for certified nursing assistants.

SEC. 2. Section 1430 of the Health and Safety Code is amended to read:

1430. (a) Except where the state department has taken action and the violations have been corrected to its satisfaction, a licensee who commits a class "A" or "B" violation may be enjoined from permitting the violation to continue or may be sued for civil damages within a court of competent jurisdiction. An action for injunction or civil damages, or both, may be prosecuted by the Attorney General in the name of the people of the State of California upon his or her own complaint or upon the complaint of a board, officer, person, corporation, or association, or by a person acting for the interests of itself, its members, or the general public. The amount of civil damages that may be recovered in an action brought pursuant to this section may not exceed the maximum amount of civil penalties that could be assessed on account of the violation or violations.

(b) A current or former resident or patient of a skilled nursing facility, as defined in subdivision (c) of Section 1250, or intermediate care facility, as defined in subdivision (d) of Section 1250, may bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights in Section 72527 of Title 22 of the California Code of Regulations, or any other right provided for by federal or state law or regulation. The suit shall be brought in a court of competent jurisdiction. The licensee shall be liable for the acts of the licensee's employees. The licensee shall be liable for up to five hundred dollars ($500), and for costs and attorney fees, and may be enjoined from permitting the violation to continue. An agreement by a resident or patient of a skilled nursing facility or intermediate care facility to waive his or her rights to sue pursuant to this subdivision shall be void as contrary to public policy.

(c) The remedies specified in this section shall be in addition to any other remedy provided by law.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the

only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

No. 230

CALIFORNIA LEGISLATURE

AT SACRAMENTO

2003–04 REGULAR SESSION

ASSEMBLY RECESS HISTORY

COMMENCING WITH AB 1 AND ENDING WITH AB 3118

THURSDAY, SEPTEMBER 2, 2004

Assembly Convened December 2, 2002

HON. FABIAN NUÑEZ
Speaker

HON. LELAND YEE
Speaker pro Tempore

HON. DARIO FROMMER
Majority Floor Leader

HON. SALLY LIEBER
Assistant Speaker pro Tempore

HON. KEVIN McCARTHY
Minority Floor Leader

Compiled Under the Direction of
E. DOTSON WILSON
Chief Clerk

AMY LEACH
History Clerk

NEVA PARKER
Assistant History Clerk

LIS - 2

(Please Report Any Omissions or Errors to History Clerk Phone 319-2363)

A.B. No. 2791—Simitian.

An act to amend Sections 1337.1 and 1430 of the Health and Safety Code, relating to health facilities.

2004

Feb. 20—Read first time. To print.
Feb. 22—From printer. May be heard in committee March 23.
April 1—Referred to Com. on HEALTH. From committee chair, with author's amendments: Amend, and re-refer to Com. on HEALTH. Read second time and amended.
April 12—Re-referred to Com. on HEALTH.
April 20—In committee: Hearing postponed by committee.
May 10—From committee: Amend, and do pass as amended. (Ayes 16. Noes 0.) (May 4).
May 11—Read second time and amended. Ordered returned to second reading.
May 12—Read second time. To third reading. Re-referred to Com. on APPR. pursuant to Joint Rule 10.5.
May 20—From committee: Do pass. To Consent Calendar. (May 19). Read second time. To Consent Calendar.
May 25—Read third time, passed, and to Senate. (Ayes 77. Noes 0. Page 6029.)
May 26—In Senate. Read first time. To Com. on RLS. for assignment.
June 9—Referred to Com. on H. & H.S.
June 21—In committee: Hearing postponed by committee.
July 1—From committee: Do pass, and re-refer to Com. on APPR. with recommendation: To Consent Calendar. Re-referred. (Ayes 11. Noes 0.)
July 29—In committee: Hearing postponed by committee.
Aug. 5—From committee: Be placed on second reading file pursuant to Senate Rule 28.8.
Aug. 9—Read second time. To third reading.
Aug. 10—Read third time, passed, and to Assembly. (Ayes 37. Noes 0. Page 4861.)
Aug. 10—In Assembly. To enrollment.
Aug. 13—Enrolled and to the Governor at 3:45 p.m.
Aug. 23—Approved by the Governor.
Aug. 23—Chaptered by Secretary of State - Chapter 270, Statutes of 2004.

A.B. No. 2792—Oropeza.

An act to add and repeal Section 17052.3 of the Revenue and Taxation Code, relating to taxation, to take effect immediately, tax levy.

2004

Feb. 20—Read first time. To print.
Feb. 22—From printer. May be heard in committee March 23.
Mar. 11—Referred to Com. on REV. & TAX.
May 3—In committee: Set, first hearing. Hearing canceled at the request of author.
May 4—From committee chair, with author's amendments: Amend, and re-refer to Com. on REV. & TAX. Read second time and amended.
May 5—Re-referred to Com. on REV. & TAX.
May 10—In committee: Set, second hearing. Referred to REV. & TAX. suspense file.
May 11—From committee: Do pass, and re-refer to Com. on APPR. Re-referred. (Ayes 5. Noes 1.) (May 10).
May 19—In committee: Set, first hearing. Referred to APPR. suspense file.
May 19—In committee: Set, first hearing. Held under submission.

A.B. No. 2793—Nakanishi.

An act to add Section 2906 to the Business and Professions Code, relating to psychiatrists.

2004

Feb. 20—Read first time. To print.
Feb. 22—From printer. May be heard in committee March 23.
Mar. 11—Referred to Com. on B. & P.

COMPLETE BILL HISTORY

BILL NUMBER : A.B. No. 2791
AUTHOR : Simitian
TOPIC : Skilled nursing and intermediate care facilities: training.

TYPE OF BILL :
Inactive
Non-Urgency
Non-Appropriations
Majority Vote Required
State-Mandated Local Program
Fiscal
Non-Tax Levy

BILL HISTORY
2004
Aug. 23 Chaptered by Secretary of State - Chapter 270, Statutes of 2004.
Aug. 23 Approved by the Governor.
Aug. 13 Enrolled and to the Governor at 3:45 p.m.
Aug. 10 In Assembly. To enrollment.
Aug. 10 Read third time, passed, and to Assembly. (Ayes 37. Noes 0. Page 4861.)
Aug. 9 Read second time. To third reading.
Aug. 5 From committee: Be placed on second reading file pursuant to Senate Rule 28.8.
July 29 In committee: Hearing postponed by committee.
July 1 From committee: Do pass, and re-refer to Com. on APPR. with recommendation: To Consent Calendar. Re-referred. (Ayes 11. Noes 0.).
June 21 In committee: Hearing postponed by committee.
June 9 Referred to Com. on H. & H.S.
May 26 In Senate. Read first time. To Com. on RLS. for assignment.
May 25 Read third time, passed, and to Senate. (Ayes 77. Noes 0. Page 6029.)
May 20 From committee: Do pass. To Consent Calendar. (May 19). Read second time. To Consent Calendar.
May 12 Read second time. To third reading. Re-referred to Com. on APPR. pursuant to Joint Rule 10.5.
May 11 Read second time and amended. Ordered returned to second reading.
May 10 From committee: Amend, and do pass as amended. (Ayes 16. Noes 0.) (May 4).
Apr. 20 In committee: Hearing postponed by committee.
Apr. 12 Re-referred to Com. on HEALTH.
Apr. 1 Referred to Com. on HEALTH. From committee chair, with author's amendments: Amend, and re-refer to Com. on HEALTH. Read second time and amended.
Feb. 22 From printer. May be heard in committee March 23.
Feb. 20 Read first time. To print.

Date of Hearing: May 4, 2004

ASSEMBLY COMMITTEE ON HEALTH
Rebecca Cohn, Chair
AB 2791 (Simitian) – As Amended: April 1, 2004

SUBJECT: Skilled nursing and intermediate care facilities: liability.

SUMMARY: Expands rights of nursing home residents to bring civil suits against nursing homes that violate patient rights. Specifically, this bill:

1) Specifies that either a "current or former" resident or patient of a skilled nursing facility (SNF), or intermediate care facility (ICF), may bring a civil action against the licensee of a facility who violates any rights of the resident or patient. Specifies that the rights covered include those set forth in the Patients Bill of Rights, as specified in California nursing home regulations, as well as any other right provided for by federal or state law or regulation.

2) Increases a licensee's maximum civil liability for resident rights violations pursuant to #1) above from $500 to $5,000, plus costs and attorney fees.

EXISTING LAW:

1) Permits a resident or patient of a skilled nursing facility, or intermediate care facility, to bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights, as specified in California nursing home regulations.

2) Requires the licensee to be liable for the acts of the licensee's employees.

3) Makes the licensee liable for up to $500 and for costs and attorney fees, and authorizes the licensee to be enjoined from permitting the violation to continue. Makes an agreement by a resident or patient to waive his or her rights to sue pursuant to this bill void as contrary to public policy.

4) Establishes in SNF regulation, a Patients Bill of Rights, which enumerates 26 rights, including the right to be fully informed, to be transferred only for specified reasons, to be free from abuse, and to be treated with consideration and respect.

FISCAL EFFECT: None

LIS - 3

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill is necessary because, despite numerous deficiencies reported by the Department of Health Services every year and thousands of unresolved complaints received by the Ombudsman, SNF residents have not exercised their private right of action under current law which limits a nursing home's liability to $500. The author states that current law intended to provide a specific mechanism for an individual resident to enforce his or her rights through a private right of action. However, the author believes that the intent of that law remains unfulfilled for a variety of

reasons. First, current residents may fear reprisal if they sue the facility because the home or facility controls every aspect of a resident's daily life. Second, residents' rights cases can be complicated and attorneys will not take cases that involve many hours of work, if the time spent on the case greatly exceeds the maximum damage award of $500. Finally, the damage award may not reflect the extent of the violation. The author notes that the State is facing severe health care cost pressures that are likely to continue and that the number of seniors in California is expected to double in the next 15 years. With such cost and demographic pressures, the author believes that state functions such as licensing and certification of health facilities may suffer, and it thus becomes more important than ever to ensure that residents' rights be respected and enforced.

2) BACKGROUND. Existing law, which makes SNFs and ICFs liable for up to $500 along with litigation costs, has been in effect since 1982. The SNF Patients Bill of Rights, codified in regulations, was last amended in 1992.

3) SUPPORT. Supporters argue that, although federal and state law is reasonably good in establishing the rights of nursing home patients, raising the maximum financial remedy for rights violations from $500 to $5000 is necessary to provide effective enforcement of those rights. Supporters believe that bad nursing homes violate the law based on a cynical calculation that poor care is cheaper and thus more profitable than compliance with the law. This bill will allow the level of penalty to reflect the severity of harm to the patient.

4) OPPOSITION. Opponents argue that current resident rights penalties of up to $500 were enacted to provide residents with a remedy when they have suffered an intangible harm of nominal value and that increasing the penalty to $5000 creates a substantial financial incentive to sue facilities and dramatically changes the purpose of the law. Opponents state that in addition to being liable for civil damages of $500 plus litigation costs under current law, facilities are also liable for administrative penalties that range anywhere from $100 to $100,000 and for civil damages awarded under the Elder and Dependent Adult Civil Protection Act (EADACPA). Opponents argue that during the last round of nursing home reform in 2000 the increased penalty included in this bill was discussed and rejected. Finally, opponents believe that increased facility liability will inevitably raise costs for liability insurance, which has already increased substantially in the last five years, resulting in higher operating costs and necessitating higher Medi-Cal reimbursements. Opponents cite a 2003 report from the federal Centers for Medicare and Medicaid Services that states that the national average liability cost per occupied skilled nursing bed has grown at an average rate of 24% per year since 1991.

5) PREVIOUS LEGISLATION. SB 679 (Mello), Chapter 774, Statutes of 1991, enacted EADACPA, which prescribes conduct for the care of elderly or dependant adults and authorizes civil actions arising from abuse or neglect of elderly or dependent adults. In any such action, attorney's fees and costs, "pain and suffering" damages, and punitive damages may be awarded where there is clear and convincing evidence that a defendant has acted recklessly, or with malice, fraud or oppression. AB 634 (Steinberg), Chapter 242, Statutes of 2003, creates a statewide policy against confidential settlement agreements in cases brought under EADACPA.

AB 1731 (Shelley), Chapter 451, Statutes of 2000, established increased state civil penalties on SNFs and ICFs, increasing Class "AA" fines from not less than $5,000 to a range of

$25,000 to $100,000, and Class "A" fines from not less than $1,000 to a range of $2,000 to $20,000. AB 1731 also increased fines for "willful material falsification" and "willful material omission." "AA" violations are those that are a direct proximate cause of death of a patient. "A" violations present an imminent danger or substantial probability of death or serious harm to a patient.

REGISTERED SUPPORT / OPPOSITION:

Support

California Senior Legislature (sponsor)
AARP California
American Federation of State, County and Municipal Employees
California Advocates for Nursing Home Reform
Consumer Attorneys of California
National Senior Citizens Law Center

Opposition

California Association of Health Facilities
California Association of Homes and Services for the Aging
California Healthcare Association
Crestwood Behavioral Health, Inc.
658 individuals

Analysis Prepared by: John Gilman / HEALTH / (916) 319-2097

(2)REPORTS OF STANDING COMMITTEES<c2>

(2)Committee on Health

[t8] Date of Hearing: May 04, 2004 [_]<r>

¶ Mr. Speaker: Your Committee on Health reports:

¶Assembly Bill No. 2791 (16-0)

~~Assembly Bill No. 2874 (13-5)~~

(1)With amendments with the recommendation: Amend, and do pass, as amended. <1>

Rebecca Cohn, Chair
COHN

(5)Above bill(s) ordered to second reading.

AMENDMENTS ADOPTED IN COMMITTEE

BILL NO: AB 2791

AUTHOR: Simitian

STAFF: JG

HEARING DATE: 5/4

☒ The attached amendments were adopted in Committee on the above date. Please proof and return ASAP.

☐ Approved as drafted. Send as is to desk.

☐ Return to Legislative Counsel for changes.

12611

05/07/04 11:09 AM
RN0409889 PAGE 1
Substantive

AMENDMENTS TO ASSEMBLY BILL NO. 2791
AS AMENDED IN ASSEMBLY APRIL 1, 2004

Amendment 1
In line 2 of the title, strike out "Section" and insert:

Sections 1337.1 and

Amendment 2
On page 2, line 2, after "SECTION 1." insert:

Section 1337.1 of the Health and Safety Code is amended to read:

1337.1. A skilled nursing or intermediate care facility shall adopt an approved training program that meets standards established by the state department. The approved training program shall consist of at least the following:

(a) An orientation program to be given to newly employed nurse assistants prior to providing direct patient care in skilled nursing or intermediate care facilities.

(b) (1) A precertification training program consisting of at least 60 classroom hours of training on basic nursing skills, patient safety and rights, the social and psychological problems of patients, and resident abuse prevention, recognition, and reporting pursuant to subdivision (e). The 60 classroom hours of training may be conducted within a skilled nursing or intermediate care facility or in an educational institution.

(2) In addition to the 60 classroom hours of training required under paragraph (1), the precertification training program shall consist of at least 100 hours of supervised and on-the-job training clinical practice. The 100 hours may consist of normal employment as a nurse assistant under the supervision of either the director of nurse training or a licensed nurse qualified to provide nurse assistant training who has no other assigned duties while providing the training.

(3) At least two hours of the 60 hours of classroom training and at least four hours of the 100 hours of the supervised clinical training shall address the special needs of persons with developmental and mental disorders, including mental retardation, Alzheimer's disease, cerebral palsy, epilepsy, dementia, Parkinson's disease, and mental illness.

(4) In a precertification training program subject to this subdivision, credit shall be given for the training received in

an approved precertification training program adopted by another skilled nursing or intermediate care facility.

(5) This subdivision shall not apply to a skilled nursing or intermediate care facility that demonstrates to the state department that it employs only nurse assistants with a valid certification.

(c) Continuing in-service training to assure continuing competency in existing and new nursing skills.

(d) Each facility shall consider including training regarding the characteristics and method of assessment and treatment of acquired immune deficiency syndrome (AIDS).

(e) (1) The approved training program shall include, within the 60 hours of classroom training, a minimum of six hours of instruction on preventing, recognizing, and reporting instances of resident abuse utilizing those courses developed pursuant to Section 13823.93 of the Penal Code, and a minimum of one hour of instruction on preventing, recognizing, and reporting residents' rights violations.

(2) A minimum of four hours of instruction on preventing, recognizing, and reporting instances of resident abuse, including instruction on preventing, recognizing, and reporting residents' rights violations, shall be included within the total minimum hours of continuing education or in-service training required and in effect for certified nursing assistants.

SEC. 2.

Amendment 3

On page 2, line 29, strike out "thousand dollars ($5,000)," and insert:

hundred dollars ($500),

Amendment 4

On page 2, below line 36, insert:

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

- 0 -

AUTHOR'S AMENDMENTS<c2>

Committee on Health

April 01, 2004 [1]<r>

¶ Mr. Speaker: The Chair of your Committee on Health reports:

¶ Assembly Bill No. 1927

¶ Assembly Bill No. 1957

¶ Assembly Bill No. 1959

¶ Assembly Bill No. 2297

¶ Assembly Bill No. 2324

¶ Assembly Bill No. 2326

¶ Assembly Bill No. 2389

¶ Assembly Bill No. 2483

¶ Assembly Bill No. 2763

¶ Assembly Bill No. 2791

¶ Assembly Bill No. 2874

(1)With author's amendments with the recommendation: Amend, and re-refer to the committee. <l>

Rebecca Cohn, Chair [1] <r>
Cohn

AUTHOR'S AMENDMENTS

BILL NO: AB2791

AUTHOR: Simitian (was Berg)

STAFF: CC

SET FOR HEARING: ?

____ The attached amendments were put across the desk and will be reflected in the following version of the bill:
"As Amended ____"

X The attached amendments were drafted by Legislative Counsel. Please review them and return them to PR ASAP so that they may go across the desk. (Please initial below)

AB Approved as Drafted/Send as is to Desk.

____ These amendments need changes as indicated.

46693

03/30/04 2:34 PM
RN0407381 PAGE 1
Substantive

AMENDMENTS TO ASSEMBLY BILL NO. 2791

Amendment 1
In line 1 of the heading, strike out "Berg" and insert:

Simitian

Amendment 2
Strike out lines 1 and 2 of the title and insert:

An act to amend Section 1430 of the Health and Safety Code, relating to health facilities.

Amendment 3
On page 1, strike out line 1, and insert:

SECTION 1. Section 1430 of the Health and Safety Code is amended to read:

1430. (a) Except where the state department has taken action and the violations have been corrected to its satisfaction, ~~any~~ a licensee who commits a class "A" or "B" violation may be enjoined from permitting the violation to continue or may be sued for civil damages within a court of competent jurisdiction. ~~Such actions~~ An action for injunction or civil damages, or both, may be prosecuted by the Attorney General in the name of the people of the State of California upon his or her own complaint or upon the complaint of ~~any~~ a board, officer, person, corporation, or association, or by ~~any~~ a person acting for the interests of itself, its members, or the general public. The amount of civil damages ~~which~~ that may be recovered in an action brought pursuant to this section ~~shall~~ may not exceed the maximum amount of civil penalties ~~which~~ that could be assessed on account of the violation or violations.

(b) A current or former resident or patient of a skilled nursing facility, as defined in subdivision (c) of Section 1250, or intermediate care ~~facilities~~ facility, as defined in subdivision (d) of Section 1250, may bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights in Section 72527 of Title 22 of the California ~~Administrative~~ Code of Regulations, or any other right provided for by federal or state law or regulation. The suit shall be brought in a court of competent jurisdiction. The licensee shall be liable for the acts of the licensee's employees. The licensee shall be liable for up to five ~~hundred~~ thousand dollars

~~($500)~~ ($5,000), and for costs and attorney fees, and may be enjoined from permitting the violation to continue. An agreement by a resident or patient of a skilled nursing facility or intermediate care facility to waive his or her rights to sue pursuant to this subdivision shall be void as contrary to public policy.

(c) The remedies specified in this section shall be in addition to any other remedy provided by law.

Amendment 4

On page 1, strike out lines 2 to 8, inclusive, and strike out pages 2 to 11, inclusive

- 0 -

ASSEMBLY COMMITTEE ON HEALTH

Rebecca Cohn, Chair

MEMORANDUM

TO: LEGISLATIVE COUNSEL

FROM: COMMITTEE ON HEALTH

DATE: 5/5/04

RE: COMMITTEE AMENDMENTS TO: AB 2791

☐ Draft bill as per attached.

☒ Draft amendments as per attached.

☐ Coauthors _____

_____.

☐ Opinion as per attached. WRITTEN VERBAL

☒ If necessary, confer with John Gilman (319-2607) (Cell: 616-4788)

☐ Confer with me before final drafting.

☐ This is to authorize _____ to work with your office on the above legislation.

☒ I need request by ~~5/6/04~~ 5/7/04 Noon - Sure

☐ Above requested by phone.

☐ Other Please deliver to 6005.

[John Gilman]

Attachment(s)

p:\ldc\legcoun2.doc

Proposed Amendments to AB 2791 (Simitian)

On Page 2, lines 2-3, add a new Section 1, as follows:

SECTION 1. Section 1337.1 of the Health and Safety Code is amended to read:

.....

.....

(e) (1) The approved training program shall include, within the 60 hours of classroom training, a minimum of six hours of instruction on preventing, recognizing, and reporting instances of resident abuse utilizing those courses developed pursuant to Section 13823.93 of the Penal Code, and a minimum of one hour of instruction on preventing, recognizing and reporting resident=s rights violations.

(2) A minimum of four hours of instruction on preventing, recognizing, and reporting instances of resident abuse, including instruction on preventing, recognizing and reporting resident=s rights violations shall be included within the total minimum hours of continuing education or in-service training required and in effect for certified nursing assistants.

On Page 2, line 2, add a new Section 2, as follows:

SECTION 2. Section 1430 of the Health and Safety Code is amended to read:

On Page 2, lines 28-29, convert language back to current law:

liable for the acts of the licensee=s employees. The licensee shall be liable for up to five hundred ~~thousand~~ dollars ($500) ~~($5,000)~~,

Date of Hearing: May 4, 2004

ASSEMBLY COMMITTEE ON HEALTH
Rebecca Cohn, Chair
AB 2791 (Simitian) – As Amended: April 1, 2004

SUBJECT: Skilled nursing and intermediate care facilities: liability.

SUMMARY: Expands rights of nursing home residents to bring civil suits against nursing homes that violate patient rights. Specifically, this bill:

1) Specifies that either a "current or former" resident or patient of a skilled nursing facility (SNF), or intermediate care facility (ICF), may bring a civil action against the licensee of a facility who violates any rights of the resident or patient. Specifies that the rights covered include those set forth in the Patients Bill of Rights, as specified in California nursing home regulations, as well as any other right provided for by federal or state law or regulation.

2) Increases a licensee's maximum civil liability for resident rights violations pursuant to #1) above from $500 to $5,000, plus costs and attorney fees.

EXISTING LAW:

1) Permits a resident or patient of a skilled nursing facility, or intermediate care facility, to bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights, as specified in California nursing home regulations.

2) Requires the licensee to be liable for the acts of the licensee's employees.

3) Makes the licensee liable for up to $500 and for costs and attorney fees, and authorizes the licensee to be enjoined from permitting the violation to continue. Makes an agreement by a resident or patient to waive his or her rights to sue pursuant to this bill void as contrary to public policy.

4) Establishes in SNF regulation, a Patients Bill of Rights, which enumerates 26 rights, including the right to be fully informed, to be transferred only for specified reasons, to be free from abuse, and to be treated with consideration and respect.

FISCAL EFFECT: None

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill is necessary because, despite numerous deficiencies reported by the Department of Health Services every year and thousands of unresolved complaints received by the Ombudsman, SNF residents have not exercised their private right of action under current law which limits a nursing home's liability to $500. The author states that current law intended to provide a specific mechanism for an individual resident to enforce his or her rights through a private right of action. However, the author believes that the intent of that law remains unfulfilled for a variety of

reasons. First, current residents may fear reprisal if they sue the facility because the home or facility controls every aspect of a resident's daily life. Second, residents' rights cases can be complicated and attorneys will not take cases that involve many hours of work, if the time spent on the case greatly exceeds the maximum damage award of $500. Finally, the damage award may not reflect the extent of the violation. The author notes that the State is facing severe health care cost pressures that are likely to continue and that the number of seniors in California is expected to double in the next 15 years. With such cost and demographic pressures, the author believes that state functions such as licensing and certification of health facilities may suffer, and it thus becomes more important than ever to ensure that residents' rights be respected and enforced.

2) BACKGROUND. Existing law, which makes SNFs and ICFs liable for up to $500 along with litigation costs, has been in effect since 1982. The SNF Patients Bill of Rights, codified in regulations, was last amended in 1992.

3) SUPPORT. Supporters argue that, although federal and state law is reasonably good in establishing the rights of nursing home patients, raising the maximum financial remedy for rights violations from $500 to $5000 is necessary to provide effective enforcement of those rights. Supporters believe that bad nursing homes violate the law based on a cynical calculation that poor care is cheaper and thus more profitable than compliance with the law. This bill will allow the level of penalty to reflect the severity of harm to the patient.

4) OPPOSITION. Opponents argue that current resident rights penalties of up to $500 were enacted to provide residents with a remedy when they have suffered an intangible harm of nominal value and that increasing the penalty to $5000 creates a substantial financial incentive to sue facilities and dramatically changes the purpose of the law. Opponents state that in addition to being liable for civil damages of $500 plus litigation costs under current law, facilities are also liable for administrative penalties that range anywhere from $100 to $100,000 and for civil damages awarded under the Elder and Dependent Adult Civil Protection Act (EADACPA). Opponents argue that during the last round of nursing home reform in 2000 the increased penalty included in this bill was discussed and rejected. Finally, opponents believe that increased facility liability will inevitably raise costs for liability insurance, which has already increased substantially in the last five years, resulting in higher operating costs and necessitating higher Medi-Cal reimbursements. Opponents cite a 2003 report from the federal Centers for Medicare and Medicaid Services that states that the national average liability cost per occupied skilled nursing bed has grown at an average rate of 24% per year since 1991.

5) PREVIOUS LEGISLATION. SB 679 (Mello), Chapter 774, Statutes of 1991, enacted EADACPA, which prescribes conduct for the care of elderly or dependant adults and authorizes civil actions arising from abuse or neglect of elderly or dependent adults. In any such action, attorney's fees and costs, "pain and suffering" damages, and punitive damages may be awarded where there is clear and convincing evidence that a defendant has acted recklessly, or with malice, fraud or oppression. AB 634 (Steinberg), Chapter 242, Statutes of 2003, creates a statewide policy against confidential settlement agreements in cases brought under EADACPA.

AB 1731 (Shelley), Chapter 451, Statutes of 2000, established increased state civil penalties on SNFs and ICFs, increasing Class "AA" fines from not less than $5,000 to a range of

$25,000 to $100,000, and Class "A" fines from not less than $1,000 to a range of $2,000 to $20,000. AB 1731 also increased fines for "willful material falsification" and "willful material omission." "AA" violations are those that are a direct proximate cause of death of a patient. "A" violations present an imminent danger or substantial probability of death or serious harm to a patient.

REGISTERED SUPPORT / OPPOSITION:

Support

California Senior Legislature (sponsor)
AARP California
American Federation of State, County and Municipal Employees
California Advocates for Nursing Home Reform
Consumer Attorneys of California
National Senior Citizens Law Center

Opposition

California Association of Health Facilities
California Association of Homes and Services for the Aging
California Healthcare Association
Crestwood Behavioral Health, Inc.
658 individuals

Analysis Prepared by: John Gilman / HEALTH / (916) 319-2097

May 5, 2004

Hon. Assemblymember Rebecca Cohn, Chair
Assembly Health Committee
State Capitol, Room 6005 Sacramento, CA 95814

Phone: (916) 319-2097 Fax: (916) 319-2197
Assemblymember.Cohn@assembly.ca.gov

RE: Request for support of Assembly Bills AB2791

Dear Chair and members of the Assembly Health Committee,

I am writing on behalf of Home Sweet Home Care to voice our support of Assembly Bill AB 2791, which expands the liability limit for nursing home violations. This important legislation deserves your support to raise the liability limit from the current level of $500 to a modest amount of $5,000.

In nearly 20 years no suits have been filed by residents because lawyers will not take cases when the damage limit is so low and the law did not specifically give former nursing home residents the right to sue. AB 2791 is a step in the right direction to improve the Patients Bill of Rights. Please support this vital legislation for our at-risk elders.

Sincerely,

Shirley Cohen
Executive Director

One Flynn Center
825 Van Ness Ave.
Suite 500
San Francisco
CA 94109
tel: 415.776.7337
fax: 415.776.5209
eldercareexperts.com

The Monterey Offices
617 Veterans Blvd.
Suite 111
Redwood City
CA 94063
tel: 650.556.9906
fax: 650.556.1699

HELIOS
HEALTHCARE, LLC

MAY 6 2004

April 28, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, Ca. 95814

Re: AB2791(Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB2791(Simitian), which would raise the penalty for a resident's rights violation from $500.00 up to $5,000.00 per violation. I believe we are a good nursing home that works very hard to ensure that resident rights are not violated. Please consider my request not to raise the violation.

Sincerely,

Theresa Harrison
Administrator

TH/th

ELK GROVE CARE &
REHABILITATION CENTER
9461 BATEY AVENUE
ELK GROVE, CA 95624
OFFICE: 916.685.9525
FAX: 916.685.6943

AARP California

April 30, 2004

Honorable Rebecca Cohn, Chair
Assembly Health Committee
State Capitol, Room 6005
Sacramento, California 95814

via Facsimile & Mail

Re: AB 2791 (Simitian) Support

Dear Assemblymember Cohn:

On behalf of the over 3 million members of AARP in California I am pleased to communicate our support for AB 2791.

We commend this legislation to expand the provisions of a private right of action for nursing home residents whose rights have been violated.

Health and Safety Code 1430(b) provides for the only remedy available for violation of residents' rights in California. Unfortunately, since this law was first enacted in 1982, fewer than five such actions have been filed. Although remedies available under this section include injunctive relief, an important remedy for violation of residents' rights the $500 limit on damages so reduces the likelihood of legal representation, any opportunity for relief is moot.

As a consequence, residents who are illegally evicted, denied phone calls or visitors or subjected to humiliation in any form, are denied any relief.

AARP strongly urges your support for AB 2791, which would help make enforcement of residents' rights more than just a symbolic gesture.

Thank you for your consideration. If you have any questions on our position or need more information, please contact, Lupe De La Cruz, Manager of Advocacy, at 916-556-3036.

Respectfully,

Helen Russ
California State President

cc: Assemblymemeber Simitian
Members Health Committee

980 9th Street, Suite 700 | Sacramento, CA 95814 | 916-446-2277 | 916-556-3000 fax
200 South Los Robles Avenue, Suite 400 | Pasadena, CA 91101 | 626-585-9500 | 626-583-8500 fax
James G. Parkel, President | William D. Novelli, Executive Director and CEO | www.aarp.org/ca

CALIFORNIA HEALTHCARE ASSOCIATION

Providing Leadership in Health Policy and Advocacy

April 28, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, California 95814

SUBJECT: AB 2791 (Simitian) – OPPOSE

Dear Assembly Member Cohn:

The California Healthcare Association (CHA), which represents California's 500 hospitals and health systems, many of which operate skilled nursing facilities opposes AB 2791 (Simitian), which would (1) increase the penalty for a residents' rights violation from $500 to $5,000 per violation, and (2) expand the residents' rights that serve as a basis for such penalty.

The residents' rights penalty was enacted to provide residents with a remedy when they have suffered an intangible harm of nominal value. In enacting the statute, the legislature recognized a balance between acknowledging these intangible harms and creating an incentive to sue. Increasing the penalty to $5,000, however, creates a substantial financial incentive to sue facilities and dramatically changes the purpose of this statutory provision.

CHA supports residents' rights. Enumeration of these rights in law makes it clear that public policy values the personal integrity and dignity of residents. It does not logically follow, however, that people should be able to obtain a monetary windfall by stringing together a series of alleged rights violations into a lawsuit. It is not difficult for a resident to claim that their rights have been violated; relatively minor behavior can be framed as a residents' rights violation.

The Elder and Dependent Adult Civil Protection Act; which provides nursing home residents with enhanced remedies (including attorneys' fees and cost and treble punitive damages); already creates a significant incentive to sue nursing homes. Additional incentive to sue is not necessary and will exacerbate the existing liability insurance coverage crisis that nursing homes are experiencing.

In addition to personal causes of action, the state has extensive enforcement authority over nursing homes, including oversight by the Department of Health Services in the form of annual and complaint surveys, the Ombudsman program in the form of spontaneous visitations, the Attorney General through "Operation Guardian" inspections and criminal prosecution. The federal Centers for Medicare and Medicaid also conducts "look back" surveys on nursing homes

1215 K Street, Suite 800, Sacramento, CA 95814 *Telephone:* 916-443-7401 *Facsimile:* 916-552-7596 *Website:* www.calhealth.org

with increasing frequency. These mechanisms provide extensive oversight of nursing home quality, including the respect of residents' rights.

For the above-stated reasons, CHA urges your "No" vote on AB 2791.

Sincerely,

Judy Citko
Vice President, Continuing Care Services

JJC:dlv

cc: Assembly Member Joseph Simitian
Members of the Assembly Health Committee
John Gilman, consultant, Assembly Health Committee
Peter Anderson, consultant, Assembly Republican Caucus

PROTECT OUR PARENTS

A COALITION OF:

The Congress of California Seniors, GRAY Panthers, California Advocates for Nursing Home Reform, Older Women's League, Californians For Quality Care, Consumer Attorneys of California, AARP, and the Consumer Federation of California

May 3, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, CA 95814

RE: AB 2791 (SIMITIAN) SUPPORT

On behalf of the Protect Our Parents coalition, a coalition of senior advocate organizations, I would like to express our support for AB 2791 (Simitian), which would expand the civil liability limit for a private right of action for nursing home residents whose rights have been violated.

Residents' rights are more than just words. They reflect the quality of daily living in care facilities. Health and Safety Code 1430(b) provides a remedy for violations of residents' rights in California. But since the law was first enacted, few actions have been filed despite the numerous documented violations of residents' rights. By raising the cap on civil damages from $500 to $5,000 for a violation of residents' rights, AB 2791 will help to compel compliance with the law.

AB 2791 is a positive step toward protecting California's growing senior population. We strongly urge your support of AB 2791.

cc: Assemblyman Joe Simitian
Assembly Health Committee

Ombudsman/Advocate, Inc.
525 Laurel St. Ste.140
Santa Cruz, CA 95060
Santa Cruz (831) 429-1913 San Benito (831) 636-1638 Fax 429-9102

Protect, through advocacy, education and intervention, the rights of facility-placed seniors and disabled persons, and individuals with mental health needs.

April 24, 2004

Assemblywoman Rebecca Cohn, Chair
Assembly Health Committee
State Capitol, Rm. 6005
Sacramento, CA 95814
Fax #: 916-319-2197

RE: AB 2791

Dear Assemblywoman Cohn,

As Executive Director of Ombudsman/Advocate, Inc., I'm writing, on behalf of the Long-Term Care Ombudsman Program and the Patients' Rights Advocate Program serving Santa Cruz and San Benito Counties, in support of AB 2791, introduced by Assemblyman Simitian.

The long-term care facility-placed residents deserve a legal outlet that can realistically assist in rights protection. In the best of cases, facility residents have limited access to legal assistance. With so little value placed on rights violations and abuse occurrences, legal counsel has been virtually nonexistent. Increasing the damages available improves the practicality of legal recourse.

As you may be aware, state oversight agencies do not, or are unable to, adequately address rights and abuse issues to the residents' satisfaction. Since we are a society in which importance is often attached to a dollar value, increasing the amount of damages from $500 to $5,000, not only provides a more viable course of action for residents, but increases the importance of residents' rights to dignity and quality of care, regardless of their residence.

Ombudsman/Advocate, Inc., an independent nonprofit providing advocacy and rights protection to seniors, facility-placed residents and mental health clients, urges your support of AB 2791 in Committee and active support for an Assembly full vote.

Sincerely,

Kathleen Johnson
Executive Director
Ombudsman/Advocate, Inc.
525 Laurel St., Ste. 140
Santa Cruz, CA 95010
831-429-1913

cc: Assemblyman Joe Simitian

Bet Tzedek Legal Services
THE HOUSE OF JUSTICE
12821 Victory Boulevard • North Hollywood • California 91606
Telephone (818) 769-0136 • Facsimile (818) 769-3299 • www.bettzedek.org

MAY 3 2004

BET TZEDEK THE HOUSE OF JUSTICE

Writer's Direct Line: (818) 487-5226
Writer's E-mail: jspiegel@bettzedek.org

April 30, 2004

VIA FACSIMILE (916)319-2121

The Honorable Joseph Simitian
California State Assembly
State Capitol, Room 5119
Sacramento, California 95814

Re: Support for AB 2791 (Simitian),

Dear Assemblymember Simitian:

I am writing on behalf of Bet Tzedek Legal Services to express our strong support for AB 2791, which would modestly increase the liability limit against nursing homes who violate fundamental residents' rights from $500 to $5,000.

Bet Tzedek is a non-profit public interest law center providing free legal representation to over 10,000 low-income, elderly, and disabled people each year throughout Los Angeles County. As Director of the Nursing Home Advocacy Project at Bet Tzedek, I receive numerous telephone calls every week from distraught seniors and their families regarding violations of residents' rights by nursing facilities, including: illegal transfers and discharges; mental and physical abuse; medically unnecessary use of restraints; failure to communicate and coordinate health care; lack of quality care; and denial of access to visitors, telephones, and mail.

AB 2791 is an important and necessary step in helping the elderly and disabled. No California citizen should have to surrender basic rights and civil protections because he or she has been admitted to a nursing home. Although federal and state laws establish the rights of nursing home residents, these rights are frequently infringed upon by nursing facilities because of the lack of oversight and enforcement. By raising the cap on damages for a violation of resident's rights from $500 to $5,000, AB 2791 will help to safeguard fundamental freedoms which no person should have to do without.

Thank you for your stewardship in helping our seniors in their homes away from home, and for making enforcement of their rights a top priority.

Sincerely,

Jody L. Spiegel
Director, Nursing Home Advocacy Project

G:\Jody\Legislation\AB 2791 ltr 2Simitian 4.30.04.wpd

MAY 3 2004

L.A. METRO MULTI-DISCIPLINARY TEAM
For Consultation on Elders at Risk

"A Community-Government Partnership Working Together to Insure Safety, Respect, Quality of Life and Justice for Seniors"

May 3, 2004

The Honorable S. Joseph Simitian
California State Assembly
State Capitol, Room 5119
Sacramento, California 95814

RE: AB 2791 (Simitian)

Dear Assembly Member Simitian:

As Co-Chair of the Los Angeles Metro Multi-Disciplinary Team (MDT) for Consultation on Elders at Risk and Publisher of *www.LA4Seniors.com*, I want to thank you for introducing AB 2791 to protect the rights and dignity of nursing home residents.

By expanding the liability limit when a nursing home violates residents' rights from $ 500 to $ 5,000, AB 2791 will provide a needed remedy and access to justice. AB 2791 will also create an incentive for facilities to provide quality care to elderly residents and be an effective deterrent against abuse and neglect.

Nursing home patients are the most vulnerable, isolated and forgotten members of our community. I am grateful for your work on their behalf and am committee to working with you to ensure the passage and signing of AB 2791.

Sincerely,

Anne Marie Lardeau
Co-chair, L.A. Metro MDT

Organization Address:
3440 Troy Drive
Hollywood, CA 90068-1436

Web Address:
http://www.la4seniors.com

Phone: 323-876-4121
Fax: 323-876-4197
Email: MDT@la4seniors.com

AARP California

RECEIVED MAY 0 3 2004

April 30, 2004

Honorable Rebecca Cohn, Chair
Assembly Health Committee
State Capitol, Room 6005
Sacramento, California 95814

via Facsimile & Mail

Re: AB 2791 (Simitian) Support

Dear Assemblymember Cohn:

On behalf of the over 3 million members of AARP in California I am pleased to communicate our support for AB 2791.

We commend this legislation to expand the provisions of a private right of action for nursing home residents whose rights have been violated.

Health and Safety Code 1430(b) provides for the only remedy available for violation of residents' rights in California. Unfortunately, since this law was first enacted in 1982, fewer than five such actions have been filed. Although remedies available under this section include injunctive relief, an important remedy for violation of residents' rights the $500 limit on damages so reduces the likelihood of legal representation, any opportunity for relief is moot.

As a consequence, residents who are illegally evicted, denied phone calls or visitors or subjected to humiliation in any form, are denied any relief.

AARP strongly urges your support for AB 2791, which would help make enforcement of residents' rights more than just a symbolic gesture.

Thank you for your consideration. If you have any questions on our position or need more information, please contact, Lupe De La Cruz, Manager of Advocacy, at 916-556-3036.

Respectfully,

Helen Russ
California State President

cc: Assemblymemeber Simitian
Members Health Committee

980 9th Street, Suite 700 | Sacramento, CA 95814 | 916-446-2277 | 916-556-3000 fax
200 South Los Robles Avenue, Suite 400 | Pasadena, CA 91101 | 626-585-9500 | 626-583-8500 fax
James G. Parkel, President | William D. Novelli, Executive Director and CEO | www.aarp.org/ca

STATE OF CALIFORNIA
CALIFORNIA SENIOR LEGISLATURE
1600 K Street, 4th Floor, Sacramento, CA 95814
Phone (916) 322-5630 Fax (916) 327-1859

April 20, 2004

The Honorable S. Joseph Simitian
California State Assembly
State Capitol, Room 5119
Sacramento, California 95814

Dear Assembly Member Simitian:

Sponsor for AB 2791 (Simitian), as amended April 1, 2004

On behalf of the 120 members of the California Senior Legislature (CSL), representing 4 million seniors through effective legislative advocacy, I want to thank you for introducing AB 2791. This bill will expand the liability limit for nursing homes for violation of residents' rights from $ 500 to $ 5,000 and it will clarify that it applies to both current and former residents.

It has been two decades since the Health and Safety Code was amended to allow a private right of action for residents of nursing homes whose rights have been violated. Despite many cases of documented violations of residents' rights, the code has been ineffective due to the $ 500 award limit on these cases. The appropriateness of the penalty for a violation of a resident's rights should depend on the severity of the harm to the resident. AB 2791 seeks to make the awards reflect the severity of harm to the resident.

AB 2791 is a positive step in our efforts to protect California's senior population and to reduce the number of violations of residents' rights . We are committed to working with you to ensure the passage and signing of AB 2791. If you would like to discuss this bill with us, please contact Senior Assembly Members Donna Ambrogi at (909) 625-2558 or Helen Karr at (650) 992-5793 or by email: hehkarr@aol.com, or June P. Hamilton, Legislative Llaison, at (916) 322-5630 or by email: jhamil@ccoa.ca.gov.

Sincerely,

Edward Woods

Ed Woods, Chair
Joint Rules Committee (CSL)

jph.sb2791sponsor.ltr4.04

Sponsored by the California Commission on Aging and funded by the California Fund for Senior Citizens

CALIFORNIA
ASSOCIATION OF
HEALTH FACILITIES

CAHF

Supporting People, Health and Quality of Life

2201 K Street
P.O. Box 537004
Sacramento, CA
(95816) 95853-7004
fax (916) 441-6441
(916) 441-6400

1125 West Sixth Street
Suite 304
Los Angeles, CA
90017
fax (213) 627-6106
(213) 627-3000

P.O. Box 370
La Jolla, CA
92038
fax (760) 944-1049
(760) 944-1666

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RECEIVED APR 2 C 2004

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

The California Association of Health Facilities (CAHF), a non-profit professional organization representing a majority of the state's licensed long-term health care facilities, is opposed to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

"Resident's Rights" Are All Inclusive In Nursing Facilities

Resident's Rights have been substantially expanded by both state and federal law over the years. This is evident in current regulations, which have been broadly drafted in very general terms to cover every aspect of care. The "resident rights" category was designed to catch violations of a personal nature, which do not involve any resident harm, or even the potential thereof. Typical violations include not offering a preferred food alternative as a substitute for a specific menu item, resident privacy curtains left open, and caregivers not speaking in the resident's language while providing services. The Legislature never intended this section to be abused in the way it has under current practice by attorneys who dress up a complaint with alleged behavior that has artfully been plead to meet the technical definitions of a resident's right violation. AB 2791 would absolutely encourage more of this behavior given the increased penalty amount.

Available Remedies Against Facilities Are Not Limited To $500

In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief) for a resident's rights violation, a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder and Dependent Adult Civil Protection Act (EADACPA), which gives long-term care residents an additional private right of action and the ability to collect significant enhanced remedies (i.e., attorney's fees and costs, and a $250,000 pain and suffering award) for any harm suffered.

Administrative penalties are based on a direct relationship between the severity of the violation and actual or potential harm suffered by a resident. A lesser violation that does not actually cause (nor poses even a potential for) harm to the resident, but rather might cause disrespect or embarrassment is appropriately categorized as a resident's rights violation and is assigned a civil penalty of $500, plus litigation costs and attorneys fees. If the resident's rights violation leads to actual harm, the EADACPA statute confers enhanced remedies upon any resident who has suffered harm and is a strong catalyst for litigation. By increasing the value of a resident's rights violation from $500 to $5,000 per violation, AB 2791 only serves to encourage plaintiffs to add another cause of action to an EADACPA claim.

Ample Opportunity And Incentives Exist For Private Right of Action
The proponents of AB 2791 argue that this bill is necessary because it has been over twenty years since Health & Safety Code §1430 was enacted to allow a private right of action and it has allegedly been "completely ineffective because of the $500 limit on civil damages." When the Legislature enacted EADACPA in 1991, it encouraged another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Increased Penalties Are Inappropriate and Unwarranted
The last round of nursing home "reform" (AB 1731\Shelley\Statutes of 2000) enacted huge new fine levels against facilities for violations of statute that result in a class "AA" or "A" citation. The increased penalty included in AB 2791 was discussed and rejected as part of this reform. Under existing criteria, penalties are awarded for acts or omissions by the facility that range from causing death to having a loose relationship to the health, safety, or security of residents at the facility. Citations are issued without any differentiation between incidents involving an isolated, unintentional mistake on the part of a single employee and incidents involving an actual failure on the part of facility management. There is no reason, and especially no data, to suggest that additional fines will reduce the incidence of violations or increase quality. In fact, these fines and penalties reduce facility funds available for staffing and other critical resident care activities.

LTC Facilities And The State Budget Would Be Negatively Impacted
Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. In fact, the high cost of coverage triggered a $36 million Medi-Cal rate increase to cover the liability component of the rate in 2002; if this trend continues, the additional cost to Medi-Cal for liability coverage will soon be more than $100 million per year. With annual premiums approaching $200,000, many facilities have been forced to go without coverage altogether, others are declaring bankruptcy and some are closing. One million deductibles are common place and many facilities are one claim away from financial ruin. AB 2791 will make the overall situation worse without adding anything to improve resident care.

Long Term Care Facilities Are Already Heavily Regulated
As with many industries, long-term care providers are heavily regulated by both the state and federal governments. Nearly 300 state survey staff spend an average of 200 hours in each facility per year to identify areas of improvement and to examine facility compliance with hundreds of conditions of participation that allow that provider to remain in the Medicaid and Medicare system. Each facility must go through an annual survey, at which time the Department of Health Services (DHS) sends a team of surveyors (usually for a period of one week) to examine facility records, interview staff and residents, and to make observations to determine whether the facility is in compliance with the law. If the facility is found to have been out of compliance with any provision of the law, including resident rights, then DHS has the ability to seek remedies in the form of deficiencies, citations, fines, and/or directed plans of correction.

Moreover, if the state survey agency does not find any deficiencies during the annual survey process, the federal government automatically initiates its own "look-back" survey within ten (10), but not

later than thirty (30), working days following completion of the state survey. During this survey, the federal team is directed to cite all deficient practices and allegations of noncompliance that are found, regardless of whether the practice was previously cited by the state agency.

Facilities are also subject to "complaint surveys," which are in addition to the annual and comparative surveys. DHS must investigate any complaint that is called in, whether it be from the resident, the resident's family, the Ombudsman, or other source. During the complaint survey, if a violation is found, then DHS has the ability to again seek remedies in the form of deficiencies, citations, fines, and directed plans of correction.

Finally, facilities are also subject to unannounced reviews by the Attorney General's office and regular visits by the LTC Ombudsman. The AG's "Operation Guardian" surprise inspections, which are conducted by a multi-disciplinary team of investigative and clinical personnel, can result in criminal charges and/or referral for administrative action. The Ombudsman conducts its own complaint investigations and can also make referrals to administrative or law enforcement personnel.

If 20 years of continual increases in penalties and enforcement activities has not improved nursing home care in the minds of the sponsors of this bill, additional penalties will never be the answer. If there really is a concern over Resident's Rights, perhaps mandating that specific instruction on preventing Resident's Rights violations be included in the total minimum hours of continuing education or in-service training required for certified nurse assistants under Health & Safety Code §1337.1.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Nancy C. Armentrout
Director of Legislative Affairs

cc: Members of the Assembly Health Committee
Assembly Member Joseph Simitian
Teri Boughton, Consultant, Assembly Health Committee
Peter Anderson, Consultant, Assembly Republican Caucus

CALIFORNIA HEALTHCARE ASSOCIATION

Providing Leadership in Health Policy and Advocacy

RECEIVED APR 29 2004

April 28, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, California 95814

SUBJECT: AB 2791 (Simitian) – OPPOSE

Dear Assembly Member Cohn:

The California Healthcare Association (CHA), which represents California's 500 hospitals and health systems, many of which operate skilled nursing facilities opposes AB 2791 (Simitian), which would (1) increase the penalty for a residents' rights violation from $500 to $5,000 per violation, and (2) expand the residents' rights that serve as a basis for such penalty.

The residents' rights penalty was enacted to provide residents with a remedy when they have suffered an intangible harm of nominal value. In enacting the statute, the legislature recognized a balance between acknowledging these intangible harms and creating an incentive to sue. Increasing the penalty to $5,000, however, creates a substantial financial incentive to sue facilities and dramatically changes the purpose of this statutory provision.

CHA supports residents' rights. Enumeration of these rights in law makes it clear that public policy values the personal integrity and dignity of residents. It does not logically follow, however, that people should be able to obtain a monetary windfall by stringing together a series of alleged rights violations into a lawsuit. It is not difficult for a resident to claim that their rights have been violated; relatively minor behavior can be framed as a residents' rights violation.

The Elder and Dependent Adult Civil Protection Act; which provides nursing home residents with enhanced remedies (including attorneys' fees and cost and treble punitive damages); already creates a significant incentive to sue nursing homes. Additional incentive to sue is not necessary and will exacerbate the existing liability insurance coverage crisis that nursing homes are experiencing.

In addition to personal causes of action, the state has extensive enforcement authority over nursing homes, including oversight by the Department of Health Services in the form of annual and complaint surveys, the Ombudsman program in the form of spontaneous visitations, the Attorney General through "Operation Guardian" inspections and criminal prosecution. The federal Centers for Medicare and Medicaid also conducts "look back" surveys on nursing homes

1215 K Street, Suite 800, Sacramento, CA 95814 *Telephone:* 916-443-7401 *Facsimile:* 916-552-7596 *Website:* www.calhealth.org

with increasing frequency. These mechanisms provide extensive oversight of nursing home quality, including the respect of residents' rights.

For the above-stated reasons, CHA urges your "No" vote on AB 2791.

Sincerely,

Judy Citko
Vice President, Continuing Care Services

JJC:dlv

cc: Assembly Member Joseph Simitian
Members of the Assembly Health Committee
John Gilman, consultant, Assembly Health Committee
Peter Anderson, consultant, Assembly Republican Caucus

April 26, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol
Sacramento, CA 95814

RE: Opposition to AB 2791 (Simitian)

Dear Assembly Member Cohn:

I am writing to express our opposition to AB 2791 (Simitian), which raises the penalty for a resident's rights violation from $500 to $5,000 per violation.

Crestwood Behavioral Health, Inc. is a mental healthcare provider offering a continuum of services for people with psychiatric disabilities. Crestwood provides institutional and residential services to residents of 48 of California's 58 counties, operating programs in 18 facilities (including skilled nursing facilities) throughout the state.

AB 2791 would create yet another avenue for frivolous litigation by increasing the civil liability of a long-term care provider for resident's rights violations. A ten-fold increase in the amount of liability will only serve to increase lawsuits and does nothing to enhance or promote resident care and dignity.

Patient rights violations have nothing to do with quality of care issues and rarely place a patient in any jeopardy. AB 2791 will put more money in attorney's pockets and impose a greater financial burden on an already financially strapped long-term care system.

There doesn't appear to be a need for increased penalties other than to create greater incentive for attorney's to file lawsuits. The Department of Health Services conducts annual inspections of long-term care facilities and imposes fines for violation of regulations.

For these reasons, we strongly oppose AB 2791.

Sincerely,

Bob Macaluso
Director, Public Affairs

AARP California

RECEIVED APR 27 2004

April 26, 2004

Honorable Rebecca Cohn, Chair
Assembly Health Committee
State Capitol, Room 6005
Sacramento, California 95814

via Facsimile & Mail

Re: AB 2791 (Simitian) Support

Dear Assemblymember Cohn:

On behalf of the over 3 million members of AARP in California I am pleased to communicate our support for AB 2791.

We commend this legislation to expand the provisions of a private right of action for nursing home residents whose rights have been violated.

Health and Safety Code 1430(b) provides for the only remedy available for violation of residents' rights in California. Unfortunately, since this law was first enacted in 1982, fewer than five such actions have been filed. Although remedies available under this section include injunctive relief, an important remedy for violation of residents' rights the $500 limit on damages so reduces the likelihood of legal representation, any opportunity for relief is moot.

As a consequence, residents who are illegally evicted, denied phone calls or visitors or subjected to humiliation in any form, are denied any relief.

AARP strongly urges your support for AB 2791, which would help make enforcement of residents' rights more than just a symbolic gesture.

Thank you for your consideration. If you have any questions on our position or need more information, please contact, Lupe De La Cruz, Manager of Advocacy, at 916-556-3036.

Respectfully,

Helen Russ
California State President

cc: Assemblymemeber Simitian
Assembly Committee on Aging & LTC

980 9th Street, Suite 700 | Sacramento, CA 95814 | 916-446-2277 | 916-556-3000 fax
200 South Los Robles Avenue, Suite 400 | Pasadena, CA 91101 | 626-585-9500 | 626-583-8500 fax
James G. Parkel, President | William D. Novelli, Executive Director and CEO | www.aarp.org/ca

APR 29 2004

California Association of Homes and Services for the Aging

1315 I Street, Ste. 100 • Sacramento, CA 95814
916-392-5111 • Fax 916-428-4250 • www.aging.org

April 27, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, CA 95814

Re: AB 2791 (Simitian) OPPOSE

Dear Chairwoman Cohn:

The California Association of Homes and Services for the Aging (CAHSA) represents non-profit, community-based providers of affordable housing, assisted living (Residential Care Facilities for the Elderly (RCFEs)), Skilled Nursing, and Continuing Care Retirement Communities (CCRCs). I am writing to state CAHSA's opposition to AB 2791 (Simitian).

AB 2791 increases existing penalties for Patients' Rights violations ten fold. The rights described in Title 22 of the Code of Regulations, referenced in the bill, pertain to issues of process, residents' pride, privacy, and dignity. These are important rights, but they were never intended to be subject to a five thousand dollar fine, plus costs and attorney fees. Violations of Patients' Rights do not result in harm to the patient. The existing penalty recognizes the nature of such violations and penalizes violators accordingly. A ten-fold increase in the penalty is gratuitously punitive with no reasonable basis in public policy.

Moreover, California law already provides substantial incentives for aggrieved patients to seek redress. The Elderly and Dependant Adult Civil Protection Act (EADACPA) provides for attorney fees, costs, and punitive damages. In contrast to traditional tort remedies in California, EADACPA even allows causes of action to survive the death of the patient. The overly punitive penalty proposed by AB 2791 only serves to make unnecessary litigation more probable.

CAHSA urges a no vote on AB 2791.

Sincerely,

Jack E. Christy
Director of Public Policy

cc: The Honorable Joseph Simitian

Proposed Amendments to AB 2791 (Simitian)

On Page 2, lines 2-3, add a new Section 1, as follows:

SECTION 1. Section 1337.1 of the Health and Safety Code is amended to read:

.....

.....

(e) (1) The approved training program shall include, within the 60 hours of classroom training, a minimum of six hours of instruction on preventing, recognizing, and reporting instances of resident abuse utilizing those courses developed pursuant to Section 13823.93 of the Penal Code, and a minimum of one hour of instruction on preventing, recognizing and reporting resident=s rights violations.

(2) A minimum of four hours of instruction on preventing, recognizing, and reporting instances of resident abuse, including instruction on preventing, recognizing and reporting resident=s rights violations shall be included within the total minimum hours of continuing education or in-service training required and in effect for certified nursing assistants.

On Page 2, line 2, add a new Section 2, as follows:

SECTION 2. Section 1430 of the Health and Safety Code is amended to read:

On Page 2, lines 28-29, convert language back to current law:

liable for the acts of the licensee=s employees. The licensee shall be liable for up to five hundred ~~thousand~~ dollars ($500) ~~($5,000)~~,

CALIFORNIA HEALTHCARE ASSOCIATION

Providing Leadership in Health Policy and Advocacy

April 28, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, California 95814

SUBJECT: AB 2791 (Simitian) – OPPOSE

Dear Assembly Member Cohn:

The California Healthcare Association (CHA), which represents California's 500 hospitals and health systems, many of which operate skilled nursing facilities opposes AB 2791 (Simitian), which would (1) increase the penalty for a residents' rights violation from $500 to $5,000 per violation, and (2) expand the residents' rights that serve as a basis for such penalty.

The residents' rights penalty was enacted to provide residents with a remedy when they have suffered an intangible harm of nominal value. In enacting the statute, the legislature recognized a balance between acknowledging these intangible harms and creating an incentive to sue. Increasing the penalty to $5,000, however, creates a substantial financial incentive to sue facilities and dramatically changes the purpose of this statutory provision.

CHA supports residents' rights. Enumeration of these rights in law makes it clear that public policy values the personal integrity and dignity of residents. It does not logically follow, however, that people should be able to obtain a monetary windfall by stringing together a series of alleged rights violations into a lawsuit. It is not difficult for a resident to claim that their rights have been violated; relatively minor behavior can be framed as a residents' rights violation.

The Elder and Dependent Adult Civil Protection Act; which provides nursing home residents with enhanced remedies (including attorneys' fees and cost and treble punitive damages); already creates a significant incentive to sue nursing homes. Additional incentive to sue is not necessary and will exacerbate the existing liability insurance coverage crisis that nursing homes are experiencing.

In addition to personal causes of action, the state has extensive enforcement authority over nursing homes, including oversight by the Department of Health Services in the form of annual and complaint surveys, the Ombudsman program in the form of spontaneous visitations, the Attorney General through "Operation Guardian" inspections and criminal prosecution. The federal Centers for Medicare and Medicaid also conducts "look back" surveys on nursing homes

1215 K Street, Suite 800, Sacramento, CA 95814 *Telephone:* 916-443-7401 *Facsimile:* 916-552-7596 *Website:* www.calhealth.org

Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Healthcare Association of San Diego and Imperial Counties

with increasing frequency. These mechanisms provide extensive oversight of nursing home quality, including the respect of residents' rights.

For the above-stated reasons, CHA urges your "No" vote on AB 2791.

Sincerely,

Judy Citko
Vice President, Continuing Care Services

JJC:dlv

cc: Assembly Member Joseph Simitian
Members of the Assembly Health Committee
John Gilman, consultant, Assembly Health Committee
Peter Anderson, consultant, Assembly Republican Caucus

CONSUMER ATTORNEYS OF CALIFORNIA

April 20, 2004

The Honorable Joe Simitian
5119 State Capitol
Sacramento, CA 95814

RE: AB 2791 (Simitian) SUPPORT

Dear Assembly Member Simitian:

The Consumer Attorneys of California, as a member of the Protect Our Parents coalition, support AB 2791 (Simitian), which is scheduled to be heard before the Assembly Health Committee on April 27, 2004.

AB 2791 increases the fines for a licensee's violation of the rights of a resident or patient (as detailed in the Patients Bill of Rights) from $500 to $5,000.

Elder abuse in California is a serious problem. In California, a recent report found that more than 40% of the state's 1,352 nursing homes were cited for abuse. In Los Angeles County, 37% of the homes were cited.

Further, a 2003 GAO report found that "despite federal and state oversight infrastructure currently in place, certain California nursing homes have not been and currently are not sufficiently monitored to guarantee the safety and welfare of their residents."

If you or a member of your staff would like to discuss this further, please contact me or one of our legislative representatives in Sacramento.

Sincerely,

James C. Sturdevant
President

Sharon Arkin
President-Elect

cc: Assembly Health Committee

LEGISLATIVE DEPARTMENT
770 L Street, Suite 1200, Sacramento, CA 95814-2721 • (916) 442-6902 • FAX (916) 442-7734
info@caoc.org • http://www.caoc.com

AFSCME®
in the public service

April 21, 2004

RECEIVED APR 2 1 2004

TO: Assembly Member Cohn, Chair
and Members of the Assembly Committee on Health

RE: Assembly Bill 2791 (Berg) - Support

The American Federation of State, County and Municipal Employees (AFSCME), AFL-CIO, would like to inform you of our **support** of Assembly Bill 2791, as amended.

Current law authorizes a resident or patient of a skilled nursing facility or intermediate care facility to bring a civil action against the licensee of a facility that violates any rights of the resident or patient as set forth in the Patients Bill of Rights. Existing law provides that the licensee is liable for up to $500, and for costs and attorney fees, and may be enjoined from permitting the violation to continue.

AFSCME supports this bill, which would increase the licensee's liability to $5,000 because we feel that the increase in penalties for a civil suit will make facilities put more effort into not being negligent. Therefore, we ask that you vote **Yes on AB 2791.**

Should you have any questions regarding our position on this matter you may contact me at your earliest convenience. AFSCME also reserves the right to change its position in the event of further amendments.

Sincerely,

Willie L. Pelote, Sr.
Political & Legislative Director, California

cc: committee consultant(s)
WLP/jga

1121 L Street • Suite 904 • Sacramento, California 95814-3926 • (916) 441-1570 • (916) 441-3426 FAX

National Senior Citizens Law Center

3435 Wilshire Boulevard, Suite 2860 • Los Angeles, CA 90010 • Tel: (213) 639-0930 • Fax: (213) 639-0934
www.nsclc.org
Writer's email: ecarlson@nsclc.org
Writer's extension: 313

Edward C. King
Executive Director

Gerald A. McIntyre
Directing Attorney

April 21, 2004

Hon. Joseph Simitian
State Capitol
Sacramento, California 95814

Re: Support for AB 2791 (Simitian);
Protection of Rights of Nursing Home Residents

Dear Assemblymember Simitian:

We are pleased to support your Assembly Bill 2791, which takes an important step in protecting the rights of nursing home residents.

For almost 30 years, the National Senior Citizens Law Center has worked to protect the rights of elder Americans in relation to Social Security, Medicare, Medicaid, nursing homes, and other areas. I have worked full-time in protecting the rights of nursing facility residents (and residential care facility residents) since 1989, first in a Los Angeles legal services program and then, since 2001, with the National Senior Citizens Law Center. I am well aware of the difficulties faced by residents and their family members

Although federal and state law is reasonably good in establishing rights, too often enforcement of those rights is negligible or nonexistent. There are good and bad nursing homes, and the bad nursing homes will violate the law based on a cynical calculus that poor care is cheaper (and thus more profitable) than compliance with law.

By raising the cap on actual damages from $500 to $5,000, for a violation of a resident's rights, AB 2791 will help to compel compliance with law. There is no good reason why under current law a nursing facility can cause damages of $4,000 (for example), and have its liability for a proven resident's rights violation capped at $500.

Sincerely,

Eric M. Carlson, Esq.

1101 14th Street NW, Suite 400 • Washington, DC 20005 • Tel: (202) 289-6976 • Fax: (202) 289-7224

Being Alive

People with HIV/AIDS Action Coalition

April 26, 2005 04/22/04

The Honorable Patty Berg
State Capitol
PO Box 942849
Sacramento, CA 92429-0001

Via Fax: (916) 319-2101

Re: Assembly Bill No. 2791 – Support

Dear Assembly Member Berg:

On behalf of Being Alive Los Angeles, Inc., an organization of, by, and for people living with HIV and AIDS in Los Angeles County, I am writing to express our support for AB 2791. We believe AB 2791 is sound and reasonable public health policy because:

- AB 2791 would re-codify a list of comprehensive Medi-Cal benefits including those for people living with AIDS.
- AB 2791 removes barriers to accessing healthcare for people living with AIDS by ensuring Medi-CAL services legislatively mandated
- AB 2791 recognizes that Medi-CAL is the largest provider of healthcare services for people living with AIDS in California and these services are necessary to keep people healthy and as well as productive residents of the state of California.

Thank you for your consideration. You should be aware that this letter has been prepared by a volunteer and has not been financed out of the governmental and other charitable funding that Being Alive receives.

If you have any questions about this letter, please do not hesitate to contact me at (323) 650-1979

Very truly yours,

Howard Jacobs

Howard R. Jacobs
President, Being Alive, Los Angeles

CC: The Honorable Rebecca Cohn via Fax:(916) 319-2124
The Honorable Judy Chu via Fax: (916) 319-2149

at the Ron Stone Center
621 N. San Vicente Boulevard
West Hollywood, CA 90069
(310) 289-2551 Phone
(310) 289-9866 Fax
beialive@aol.com
Web Site: http://www.beingalivela.org/

California Advocates for Nursing Home Reform

415-974-5171 • 800-474-1116 • Fax 415-777-2904 • www.canhr.org • info@canhr.org
650 Harrison Street, 2nd Floor • San Francisco, California 94107

April 20, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, CA 95814

RE: AB 2791(Simitian) - Support

Dear Assemblymember Cohn:

On behalf of California Advocates for Nursing Home Reform, I would like to express our support for AB 2791 (Simitian), which would expand the provisions of a private right of action for nursing home residents whose rights have been violated.

Health and Safety Code §1430(b) provides for the only remedy available for violation of residents' rights in California. Unfortunately, since this law was first enacted in 1982, fewer than five such actions have been filed. Although remedies available under this section include injunctive relief - an important remedy for violation of residents' rights - the $500 limit on damages so reduces the likelihood of legal representation, any opportunity for relief is moot.

Thus, residents who are illegally evicted, denied phone calls or visitors or subjected to humiliation by being paraded naked through a facility, are denied any relief.

I strongly urge your support of AB 2791, which would help make enforcement of residents' rights more than just words.

Sincerely,

Patricia L. McGinnis
Executive Director

cc: Assemblyman Joseph Simitian

National Senior Citizens Law Center
3435 Wilshire Boulevard, Suite 2860 • Los Angeles, CA 90010 • Tel: (213) 639-0930 • Fax: (213) 639-0934
www.nsclc.org
Writer's email: ecarlson@nsclc.org
Writer's extension: 313

Edward C. King
Executive Director

Gerald A. McIntyre
Directing Attorney

April 21, 2004

Hon. Joseph Simitian
State Capitol
Sacramento, California 95814

Re: Support for AB 2791 (Simitian);
Protection of Rights of Nursing Home Residents

Dear Assemblymember Simitian:

We are pleased to support your Assembly Bill 2791, which takes an important step in protecting the rights of nursing home residents.

For almost 30 years, the National Senior Citizens Law Center has worked to protect the rights of elder Americans in relation to Social Security, Medicare, Medicaid, nursing homes, and other areas. I have worked full-time in protecting the rights of nursing facility residents (and residential care facility residents) since 1989, first in a Los Angeles legal services program and then, since 2001, with the National Senior Citizens Law Center. I am well aware of the difficulties faced by residents and their family members

Although federal and state law is reasonably good in establishing rights, too often enforcement of those rights is negligible or nonexistent. There are good and bad nursing homes, and the bad nursing homes will violate the law based on a cynical calculus that poor care is cheaper (and thus more profitable) than compliance with law.

By raising the cap on actual damages from $500 to $5,000, for a violation of a resident's rights, AB 2791 will help to compel compliance with law. There is no good reason why under current law a nursing facility can cause damages of $4,000 (for example), and have its liability for a proven resident's rights violation capped at $500.

Sincerely,

Eric M. Carlson, Esq.

CONSUMER ATTORNEYS OF CALIFORNIA

April 20, 2004

The Honorable Joe Simitian
5119 State Capitol
Sacramento, CA 95814

RE: AB 2791 (Simitian) SUPPORT

Dear Assembly Member Simitian:

The Consumer Attorneys of California, as a member of the Protect Our Parents coalition, support AB 2791 (Simitian), which is scheduled to be heard before the Assembly Health Committee on April 27, 2004.

AB 2791 increases the fines for a licensee's violation of the rights of a resident or patient (as detailed in the Patients Bill of Rights) from $500 to $5,000.

Elder abuse in California is a serious problem. In California, a recent report found that more than 40% of the state's 1,352 nursing homes were cited for abuse. In Los Angeles County, 37% of the homes were cited.

Further, a 2003 GAO report found that "despite federal and state oversight infrastructure currently in place, certain California nursing homes have not been and currently are not sufficiently monitored to guarantee the safety and welfare of their residents."

If you or a member of your staff would like to discuss this further, please contact me or one of our legislative representatives in Sacramento.

Sincerely,

James C. Sturdevant
President

Sharon Arkin
President-Elect

cc: Assembly Health Committee

LEGISLATIVE DEPARTMENT
770 L Street, Suite 1200, Sacramento, CA 95814-2721 • (916) 442-6902 • FAX (916) 442-7734
info@caoc.org • http://www.caoc.com

STATE OF CALIFORNIA
CALIFORNIA SENIOR LEGISLATURE
1600 K Street, 4th Floor, Sacramento, CA 95814
Phone (916) 322-5630 Fax (916) 327-1859

April 20, 2004

The Honorable S. Joseph Simitian
California State Assembly
State Capitol, Room 5119
Sacramento, California 95814

Dear Assembly Member Simitian:

Sponsor for AB 2791 (Simitian), as amended April 1, 2004

On behalf of the 120 members of the California Senior Legislature (CSL), representing 4 million seniors through effective legislative advocacy, I want to thank you for introducing AB 2791. This bill will expand the liability limit for nursing homes for violation of residents' rights from $ 500 to $ 5,000 and it will clarify that it applies to both current and former residents.

It has been two decades since the Health and Safety Code was amended to allow a private right of action for residents of nursing homes whose rights have been violated. Despite many cases of documented violations of residents' rights, the code has been ineffective due to the $ 500 award limit on these cases. The appropriateness of the penalty for a violation of a resident's rights should depend on the severity of the harm to the resident. AB 2791 seeks to make the awards reflect the severity of harm to the resident.

AB 2791 is a positive step in our efforts to protect California's senior population and to reduce the number of violations of residents' rights . We are committed to working with you to ensure the passage and signing of AB 2791. If you would like to discuss this bill with us, please contact Senior Assembly Members Donna Ambrogi at (909) 625-2558 or Helen Karr at (650) 992-5793 or by email: hehkarr@aol.com, or June P. Hamilton, Legislative Liaison, at (916) 322-5630 or by email: jhamil@ccoa.ca.gov.

Sincerely,

Edward Woods

Ed Woods, Chair
Joint Rules Committee (CSL)

Sponsored by the California Commission on Aging and funded by the California Fund for Senior Citizens

jph.ab2791sponsor.ltr4.04

CALIFORNIA
ASSOCIATION OF
HEALTH FACILITIES

CAHF

Supporting People, Health and Quality of Life

2201 K Street
P.O. Box 537004
Sacramento, CA
(95816) 95853-7004
fax (916) 441-6441
(916) 441-6400

1125 West Sixth Street
Suite 304
Los Angeles, CA
90017
fax (213) 627-6106
(213) 627-3000

P.O. Box 370
La Jolla, CA
92038
fax (760) 944-1049
(760) 944-1666

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

The California Association of Health Facilities (CAHF), a non-profit professional organization representing a majority of the state's licensed long-term health care facilities, is opposed to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

"Resident's Rights" Are All Inclusive In Nursing Facilities

Resident's Rights have been substantially expanded by both state and federal law over the years. This is evident in current regulations, which have been broadly drafted in very general terms to cover every aspect of care. The "resident rights" category was designed to catch violations of a personal nature, which do not involve any resident harm, or even the potential thereof. Typical violations include not offering a preferred food alternative as a substitute for a specific menu item, resident privacy curtains left open, and caregivers not speaking in the resident's language while providing services. The Legislature never intended this section to be abused in the way it has under current practice by attorneys who dress up a complaint with alleged behavior that has artfully been plead to meet the technical definitions of a resident's right violation. AB 2791 would absolutely encourage more of this behavior given the increased penalty amount.

Available Remedies Against Facilities Are Not Limited To $500

In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief) for a resident's rights violation, a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder and Dependent Adult Civil Protection Act (EADACPA), which gives long-term care residents an additional private right of action and the ability to collect significant enhanced remedies (i.e., attorney's fees and costs, and a $250,000 pain and suffering award) for any harm suffered.

Administrative penalties are based on a direct relationship between the severity of the violation and actual or potential harm suffered by a resident. A lesser violation that does not actually cause (nor poses even a potential for) harm to the resident, but rather might cause disrespect or embarrassment is appropriately categorized as a resident's rights violation and is assigned a civil penalty of $500, plus litigation costs and attorneys fees. If the resident's rights violation leads to actual harm, the EADACPA statute confers enhanced remedies upon any resident who has suffered harm and is a strong catalyst for litigation. By increasing the value of a resident's rights violation from $500 to $5,000 per violation, AB 2791 only serves to encourage plaintiffs to add another cause of action to an EADACPA claim.

Ample Opportunity And Incentives Exist For Private Right of Action
The proponents of AB 2791 argue that this bill is necessary because it has been over twenty years since Health & Safety Code §1430 was enacted to allow a private right of action and it has allegedly been "completely ineffective because of the $500 limit on civil damages." When the Legislature enacted EADACPA in 1991, it encouraged another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Increased Penalties Are Inappropriate and Unwarranted
The last round of nursing home "reform" (AB 1731\Shelley\Statutes of2000) enacted huge new fine levels against facilities for violations of statute that result in a class "AA" or "A" citation. The increased penalty included in AB 2791 was discussed and rejected as part of this reform. Under existing criteria, penalties are awarded for acts or omissions by the facility that range from causing death to having a loose relationship to the health, safety, or security of residents at the facility. Citations are issued without any differentiation between incidents involving an isolated, unintentional mistake on the part of a single employee and incidents involving an actual failure on the part of facility management. There is no reason, and especially no data, to suggest that additional fines will reduce the incidence of violations or increase quality. In fact, these fines and penalties reduce facility funds available for staffing and other critical resident care activities.

LTC Facilities And The State Budget Would Be Negatively Impacted
Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. In fact, the high cost of coverage triggered a $36 million Medi-Cal rate increase to cover the liability component of the rate in 2002; if this trend continues, the additional cost to Medi-Cal for liability coverage will soon be more than $100 million per year. With annual premiums approaching $200,000, many facilities have been forced to go without coverage altogether, others are declaring bankruptcy and some are closing. One million deductibles are common place and many facilities are one claim away from financial ruin. AB 2791 will make the overall situation worse without adding anything to improve resident care.

Long Term Care Facilities Are Already Heavily Regulated
As with many industries, long-term care providers are heavily regulated by both the state and federal governments. Nearly 300 state survey staff spend an average of 200 hours in each facility per year to identify areas of improvement and to examine facility compliance with hundreds of conditions of participation that allow that provider to remain in the Medicaid and Medicare system. Each facility must go through an annual survey, at which time the Department of Health Services (DHS) sends a team of surveyors (usually for a period of one week) to examine facility records, interview staff and residents, and to make observations to determine whether the facility is in compliance with the law. If the facility is found to have been out of compliance with any provision of the law, including resident rights, then DHS has the ability to seek remedies in the form of deficiencies, citations, fines, and/or directed plans of correction.

Moreover, if the state survey agency does not find any deficiencies during the annual survey process, the federal government automatically initiates its own "look-back" survey within ten (10), but not

later than thirty (30), working days following completion of the state survey. During this survey, the federal team is directed to cite all deficient practices and allegations of noncompliance that are found, regardless of whether the practice was previously cited by the state agency.

Facilities are also subject to "complaint surveys," which are in addition to the annual and comparative surveys. DHS must investigate any complaint that is called in, whether it be from the resident, the resident's family, the Ombudsman, or other source. During the complaint survey, if a violation is found, then DHS has the ability to again seek remedies in the form of deficiencies, citations, fines, and directed plans of correction.

Finally, facilities are also subject to unannounced reviews by the Attorney General's office and regular visits by the LTC Ombudsman. The AG's "Operation Guardian" surprise inspections, which are conducted by a multi-disciplinary team of investigative and clinical personnel, can result in criminal charges and/or referral for administrative action. The Ombudsman conducts its own complaint investigations and can also make referrals to administrative or law enforcement personnel.

If 20 years of continual increases in penalties and enforcement activities has not improved nursing home care in the minds of the sponsors of this bill, additional penalties will never be the answer. If there really is a concern over Resident's Rights, perhaps mandating that specific instruction on preventing Resident's Rights violations be included in the total minimum hours of continuing education or in-service training required for certified nurse assistants under Health & Safety Code §1337.1.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Nancy C. Armentrout
Director of Legislative Affairs

cc: Members of the Assembly Health Committee
Assembly Member Joseph Simitian
Teri Boughton, Consultant, Assembly Health Committee
Peter Anderson, Consultant, Assembly Republican Caucus

BILL ANALYSIS BACKGROUND INFORMATION WORKSHEET

BILL NUMBER: **AB 2791** AUTHOR: **Simitian**

*Please return a total of **FIVE COPIES** of the completed worksheet, including position letters.*

The above bill has been referred to the Assembly Health Committee. Please bring the following information to the Committee, **Room 6005** of the State Capitol. Please **type your comments** on this form or on attachments. The **information and amendments** must be submitted at least **seven days** before the bill is to be heard at the Committee's hearing. **We require the original amendments plus nine copies.** The Chair may **withdraw** the bill from its scheduled hearing if the worksheet and/or the amendments are not received within the specified timeline. The bill "set" that is put over for this reason will count against the author's limit of three sets. Please call the Committee Secretary at **319-2097** if you have any questions.

1. What does your bill do?

AB 2791 expands the currently liability limit for nursing homes for violation of residents' rights from $500 to $5,000. It clarifies that former residents also have a right of private action under H&S 1430(b), and expands the scope of rights to include other rights in state and federal law and regulation in addition to those enumerated in the Patients Bill of Rights.

2. Describe the deficiency in existing law in this area (include code citations).

Existing law, Section 1430 (B) of Health and Safety Code, allows a resident or patient of a skilled nursing facility to bring a civil action against the licensee of a facility who violates any rights set forth in the Patients Bill of Rights in Section 72527 of Title 22 of the California Code of Regulations. The law allows for an award of $500 maximum in civil damages plus cost and attorney's fees.

The current maximum damage award is insufficient to attract attorneys to take these cases. Existing law is also silent on whether former residents have this right. Additionally, many other resident rights have been added to state and federal law and regulation since the Patients Bill of Rights was updated.

3. Why is this bill needed? Please be specific and present significant facts, research studies, and pertinent background. Please provide any relevant background materials supporting the need for the bill. Attach copies of all Assembly (if there are multiple committee referrals) and Senate analyses (policy, fiscal and floor).

Since 1430(B) went into effect nearly two decades ago, virtually no stand-alone residents' rights suits have been filed. An estimate by the California Advocates for Nursing Home Reform (CANHR) puts the number of stand-alone 1430(b) suits at five in the last two decades. Despite the numerous citations and deficiencies reported by the Department of Health Services every year [CANHR report attached cites at least 25,000 deficiencies and 700 citations annually according to DHS/Licensing and Certification Program, Automated Certification and Licensing Administrative Information and Management Systems], and the many thousands of complaints received by the Ombudsman that are not successfully resolved, residents have not exercised their private right of action.

Following the enactment of the Patients Bill of Rights in 1979, Senator Nicholas Petris introduced SB 1930 in 1982 to ensure that nursing homes and intermediate care facilities respect the fundamental rights of their residents. With the passage of SB 1930, H&S 1430(b) provided for a specific mechanism for an individual resident to enforce his or her rights through private right of action.

The intent of the bill, however, remains unfulfilled for a variety of reasons. 1) Current residents may fear reprisal if they sue the nursing home or intermediate care facility. Because every aspect of a resident's daily life is controlled by the home or facility, there is little incentive to go forward with a suit while remaining under a violator's care. 2) Residents' rights cases can be complicated; attorneys will not take cases that involve many hours of work, if the time spent on the case greatly exceeds the maximum damage award of $500. Additionally, the damage award may not reflect the extent of the violation.

Though opponents of this bill suggest that private right of action is already available and much used with the enactment of WIC 15657, the high burden of proof—clear and convincing—for the underlying offense, liability, as well as bad faith, recklessness, oppression or malice make it so that only the most egregious cases of neglect and abuse go forward. H&S 1430(b) is meant to address less egregious violations, but ones that are still fundamental to a resident's daily life.

The elderly population is increasing. According to the U.S. Census Bureau, the 65+ age group in California will double by the year 2020 to over 7 million. The State is facing severe cost pressures which are unlikely to be relieved in the near future. In the context of these trends, functions such as licensing and certification of health facilities may suffer. It becomes more important than ever to fulfill the intent of the Legislature in ensuring that residents' rights be respected and that the enforcement mechanism work.

BACKGROUND WORKSHEET
PAGE 2

4. **What state agencies does this bill affect? (NOTE: The Chair has asked that departments, agencies, boards, etc. affected by proposed legislation provide testimony on bills that affect their program areas.)**

None.

5. **Has a similar bill been introduced either this session or during a previous legislative session? _____ If yes, please identify the bill, the legislative session, and its disposition, and include all bill analyses related to it.**

AB 2696, 1990. The bill increases the civil penalty from $500 to $10,000, which a resident or patient of specified care facility may seek for violation of his her rights as set forth in the Patients' Bill of Rights and prohibits a party from seeking the civil penalty until attempting to resolve the dispute directly with the facility. Held in Senate Rules Committee.

AB 1160, 1999. Omnibus Bill affecting long-term health facilities. Among other things, this bill would authorize civil action for violations of any rights of the resident or patient as set forth in the Patients Bill of Rights under state and federal law and would increase the maximum liability to $25,000. Amended out of bill.

6. **Has there been an interim hearing or report on the bill or on this topic? If yes, please provide the hearing transcript and/or the report.**

No.

7. **Please provide the Committee with a total of 5 copies of all letters of <u>support and opposition</u> received for bill. Support and opposition letters must be received by the committee no later than 12:00 noon on the Wednesday prior to a Tuesday hearing to be assured reference in the committee analysis.**

8. **Do you plan to <u>amend</u> this bill prior to the hearing? YES ____ NO __x__**

If yes, briefly explain the substance of the amendments and attach a copy of the proposed language. Legislative Counsel amendments must be received by Tuesday, 7 days prior to the hearing. Please hand deliver the signed original amendment(s) plus 9 copies (unsigned) to the Committee Secretary.

NOTE: If the deadline for submitting amendments is not met by the author, the bill may be put over by the Chair. The bill "set" that is put over for this reason will count against the author's limit of 3 sets.

9. Please list the witnesses you plan to have testify.

To be determined.

10. Does this bill have a sponsor? yes If yes, please provide the sponsor's name and phone number.

California Senior Legislature

June Hamilton, 916-322-5630
Donna Ambrogi, (909) 625-2558, dlambrogi@verizon.net

11. Please provide the name and phone number of your legislative staff contact for this bill.

Lark Park, 319-2021

*Please return a total of **FIVE COPIES** of the completed worksheet, including position letters.*

Date of Hearing: June 20, 1990

ASSEMBLY COMMITTEE ON JUDICIARY
Phillip Isenberg, Chair

AB 2696 (Friedman) - As Amended: June 13, 1990

SUBJECT: This bill increases the civil penalty from $500 to $10,000, which a resident or patient of specified care facility may seek for violation of his or her rights as set forth in the Patients' Bill of Rights and prohibits a party from seeking the civil penalty until attempting to resolve the dispute directly with the facility.

BACKGROUND

Facts. The sponsor has not supplied data regarding the number and types of violations under current law or the number of patients discouraged from exercising their "right of private action" against the licensee.

DIGEST

Existing law:

1) Permits a resident or patient of a skilled nursing facility or intermediate care facility to bring a civil action against the licensee of the facility who violates any rights of the resident or patient provided in the Patients' Bill of Rights. The licensee is liable for up to $500 in damages, for attorneys fees and costs, and may be subject to an injunction.

2) Provides that a licensee who commits certain classes of licensing law violations, except for those violations where the state has taken action and the violations have been satisfactorily corrected, also may be subject to an action for injunction relief and civil damages. Such suit may be brought by the Attorney General or by any person acting for the interests of itself, its members or the general public. The amount of civil damages shall not exceed the maximum amount of civil penalties which could be assessed on account of the violations.

3) Specifies that (1) and (2) above are in addition to any other remedy provided by law.

4) Prohibits waiver of the right to sue under (1) above by the resident or patient.

5) Sets forth various other civil and criminal penalties for violation of rules, regulations, and any laws by these facilities.

- continued -

This bill revises (1) above to:

1) Prohibit an action for civil penalty:

   a) Until the patient or patient's representative has complained to the facility administrator, in writing, of the rights violation within 60 days of discovery of the violation; and,

   b) Until the facility administrator, within 30 days of receipt, has investigated the complaint, notified the licensee of the complaint, and presented the patient or the patient's representative with a written response, which may include a plan of corrective action, compensation for the violation, or other action; and,

   c) Unless the facility fails to respond in writing within 30 days or the patient or the patient's representative believes that such written response fails to adequately remedy the rights violation.

2) Clarify that the civil action, for violation of the Patients' Bill of Rights, may also be brought by a guardian or conservator of the resident or patient, and to provide a one year statute of limitations from the date of the alleged violation.

3) Delete the $500 limitation on damages, and instead to provide that the licensee shall be liable for a civil penalty of up to $10,000, payable to the patient, the amount to be commensurate with the rights violated.

4) Set forth some of the considerations the court is to use in assessing whether to impose a civil penalty or the amount of the civil penalty:

   a) The nature and severity of the rights violation.

   b) The patient's medical condition and his or her history of medical disability.

   c) Good faith efforts exercised by the facility to prevent the violation from occurring.

   d) The licensee's history of compliance the the patients' rights;

   e) Whether the plaintiff or the defendant made a good faith effort to resolve the dispute before resorting to litigation.

5) Provides that the written complaints and responses pursuant to (1) above (the informal resolution process) are discoverable.

6) Prohibits the court from considering the facility administrator's written response to the alleged violation as an admission of guilt.

- continued -

FISCAL EFFECT

This bill may increase the cost of operating these facilities, due to the cost of defending more lawsuits and the payment of larger damages. This bill will not be referred to the Assembly Committee on Ways and Means.

COMMENTS

1) Author's Statement. According to the author, the sponsor is the Bay Area Advocates for Nursing Home Reform (BAANHR). The author states:

> Current law allows patients to bring civil actions against any facility which violates their rights as specified in the Nursing Home Patients' Bill of Rights. There is a $500 cap, however, on the civil penalty which can be awarded in such cases. This $500 penalty is an arbitrary amount which bears no relation to the severity of the rights violation. The presence of the cap trivializes the fundamental prerogatives contained in the Bill of Rights and discourages patients whose rights have been violated from exercising their right of private action.
>
> There have only been two instances of action against a facility for violation of patients' rights since this provision was enacted in 1982. Despite a provision in the law which allows for attorneys fees, attorneys are reluctant to advise frail elderly clients to pursue cases where the maximum award is $500. As a result, substantial rights' violations go unaddressed. One attorney told of refusing a case where in an effort to motivate an elderly man in his bowel training, a particular facility would announce any "accidents" the patient had over the public address system to the entire facility. Clearly the deliberate humiliation of a patient is a rights' violation which warrants more than a $500 'slap on the wrist.'
>
> The intent of the bill is to increase the utility of this law and to provide a meaningful incentive for facilities to avoid patients rights' violations.

2) Proponents. According to proponents, the current penalty amount is so minor that potential plaintiffs are deterred from filing actions, and it is not in keeping with the severity of many patients' rights violations. Further, they state that this bill will provide patients with significantly enhanced abilities to redress their grievances.

3) Opponents.

a) The California Association of Homes for the Aging raises the concern that this bill permits liability up to $10,000 for "unintentional" violation of the Patients' Bill of Rights.

- continued -

b) The California Association of Health Facilities asserts that the bill will not improve the quality of patient care, but will instead encourage questionable lawsuits, deflect vital resources away from patient care, and discourage high quality health care professionals from entering the field of long term care. It further opposes this bill because:

i) The amount of civil penalties which may be recovered by a patient could greatly exceed the maximum amount of civil penalties which could be assessed by the Department of Health Services (DHS) for the same patients' rights violation.

ii) There are no standards regarding the specific conduct of employees which may lead to a violation and liability. A facility could be liable for this extraordinary penalty and attorney's fees without any required proof of negligence.

iii) Traditional tort remedies are available and successfully used against facilities in cases where patients have suffered loss or injury.

iv) There are over 20 specific types of patients' rights, which were designed to set ideal standards for performance. The rights are stated in very general terms and are open to varying and subjective interpretations. This will lead to inconsistent resolution in the courts and subject facilities to unpredictable penalties.

v) Facilities would be subject to <u>multiple penalties</u> for a single alleged patients' rights violation, including a citation and civil penalty issued by the Department of Health Services, an <u>additional</u> civil penalty of up to $10,000, and being sued for damages by the patient or representative. Facilities would have to bear the substantial legal costs.

4) <u>Other Issues</u>. The author has revised this bill since the last hearing to mandate an informal resolution process which a patient is to pursue prior to filing suit. However, the following issues remain:

a) A violation of the Patients' Bill of Rights by a facility or its employees risks liability of up to $10,000. Intentional or negligent conduct may give rise to the violation. Damages may be minimal, but the award may be up to $10,000 in an amount which is to be 'commensurate with the rights violated."

For example, an employee rushes in to assist a patient who has urgently requested assistance but fails to close the privacy curtain fully. This is an unintentional violation of the Bill of Rights, yet the licensee can be found liable up to $10,000 for such conduct.

- continued -

Should not liability under this provision be limited to intentional conduct or conduct which is in reckless disregard of the patient?

b) There are no standards provided in this bill to assist the court in determining what amount is "commensurate with the rights violated?" Should not the amount be based upon the determination of the dollar value of the damages suffered by patient and the degree of fault of the licensee?

c) According to one opponent, the Patients' Bill of Rights was designed to set ideal standards for performance but were not intended to expose individuals to unlimited claims for damages. Therefore, many of its provisions are vague as to the specific conduct of the employees and licensee which may lead to liability. Is it appropriate to impose a penalty for any conceivable violation of vaguely defined rights? Should not this bill be narrowly focused to more serious specific violation of rights? Should not the rights identified as minor, have a lower cap on the penalties?

d) A licensee could be subject to cumulative liability for the same conduct of an employee: for civil penalties sought by the DHS; criminal penalties; civil damages sought by the Attorney General or any other person; civil penalty up to $10,000 sought by a patient or resident; and also tort or other damages sought by a patient or resident. Should not a patient or resident be able to collect damages only once for the same violative act of the licensee or its employee (for example, as an offset of penalty against any damages award)?

e) This bill states that the court shall consider "the nature and severity of the rights violation." The statute authorizing the imposition of penalties by the State requires the consideration of "the probability and severity of the risk which the violation presents to the patient's mental and physical condition." Is not the latter a more appropriate standard?

f) It is unclear as to whether or not any award under this provision can exceed the maximum amount of civil penalties which could be assessed by DHS on account of the violation or violations. The last sentence of subdivision (a) of Health and Safety Code Section 1430 (Section 1 of this bill) suggests that this limitation may exist as to conduct which is also a violation of the licensing law. Is this limitation consistent with the purposes of the bill?

5) <u>Technical Amendments</u>.

a) On page 4, line 3, after "(f)" insert:

Under subdivision (b)

- continued -

b) On page 4, lines 9 and 10, delete "(3) The patient's medical condition" or delete "medical" in both places and insert:

"mental".

The latter amendment is consistent with the current facility citation law.

c) On page 4, line 14, delete "rights" and insert:

Bill of Rights regulation

6) Patients' Bill of Rights. Contained in 22 California Administrative Code Section 72527 is the Patients' Bill of Rights. Each facility is to have written policies regarding these rights, which are to be made available to the patient, guardian, and anyone requesting them. A patient's rights may be denied or limited only for good cause which shall be evidenced by the written order of the attending physician and if such denial or limitation is otherwise authorized by law. Some of the rights are as follows:

a) To be fully informed at all times of services available in the facility and of related charges.

b) To refuse treatment to the extent permitted by law and to be informed of the medical consequence of such refusal.

c) To be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment of his/her stay and to be given reasonable advance notice to ensure orderly transfer or discharge.

d) To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

e) To be free from mental and physical abuse and to be free from chemical and physical restraints except as authorized in writing by a physician or other authorized person, or when necessary.

f) To be assured confidential treatment of records and to approve or refuse their release to any individual outside the facility.

g) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.

h) To associate and communicate privately with persons of the patient's

- continued -

choice, and to send and receive personal mail unopened.

i) To meet with others and participate in activities of social, religious and community groups, unless medically contraindicated.

j) To retain and use personal clothing and possessions as space permits.

k) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

l) To have visits from members of the clergy at any time at the request of the patient or the patient's guardian.

m) To allow relatives, or persons responsible, to visit critically ill patients at any time, unless medically contraindicated.

n) To have reasonable access to telephones and to make and receive confidential calls.

SUPPORT

Area XI Developmental Disabilities Board
California Seniors Coalition
Estate Planning, Trust and Probate Law Section, State Bar
California Council on Mental Health
California Advocates for Nursing Home Reform

OPPOSITION

California Association of Homes For the Aging
California Association of Health Facilities

AMENDED IN ASSEMBLY JUNE 13, 1990

AMENDED IN ASSEMBLY MAY 2, 1990

CALIFORNIA LEGISLATURE—1989-90 REGULAR SESSION

ASSEMBLY BILL No. 2696

Introduced by Assembly Member Friedman

January 25, 1990

An act to amend Section 1430 of the Health and Safety Code, relating to long-term care.

LEGISLATIVE COUNSEL'S DIGEST

AB 2696, as amended, Friedman. Long-term health care facilities.

Under the Long-Term Care, Health, Safety, and Security Act of 1973, a resident or patient of a skilled nursing facility or intermediate care facility is authorized to bring a civil action against the licensee of the facility who violates any rights of the resident or patient provided in the Patients Bill of Rights, as contained in specified regulations of the State Department of Health Services. A licensee is liable for up to $500 in damages in an action under these provisions.

This bill would authorize a guardian or conservator of a resident or patient of a skilled nursing facility or intermediate care facility to bring a civil action under these provisions and would make a conforming change.

This bill would, instead, make a licensee liable for *a civil penalty of* up to ~~$25,000 in damages~~ *$10,000, payable to the patient*, the amount to be commensurate with the rights violated, in a civil action maintained under these provisions.

The bill would prohibit a party from invoking the above-described remedy unless the patient or patient's representative has complained in writing to the administrator of the facility within 60 days of discovery of the violation and

97 80

unless the administrator of the facility, within 30 days of receipt of the complaint, has investigated the complaint, notified the licensee of the facility of the complaint, and presented the patient with a written response to the complaint, except that if the administrator of the facility has failed to respond in writing within 30 days, or if the patient or patient's representative believes the written response fails to adequately remedy the rights violation, a party is entitled to the above-described remedy.

The bill would impose certain requirements on the court with regard to the above-described action.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 1430 of the Health and Safety Code is amended to read:

1430. (a) Except where the state department has taken action and the violations have been corrected to its satisfaction, any licensee who commits a class "A" or "B" violation may be enjoined from permitting the violation to continue or may be sued for civil damages within a court of competent jurisdiction. These actions for injunction or civil damages, or both, may be prosecuted by the Attorney General in the name of the people of the State of California upon his or her own complaint or upon the complaint of any board, officer, person, corporation or association, or by any person acting for the interests of itself, its members or the general public. The amount of civil damages which may be recovered in an action brought pursuant to this section shall not exceed the maximum amount of civil penalties which could be assessed on account of the violation or violations.

(b) A resident or patient of a skilled nursing facility, as defined in subdivision (c) of Section 1250, or intermediate care facility, as defined in subdivision (d) of Section 1250, or a guardian or conservator of that resident or patient, may bring a civil action against the licensee of a facility who violates any of the resident or patient

as set forth in the Patients Bill of Rights in Section 72 of Title 22 of the California Code of Regulations. The a shall be brought in a court of competent jurisdiction. T licensee shall be liable for the acts of the license employees. The licensee shall be liable for ~~damages of to twenty-five thousand dollars ($25,000), the amount~~ *a civil penalty of up to ten thousand dollars ($10,00 payable to the patient,* the *amount to* be commensur with the rights violated, and for costs and attorney fe and may be enjoined from permitting the violation continue. An agreement by a resident or patient o skilled nursing facility or intermediate care facility, o guardian or conservator of that resident or patient, waive his or her rights to sue pursuant to this subdivisi shall be void as contrary to public policy.

(c) *A party shall not invoke the remedy contained subdivision (b) unless all of the following steps have be taken:*

(1) The patient or patient's representative l complained to the administrator of the facility, in writi of the rights violation within 60 days of discovery of t violation by the patient or patient's representative.

(2) Within 30 days of receipt of the complaint, t administrator of the facility has investigated t complaint, notified the licensee of the complaint, a presented the patient or the patient's representati with a written response, which may include a plan corrective action, compensation for the violation, other action. If the administrator of the facility has fail to respond in writing to the complaint within 30 days receipt of the complaint, or if the patient or the patien representative believes that the written response fails adequately remedy the rights violation, then the pa shall be entitled to the remedies provided by subdivisi (b).

(d) All written complaints and responses pursuant paragraphs (1) and (2) of subdivision (c) shall discoverable.

(e) The court shall not consider the ten respon of the administrator of the facility to the alleged violati

pursuant to paragraph (2) of subdivision (c) as an admission of guilt.

(f) In assessing whether there shall be a civil penalty, or the amount of the civil penalty, for the patients' rights violation, the court shall consider all relevant factors, including, but not limited to, all of the following:

(1) The nature and severity of the rights violation.

(2) The patient's medical condition.

(3) The ~~patient's medical condition and his or~~ her history of ~~medical~~ disability.

(4) The good faith efforts exercised by the facility to prevent the violation from occurring.

(5) The licensee's history of compliance with the patients' rights.

(6) Whether the plaintiff or the defendant made a good faith effort to resolve the dispute before resorting to litigation.

(g) The remedies specified in this section shall be in addition to any other remedy provided by law.

(h) Any action brought pursuant to subdivision (b) shall be commenced within one year of the date of the alleged patients' rights violation.

O

A.B. No. 2695—Johnston.

An act to amend Section 3751 of the Labor Code, relating to workers' compensation.

1990

Jan. 25—Read first time. To print.
Jan. 26—From printer. May be heard in committee February 25.
Feb. 1—Referred to Com. on FIN. & INS.
May 8—In committee: Hearing postponed by committee.
May 10—Joint Rule 61 suspended.
May 16—From committee: Amend, and do pass as amended. (Ayes 13. Noes 1.) (May 15).
May 17—Read second time and amended. Ordered returned to second reading.
May 21—Read second time. Re-referred to Com. on W. & M.
June 7—From committee: Do pass. (Ayes 20. Noes 1.) (June 6).
June 11—Read second time. To third reading.
June 13—Read third time, passed, and to Senate. (Ayes 49. Noes 17. Page 8089.)
June 14—In Senate. Read first time. To Com. on RLS. for assignment.
June 18—Referred to Com. on I.R.
June 28—From committee: Do pass, and re-refer to Com. on APPR. Re-referred. (Ayes 6. Noes 0.)
July 10—From committee: Be placed on second reading file pursuant to Senate Rule 28.8.
July 27—Read second time. To third reading.
Aug. 16—To inactive file on motion of Senator Lockyer.
Aug. 29—From inactive file. Read second time and amended. Ordered returned to second reading.
Aug. 30—Read second time. To third reading.
Aug. 31—Read third time, passed, and to Assembly. (Ayes 26. Noes 1. Page 8368.)
Aug. 31—In Assembly. Senate amendments concurred in. To enrollment. (Ayes 77. Noes 0. Page 10603.)
Sept. 14—Enrolled and to the Governor at 3 p.m.
Sept. 17—Approved by the Governor.
Sept. 18—Chaptered by Secretary of State - Chapter 997, Statutes of 1990.

A.B. No. 2696—Friedman.

An act to amend Section 1430 of the Health and Safety Code, relating to long-term care.

1990

Jan. 25—Read first time. To print.
Jan. 29—From printer. May be heard in committee February 28.
Feb. 1—Referred to Com. on AGING & L.T.C.
Mar. 13—In committee: Hearing postponed by committee.
Mar. 22—Withdrawn from committee. Re-referred to Com. on JUD.
May 2—From committee chairman, with author's amendments: Amend, and re-refer to Com. on JUD. Read second time and amended.
May 3—Re-referred to Com. on JUD.
May 9—In committee: Hearing postponed by committee.
May 10—Joint Rule 61 suspended.
June 13—From committee chairman, with author's amendments: Amend, and re-refer to Com. on JUD. Read second time and amended.
June 18—Re-referred to Com. on JUD.
June 20—In committee: Hearing postponed by committee.
July 3—From committee: Amend, and do pass as amended. (Ayes 6. Noes 3.) (June 27).
July 5—Read second time and amended. Ordered returned to second reading.
July 6—Read second time. To third reading.
Aug. 6—Joint Rule 61 suspended.
Aug. 9—Read third time, passed, and to Senate. (Ayes 45. Noes 28. Page 9221.)
Aug. 9—In Senate. Read first time. To Com. on RLS. for assignment.
Nov. 30—From Senate committee without further action.

Gilman, John

From: Nancy Armentrout [narmentrout@cahf.org]
Sent: Thursday, April 29, 2004 4:57 PM
To: John.Gilman@asm.ca.gov
Subject: AB 2791

John-

Here is our oppose letter and the chronology of legislation. They have all increased the level of scrutiny and the liability for any negligent act or "ommission" that happens in a facility, and have led to the liability crisis facilities face today:

AB 1133 (Gallegos) - Ch. 650, Statutes of 1998
- Increased civil penalties for violations affecting the health of patients in skilled nursing facilities.

AB 1731 (Shelley) - Ch. 451, Statutes of 2000
- Significantly increased civil penalties for skilled nursing facilities up to $100,000.
- Established a state remedy to allow for a temporary manager to be appointed by DHS to run a facility; made it easier for DHS to appoint a court-appointed receiver; and, allows DHS the authority to grant provisional licenses.
- Requires allegations of suspected abuse and neglect to be investigated by DHS within 24-hours.

AB 828 (Cohn) - Ch. 680, Statutes of 2001
- Requires DHS to establish a centralized consumer response unit to respond to complaints about resident care in long-term care facilities.

AB 1212 (Shelley) - Ch. 685, Statutes of 2001
- Clean-up bill to AB 1731 (Shelley) and, subject to penalties, the bill requires skilled nursing facilities to post a "Notice of Violation Remedies" form on all doors of the facility if specified remedies are imposed.

SB 333 (Escutia) - Ch. 301, Statutes of 2002
- Authorizes each county to establish an interagency elder death review team to assist local agencies in identifying and reviewing suspicious elder deaths.

AB 255 (Zettel) - Ch. 54, Statutes of 2003
- Makes changes to the individual mandated reporting requirements for reporting suspected or alleged elder abuse.

AB 1946 (Corbett) - Ch. 550, Statutes of 2003
- Requires each facility, upon admission of a resident, to ask the resident if s/he would like the facility to provide the resident's responsible party with materials regarding resident's rights and responsibilities.

SB 339 (Ortiz) - Ch. 242, Statutes of 2004
- Subject to penalties, the bill imposes new requirements upon long-term care facilities to carrying out a lengthy process of assessment and notification prio to transferring residents from the facility.

AB 634 (Steinberg) - Ch. 242, Statutes of 2004
Creates a statewide policy prohibiting confidential settlement agreements or agreements to keep information obtained during discovery confidential if the case includes a cause of action for elder abuse or neglect.

SB 577 (Kuehl) - Ch. 878, Statutes of 2004
- Expands the authority of Protection and Advocacy Inc to enter long-term care facilities to investigate any incident of abuse or neglect of any person with a disability.

SB 130 (Chesbro) - Ch. 750, Statutes of 2004
- Prohibits facilities from using any type of seclusion or restraint unless there is a behavioral emergency.

Proposed Amendments to AB 2791 (Simitian)

On Page 2, lines 2-3, add a new Section 1, as follows:

SECTION 1. Section 1337.1 of the Health and Safety Code is amended to read:

.....

.....

(e) (1) The approved training program shall include, within the 60 hours of classroom training, a minimum of six hours of instruction on preventing, recognizing, and reporting instances of resident abuse utilizing those courses developed pursuant to Section 13823.93 of the Penal Code, and a minimum of one hour of instruction on preventing, recognizing and reporting resident=s rights violations.

(2) A minimum of four hours of instruction on preventing, recognizing, and reporting instances of resident abuse, including instruction on preventing, recognizing and reporting resident=s rights violations shall be included within the total minimum hours of continuing education or in-service training required and in effect for certified nursing assistants.

On Page 2, line 2, add a new Section 2, as follows:

SECTION 2. Section 1430 of the Health and Safety Code is amended to read:

On Page 2, lines 28-29, convert language back to current law:

liable for the acts of the licensee=s employees. The licensee shall be liable for up to five hundred ~~thousand~~ dollars ($500) ~~($5,000)~~,

SENATE COMMITTEE ON JUDICIARY 1981-82 Regular Session

SB 1930 (Petris)
As amended April 26
Health & Safety Code
MRR

CIVIL ACTIONS
-PATIENT'S BILL OF RIGHTS-

HISTORY

Source: Author

Prior Legislation: None

Support: CRLA; United Neighbors in Action; Grey Panthers; Alameda County Legal Aid Society; Standing Committee on Legal Problems of Aging of the Legal Services Section of the State Bar

Opposition: No Known

KEY ISSUE

SHOULD A RESIDENT OF A SKILLED NURSING OR INTERMEDIATE CARE FACILITY BE AUTHORIZED TO BRING A CIVIL ACTION AGAINST THE FACILITY FOR VIOLATION OF THE PATIENT'S BILL OF RIGHTS?

PURPOSE

AB 1203 (Levine) of 1979 enacted the Patient's Bill of Rights, which sets forth fundamental human rights to which all patients in skilled nursing or intermediate care facilities are entitled. A licensee who violates these rights may be enjoined from permitting the violation to continue or may be sued for civil damages by the Attorney General.

This bill would, in addition, authorize a patient or resident of a skilled nursing or intermediate care

(More)

facility to bring an action for damages or for an injunction under the Patient's Bill of Rights.

The purpose of this bill is to protect and ensure the rights of people residing in nursing homes.

COMMENT

1. Inadequacy of existing law

Existing law authorizes the Attorney General, upo her own complaint or upon the complaint of any board, officer, person, corporation, or association, to bring an action against a license who violates specified licensing provisions.

According to the author, this protection is not sufficient to ensure a patient her rights. The author argues that "since the State is making major cuts in services to people, it is more important than ever to allow the institutionalize individual the ability to protect their own constitutional rights in the private sector."

2. Rights protected

The Patient's Bill of Rights grants the following to residents of nursing homes:

(a) An adequate number of qualified personnel to carry out all the functions of the facili

(b) Good personal hygiene, care to prevent bedsores, measures to prevent and reduce incontinence;

(More)

EXHIBIT 1B

EXHIBIT 3B

(c) Food of a quality and quantity in accordance with physician's orders;

(d) An activity program staffed and equipped to meet each patient's orders;

(e) A clean facility in good repair;

(f) A nurses' call system;

(g) Additional rights guaranteed by regulation.

Additional rights that would be protected by this bill include those listed in Title 22, Sec. 72527 of the Administrative Code. These include the opportunity to visit people of the patient's choice, to participate in planning medical treatment, the right to be fully informed of fees and rates, to be free from mental and physical abuse, and to confidential treatment of personal and medical records.

3. Facilities affected

The facilities against which a patient could bring a civil action under this bill would be skilled nursing facilities and intermediate care facilities.

The former are defined as health facilities that provide skilled nursing care and supportive care to patients whose primary need is for skilled nursing care on an extended basis.

The latter are health facilities that provide inpatient care to ambulatory or semiambulatory patients who have a recurring need for skilled

(More)

nursing supervision and supportive care but who d not require continuous skilled nursing care.

4. Damages and injunction allowed

This bill would authorize a patient or resident whose rights under the Patient Bill of Rights had been violated to bring an action for damages and an injunction against the licensee of the facility.

The damages for which a licensee could be liable under this bill would be limited to $2,500 or three times the actual damages, whichever was greater, and for costs and attorney fees. Licensees would be liable for their employee's acts.

The bill would provide also that any attempted waiver of the right to sue on the part of a patient would be void.

****

ASSEMBLY COMMITTEE ON JUDICIARY
ELIHU M. HARRIS, Chairman

SB 1930

SB 1930 (Petris) As amended 08/02/82

Correction Coming

PRIOR ACTION

Sen. Jud. Com. 7-0 Sen. Floor 37-0

SUBJECT

This bill is intended to provide residents of skilled nursing or intermediate care facilities with a private cause of action for violation of the Patient's Bill of Rights.

DIGEST

Under existing law, the Legislature has recognized that residents or patients in skilled nursing and intermediate care facilities are entitled to certain fundamental rights (the Patient's Bill of Rights). Although existing law authorizes the Attorney General to initiate actions for damages or to enjoin violation of regulations related to the health and safety of residents of such facilities, there is no specific authority to initiate actions for violation of all the rights protected in the Patient's Bill of Rights.

This bill would authorize a patient or resident of a skilled nursing or intermediate care facility to bring an action for damages or an injunction against the licensee of such a facility who violates any of the rights protected by the Patient's Bill of Rights. A licensee would be liable for damages up to $500 and for costs and attorneys' fees. In addition, the licensee of the facility would be liable for the action of his or her employees. The right to bring such action could not be waived.

STAFF COMMENTS

1. Western Center on Law and Poverty, Inc.,the source of this bill, states that by enacting the Patient's Bill of Rights (H&S Code Sections 1599 et seq.) it was clear that the Legislature intended to ensure that nursing homes and intermediate care facilities respect the fundamental rights of their resident. However, the source points out that the legislation failed to provide for any specific mechanism for either an individual resident to enforce his or her rights or for a regulating agency (e.g., Department of Health) to punish or prevent violation of rights which were not directly related to health or safety within the facilities. This bill, argues the source, will provide the needed enforcement mechanism.

(CONTINUED)

2. In Health and Safety Code Section 1599 et seq. (The Patient's Bill of Rights) the Legislature "expressly set forth fundamental human rights which all patients in skilled nursing homes or intermediate care facilities are entitled to..." The Patient's Bill of Rights grants the following to residents of these facilities:

   (a) An adequate number of qualified personnel to carry out all the functions of the facility;

   (b) Good personal hygiene, care to prevent bedsores, measures to prevent and reduce incontinence;

   (c) Food of a quality and quantity in accordance with physician's orders;

   (d) An activity program staffed and equipped to meet each patient's orders;

   (e) A clean facility in good repair;

   (f) A nurses' call system;

   (g) Additional rights guaranteed by regulation.

   Additional rights that would be protected by this bill include those listed in Title 22, Sec. 72527 of the Administrative Code. These rights include the opportunity to visit people of the patient's choice, to participate in planning medical treatment, the right to be fully informed of fees and rates, to be free from mental and physical abuse, and to confidential treatment of personal and medical records.

3. The facilities against which a patient could bring a civil action under this bill would be skilled nursing facilities and intermediate care facilities. The former are defined as health facilities that provide skilled nursing care and supportive care to patients whose primary need is for skilled nursing care on an extended basis. The latter are health facilities that provide inpatient care to ambulatory or semiambulatory patients who have a recurring need for skilled nursing supervision and supportive care but who do not require continuous skilled nursing care.

SOURCE

Western Center on Law and Poverty

SUPPORT

Gray Panthers
United Neighbors in Action
California Association of Health ~~Services~~ Facilities

OPPOSITION

Unknown

Ayala.

dd Section 7910.5 to the Government Code, relating to state and local ment, and declaring the urgency thereof, to take effect immediately.

—Introduced. Read first time. To Com. on RLS. for assignment. To print.
—To Com. on ED.
—Art. IV, Sec. 8(a), of Constitution suspended. Joint Rule 55 suspended. Set for hearing April 21, 1982.
—From committee with author's amendments. Read second time. Amended. Re-referred to committee.
—From committee: Do pass as amended, but first amend, and re-refer to Com. on FIN. (Ayes 6. Noes 0. Page 8955.)
—Read second time. Amended. Re-referred to Com. on FIN.
—From committee: Be placed on second reading file pursuant to Senate Rule 28.8.
—Read second time. To third reading.
—To Special Consent Calendar.
—Read third time. Urgency clause adopted. Passed. (Ayes 35. Noes 0. Page 10306.) To Assembly.
—In Assembly. Read first time. Held at Desk.
—To Com. on ED.
—From committee without further action.
—From Assembly without further action.

—Petris.

o amend Section 1430 of the Health and Safety Code, relating to health ties.

7—Introduced. Read first time. To Com. on RLS. for assignment. To print.
8—From print. May be acted upon on or after April 17, 1982.
25—To Com. on JUD.
7—Set for hearing April 20, 1982.
14—Set, first hearing. Hearing canceled at the request of author.
26—From committee with author's amendments. Read second time. Amended. Re-referred to committee.
27—Hearing postponed by committee. Set for hearing May 4, 1982.
11—From committee: Do pass as amended. (Ayes 7. Noes 0. Page 9309.)
12—Read second time. Amended. To third reading.
17—To Special Consent Calendar.
20—Read third time. Passed. (Ayes 37. Noes 0. Page 9730.) To Assembly.
20—In Assembly. Read first time. Held at Desk.
2—To Com. on JUD.
2—From committee with author's amendments. Read second time. Amended. Re-referred to committee.
5—From committee: Do pass. To Consent Calendar.
9—Read second time. To Consent Calendar.
12—Read third time. Passed. (Ayes 78. Noes 0. Page 16914.) To Senate.
12—In Senate. To unfinished business.
16—To Special Consent Calendar.
18—Senate concurs in Assembly amendments. (Ayes 39. Noes 0. Page 13448.) To enrollment.
23—Enrolled. To Governor at 2 p.m.
27—Approved by Governor.
28—Chaptered by Secretary of State. Chapter 1455, Statutes of 1982.

Health & Safety Code

1599.1. Written policies regarding the rights of patients shall be established and shall be made available to the patient, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. Those policies and procedures shall ensure that each patient admitted to the facility has the following rights and is notified of the following facility obligations, in addition to those specified by regulation:

(a) The facility shall employ an adequate number of qualified personnel to carry out all of the functions of the facility.

(b) Each patient shall show evidence of good personal hygiene, be given care to prevent bedsores, and measures shall be used to prevent and reduce incontinence for each patient.

(c) The facility shall provide food of the quality and quantity to meet the patients' needs in accordance with physicians' orders.

(d) The facility shall provide an activity program staffed and equipped to meet the needs and interests of each patient and to encourage self-care and resumption of normal activities. Patients shall be encouraged to participate in activities suited to their individual needs.

(e) The facility shall be clean, sanitary, and in good repair at all times.

(f) A nurses' call system shall be maintained in operating order in all nursing units and provide visible and audible signal communication between nursing personnel and patients. Extension cords to each patient's bed shall be readily accessible to patients at all times.

(g) (1) If a facility has a significant beneficial interest in an ancillary health service provider or if a facility knows that an ancillary health service provider has a significant beneficial interest in the facility, as provided by subdivision (a) of Section 1323, or if the facility has a significant beneficial interest in another facility, as provided by subdivision (c) of Section 1323, the facility shall disclose that interest in writing to the patient, or his or her representative, and advise the patient, or his or her representative, that the patient may choose to have another ancillary health service provider, or facility, as the case may be, provide any supplies or services ordered by a member of the medical staff of the facility.

(2) A facility is not required to make any disclosures required by this subdivision to any patient, or his or her representative, if the patient is enrolled in an organization or entity which provides or arranges for the provision of health care services in exchange for a prepaid capitation payment or premium.

(h) (1) If a resident of a long-term health care facility has been hospitalized in an acute care hospital and asserts his or her rights to readmission pursuant to bed hold provisions or readmission rights of either state or federal law and the facility refuses to readmit him or her, the resident may appeal the facility's refusal.

(2) The refusal of the facility as described in this subdivision shall be treated as if it were an involuntary transfer under federal law and the rights and procedures that apply to appeals of transfers and discharges of nursing facility residents shall apply to the resident's appeal under this subdivision.

(3) If the resident appeals pursuant to this subdivision, and the resident is eligible under the Medi-Cal program, the resident shall remain in the hospital and the hospital may be reimbursed at the administrative day rate, pending the final determination of the hearing officer, unless the resident agrees to placement in another facility.

(4) If the resident appeals pursuant to this subdivision, and the resident is not eligible under the Medi-Cal program, the resident shall remain in the hospital if other payment is available, pending the final determination of the hearing officer, unless the resident

agrees to placement in another facility.

(5) If the resident is not eligible for participation in the Medi-Cal program and has no other source of payment, the hearing and final determination shall be made within 48 hours.

1. Establishing, reviewing, monitoring and approving policies and procedures for investigating, controlling and preventing infections in the facility.

2. Maintaining, reviewing and reporting statistics of the number, types, sources and locations of infections within the facility.

(3) Pharmaceutical service committee.

(A) A pharmaceutical service committee shall direct the pharmaceutical services in the facility.

(B) The committee shall be composed of the following: a pharmacist, the director of nursing service, the administrator and at least one physician.

(C) The committee shall meet at least quarterly.

(D) The functions of the pharmaceutical service committee shall include, but not be limited to:

1. Establishing, reviewing, monitoring and approving policies and procedures for safe procurement, storage, distribution and use of drugs and biologicals.

2. Reviewing and taking appropriate action on the pharmacist's quarterly report.

3. Recommending measures for improvement of services and the selection of pharmaceutical reference materials.

NOTE

Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code.

HISTORY

1. Amendment filed 2-8-83; designated effective 3-2-83 (Register 83, No. 7).

§72527. Patients' Rights.

§ • Note • History

(a) Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated. The facility shall establish and implement written policies and procedures which include these rights and shall make a copy of these policies available to the patient and to any representative of the patient. The policies shall be accessible to the public upon request. Patients shall have the right:

(1) To be fully informed, as evidenced by the patient's written acknowledgement prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(2) To be fully informed, prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or not covered under Titles XVIII or XIX of the Social Security Act.

(3) To be fully informed by a physician of his or her total health status and to be afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care including the identification of medical, nursing and psychosocial needs and the planning of related services.

(4) To consent to or to refuse any treatment or procedure or participation in experimental research.

(5) To receive all information that is material to an individual patient's decision concerning whether to accept or refuse any proposed treatment or procedure. The disclosure of material information for administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function shall include the disclosure of information listed in Section 72528(b).

(6) To be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment for his or her stay and to be given reasonable advance notice to ensure orderly transfer or discharge. Such actions shall be documented in the patient's health record.

(7) To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

(8) To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept written delegation of this responsibility subject to the provisions of Section 72529.

(9) To be free from mental and physical abuse.

(10) To be assured confidential treatment of financial and health records and to approve or refuse their release, except as authorized by law.

(11) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.

(12) Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.

(13) To associate and communicate privately with persons of the patient's choice, and to send and receive personal mail unopened.

(14) To meet with others and participate in activities of social, religious and community groups.

(15) To retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the health, safety or rights of the patient or other patients.

(16) If married, to be assured privacy for visits by the patient's spouse and if both are patients in the facility, to be permitted to share a room.

(17) To have daily visiting hours established.

(18) To have visits from members of the clergy at any time at the request of the patient or the patient's representative.

(19) To have visits from persons of the patient's choosing at any time if the patient is critically ill, unless medically contraindicated.

(20) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

(21) To have reasonable access to telephones and to make and receive confidential calls.

(22) To be free from any requirement to purchase drugs or rent or purchase medical supplies or equipment from any particular source in accordance with the provisions of Section 1320 of the Health and Safety Code.

(23) To be free from psychotherapeutic drugs and physical restraints used for the purpose of patient discipline or staff convenience and to be free from psychotherapeutic drugs used as a chemical restraint as defined in Section 72018, except in an emergency which threatens to bring immediate injury to the patient or others. If a chemical restraint is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient and used only for a specified and limited period of time.

(24) Other rights as specified in Health and Safety Code, Section 1599.1.

(25) Other rights as specified in Welfare and Institutions Code, Sections 5325 and 5325.1, for persons admitted for psychiatric evaluations or treatment.

(26) Other rights as specified in Welfare and Institutions Code Sections 4502, 4503 and 4505 for patients who are developmentally disabled as defined in Section 4512 of the Welfare and Institutions Code.

(b) A patient's rights, as set forth above, may only be denied or limited if such denial or limitation is otherwise authorized by law. Reasons for denial or limitation of such rights shall be documented in the patient's health record.

(c) If a patient lacks the ability to understand these rights and the nature and consequences of proposed treatment, the patient's representative shall have the rights specified in this section to the extent the right may devolve to another, unless the representative's authority is otherwise limited. The patient's incapacity shall be determined by a court in accordance with state law or by the patient's physician unless the physician's determination is disputed by the patient or patient's representative.

(d) Persons who may act as the patient's representative include a conservator, as authorized by Parts 3 and 4 of Division 4 of the Probate Code (commencing with Section 1800), a person designated as attorney in fact in the patient's valid durable power of attorney for health care, patient's next of kin, other appropriate surrogate decisionmaker designated consistent with statutory and case law, a person appointed by a court authorizing treatment pursuant to Part 7 (commencing with Section 3200) of Division 4 of the Probate Code, or, if the patient is a minor, a person lawfully authorized to represent the minor.

(e) Patients' rights policies and procedures established under this section concerning consent, informed consent and refusal of treatments or procedures shall include, but not be limited to the following:

(1) How the facility will verify that informed consent was obtained or a treatment or procedure was refused pertaining to the administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability of the patient to regain the use of a normal bodily function.

(2) How the facility, in consultation with the patient's physician, will identify consistent with current statutory case law, who may serve as a patient's representative when an incapacitated patient has no conservator or attorney in fact under a valid Durable Power of Attorney for Health Care.

NOTE

Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1320, 1599, 1599.1, 1599.2 and 1599.3, Health and Safety Code; and *Cobbs* v. *Grant* (1972) 8 Cal.3d 229.

HISTORY

1. Amendment of subsections (a) and (b), repealer of subsection (c), and new subsections (c), (d), and (e) filed 5-27-92; operative 5-27-92 (Register 92, No. 22).

Date of Hearing: April 25, 2000

ASSEMBLY COMMITTEE ON HEALTH
Martin Gallegos, Chair
AB 1731 (Shelley) - As Amended: April 24, 2000

SUBJECT : Long-term care facilities: skilled nursing facilities.

SUMMARY : Makes a variety of changes to existing law relating to nursing home enforcement and oversight, including increases in fine amounts and creation of a financial review advisory board. Specifically, this bill :

1) States legislative intent to increase access to quality alternatives to nursing home facilities by providing improved in-home support services and community-based care services.

2) Revises the definition of "nursing facility" to mean a licensed health facility that is certified as either a skilled nursing health facility in the federal Medicare program or as a nursing facility in the federal medicaid program.

3) Permits an entity acting as a "receiver" to operate, establish, manage, conduct, or maintain a health facility without a license, as specified.

4) Requires an entity approved to manage a skilled nursing facility or intermediate care facility that has not filed an application for a license to file with the state a verified application.

5) States that the license of a facility operated by a receiver, as specified, does not expire during the period of the receivership, and for 30 days thereafter.

6) Requires certain information to be disclosed to the state if the management company is a subsidiary of one or more other organizations, including the names and addresses of the parent organizations and the names and addresses of any officer or director of the parent organizations. Provides that failure to comply may result in action to revoke or deny a license. Requires the information to be updated within 30 calendar days of any change.

7) Adds to the grounds under which a license or special permit may be suspended or revoked, a violation by a Medicare certified skilled nursing facility or a medicaid certified nursing facility, or both, of any federal statutes or regulations.

8) Authorizes the Department of Health Services (DHS) to appoint a temporary manager to operate the facility in certain circumstances, including in lieu of a temporary manager appointed under federal law, when denying a license at the expiration of a provisional license, and when revoking a license. Establishes the purpose, qualifications and salary requirements of the temporary manager.

9) Extends liability protections currently granted to receivers to temporary managers.

10) Limits the circumstances under which facility management may be returned to the licensee after a receivership and temporary management.

11) Permits DHS to recover the cost of the receivership from the revenues accruing to the licensee or an entity related to the licensee.

12) Requires facilities to file a relocation plan in the event of an involuntary change in the status of a license or operation involving 10 or more residents.

13) Lifts the cap on the Health Facilities Citation Penalties Account from $1,000,000 to $10,000,000.

14) Requires DHS to include topics related to the provision of quality of care and quality of life for facility residents as part of their efforts to provide statewide training on effective facility practices.

15) Provides that state employees providing technical assistance to facilities are only required to report violations they discover during the provision of the assistance to the appropriate district office if the violations constitute an immediate and serious threat to the health and welfare of, or has resulted in actual harm to, patients, residents, or clients.

16) Requires DHS to measure the facility satisfaction and effectiveness of the technical assistance. Prohibits any person employed in the technical assistance or training units from also participating in the licensing, surveying, or direct regulation of facilities.

17) Establishes the Quality Awards Program for nursing homes, under which monetary awards are made to facilities that serve

high proportions of Medi-Cal residents and are used for staff bonuses, and under the program monetary awards are also paid to facilities in the form of innovative facility grants to improve the quality of life for residents.

18) Requires facilities to report all incidents of alleged abuse or suspected abuse, defined under the Elder Abuse and Dependent Adult Civil Protection Act, within 24-hours, and makes failure to report a class "B" violation.

19) Requires onsite inspections or investigations within 48 hours of the receipt of a complaint in any case that involves a serious threat of imminent danger of death or serious bodily harm. Requires DHS, within 10 working days of the completion of the complaint investigation, to notify the complainant in writing of the determination.

20) Provides that it is unlawful to discriminate or seek retaliation against the complainant.

21) Requires licensees to notify DHS within 24 hours of the occurrence of specified events including receipt of a judgment lien that has been levied against the facility. Prevents this information from being released to the public unless it is needed to justify an action taken by DHS or it otherwise becomes a matter of public record. Makes a violation of this provision a class "B" violation.

22) Establishes an 8 member Skilled Nursing Facility Financial Solvency Advisory Board to advise the director on matters of financial solvency affecting the delivery of services, develop and recommend financial solvency licensing requirements and standards, and periodically monitor and report on the implementation and results of financial solvency licensing requirements and standards.

23) Requires the board to report to the director on or before

July 1, 2002. Sunsets the board on January 1, 2004.

24) Requires DHS to develop a method whereby specified complaint and citation information is provided to the public and consumers on long-term health care facilities by January 1, 2002. Sunsets this requirement on July 1, 2003.

25) Requires DHS to centrally review federal deficiencies and supporting documentation that require the termination of certification for a nursing facility. Requires DHS to develop a standardized methodology for conducting the central review of these deficiencies and establishes requirements for assessment of the methodology, including the extent to which the survey team followed established protocols, the thoroughness of the review, the quality of documentation, and the consistency in interpreting federal requirements.

26) Requires DHS to develop a system for tracking patterns and a quality assurance process for preventing, detecting, and correcting inconsistent or poor quality survey practices, and requires DHS to report to the Legislature by October 1 each year a summary of federal enforcement actions.

27) Requires skilled nursing facilities and intermediate care facilities to post information about the Office of the State Ombudsman in specified locations, and assesses a civil penalty of $100 for each day a facility fails to comply. Classifies the violation in the same manner as a class "B" violation where the total penalty is $2,000 or less with a right to appeal, as specified. Classifies the violation in the same manner as a class "A" violation where the total penalty is $2,000 or more, as specified.

28) Requires DHS to provide a copy of all citations issued, as specified, to the affected residents mentioned in the violation and to the affected residents' family or designated legal representative.

29) Establishes an increase in specified fine levels for skilled nursing facilities and intermediate care facilities as follows:

a) Class AA $25,000 to $100,000
b) Class A $2,000 to $20,000
c) Willful material falsification or willful material omission

$2,000 to $20,000

4) Requires DHS to submit draft class "AA" and class "A" citations and supporting documentation to department medical and legal consultants prior to issuance. Requires review from an independent, board-certified physician who has no direct or indirect ownership interest in any nursing facility or nursing facility management entity for a class "AA" and possibly a class "A" if the violation involves a complex medical issue.

5) Authorizes a licensee to pay a discounted fine in lieu of contesting a class "AA" or "A" citation within 30 business days after the issuance of the citation.

6) Repeals certain specified reporting and advertising requirements of DHS.

7) Enables DHS to rescind a Medicare or Medicaid certified facility's permanent license and instead, issue a provisional license under specified circumstances. However, action may not be taken until a final administrative decision is issued if the facility has requested a hearing, the facility has waived its right to a hearing, or until the time for

requesting a hearing has expired, pursuant to federal law. Authorizes DHS to issue a 6-month provisional license if a receiver or temporary manager is appointed, and upon inspection, extend it for another 6-months. Authorizes the facility to request a hearing to appeal the denial of a permanent license, and requires the hearing officer to uphold the denial if DHS proves by a preponderance of the evidence that the licensee did not meet the licensure requirements.

8) Provides a resident who has been hospitalized and is refused readmission, an opportunity to appeal the refusal as if it were an involuntary transfer, as specified. If the resident is a Medi-Cal beneficiary, requires the resident to remain in the hospital and permits the hospital to be reimbursed at the administrative day rate, pending the final determination of the hearing officer, unless the resident agrees to placement in another facility. If the resident is not eligible for Medi-Cal and has no other source of payment, requires the hearing and final determination to be made within 48 hours.

EXISTING LAW :

1) Establishes an inspection and citation system for imposing civil penalties against long-term health care facilities that are in violation of patient care laws and regulations. Classifies violations as class AA, class A and class B, and provides a range of civil penalties for each citation. Requires relevant facts considered by DHS in determining the amount of the civil penalty to be attached to the citation and available in the public record.

2) Establishes a procedure under which a licensee may contest a citation or the proposed assessment of a civil penalty, and provides licensees with the option to submit appeals of class B citations to binding arbitration.

3) Requires, in determining the amount of a civil penalty, the consideration of the risk to the patient, the patient's medical and mental condition, the good faith efforts exercised by the facility to prevent the violation from occurring and the licensee's history of compliance with regulations. Requires DHS to hold an exit conference with the licensee before completing an investigation.

4) Requires DHS to promote quality in long-term health care facility services through specific activities, including statewide training on effective facility practices and responding to
technical assistance regarding licensing and certification requirements, federal and state compliance issues and operational issues.

5) Requires DHS to ensure that certain district office activities

are consistent with the requirements of all applicable laws and regulations, and requires DHS to establish a statewide process for the collection of post-survey evaluations from affected facilities.

6) Authorizes DHS to petition the courts to vest operation of a "receivership" if continued management of a nursing facility by the current licensee would pose substantial harm or imminent danger to the patients, as determined by DHS. Permits DHS to recover the costs of a court appointed receiver from the facility.

7) Requires a facility to file a relocation plan in the event of

a voluntary change in the status of a license or operation involving 10 or more residents.

FISCAL EFFECT : Unknown

COMMENTS :

1) PURPOSE OF THIS BILL . According to the author, in July 1998, the U.S. General Accounting Office released a scathing report on skilled nursing care in California during a two-day series of hearings in Washington, D.C. The findings suggested that California's existing nursing facility regulatory and enforcement system does not effectively assess or ensure the quality of resident care. Therefore, the author believes that California's nursing home enforcement system should be strengthened to enhance overall system integrity and the quality of life for all residents receiving care in these facilities. DHS is sponsoring this bill as part of the Governor's Aging with Dignity Budget Proposal. Related budget proposals and this bill are intended to protect the most vulnerable Californians by increasing nursing home inspections, ensuring rapid response in complaint investigations, and strengthening enforcement activities.

2) DEMOGRAPHICS . California's population of 33 million people represents just over 12% of the entire United States population. That number is expected to increase by 30% to nearly 41 million people by 2010. The fastest growing segment of California's population is among persons over the age of 85. By 2020, the number of people over 60 years of age will grow from 4.9 million (2000) to 9 million. California has over 1,200 freestanding (non-hospital based) skilled nursing and intermediate care facilities. Together, these facilities have over 119,000 beds. Patients in these facilities require 24-hour nursing care at a level less intense than acute care. Sixty-nine percent of the patients are discharged within three months. Almost 85% are discharged within a year of admission.

3) GOVERNOR'S BUDGET PROPOSAL . The Governor's Aging with Dignity Initiative commits $140.4 million from the General Fund for a

variety of programs intended to help seniors live independently and improve the quality of long-term care. The Governor's Proposal includes: an increase in the state share of wages for public authority In-Home Supportive Services, long-term care innovation grants to expand alternatives to

nursing home placement, and an additional 5% wage increase for caregivers in nursing facilities over and above the 5% provided in the 1999 Budget Act. The initiative also proposes to increase the number of unannounced nursing home inspections, expand a program that intensively reviews poor performing nursing homes, decrease response times for complaint investigations and increase fines for serious or repeat violations.

4) STAKEHOLDER ISSUES . A number of stakeholders have written to comment on the provisions of this bill including the California Advocates for Nursing Home Reform (CANHR), the American Association of Retired People (AARP), Bet Tzedek Legal Services, National Senior Citizens Law Center (NSCL), the Service Employees International Union (SEIU), the California Association of Health Facilities (CAHF), the California Association of Homes and Services for the Aging (CAHSA), the California Healthcare Association (CHA), and the California Rehabilitation Association (CRA).

License revocation based on federal deficiencies. Because annual surveys, and much the enforcement actions, are based on federal deficiencies, this bill proposes to give DHS the authority to revoke a facility's state license based on federal surveys instead of comparable state deficiencies. CAHSA believes license revocation should only be considered under extreme circumstances and that the bill should be amended to clarify that federal deficiencies only be considered once a facility has exhausted their appeal rights.

Provisional License Issuance. This bill proposes to authorize DHS to change the status of a license to "provisional" if the licensee has had significant federal and state enforcement actions imposed for poor quality of care. CAHSA believes this provision should be amended to assure only serious quality of care violations at the federal level are used as triggers for this situation.

Temporary Manager and Receivership. The existing receivership process requires DHS to petition the court and present substantial proof before operation of the facility can be placed in receivership. This bill proposes to permit a "temporary manager" to be appointed before and in lieu of a court-appointed "receiver." CANHR believes the requirements that DHS obtain consent of the facility prior to appointment

of a temporary manager, and petition for receivership upon refusal, defeats the purpose of the temporary manager. CANHR explains that the temporary manager is necessary to apply swift and immediate protection of residents while avoiding lengthy court proceedings. CANHR contends that a temporary manager should be put in place when the residents' lives are in danger and that failure to consent should result in the licensee being placed on provisional license status. CAHF requests that this provision be amended to enable a facility to be returned to the licensee when the court, instead of DHS, determines that the facility can achieve/maintain compliance and continued operation is in the best interest of the clients. Additionally, CAHF believes either DHS or the facility should be able to initiate the court review necessary to make such determinations.

Increasing fines. Many stakeholders have objected to the proposal in this bill to consider a review by an independent physician when an A citation involves a complex medical issue. NSCL believes that this provision will result in facility court challenges in every A citation where DHS determines not to consult the outside physician. CANHR objects to the requirement that AA citations be reviewed by an independent physician. CAHNR believes that it will delay the enforcement process. CAHF and CAHSA suggest that the fine increases are too high and should be cut in half. CAHF and CAHSA believe fine increases should be accompanied by enforcement system changes that link the citation/fine level to the scope and severity of the violation. CAHF also asks that the review criteria include all of the considerations listed under the existing fine and citation system. CAHSA asserts that the proposal should be amended to include binding arbitration, an opportunity for facilities to submit information to the review group, and reimbursement of facilities for reasonable attorney fees when the court dismisses a citation.

Technical Assistance. Under this proposal, DHS employees providing technical assistance to facilities are only required to report immediate and serious violations to the department. The proposal also requires DHS to measure facility satisfaction with the technical assistance provided. Advocates object to taxpayers dollars being spent on consulting services for the industry. SEIU believes staff providing technical assistance should not be licensing and certification staff. CANHR indicates the role of DHS is to

protect residents and not satisfy the industry.

Minimum-Staffing Requirements. NACL believes this bill should be amended to include provisions requiring facilities to forego additional reimbursement for staff wage increases until the facility certifies under oath that the minimum staffing is being met.

Reimbursement System Reform. CAHF suggests that this bill be amended to direct DHS to review the current Medi-Cal reimbursement methodology and work with stakeholders to devise a system reform that will promote quality, access and compliance with state/federal requirements. CAHF indicates that unlike last year's package, this bill falls well short of "comprehensive" reform. CAHF believes successful reform must address the level of Medi-Cal funding and the methodology used to pay for nursing facility care. CAHF is also requesting an amendment to include a 10% overall increase in the basic Medi-Cal long-term care rate that is over and above the 5% wage pass through.

Consumer information. CAHNR assumes that this bill proposes to repeal certain reporting requirements because new provisions for on-line reporting are being proposed. CAHNR suggests that the repeal of these provisions should be delayed until DHS has a fully on-line system in place to a public to obtain the information. SEIU also supports maintaining these sections in statute and suggests an amendment that would require distribution of this information to consumer organizations, senior groups, collective bargaining agents, health care professional associations, local commissions on aging and any other interested parties.

5) OPPOSITION . CHA opposes this bill because the association has not had enough time to review the amendments. CHA supports legislative changes that will improve nursing home quality. However, because CHA has not had an opportunity to review the amendments and this bill is intended to impose major reform in the regulation of skilled nursing facilities, CHA remains opposed.

6) PRIOR LEGISLATION . Last year, AB 1160 (Shelley) was vetoed by the Governor. AB 1160 would have established goals for direct care staffing in skilled nursing facilities, revised the calculation for determining nursing hours in nursing

facilities and intermediate care facilities and would have made several other changes to existing law impacting nursing homes, including requiring that a new acuity-based reimbursement system be developed and presented to the Legislature by January 1, 2001. Based on his veto message, the Governor's primary reason for vetoing AB 1160 was the out-year cost of implementing staffing ratio changes beyond what he approved in the Budget Act of 1999. The budget funded

$36 million (General Fund) to raise the minimum staff-to-patient ratio from 2.9 to 3.2 hours per patient per day, and increased by 5% wages to nursing-home staff involved in providing direct patient care.

REGISTERED SUPPORT / OPPOSITION :

Support

Department of Health Services (sponsor)
California Advocates for Nursing Home Reform (if amended)
Service Employees International Union (if amended)
American Association of Retired Persons (if amended)
Bet Tzedek Legal Services (if amended)
National Senior Citizens Law Center (if amended)
Little Hoover Commission

Opposition

California Healthcare Association

Analysis Prepared by : Teri Boughton / HEALTH / (916) 319-2097

NO RISK BUSINESS

The insurance industry is in turmoil. Here's what it's doing to minimize losses

BY DEBORAH ROSENTHAL AND LUCIA HWANG

It's no secret that California is facing a hard insurance market. Several years of catastrophic events, investment losses, rising repair costs, litigation, and fraud have generated huge industry losses and driven carriers scrambling for ways to recover. "They really feel like they're hemorrhaging from the late 1990s," says Norman Allen, senior broker and manager of West Coast claims for Carpenter Moore Insurance Services. Across most lines of coverage, policyholders are seeing their premiums and deductibles soar, their limits plummet, and their ability to obtain coverage become more difficult as carriers abandon high-risk markets and underwriters scrutinize applications like never before, writing more exclusions and fewer policies.

For lawyers in insurance practice, this is more or less business as usual, although in some ways the insurance industry itself is also changing. For example, Los Angeles attorney John Marder says that as carriers consolidate and businesses globalize, the insurance industry is moving away from using local and regional firms and toward using national and global firms that can serve their demands more efficiently. And San Francisco litigator Jordan Stanzler anticipates that he and his colleagues will be needed to interpret policy language that is becoming increasingly individualized as insurers find new ways to sell coverage for high-risk activities while at the same time protecting themselves against sustaining major losses.

Deborah Rosenthal (deborah_rosenthal@dailyjournal.com) is a senior editor and Lucia Hwang (lucia_hwang@dailyjournal.com) is an associate editor at CALIFORNIA LAWYER.

THE FIVE COVERAGE AREAS THAT ARE CURRENTLY PRESENTING THE GREATEST CHALLENGES FOR INSURERS:

WORKERS COMPENSATION

By all accounts, California's workers comp system is in crisis. Most carriers have been losing money writing workers comp, so many have gone out of business, merged, or withdrawn. According to Pete Moraga, a spokesperson with the Insurance Information Network of California—an industry-supported nonprofit, nonlobbying resource group—for every dollar that workers comp insurers collected in premiums in 1999 (the most up-to-date data available), they paid $1.48 in expenses.

"Nobody's making any money on this," Moraga says. With so few insurers, competition is nonexistent, and employers' premiums have jumped 25 to 50 percent. Without many options, so many employers have been turning to the State Compensation Insurance Fund, intended as the insurer of last resort, that Insurance Commissioner John Garamendi announced in March that the State Fund was covering more than half of all California businesses and that it must raise its rates to cover this huge liability.

Insurers and employers blame escalating premiums on increased worker benefits ($602 a week this year, up from $490 in 2002), but Garamendi says California's injured workers collect payments ranking in the lowest third of all states. In fact, according to Department of Insurance spokesperson Nanci Kramer, employer fraud—in which the employer underreports the amount of payroll and/or misclassifies its employees into lower-risk categories—is one of the factors responsible for the disastrous state of the system. Such fraud cheats the system out of hundreds of millions of dollars each year, Kramer says. Moreover, it seems to be on the rise, as does litigation over workers comp claims. Commissioner Garamendi has proposed a massive overhaul of the system and has convened two panels of advisors to review the current crisis.

D&O LIABILITY

Although plenty of carriers still write directors and officers (D&O) policies, the problems plaguing corporate directors and officers in the past year and a half have caused insurers to react to their losses by increasing their pricing on D&O policies for the first time in a decade, according to Eric Andersen, national managing director for Aon Financial Services Group in New York. When the market was soft, insurers lowered rates and dramatically expanded the scope of coverage. They also wrote exclusions that would not be triggered until a final judgment had been reached in the underlying case—a relatively rare occurrence, since more than 90 percent of cases settle. Then came the corporate scandals of 2002, followed by an onslaught of securities litigation the likes of which had not been seen since Congress passed the Private Securities Litigation Reform Act in December 1995.

"The degree of securities claims and the amount of settlements associated with these claims went way beyond the amount anybody ever expected," Andersen says. "So you had broadened coverage, terrible claims, a very competitive pricing market, exclusions you couldn't use, and on top of that, a stock market that stinks. It's the perfect storm."

In the wake of this squall, policyholders not only face new coverage restrictions, such as the elimination of severability clauses, but also the prospect of no coverage at all if an entity goes bankrupt or its carrier, suspecting fraud when a company issues financial restatements, attempts to rescind the policy. In response, individual directors and officers have begun looking at alternative ways to lower their risk, such as policies that cover their nonindemnifiable losses, portable director policies that follow the individual regardless of the board he or she sits on, and co-insurance on the entity coverage.

PROPERTY/CASUALTY

When it comes to personal and business lines of insurance covering property losses, brokers have some good news and some bad news. "The trend for large increases in premiums has slowed," says James Stuart, senior vice president of Marsh Risk & Insurance Services in Los Angeles. "I think premiums probably peaked in the fourth quarter of last year, and we are starting to see some stabilization. In some cases it's flat, and in other cases we've had some decreases." Barring another catastrophe like 9/11, he adds, "the property/casualty industry has returned to being somewhat profitable."

That may help prospective policyholders down the line, but for now the industry's recent losses are still rippling through the market. Irell & Manella partner Marc S. Maister says that carriers are narrowing their coverage for large commercial properties and undertaking due diligence before deciding what to underwrite in order to avoid huge losses resulting from a single major event, such as a terrorist attack. "We've seen the capacity in the marketplace change such that full coverage is not always available for the larger deals," he says.

Last November the industry and policyholders convinced Congress to pass legislation putting a three-year backstop to the loss that carriers will bear as a result of foreign terrorist acts. Under the legislation, the government will cover 90 percent of losses above a set deductible (a percentage of the insured company's annual earned premiums). In exchange, carriers must offer coverage for terrorist acts. Because the industry has no risk models for such events, pricing is difficult to determine but generally high, says Insurance Information Network of California's Moraga.

Thus far, insurers have been unable to convince the state and federal legislatures that toxic mold, like terrorism, is essentially uninsurable. Nonetheless, due in part to a handful of large verdicts and settlements,

hundreds of claims, and a boatload of bad press, a few carriers have pulled out of the highly litigious California market completely; at the same time more than 80 percent of the carriers writing homeowners' policies in California have applied to the Department of Insurance for mold exclusions or mold-remediation limits as low as $5,000. According to insurance litigator Stanzler, however, the carriers are fighting an uphill battle. "The excludability of mold is undoubtedly going to be a contested issue," he says. "Usually mold is a result of water intrusion, and I predict in the end it will likely have to be treated like any other construction-defect case."

HEALTH CARE LIABILITY

Both traditional insurance customers, which include hospitals and nursing homes, and managed-care customers, which include HMOs, PPOs, networks, and other alliances, have faced sharply rising premiums. Nursing homes, assisted-living, and other long-term care facilities are discovering that it's "just about impossible to find professional liability or malpractice insurance," says Bill Lewis, a senior vice president with Bolton & Company, a commercial brokerage company in Pasadena. Although California caps emotional distress damage awards at $250,000 in medical malpractice cases, many plaintiffs have been maneuvering around that obstacle by adding elder-abuse claims to their complaints, which has resulted in high awards. Many facilities are turning to captive insurance arrangements and other alternative risk-financing mechanisms instead of using traditional insurance companies, and some are just going bare.

The number of carriers writing managed-care errors and omissions policies has dropped dramatically in the past two years, from about 20 to approximately 6, says Carpenter Moore broker Allen. Though health care companies can still find relatively broad coverage, they're also finding their rates have climbed 30 to 50 percent, and some have even tripled. An increasing number of companies can't buy any coverage at all, says Allen. Carriers are also scrutinizing revenues to determine the applicant companies' financial health, as well as scrutinizing the risks associated with their businesses. For example, a health care claims-processing company that just processes paperwork is considered less of a liability than one that actually analyzes the viability of claims for health services.

MEDIA & ENTERTAINMENT

"Not unlike the rest of the insurance world, the entertainment industry was overserviced [in the 1990s], and now many of the carriers have become more selective or gotten out of the business entirely," says Brian Kingman, senior vice president of Aon/Albert G. Ruben Insurance Services, which handles about 80 percent of the filmed entertainment industry market. According to Kingman, "the insurance companies that were writing the business have all taken their lumps" as a result of years of underpricing coverage and failing to adequately assess and allocate the risks involved in specific projects. The music and reality television industries have experienced the greatest losses, resulting from increasingly frequent and severe claims of defamation, copyright infringement, idea and format theft, and other torts.

To combat these losses, the few carriers still writing entertainment insurance policies now provide less coverage, charge tripled premiums, and require bigger retentions.

Fortunately for producers and film and reality TV buffs, Kingman says he and his colleagues have been able to find coverage for almost any risk through new solutions such as layering limits, educating underwriters as to the producers' clearance procedures, and "establishing a dialogue" between the parties. "You roll up your sleeves, sit around the table with the prospective insured, his lawyers, the risk-takers, and their lawyers, and talk about everyone's concerns and what's happening in the insured's business," Kingman explains. "It's brokering the old-fashioned way." ■

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

HEALTH CARE INDUSTRY MARKET UPDATE

Nursing Facilities

May 20, 2003

Dear Friends of CMS:

As the regulators of over $500 billion per year of Medicare, Medicaid, and S-CHIP funds, we believe it is incumbent on us to better understand the finances of our contractors, health providers, and other related businesses that provide services to the more than 70 million beneficiaries these programs serve. Health plans, hospitals, nursing homes, home health agencies, medical device manufacturers, and pharmaceutical companies are just some of those whose finances depend heavily on these public programs.

I have always been surprised at how little Wall Street and Washington interact—and how companies often paint different financial pictures for each audience. I am a strong believer in adequate funding for our major partners in these programs, but I do not think they should be saying one thing to investors and another to regulators (as it is occasionally in their interest to do). If health plans or providers are struggling to serve our beneficiaries, we should have a thorough understanding of their real financial status to assess the true level of need. Many investment banking firms conduct detailed analyses of major health providers, both for the equity investors in for-profit companies, and for the debt holders of for-profit and nonprofit entities. Health systems typically provide these investors with clear financial data. These data can be used by regulators and legislators to assess funding adequacy or the need for regulatory reforms.

CMS' Office of Research, Development & Information (ORDI) has gathered research reports from the major investment firms, summarized their analyses, and condensed them into a short, and hopefully, understandable format. Our goal is to provide objective summary information that can be quickly used by CMS, HHS, Congress, and their staffs that oversee these programs. The primary person at CMS assigned to this task is Lambert van der Walde. Lambert previously worked for Salomon Smith Barney in New York and is experienced with corporate financial analysis and research review. Also on the team is Kristen Choi who previously worked for JPMorgan in New York in health care equity research.

This Market Update focuses on nursing facility companies, updating our first report about this sector published February 6, 2002. The industry currently faces issues including the effect of the sunset of certain Medicare add-on payment provisions, risk to Medicaid payments as states balance tight budgets, and rising liability costs. In coming months, we will continue to review the major provider and supplier sectors. Though I am proud of this effort, and believe it will add to understanding of the programs, we welcome comments on the content and format of this report. We want to make this as consumer friendly as possible for everyone who reads it. Please provide comments to Lambert van der Walde at lvanderwalde@cms.hhs.gov or Kristen Choi at kchoi@cms.hhs.gov.

Sincerely,

Tom Scully

CMS CENTERS for MEDICARE & MEDICAID SERVICES

HEALTH CARE INDUSTRY MARKET UPDATE

Nursing Facilities

May 20, 2003

Tom Scully
Administrator

Office of Research, Development & Information:

Lambert van der Walde
lvanderwalde@cms.hhs.gov

Kristen Choi
kchoi@cms.hhs.gov

Wall Street's View of Nursing Facilities

Investor sentiment is mostly negative due to uncertainties related to government payment and the rising cost of liability insurance.

- **Profit margins continue to decline after the October 2002 sunset of over $1 billion of federal Medicare add-on payment provisions, exacerbating Wall Street's concerns about Medicaid payment levels.**
- **Rising insurance costs and aggressive litigation have led to the exit of many nursing facility chains from states where liability costs are high.**
- **Analysts worry how some chains, especially those that have recently emerged from bankruptcy, will weather the uncertain government payment environment.**
- **Three chains have filed for bankruptcy in the last six months.**
- **For nursing facilities, access to equity financing is essentially nonexistent and debt financing is available to only a few.**

CONTENTS

EXECUTIVE SUMMARY

Wall Street is more pessimistic about sector prospects.

Wall Street's outlook for the nursing facility sector has grown more negative over the past year. Investment analysts' main concerns are the sunset of certain Medicare add-on payment provisions, potential Medicaid cuts by states, and skyrocketing liability costs.

About $1.4 billion of Medicare add-on payment provisions sunset on October 1, 2002.

The Medicare add-on payment provisions sunset on October 1, 2002. Congress originally created these add-on payments to help skilled nursing facilities transition from a cost-based to a prospective payment system. Average profit margins of the publicly traded, for-profit nursing facility companies were declining both before the sunset, (from 2.8% in the first quarter of 2002 to 2.0% in the third quarter) and after the sunset (down to 1.4% in the fourth quarter of 2002 and 1.1% in first quarter of 2003). Some investment analysts believe the not-for-profit and smaller facilities may be hit harder by the sunset. These facilities may be less able to absorb the sunset's impact due to slimmer operating profit margins and declines in investment income from endowments and charitable contributions in 2002.

Higher Medicare payments subsidize lower Medicaid payments for nursing facilities.

Wall Street analysts understand that many nursing facilities use higher Medicare and private pay rates to subsidize lower Medicaid payments. Medicare, however, covers only about 10%-15% of nursing facility residents while Medicaid covers 65%-70% at typically lower per diem rates. The Medicare add-on provision sunset has exacerbated Wall Street analyst concerns about Medicaid payment. Analysts worry that fiscal concerns may force states to reduce or freeze Medicaid rates. According to a January 2003 Kaiser Commission on Medicaid and the Uninsured study, 37 states plan to reduce or freeze funding for nursing care in fiscal 2004.

Many chains are exiting states where liability costs are prohibitively high.

Nursing facility margins have also declined due to increases in patient care liability cases, average claim sizes, and insurance premium costs. High and unpredictable liability costs have become a significant driver in many business decisions, including asset sales, relatively expensive financing structures, and bankruptcy filings. Many chains are divesting nursing facilities in those states where liability costs are disproportionately high. In 2002, the three largest nursing facility chains each had large, unexpected increases to the amount of resources reserved that estimate future settlement payments.

Although most investment analysts believe the industry is struggling, many do not believe that the industry is necessarily returning to the early days of PPS implementation, during which time five of the top eight nursing facility chains filed for bankruptcy. Two of these companies emerged from bankruptcy in 2001, and another two emerged in 2002. Some investors, however, are concerned that current market conditions could result in a second wave of bankruptcies. Since December 2002, Centennial Healthcare (the 12th largest chain) and two smaller regional chains have filed for bankruptcy.

Access to capital is extremely limited.

With these uncertainties looming, access to capital is limited. New equity capital is almost non-existent, while publicly-held debt is available to only the highest quality issuers. Other sources of capital, including real estate investment trusts (REITs) and commercial banks, have also diminished for those facilities that have not branched out into other more profitable types of senior care businesses, such as assisted living and continuing care retirement communities (CCRCs). The industry will require a significant amount of capital to refinance maturing debt and maintain facilities in the near-term.

WALL STREET'S VIEW

Skilled nursing facilities struggled after the BBA and profit margins continue to decline due to the sunset of certain BBRA and BIPA add-on provisions on October 1, 2002.[1] Congress created these temporary provisions to help nursing facilities transition from a cost-based to a prospective payment system. Waxing and waning prospects for legislation that would restore these add-on payments have clouded the outlook for the sector, whose profit margins have been declining. Jerry Doctrow of Legg Mason writes, "2002 began and ended with concerns over government reimbursement for nursing home operators taking a toll on share prices." The future is especially murky for the smaller and not-for-profit homes, as well as the larger chains that have recently re-emerged from Chapter 11 bankruptcy filings. A.J. Rice of Merrill Lynch describes CMS' recently proposed 2.9% full market basket increase to Medicare SNF payments in fiscal 2004 as "welcome," although "the nursing home industry continues to be in dire straights...."

Decreased Medicare payments have reduced profit margins.

With states under increasing fiscal pressure, analysts worry that Medicaid nursing facility rates may be frozen or reduced. Every Wall Street nursing facility analyst is concerned states will freeze or cut Medicaid payments to nursing facility providers due to mounting fiscal distress and rising Medicaid costs. Unlike the federal government, many states must balance their budgets. As state revenues fall, funding must be cut. Several states have announced Medicaid provider payment cuts, others have maintained existing levels, and a smaller number have announced modest increases. It is widely understood by Wall Street that for most nursing facilities higher Medicare payment helps subsidize lower Medicaid payment. With the sunset of Medicare add-on provisions, investors worry that nursing facilities will not have much room to absorb potential Medicaid cuts as well.

Investors worry that nursing facilities will not be able to absorb Medicaid cuts.

Skyrocketing liability insurance cost increases are a major contributor toward the exit or bankruptcy of nursing facility operators in certain states. Jason Kroll of Bear Stearns estimates that nursing facility liability insurance costs continue to rise between 25% and 35%. Both the number of lawsuits per 1,000 beds as well as the average claim size have tripled over the past ten years, according to AON Risk Consultants. Unexpected material increases in insurance accruals (*i.e.*, reserved resources which estimate future settlement payments) have also depressed stock prices: in 2002, Beverly's annual insurance accruals grew 50% to $66 million, Kindred's grew 50% to $82 million, and Manor Care's grew 20% to $72 million. Doctrow writes, "[V]ery high liability expense levels will continue to pressure nursing home operator cash flows and operating margins for the next year or two at least, in some cases forcing firms into bankruptcy reorganization when liability costs are added to Medicare and potential Medicaid cuts." In states where liability costs have become too burdensome, or where liability insurers have been unwilling to offer products to long-term care providers, nursing facilities are being closed or divested. Wall Street analysts believe state tort reform may help control rising costs.

Aggressive patient care litigation has driven up insurance premiums and uncertainty over the timing and magnitude of future settlement payments.

[1] BBA: Balanced Budget Act of 1997.
BBRA: Balanced Budget Refinement Act of 1999.
BIPA: Beneficiary Improvement and Protection Act of 2000.

INDUSTRY OVERVIEW

Nursing homes provide both short-term rehabilitative and long-term care for patients who require skilled nursing and therapy care on an inpatient basis. There are about 16,500 nursing homes certified to provide Medicare and/or Medicaid care in the United States, with approximately 1.8 million total beds. About 3.5 million people will live in a nursing home during the course of a year.

Medicare does not cover nursing care on a long-term basis, as Medicaid does.

Skilled nursing facility (SNF) is the Medicare designation for a facility that provides beneficiaries with short-term, residentially-based skilled nursing and therapy care. Medicare SNF coverage is limited to 100 days per spell of illness for those beneficiaries who require daily skilled care following a discharge from a stay in an acute care hospital lasting at least three days. Medicare does not cover SNF care on a long-term basis. If beneficiaries continue to require care in a skilled nursing facility once Medicare coverage expires, they can pay out-of-pocket (private pay) as long as they have assets or sufficient income. Once their assets are "spent-down," they become Medicaid eligible.[2] Most SNFs are also certified as nursing facilities under Medicaid and furnish Medicaid and private pay patients with a combination of skilled rehabilitative care and long-term treatment for functional deficits and chronic conditions.

Medicare classifies about 15,000 nursing homes as SNFs. About 85% of SNFs are freestanding nursing homes while the other 15% are hospital-based (a SNF unit of an acute care hospital or under administrative control of a hospital). Three-quarters of freestanding SNFs are operated as for-profit entities, while the majority of hospital-based SNFs are attached to not-for-profit hospitals.

In total, approximately 65% of nursing homes are owned by for-profit entities, while 28% are owned by not-for-profit organizations and the remainder are owned by government agencies usually at the city or county level. About half of all freestanding SNFs, or two-thirds of all for-profit SNFs, are owned or operated by chains. Many of the largest chains also have significant non-nursing facility lines of business including home health services, long-term acute care hospitals, and assisted living facilities. The financial results for these chains are presented on a consolidated basis in this report.

Figure 1: Nursing Home Facilities and Beds, by Type of Ownership

For-profit entities own 65% of nursing homes.

Type of Ownership	Number of Facilities	Percent	Number of Beds	Percent
For-profit	10,759	65.4%	1,188,643	66.2%
Not-for-profit	4,676	28.4%	485,706	27.1%
Government	1,011	6.1%	120,923	6.7%
Total	**16,446**	**100.0%**	**1,795,272**	**100.0%**

Source: CMS, OSCAR data as of April 2003.

The industry remains very fragmented, with no dominant providers. As of April 2003, the top ten nursing facility companies by bed count accounted for 15.5% of beds, declining from 18.5% in January 2002. The largest chains have divested beds faster than the overall sector. The combined bed count of the top ten chains showed a decline of 17.9% compared to an overall decline in nursing facility beds of 2.1%. This trend may be due to recent exits of the largest chains from states with high liability costs such as Florida.

[2] Income and asset tests to determine Medicaid eligibility vary from state to state.

Figure 2: Top Ten Nursing Home Facility Companies by Bed Count

	April-03		January-02		Change in Number of Beds
	Number of Beds	% of Total Beds	Number of Beds	% of Total Beds	
Beverly Enterprises Inc.	49,396	2.8%	61,716	3.4%	-20.0%
Manor Care, Inc.	38,666	2.2%	39,659	2.2%	-2.5%
Kindred Healthcare, Inc. (formerly Vencor)	36,417	2.0%	38,909	2.1%	-6.4%
Mariner Health Care, Inc.	34,702	1.9%	44,607	2.4%	-22.2%
Integrated Health Services, Inc.	25,169	1.4%	38,282	2.1%	-34.3%
Sun Healthcare Group, Inc.	24,267	1.4%	32,311	1.8%	-24.9%
Genesis Health Ventures, Inc.	24,264	1.4%	29,666	1.6%	-18.2%
Life Care Centers of America	16,587	0.9%	19,928	1.1%	-16.8%
The Evangelical Lutheran Good Samaritan Society	14,892	0.8%	16,077	0.9%	-7.4%
Extendicare Health Services, Inc.	13,600	0.8%	17,529	1.0%	-22.4%
Top 10 Total	**277,960**	**15.5%**	**338,684**	**18.5%**	**-17.9%**
Total Beds	1,795,272	100.0%	1,834,448	100.0%	-2.1%

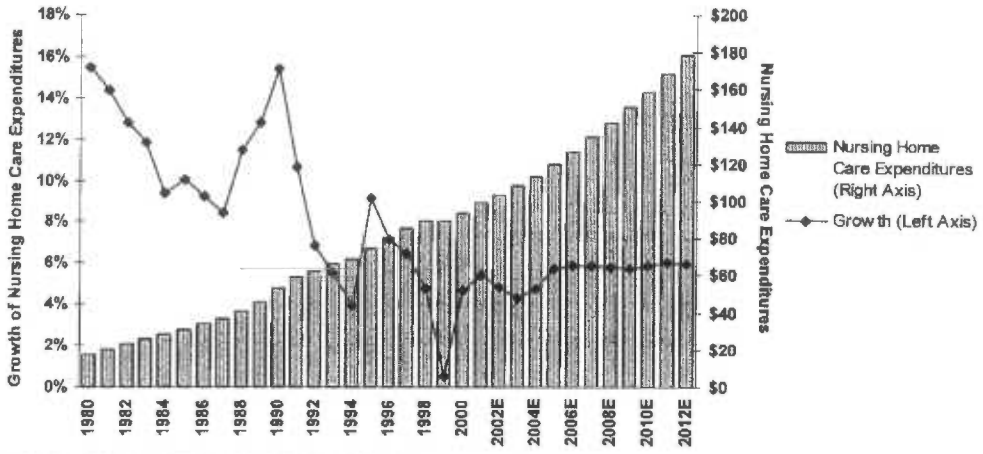
Source: CMS, OSCAR data.

The largest chains have divested beds faster than the overall sector.

According to CMS' Office of the Actuary, U.S. spending on freestanding nursing home care was $98.9 billion in 2001, up 5.5% from 2000. As seen in Figure 3, national freestanding nursing home expenditures grew from $17.7 billion in 1980 to $85.1 billion in 1997, growth of 381% or an average annual rate of 9.7%. During this same period, Medicare freestanding nursing home expenditures exploded from $307 million to $9.6 billion, growth of 3022% or an average annual rate of 30.0%. Nursing home care was one of the fastest growing components of the Medicare program during that time.

From 1980 to 1997, Medicare nursing home spending grew eight times more than total nursing home spending.

Figure 3: National Freestanding Nursing Home Care Expenditure Growth, 1980-2012E



Source: CMS, Office of the Actuary, National Health Statistics Group.

Before BBA 1997 mandated the implementation of SNF PPS, Medicare paid SNFs based on their reported costs of care, subject to certain limits for routine costs (*e.g.*, nursing, room, and board). Not being subject to the same limits, ancillary services skyrocketed during this time. Utilization also grew rapidly, while average acute-care hospital length of stay decreased.

To curb these growth rates, Congress mandated the implementation of a SNF prospective payment system, which pays a per diem rate adjusted for resource needs and geographic

location. The implementation of SNF PPS caused Medicare freestanding nursing home spending to decline 18% in 1999 and national freestanding nursing home spending grew only 0.5%. Growth picked up again after Congress created temporary add-on payment provisions to help the industry transition from the cost-based to the PPS in BBRA 1999 and BIPA 2000.

Credit Suisse First Boston (CSFB) believes that Medicare's prospective payment system for inpatient hospital stays, implemented in 1983, encourages hospitals to discharge patients "quicker and sicker" compared to a cost-based payment system. The average acute-care hospital length of stay decreased from 4.95 days in 1992 to 4.00 days in 1999, a drop of 19%. CSFB believes this trend resulted in relatively sicker hospital discharges, increasing the number and acuity of cases requiring skilled nursing facility care. Increased utilization and payment per stay contributed to the rapid rise of Medicare nursing home care expenditures in the 1990s.

INDUSTRY PERFORMANCE

Add-on Payment Sunset

About $1.4 billion of SNF add-on payment provisions sunset on October 1, 2002. For fiscal 2003, the effect of the sunset was partially offset by a market basket[3] increase of 3.1% minus 0.5% as set forth in BIPA 2000, for a net increase of 2.6% (about $400 million). In addition, SNFs retained about $1.0 billion of separate add-on payments in fiscal 2003, which will remain in effect until case-mix refinements are made to the resource utilization group (RUG) system.[4] CMS has indicated that it does not plan to implement the case-mix refinements for fiscal 2004. CMS is required to report to Congress alternatives to the existing RUG system by January 1, 2005. The add-on provision sunset is further described in the text box on page 9. In May 2003, CMS proposed a full market basket increase of 2.9% to Medicare SNF payments for fiscal 2004. The proposed rule will result in nearly $400 million in increased payments.

For-profit, Publicly Traded Nursing Facility Chains

The major, publicly traded, U.S.-based companies in the nursing facility sector are Manor Care, Beverly Enterprises, Extendicare Health Services (the U.S. subsidiary of the Canadian-based Extendicare, Inc.), Kindred Healthcare (formerly Vencor), Mariner Health Care (formerly Mariner Post-Acute Network), Sun Healthcare, and Genesis Health Ventures. Kindred and Genesis both emerged from bankruptcy proceedings in 2001. Mariner and Sun emerged from bankruptcy in 2002. Integrated Health Services, which is not publicly traded, continues to undergo Chapter 11 bankruptcy restructuring.

Figure 4: Market Cap Table, U.S. Nursing Facility Companies

($ in millions)

	Ticker	Market Cap
Manor Care	HCR	$ 2,113
Genesis Health Ventures	GHVI	$ 672
Beverly Enterprises	BEV	$ 322
Kindred Healthcare	KIND	$ 293
Extendicare Health Services	EXE/A	$ 200
Mariner Health Care	MHCA	$ 91
Sun Healthcare	SUHG	$ 15

Source: Bloomberg. As of May 15, 2003.
Note: Market capitalization is a measure of company's equity value or size, calculated by multiplying share price by the number of shares outstanding.

[3] CMS uses a skilled nursing facility "market basket" to measure inflation in the prices of an appropriate mix of goods and services included in covered skilled nursing facility stays. The price of items in the market basket is measured each year, and Medicare payments are adjusted accordingly.

[4] Medicare pays for SNF services under a prospective payment system (PPS). Under the PPS, each beneficiary is designated to one of 44 resource utilization groups (RUGs). Each RUG includes patients with similar service needs that are expected to require similar amounts of resources. The per diem payment rate for each RUG is calculated as the sum of three components for 1) routine services (*e.g.*, room and board, linens, and administrative services), 2) nursing services, and 3) therapy services.

Post-BBA Medicare Add-On Payments

After the skilled nursing facility industry asserted financial difficulty as a result of the prospective payments system (PPS) implementation, Congress passed several temporary Medicare reimbursement increases in BBRA 1999 and BIPA 2000 to help skilled nursing facilities transition from a cost-based payment system to the PPS. Congress mandated the SNF PPS in order to encourage efficiency and control skyrocketing costs of Medicare nursing facility care. Deutsche Bank's Henry Reukauf believes the nursing facility industry has already cut costs significantly and does not have many more remaining avenues to improve efficiency.

Figure 5: SNF Add-on Payment Descriptions

Add-on Description	Statute	Comment	Status	Average Per Diem Effect, FY2003	Annual Payments, FY2003
20% increase for 15 high-acuity RUGs(1)	BBRA 1999	20% increase will be eliminated once HHS refines the RUGs	Current	$19.88	$1.0 billion
6.7% increase for 14 rehabilitation therapy RUGs	BIPA 2000	Redirected the 20% increase granted in BBRA 1999 from 3 of those 15 RUGS to an additional 11 RUGs	Current	Neutral	Neutral to 20% increase in BBRA 1999
4% increase across all RUGs	BBRA 1999	Increased adjusted Federal per idem payment rate, exclusive of 20% increase	Sunset on 10/1/02	$9.94	$500 million
16.66% increase for nursing component	BIPA 2000	Increased nursing component of case-mix adjusted Federal rate	Sunset on 10/1/02	$17.89	$900 million
Elimination of market basket index reduction of 1.0% (enacted by BBA 1997)	BIPA 2000	1.0% increase in fiscal year 2001 retained in base rate when CMS applied update for fiscal 2002 rates	Current	$1.99	$100 million

Source: CMS.
Note: Average Medicare per diem payment, including beneficiary co-payment, is estimated to be $295 in fiscal year 2003. The fiscal year for SNF Medicare payment begins October 1.
(1) Resource Utilization Group (RUG): Under the SNF prospective payment system, each beneficiary is designated to one of 44 RUGs. Each RUG includes patients with similar service needs that are expected to require similar amounts of resources. Each RUG has a per diem payment rate.

Provisions for the 4% across-the-board increase and the 16.66% nursing component increase sunset as scheduled on October 1, 2002. Wall Street analysts generally do not expect legislation to restore these add-on payments given increased concerns about deficit spending and conflict in the Middle East. Even Ankur Gandhi, a Goldman Sachs debt analyst who is known for her atypically more positive outlook on the nursing facility sector, characterizes the negative impact on certain nursing facility operators:

> [T]he October 1, 2002 reduction in Medicare reimbursement has been detrimental for the nursing home sector. This, combined with Medicaid rate pressure and increases in professional liability costs, has resulted in a worsening of operating results for nursing homes and minimal future growth potential, a lack of access to capital markets for many operators, and bankruptcies of smaller chains such as Centennial Healthcare and now potentially Sun Healthcare.

In the mid-1990s, profit margins of the large, for-profit nursing facility chains were in the 5% to 7% range. In 2002, the average profit or net income margin was 2.2% for Beverly, Extendicare, Genesis, Kindred, and Manor Care, Mariner, and Sun. Calendar year 2002 results were impacted by one quarter of operations after the add-on provision sunset.

Figure 6: Publicly-Held Nursing Facility Company Income Statement Summaries, 2002

($ in millions)

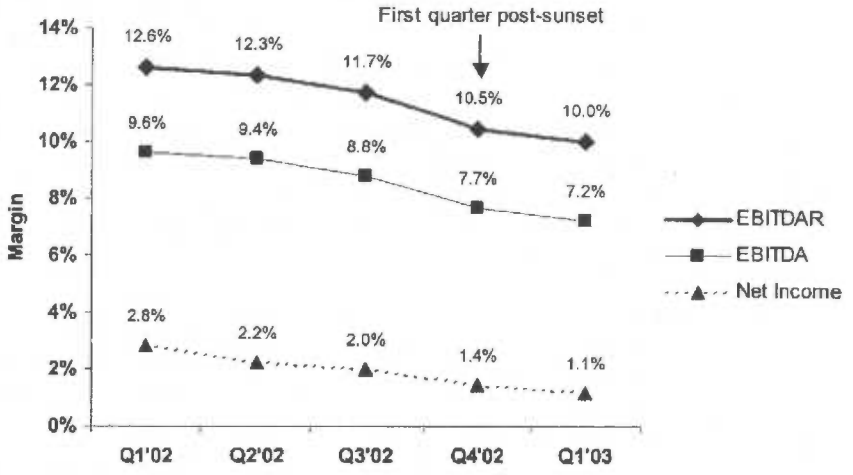
	Beverly (BEV)	Extendicare (EXE/a)[1]	Genesis (GHVI)[2]	Kindred (KIND)[2]	Manor Care (HCR)	Mariner (MHCA)[2,3]	Sun (SUHG)[2,4]	Average[5]
Revenue	$ 2,494.2	$ 815.1	$ 2,654.3	$ 3,357.8	$ 2,903.4	$ 1,183.7	$ 1,598.2	NM
EBITDAR Margin	11.9 %	11.2 %	9.6 %	12.3 %	13.9 %	8.6 %	9.1 %	10.9 %
EBITDA Margin	8.4 %	9.9 %	8.5 %	4.3 %	13.2 %	6.1 %	1.1 %	7.4 %
EBIT Margin	5.0 %	5.3 %	6.1 %	2.1 %	8.9 %	4.2 %	(0.6)%	5.2 %
Pretax Margin	2.5 %	1.1 %	4.3 %	2.0 %	7.7 %	2.3 %	(1.5)%	3.3 %
Net Inome Margin	1.6 %	0.6 %	2.6 %	1.2 %	4.8 %	2.2 %	(1.5)%	2.2 %

Sources: Company filings and analyst models.
Notes: Income statement data presented on a consolidated basis and included non-nursing facility lines of business, which may be significant. All non-recurring items are excluded from results.
(1) Canadian-based Extendicare generated 73% of 2002 revenue in the U.S. through its wholly owned subsidiary Extendicare Health Services and its subsidiaries; results shown are for U.S. operations only in U.S. dollars.
(2) Because these companies emerged from Chapter 11 bankruptcy using "fresh-start" accounting, results are shown for 2002 operations post-emergence only. Unless noted otherwise, results are shown for full calendar year 2002.
(3) Mariner results include operations for eight months ended December 31, 2002 only.
(4) Sun results include operations for ten months ended December 31, 2002 only.
(5) Averages exclude negative margin values.
Definitions: Margin: Value expressed as a percent of total revenues.
EBITDAR: Earnings before Interest, Taxes, Depreciation, Amortization, and Rent
EBITDA: Earnings before Interest, Taxes, Depreciation, and Amortization.
EBIT: Earnings before Interest and Taxes.
Pretax: Earnings before Taxes.

Since the add-on provision sunset, the nursing facility industry has reported financial results for the fourth quarter of 2002 and the first quarter of 2003. The sunset's impact varied from provider to provider. Fourth quarter revenue declines attributed to the sunset were $14.0 million for Beverly (2.3% of revenues), $8.8 million for Mariner (2.0%), and $15.0 million for Kindred (1.8%). Following the sunset, margins continued to decline.

Figure 7: Average Margins for Large Publicly Traded Nursing Facility Chains, Quarterly

The Medicare add-on provision sunset reduced margins further in the fourth quarter of 2002.



Source: Public filings, company information, and analyst models.
Note: Results exclude extraordinary and non-recurring items. Companies represented include Beverly, Extendicare Health Services, Kindred, Genesis, and Manor Care. Calendar year quarters. Meaningful quarterly data is unavailable for Sun and Mariner, which both emerged from bankruptcy mid-year. Kindred and Genesis financials reflect company reorganizations post-Chapter 11 filings.

Both Wall Street and the nursing facility industry recognize Medicare payment rates more than cover the cost of care for Medicare patients. Both the General Accounting Office (GAO)[5] and the Medicare Payment Advisory Commission (MedPAC)[6] concur that Medicare payment for nursing care exceeds costs. In its March 2003 report to Congress, MedPAC estimates that the Medicare margin for all SNFs will be about 5% in fiscal 2003. GAO estimates the median Medicare margin for all freestanding SNFs was 19% in 2000.

Medicare and private pay revenue subsidize Medicaid losses.

Investors and industry representatives also agree that many nursing facilities depend on higher payments from Medicare and private pay (about one-third of patient days combined) to subsidize lower payments from Medicaid (two-thirds of patient days).[7] The GAO acknowledges that the larger Medicaid's share of a SNF's patient days, the smaller the SNF's total margin. MedPAC also acknowledges the cross-subsidy, but believes that it is "an inefficient way of improving the financial situation of this industry." MedPAC cites Medicare's small revenue mix, a disincentive for states to increase Medicaid funding, and inappropriate fund allocation towards high-Medicare-mix instead of high-Medicaid-mix facilities as flaws in the cross-subsidy. Industry representatives counter that, although not ideal, this cross-subsidization is critical for the industry's short- to medium-term sustainability. In an industry-commissioned survey, accounting firm BDO Seidman estimated that the average Medicaid payment of about $115 per day fell short of costs by $9.78 per day in 2000. BDO also estimated that unreimbursed Medicaid nursing care costs exceeded $3.0 billion in a survey of 37 states, or $3.5 billion when extrapolated to all 50 states, in 2000.

Industry estimates suggest that average Medicaid payment falls short of costs.

Not-for-profit Nursing Facilities

About 28% of nursing homes are not-for-profit entities, meaning that revenues generated in excess of costs must be reinvested back into the entity. The GAO has used Medicare cost report data to look at nursing home profit margins by ownership. The GAO found that the median total margin for not-for-profit SNFs was 0.6% in 1999 and 0.3% in 2000, compared to for-profit margins of 1.6% in 1999 and 2.2% in 2000.

The American Association of Homes and Services for the Aging (AAHSA), an industry association for the not-for-profit long-term care industry, did a similar analysis of not-for-profit SNF margins. AAHSA bases its analysis on the 990 federal tax form, which not-for-profit organizations with annual revenues over $25,000 are required to file with the IRS. AAHSA estimated that average total margin of a not-for-profit, freestanding, Medicare-certified SNF was 1.9% for the tax year 2001. The AAHSA study found that facilities incurred a *negative* 4.3% operating margin, and relied on public contributions, investment income and principal from endowments, and the proceeds from sales of assets to cover operating losses.

Not-for-profit margins are slim.

Although neither of these analyses is directly comparable to the GAAP (generally accepted accounting principles) financial reporting required of the publicly traded nursing facilities, they do corroborate each other in showing that not-for-profit margins are slim. The GAO study shows that not-for-profit margins are lower than those of the for-profit facilities. Also, the AAHSA study illustrates how not-for-profit facilities rely on supplemental sources of income beyond program revenues.

[5] The General Accounting Office (GAO) is the audit, evaluation, and investigative arm of Congress.
[6] MedPAC is an independent federal body that advises the U.S. Congress on issues affecting the Medicare program.
[7] For further discussion on payor mix, see pages 23-24.

Expenses

Nursing facilities incur a variety of operating expenses for rent, labor, food, supplies, drugs, equipment, insurance, administration, and other overhead. Investment analysts recently have focused primarily on labor and liability insurance cost trends.

Labor

During the late 1990s, many nursing facilities cited rapidly escalating labor costs, which were exacerbated by a nursing shortage, as a contributor to deteriorating financial performance. Employee costs represent nursing facilities' largest expense at approximately 55% to 65% of net revenues, according to Bear Stearns' Jason Kroll.

A labor shortage continues to challenge the industry, although this pressure may be moderating.

While the nursing shortage continues, analysts have noticed a recent moderation in labor cost growth as nursing facilities are decreasing reliance on more expensive nursing staffing agencies and turnover is lower in a weak economy. Merrill's A.J. Rice comments that Manor Care's 2002 and first quarter 2003 results showed that "[l]abor rate pressures are showing signs of moderating." A 2002 industry survey found that nursing facilities experienced lower vacancy rates among nursing positions in June 2002 compared to June 2001. Nonetheless, a significant nursing shortage—about 96,000 vacancies in 2002, particularly for the most highly trained nurses—continues to challenge the industry. High turnover also demands that nursing facilities offer attractive wages and benefits to retain staff.

Liability Insurance

Liability costs are skyrocketing.

More concerning to analysts than labor costs is the rising cost of liability insurance and settlement payments. JPMorgan's Matthew Ripperger reports that in 2002, three major nursing facility companies announced unexpected material increases in their annual insurance accruals (*i.e.*, reserved resources which estimate future settlement payments): Beverly was up 50% to $66 million, Kindred was up 50% to $82 million, and Manor Care was up 20% to $72 million. Jason Kroll of Bear Stearns estimates that nursing facility liability insurance costs continue to grow between 25% and 35%.

The average liability claim size has tripled over the last ten years.

Lehman's Adam Feinstein notes the rising number of lawsuits and cost of settlements has depressed earnings. Based on data provided by the long-term care industry, AON Risk Consultants found, "Countrywide increases are the result of an explosion in litigation that started in a handful of states and is spreading to a multitude of regions throughout the country." The national average of liability costs per occupied skilled nursing bed has grown at an average rate of 24% per year since 1991. The analysis also found that the average size of claims, as well as the number of claims per 1,000 beds, has tripled over the past ten years. Figure 8 shows the growth of these costs in recent years.

Figure 8: Long-Term Care Faces Increasing Liability Costs

	2000	Growth	2001	Growth	2002	Growth
Average liability loss costs / occupied long term care bed	$2,100	15%	$2,340	11%	$2,880	23%
Average size of a professional liability claim	$182,000	9%	$182,000	0%	$198,000	9%
Average claims per year per 1,000 beds	11.5	6%	12.8	11%	14.5	13%

Source: AON Risk Consultants.

These increasing costs parallel the exit of many insurance carriers from the long-term care provider liability market altogether. Over the past five to six years, the number of carriers offering long-term care provider liability insurance has been declining according to a preliminary study conducted by HHS' Office of the Assistant Secretary for Planning and

Evaluation. For example, in Texas, the number of state-licensed insurance carriers who provide this type of insurance has dropped from 8 in 1996 to 2 in 2002. In Florida, there are no state-licensed carriers of long-term care provider liability insurance. Goldman's Ankur Gandhi writes:

Liability insurance premiums rise while coverage is reduced.

> As a result of the rise in severity and frequency of claims filed, and owing to the unpredictable nature of results, many insurance companies have exited the market and no longer provide coverage. Consequently, annual commercial insurance premium levels increased more than 130% on average between 2000 and 2001, often with reduced coverage. This increase is significantly higher than the annual countrywide professional liability loss cost increase of 24%, and is the result of the inadequacy of past premium levels and the uncertainty associated with projecting future claims.

Legg Mason's Jerry Doctrow writes, "[V]ery high liability expense levels will continue to pressure nursing home operator cash flows and operating margins for the next year or two at least, in some cases forcing firms into bankruptcy reorganization when liability costs are added to Medicare and potential Medicaid cuts."

Many nursing facility companies either have divested or plan to divest operations in certain states with high liability costs, including Florida, Texas, and other Gulf states. Extendicare exited the Texas market in the fourth quarter of 2001 and the Florida market in the second quarter of 2002. Beverly plans to divest facilities that represent 50% of projected 2002 patient care liability costs. Kindred plans to divest its Florida operations. Kroll believes that this strategy may stave off further increases in accruals in the near-term future, rather than reduce costs outright. Strategic exits may help limit future liability, but nursing facilities are still exposed to a liability "tail" for incidents previous to the closure or sale of the facility, depending on state statutes of limitation.

Some nursing facilities have elected to operate without liability insurance.

There have also been reports of smaller, independent nursing facilities that have elected to operate without insurance altogether. For example, a University of South Florida study found that before Florida required all nursing facilities to have liability coverage, one in five facilities were without coverage. The Texas not-for-profit nursing home association estimates that 50% of nursing facilities operate without liability coverage.

Nursing facilities may benefit from state tort reform measures, notably in Florida, Texas, California, and Mississippi. Recently enacted reform measures will, however, likely be subject to court challenges by the plaintiff bar, further delaying positive changes to nursing facility liability insurance costs. Many other state legislatures are considering reform proposals. Ohio, which has not historically been a highly litigious state from the perspective of nursing facility claims, passed pre-emptive tort reform measures as well in January 2003.

Some nursing facilities have begun using arbitration to limit medical liability. Patients are asked upon admission to agree to arbitration to settle future disputes. In the fourth quarter of 2002, Beverly reported it was able to sign up 75% of newly admitted patients for arbitration. While Kroll is hopeful that arbitration may be part of the solution, he points out, "[I]t is unclear whether it is only the less litigious patients who are agreeing to arbitration" and therefore whether this approach will materially affect liability costs.

ACCESS TO CAPITAL

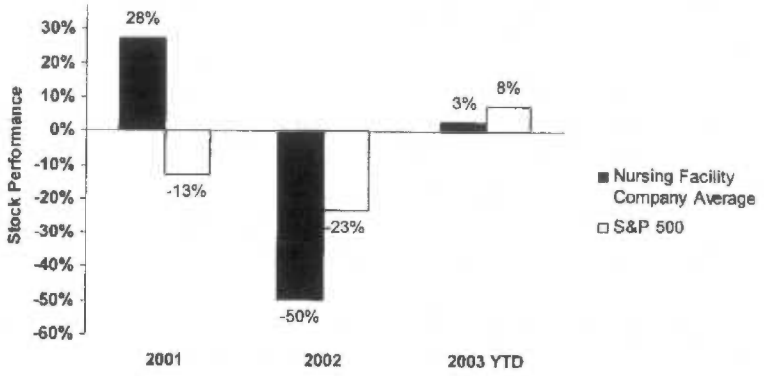
Sources & Uses of Capital

Nursing facilities invest capital for purposes including maintaining and updating current facilities, building or acquiring new facilities, reducing debt and debt payments, and repurchasing stock. If nursing facilities do not generate sufficient cash flow, capital may also be used to sustain operations.

Equity

Equity analysts have a generally negative outlook on the nursing facility sector. The publicly traded nursing facility chains have averaged a 3% year-to-date return, compared to the S&P 500 performance of 8%.

Figure 9: Average Nursing Facility Company Stock Performance versus S&P

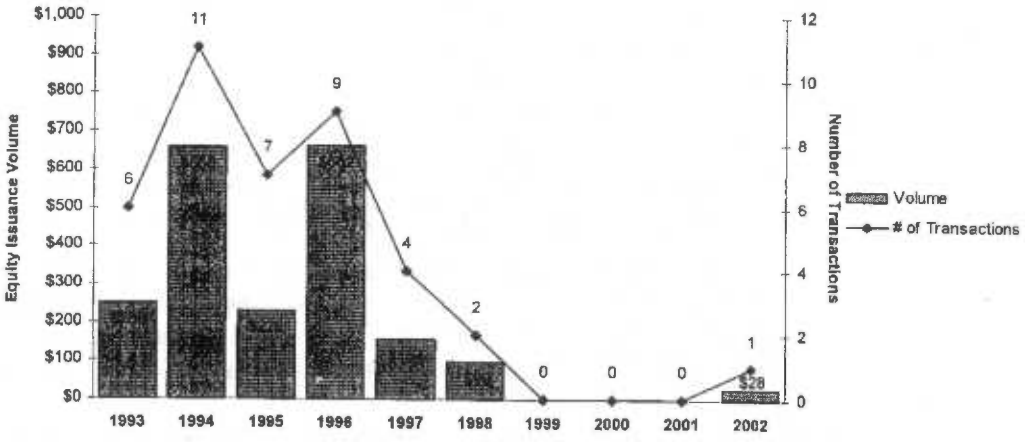


Source: Bloomberg. As of May 15, 2003. Average is equally weighted. Average includes Beverly (BEV), Extendicare (EXE/A), Genesis (GHVI), Kindred (KIND), Manor Care (HCR), Mariner (MHCA), and Sun Healthcare (SUHG) while trading under noted tickers for specified years.

Uncertainty reduces the industry's ability to forecast and manage finances, which in turn reduces access to capital. Most analysts do not believe the industry can raise capital in the equity markets due to continuing uncertainty about the possibility of legislation that may affect Medicare rates, threats to Medicaid rates, and skyrocketing liability insurance costs.

Figure 10: Public Equity Issuance for Nursing Facility Industry, 1993-2002

($ in millions)



No public equity was issued for the nursing facility sector in 1999, 2000, and 2001.

Source: SDC and Salomon Smith Barney. As of April 18, 2003.

Debt

The nursing home industry obtains most long-term financing from the debt markets. The interest rate payment typically rises as the quality of the bond declines. Being highly leveraged negatively impacts a company's profitability, as interest payments eat into profit margins.

Debt analysts focus on a company's ability to pay its debt service and other obligations. In other words, debt analysts look at what major payments are due and whether a company has the ability to meet these obligations without entering bankruptcy. The three main statistics used in this type of analysis are:

- EBITDAR - earnings before interest, taxes, non-cash charges (depreciation and amortization), and rent. EBITDAR shows cash flow available to pay interest, rent, and taxes after paying operational costs. EBITDAR is used to make apples-to-apples comparisons between companies because most companies finance their businesses differently and it represents earnings before financing costs.[8]
- Rent Adjusted Leverage - measures how much the company has borrowed or obligated through leases as a multiple of the cash flow available to pay such debt service and lease payments. The rule of thumb is that at a rent adjusted leverage multiple of 5x it is very difficult to raise new capital—at 6x it is nearly impossible.
- Fixed Charge Coverage - indicates the company's ability to pay rent and interest based on the amount of cash flow remaining after capital expenditures. Analysts consider a 2x fixed charge coverage to be the minimum required to raise capital.

The following CSFB analysis in Figure 11 shows these three ratios for the publicly traded, for-profit chains. The analysis includes a sensitivity analysis of how these ratios would have been impacted if the sunset had affected the full year of 2002 instead of just the fourth quarter. This may help investors understand ratio trends for 2003, which will be the first full year post-sunset.

Figure 11: Publicly Traded Nursing Facility Chain Debt Ratios, Sensitivity Analysis

	Actual 2002 Ratios			Estimated Ratios as if Sunset was in Effect for Full-Year 2002		
Company	Adjusted EBITDAR[1] Margin	Net Rent Adjusted Leverage[2]	Fixed Charge Coverage[3]	Adjusted EBITDAR[1] Margin	Net Rent Adjusted Leverage[2]	Fixed Charge Coverage[3]
Beverly Enterprises	12.0 %	4.8 x	1.3 x	10.9 %	5.3 x	1.1 x
Genesis Health Ventures	9.5 %	3.1 x	2.7 x	8.7 %	3.4 x	2.4 x
Extendicare Health Services	11.8 %	4.7 x	1.8 x	10.8 %	5.3 x	1.6 x
HCR Manor Care	14.1 %	2.0 x	5.1 x	12.8 %	2.2 x	4.4 x
Kindred Healthcare	12.7 %	4.9 x	1.2 x	11.9 %	5.3 x	1.1 x
Average	**12.0 %**	**3.9 x**	**2.4 x**	**11.0 %**	**4.3 x**	**2.1 x**

Source: Credit Suisse First Boston analysis based on company reports.
(1) EBITDAR is Earnings Before Interest, Tax, Depreciation, Amortization, Rent, and unusual or extraordinary items.
(2) Net Rent Adjusted Leverage = (Total Debt + 8 x Rent Expense) / EBITDAR
(3) Fixed Charge Coverage = (EBITDAR - Capital Expenditures) / (Rent Expense + Net Interest)

Most debt analysts share the negative outlook of equity analysts on the nursing facility sector for the same reasons. Deutsche Bank's Reukauf believes that the add-on provision sunset could push some other highly levered nursing facilities into bankruptcy, given that facilities are already tightly constrained in how much they can cut back on expenses. This

[8] Note: The EBITDAR margin is *not* the same as a net income margin. A net income margin is earnings (profits) after all other obligations have been met, divided by net revenues.

is particularly true for those facilities that depend heavily on Medicare revenue to subsidize Medicaid patients.

Other analysts, although in the minority, believe that certain nursing facility bonds are trading below value. Ankur Gandhi of Goldman Sachs uses Extendicare as an example of her more positive outlook for debt holders. She writes:

> From a bondholder's prospective, however, we continue to be bullish on the Extendicare subordinated notes, even though we look for marginal revenue growth and for EBITDA to decline 14.1% in 2003, owing to the Medicare reduction. We are bullish because (1) the company does not face an imminent liquidity crisis, as it has no major debt due until 2007; (2) the company does not operate in states with high patient liability costs; (3) at a current yield of 13.1%, the bonds offer an attractive relative buying opportunity versus the rest of high-yield healthcare, which trades at an average yield of 8.7%; and (4) a strong management team has been able to drive improvements in operating results by improving its quality mix.

Gandhi also notes that the price of Extendicare's subordinated notes has not moved in tandem with the improvement in certain credit statistics. This reflects investors' ongoing concerns about an uncertain external environment for all nursing facility operators.

Figure 12 shows the major debt issues for the nursing facility sector and the relative rating by Moody's and Standard and Poor's. Deteriorating industry performance has resulted in rating agency downgrades.

Figure 12: Publicly-Held Nursing Facility Bonds

($ in millions)

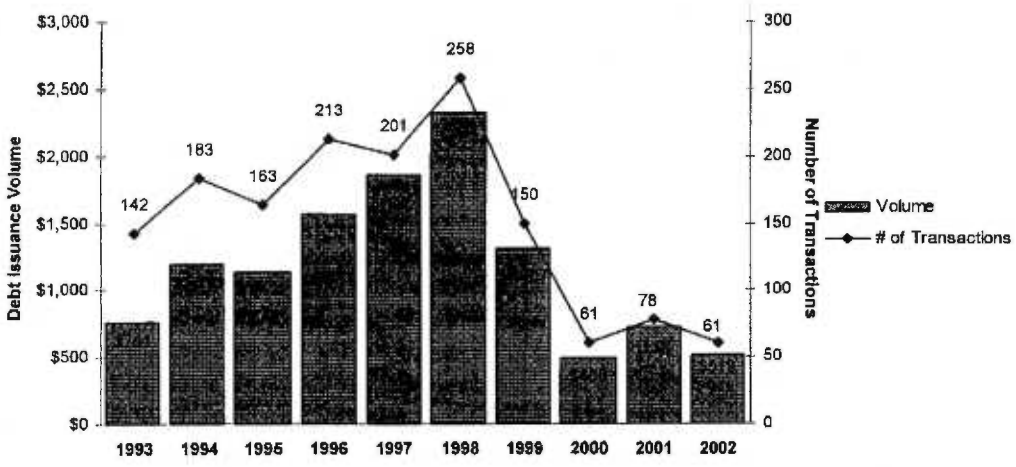
Issuer	Amount Issued	Amount Outstanding	Issue Date	Coupon	Maturity	Moody's Rating	S&P Rating
Beverly Enterprises Inc.	$ 30.0	$ 17.9	7/22/1993	8.625 %	10/1/2008	Ba2	B+
	20.0	11.0	4/29/1993	8.750 %	7/1/2008	Ba2	B+
	180.0	180.0	2/15/1996	9.000 %	2/15/2006	B1	B+
	200.0	200.0	4/25/2001	9.625 %	4/25/2009	B1	B+
Extendicare Health Services, Inc.	$ 200.0	$ 200.0	11/25/1997	9.350 %	12/15/2007	B3	CCC+
	150.0	150.0	6/20/2002	9.500 %	7/1/2010	B2	B-
Genesis Health Ventures	$ 25.0	$ 19.3	10/8/1992	9.250 %	9/1/2007	NR	NR
Kindred Healthcare Inc.	$ 300.0	$ 160.5	4/20/2001	LIBOR+4.5 %	4/20/2008	NR	NR
Manor Care Inc.	$ 200.0	$ 200.0	3/8/2001	8.000 %	3/1/2008	Ba1	BBB
	150.0	150.0	6/4/1996	7.500 %	6/15/2006	Ba1	BBB
	200.0	200.0	4/15/2003	6.250 %	5/1/2013	Ba1	BBB
	100.0 (1)	100.0	4/15/2003	2.125 %	4/15/2023	Ba1	BBB
Mariner Health Care, Inc.	$ 150.0	$ 150.0	5/13/2002	LIBOR+5.5%	5/13/2009	B3	B-

Source: Company management.
Note: Issuance of these kinds of debt involve costs such as underwriting commissions, legal & trustee expenses, debt rating fees, discounted issue price, etc. When such costs are factored in, the effective cost of financing is higher than the nominal coupon rate.
(1) Convertible bond that also has contingent interest component. Absent conversion and contingent interest components, estimated coupon is 7.34%.

As seen in Figure 13, debt issuance has been low in recent years. Debt issuance volume of $519 million in 2002 is less than one-quarter of its peak issuance of $2.3 billion in 1998.

Figure 13: Public Debt Issuance for Nursing Facility Industry, 1993-2002

($ in millions)



Source: SDC and Salomon Smith Barney. As of April 18, 2003.

Over the past twelve months, both Extendicare and Manor Care completed refinancing transactions. Extendicare completed a bond offering in the summer of 2002, although these bonds traded down as investors saw decreased likelihood of Congress extending the add-on payment provisions past October 1, 2002. Manor Care arranged for a refinancing package in April 2003. The company was advised that it would not be able to refinance the entire maturing facility as a bank loan due to the withdrawal of many banks from the nursing facility loan market. This reduced lending pool affected Manor Care even though it does not share the generally weak financial history of other nursing facility chains. In the refinancing, Manor Care arranged for $200 million in new 10-year bonds at 6.25%, another $100 million in 20-year convertible bonds at 2.125%, and a new $200 million, 3-year line of bank credit. Even though the terms of the refinancing were relatively favorable in the current nursing facility environment, the refinancing still resulted in $1 million per month in increased interest expense for Manor Care, according to the company.

Many nursing facility chains will need to refinance in the next several years as illustrated in Figure 14. Debt analysts' outlooks on access to debt markets vary based on the quality of the specific nursing facility's financial information. A high-yield analyst at CSFB believes that Manor Care's success is not a good proxy for the rest of the sector. CSFB believes that nursing facility companies with weaker balance sheets or who lease all of their properties from third party owners, such as Kindred and Sun that (which both recently emerged from bankruptcy), may have difficulty accessing the debt markets.

Figure 14: Nursing Facility Refinancing Outlook

($ in millions)

Issuer	Type of Debt to be Retired	Size of Debt	Maturity	Potential (*Actual*) Source of Refinancing	Refinancing Date	Refinancing Size	Interest Rate Increase (Decrease)
Beverly	Synthetic Lease	$ 50.0	4/26/2004	Asset sales, cash and public bonds as available	-	-	-
	Revolving Credit Line	100.0	4/26/2004				
	Med Term Notes (BFC)	70.0	6/15/2004				
	Publicly-Held Bonds	180.0	2/15/2006				
Extendicare	Bank credit facility	$ 124.5	12/31/2003	*Publicly-Held Bonds*	6/20/2002	$ 150.0	-
Genesis	Secured Notes	$ 242.0	4/2/2007	Subordinated Debt	-	$ 150.0	2.000 %
				Cash		110.0	
	Secured Credit Facility	332.0	10/2/2006	Secured Credit Facility	-	200.0	1.000 %
	Mortgages	50.0	-	-	-	-	-
Kindred	Publicly-Held Bonds	$ 160.5	4/20/2008	Publicly-Held Bonds	-	-	-
	Revolving Credit Line	120.0	4/20/2006	Commercial Bank	-	-	-
	FloridaLeaseDivestiture	72.0	ASAP	Sublease or Purchase&Sale	-	-	-
Manor Care	5 Year Revolving Credit Line	$ 500.0	9/24/2003	*3 Yr. Revolving Credit Line*	4/21/2003	$ 200.0	0.925 %
				10-Yr. Notes	4/15/2003	200.0	4.740 %
				Convertible Notes	4/15/2003	100.0	0.575 %
Mariner	Term Loan	$ 210.0	3/31/2005	Public bonds as available,	-	-	-
	Revolving Credit	22.0	3/31/2005	bankloans	-	-	-
Sun	Revolving Credit Line	$ 150.0	2/28/2005	Revolving Line of Credit	-	$ 125.0	-
	Term Loan and Discount Note	40.0	2/28/2005	Private Placement, Asset Sales, and/or Cash	-	34.0	-
	Unpaid rent	10.5	N/A	Settlement/FacilityDisposal	-	-	-
	Bank Mortgage	20.0	5/1/2004	Private Placement	-	17.0	-

Source: Company management.
Note: Potential Source of Refinancing is speculative and based on management's expectations. Future refinancing will depend upon market conditions and company performance.

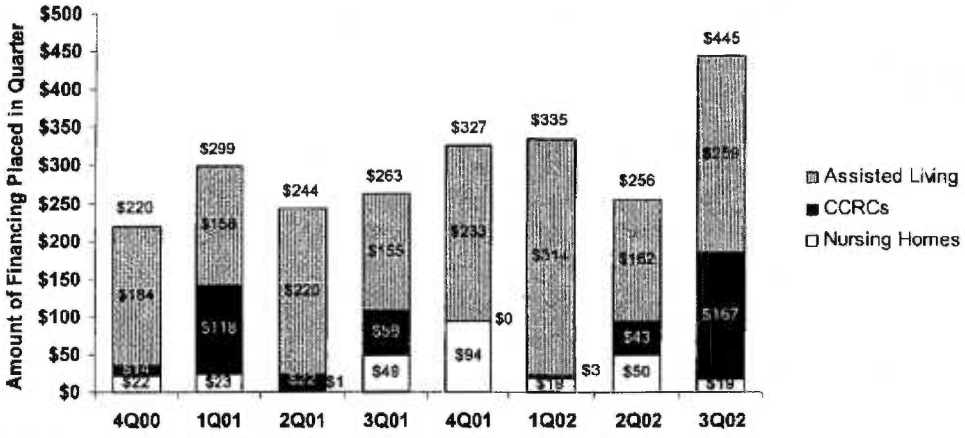
Many nursing facility chains will need to refinance in the next several years.

In addition to the public bond market, SNFs may also seek debt financing from commercial banks and other lenders. This type of financing, although usually more expensive, can be used when access to the public debt and equity markets is not viable. This type of financing is also often short-term in nature and can be attractive for companies looking to grow that are planning to recapitalize later. Figure 15 shows an industry survey of major national lenders and loan volume representing targeted, project-specific financing (not general corporate financing) for the assisted living, continuing care retirement communities (CCRCs), and nursing facility industries combined. Total loan volume peaked in the third quarter of 2002, also the most recently surveyed quarter, while nursing facility loan volume peaked in the fourth quarter of 2001.

The nursing facility long-term debt market is encouraged by government-chartered organizations such as Fannie Mae and Freddie Mac. The Department of Housing and Urban Development and the Federal Housing Administration (HUD/FHA) also supports debt by insuring loans originated by private lenders for new construction, substantial rehabilitation, refinancing, and acquisition for nursing facilities, intermediate care facilities, board care homes, and assisted living facilities. This guaranteed loan program traditionally serves as a credit enhancer in times of tightening mortgage capital availability. The agency insured $1.2 billion in nursing facility loans (which includes a very small loan amount to intermediate care facilities) in FY 2002 compared to $828 million in FY 2001. Most of the increase was to support refinancing activity in the current low-interest environment. Although access to these capital sources exists, competition for funding from these agencies is strong. Nursing facilities must meet certain underwriting requirements and are subject to ongoing certification and regulation.

Figure 15: Total Loan Volume to Long-Term Care Industry by a Sample of Major National Lenders

($ in millions)



Source: National Investment Center for the Seniors Housing & Care Industries.

REITs

Many nursing facility operators lease facilities from REITs.

Real estate investment trusts (REITs) are generally considered higher cost alternatives to more traditional debt financing. Instead of owning their facilities outright, many nursing facility operators lease facilities from REITs. These leases are a form of levered financing. Merrill Lynch's Rice explains how REITs can be the best option for both nursing facilities and other long-term care sectors such as assisted living:

> REIT financing in sale/leaseback deals generally represents 100% of the financing for a given asset, whereas a more traditional asset purchase by an operator is generally financed with a 60%/40% mix of debt and equity.... There are sectors of the healthcare services industry, such as assisted living and skilled nursing, which are utilizing substantial amounts of REIT financing. Generally speaking, the equity market does not currently represent an attractive funding option for these sectors, and the financial troubles of these sectors over the last few years have caused many traditional lenders to exit the market. Against this backdrop, the 100% financing provided by a REIT is, in many cases, the best option for many assisted living and skilled nursing operators.

REITs do not assume the same liability risks as those of the tenant operators.

Because nursing facility operators are struggling, one might ask why REITs invest in nursing home facilities. As property owners and landlords, REITs do not assume the same patient care liability risks as those of the tenant operators. Many operators who lease these facilities may be small and carry minimal insurance, or none at all. If faced with a large settlement, these operators may simply close their businesses. Although a bankrupted operator obviously can no longer pay rent, the REIT can still fall back on the hard assets of the facility and can choose to seek another operator to run the facility. There are a number of healthcare REITs, most of which have some investments in nursing facilities.

Figure 16: Examples of Health Care REITs and SNF Rental Income

($ in millions)

REIT	Nursing Facilities Owned	2002 Nursing Facility Rental Income	Percent of Total Rental Income	Total Rental Income
Health Care Property Investors	184	$85.8	24.7%	$347.8
Health Care REIT	76	$64.4	35.9%	$179.5
Healthcare Realty Trust	31	$174.0	11.7%	$1,484.9
National Health Investors	N/A	$10.6	68.9%	$15.4
Nationwide Health	158	$55.9	40.2%	$139.1
Senior Housing Properties Trust	60	$12.9	10.6%	$122.4
Ventas	220	$872.2	71.4%	$1,221.4

Source: Company filings.

One REIT analyst notes that financing for the health care REITs became more difficult after the add-on provision sunset. Nursing facility operators that function in a "hand-to-mouth" business environment may have less flexibility to meet lease obligations as Medicare payments are reduced and Medicaid payments are threatened. However, health care REIT financing is still available, albeit at a higher cost relative to both pre-PPS days as well as other REIT sectors. Despite the analyst's cautious outlook, he does not believe the sector is returning to the worst days of 1998 and 1999: "The current nursing home environment does not resemble 1998 when everybody tipped over at once, but it is more likely that we will see some fall-out throughout 2003 as a result of the add-on sunset."

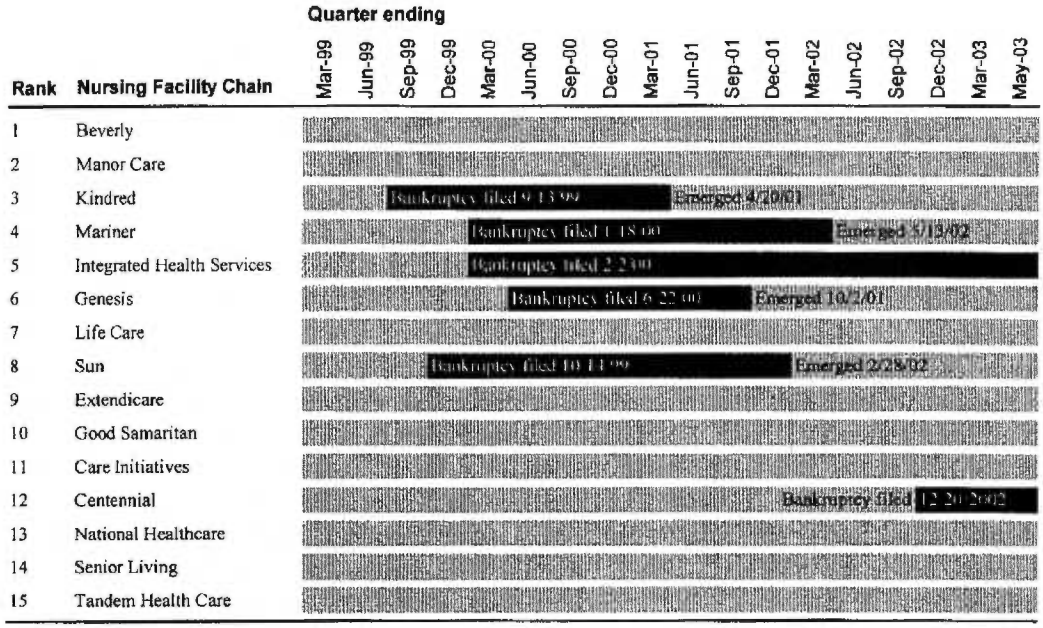
Solvency

Ultimately, access to capital is related to whether a nursing facility can generate positive operating cash flow and stay solvent to avoid bankruptcy. Ankur Gandhi, high-yield debt analyst at Goldman Sachs, notes, "We have seen a number of small operators file for bankruptcy since October 1, 2002. The largest so far has been the December 27, 2002 filing announced by Centennial Health, which operates 100 skilled nursing facilities." These continuing bankruptcies raise concerns among investors that the industry is returning to the 1999-2000 period when five of the top eight nursing facility operators filed for bankruptcy. While in bankruptcy proceedings, these nursing facilities were able to continue to operate and provide care.

Integrated Health Services continues to undergo Chapter 11 bankruptcy restructuring. Kindred and Genesis both emerged from bankruptcy in 2001. Mariner Post-Acute Network and Sun Healthcare emerged from bankruptcy in 2002. However, a CSFB high-yield bond analyst believes Mariner and Sun are "not yet fully out of the woods," with higher exposure to the California market (where Medicaid rate cuts loom) and fragile capital structures that rely on renegotiating leases to be successful. For example, Sun is withholding rent and mortgage payments for over half of its facilities to stave off re-filing for bankruptcy. Sun hopes to transition these facilities to new operators. If the landlords of these properties aggressively pursue and obtain leasehold or other property damages over the next year, Sun may be forced to re-file for bankruptcy protection, according to the company's filings with the SEC. For other large nursing facility chains, CSFB believes that despite thin margins, well-managed nursing facilities should be able to survive under current conditions. CSFB notes, "The key obstacles to these companies accessing the capital markets is the uncertainty over patient care liability, Medicaid eligibility and reimbursement levels and the possibility, however remote, that Medicare rates could be cut."

One chain is withholding rent and mortgage payments to stave off bankruptcy re-filing.

Figure 17: Bankruptcy Filings among Top 15 Nursing Facility Chains since 1999



Source: Public filings, company information, and analyst models.
Note: Chains ranked by bed count, as of April 3, 2003.

Three nursing facility chains filed for bankruptcy during the past six months.

Although most of these bankrupted chains have emerged, there have been several notable, albeit smaller, nursing facility bankruptcy filings in recent months. Centennial Healthcare (which operates 77 SNFs with 8,600 beds in 19 states and the District of Columbia) filed for bankruptcy in December 2002. Regional chains Lexington Healthcare Group (which operates 8 facilities in Connecticut) and Ballantrae Healthcare (which operates 35 facilities in six states and is based in New Mexico) filed for bankruptcy in the spring of 2003.

Not-for-Profit Access to Capital

The smaller for-profit and not-for-profit facilities are estimated to comprise 70% of the industry.

The outlook for the smaller and not-for-profit facilities may be bleaker compared to the larger, for-profit facilities. The smaller or not-for-profit facilities must rely on the debt markets to raise capital or in some cases attract philanthropic donations. Gandhi notes that the add-on had a greater impact on the smaller for-profit and not-for-profit facilities, which comprise 70% of the nursing facility industry. While not-for-profit organizations can file for bankruptcy similar to their for-profit peers, many smaller not-for-profits tend to choose to close down operations altogether when unable to overcome a liquidity crisis according to industry sources.

Nursing facilities issue a small portion of the total debt issued by not-for-profit health care providers. According to a Fitch credit rating agency analysis:

> Nonprofit nursing home bond issuance volume fell dramatically to $508.7 million in 2002 from $2.3 billion in 1998, a 78% decline. Nonprofit nursing facility bond volume composed only 1.9% of total health care bond issuance in 2002, with nearly all nursing facility issuance being speculative grade. This is a decrease from 7.1% of total health care bond issuance in 1997. Fitch expects the nonprofit nursing facility sector's volume in 2003 to approximate 2002 levels.

SNF bonds rarely achieve investment grade ratings.

Bonds that finance nursing facility operations are typically unrated because they are generally neither investment grade nor secure enough to warrant the fees associated with obtaining a credit rating. The riskiness of these bonds means that the high interest rates are often prohibitively expensive to nursing facility issuers. Skilled nursing facilities rarely have the credit strength on their own to achieve investment grade ratings, and have difficulty in securing credit enhancement in the form of private bond insurance or letters of credit from government mortgage insurance programs like HUD/FHA or Ginnie Mae. Jeanette Price, a public finance investment banker with Salomon Smith Barney, explains that access to the unrated market is helped by a strong balance sheet, adequate debt service coverage, a credible sponsor, high occupancy, decent Medicaid reimbursement, and strong Certificate-of-Need protection. If the bond issue is small, Price believes that it can find sufficient investors without needing to meet the higher credit standards of a large investor pool.

Emily Wong, an analyst at Fitch Ratings notes that her 2003 outlook for nonprofit nursing facilities is "much more negative than [her] outlook for hospitals or continuing care retirement communities," due to nursing facilities' high reliance on Medicaid, limited revenue streams, and rising costs. Wong believes, "Nonprofit nursing home credit profiles will continue to weaken in the near to long term due to industry pressures. Demand from aging baby boomers may save nursing facilities, but this demand is more than 20 years away."

Access to capital is better for SNFs that expand into assisted living and CCRC lines of business.

Rod Rolett of Herbert J. Sims Company, an underwriter that focuses on tax-exempt financing of not-for-profit long-term care companies, believes that access to capital is better for SNFs that are expanding into other types of long-term options, including assisted living and continuing care retirement communities (CCRCs). Rolett observes that seniors paying for their own care are opting for less institutional CCRC and assisted living facilities over SNFs. Charles Lynch of CIBC notes that many of the for-profit, publicly traded chains have begun to diversify in this way:

> Reimbursement environment is restrictive to organic growth for nursing homes, with Medicare rates reduced in 2002 and Medicaid rates moderating. As a result, most companies are in the midst of embarking on strategic initiatives to diversify into adjunct business, such as home care, hospice, therapy, and pharmacy services.

Not-for-profit facilities, many of which may have a religious or civic mission to provide care for seniors, typically are reluctant to respond to decreased demand by self-financed seniors by cutting beds, according to Rolett. Many aim to operate at high occupancy rates without regard to the Medicaid and charity care census.

Many of the nonprofit nursing facilities are dependent on investment income from endowments, funded by philanthropic donations. Because the nursing facility business does not have high margins and does not generate much cash flow, developing adequate endowments is one of the greatest credit challenges for long-term care facilities, according to Price. Fitch notes, "[T]he financial ratios of these [nursing homes that depend on endowment income] have suffered due to reduced investment returns in the past three years.... [P]rudent cash management is important, as the reliance on volatile investment earnings is unpredictable." Following the terrorist attacks of September 11th, philanthropic donations have also fallen off, further challenging not-for-profit SNFs.

REVENUE SOURCES

In 2001, national freestanding nursing home care expenditures totaled $98.9 billion, or 6.9% of total national health expenditures. Medicaid paid for the greatest component of nursing home expenditures at 48%, compared to private sector at 38% and Medicare at 12%.

Figure 18: Freestanding Nursing Home Care Expenditures

($ in millions)

	2001	% of Nursing Home Care Expenditures
Total National Health Expenditures	**$1,424,541**	NA
Nursing Home Care Expenditures	**$98,911**	100 %
Private	**$38,058**	38 %
Out of Pocket	26,866	27 %
Private Insurance	7,523	8 %
Other	3,670	4 %
Public	**$60,853**	**62 %**
Medicare	$11,588	12 %
Medicaid	$46,994	48 %
Federal	28,119	28 %
State and Local	18,875	19 %
Other	$2,271	2 %
Federal	2,100	2 %
State and Local	171	0 %

Source: CMS, Office of the Actuary, National Health Statistics Group.
Note: Under "Public" spending, "Medicaid" includes SCHIP expansion and "Other" includes SCHIP.

Medicaid is the largest payor for nursing home care.

The census mix of Medicare, Medicaid, and private pay patients affects nursing home profitability both due to differentials in payment rates as well as length of stays.

Private Sources

Private Pay

Residents who spend down their assets can become Medicaid eligible.

Among the large for-profit nursing facility companies, private pay and other sources typically comprise 20% of the resident census and typically generate 30% of revenue for nursing facilities. Nursing home residents who pay themselves may eventually spend down their assets to become Medicaid eligible. Some nursing facilities (such as some of those in the Manor Care chain) have historically catered to more affluent customers and still benefit from higher private-pay margins. They do, however, face increasing competition from assisted-living alternatives and expect slowing revenue growth from their private pay business.

Long-Term Care Insurance

Very few Americans buy private long-term care health insurance.

A revenue source in its infancy, long-term care insurance generates a very small portion of nursing facility revenue. Very few aging Americans buy private long-term care health insurance and when they do it is often initiated at an advanced age—defeating the purpose of the insurance design. Inevitably, unless this trend is reversed, likely through changes in tax policy, the growing financing burden will remain on the taxpayer base and present rapidly increasing fiscal pressures on the public programs—Medicare and Medicaid.

Public Sources

Medicare

Among the large for-profit nursing facility companies, Medicare typically comprises 10-15% of the resident census and approximately 25% of revenue. This revenue has dropped from prior years as a result of the Balanced Budged Act of 1997 and the implementation of SNF PPS in 1998. As noted earlier, Medicare payments exceed those of Medicaid. While many of the large for-profit nursing facilities were building up their ancillary services businesses prior to the implementation of the SNF PPS, Medicare revenues allowed the industry to expand despite losses on other lines of business. Now, under the constraints of PPS, providers are forced to operate more efficiently.

Medicare does not cover SNF care on a long-term basis.

Medicare covers SNF services for beneficiaries who have recently been discharged from a stay in an acute care hospital lasting at least 3 days and who need daily skilled care. SNF coverage is limited to 100 days per spell of illness. Medicare does not cover SNF care on a long-term basis. If beneficiaries continue to require care in a skilled nursing facility once Medicare coverage expires, they can pay out-of-pocket as long as they have assets or sufficient income (private pay). Once their assets are "spent-down," they become Medicaid eligible. The per diem rate to the provider typically decreases as patients move along each step from Medicare to private pay to Medicaid.

Medicaid

Medicare payments cross-subsidize lower Medicaid payments in nursing facilities.

Among the large for-profit nursing facility companies, Medicaid typically comprises 65-70% of the resident census and typically generates 45% of revenue for nursing facilities. A nursing home industry trade association estimates that the average Medicaid rate for nursing home care was $113.50 per day in 2001. Higher Medicare payments cross-subsidize lower Medicaid payments in nursing facilities. With Medicaid comprising a much greater percentage of nursing home residents and revenues than Medicare, CSFB believes that uncertainty over Medicaid reimbursement poses a greater threat than Medicare.

As most states must balance their budgets annually, spending for state programs must be cut as revenues fall. Several states have announced Medicaid payment cuts, others have maintained existing levels, and a smaller number have announced modest increases. According to a January 2003 Kaiser Commission on Medicaid and the Uninsured study, 37 states plan to reduce or freeze the amount of funding for nursing care in fiscal 2004.

For the state fiscal year beginning July 1, 2003, the major for-profit nursing facilities chains have projected Medicaid payment increases of 2% to 3%. However, many analysts are more pessimistic, as major hospital chains have projected neutral to negative changes in Medicaid payment to providers.

Recent CMS Issues Related to Medicare SNFs

Proposed 2.9% Increase to Medicare SNF Payments in Fiscal 2004

On May 8, 2003, CMS announced a proposed 2.9% increase in Medicare payment rates to SNFs for fiscal year 2004. The increase will result in nearly $400 million more in Medicare SNF payments. The proposed rule, published in the Federal Register on May 16, also reflects the decision by CMS to retain the current RUG classification system that establishes daily payment rates to skilled nursing facilities based on the needs of Medicare beneficiaries. CMS is continuing to research case mix refinement methods that could appropriately pay nursing facilities for complicated care. The 60-day public comment period ends July 7. CMS will publish the final rule by August 1 for implementation on October 1, 2003, the first day of fiscal year 2004.

Rehabilitation Therapy Caps

The Balanced Budget Act of 1997 created SNF therapy caps for Part B outpatient rehabilitation services. The caps apply to certain providers of outpatient rehabilitation, including SNFs. The payment caps are an annual $1,590 per beneficiary limit on certain Part B outpatient rehabilitation services. The cap applies twice: one $1,590 cap applies to occupational therapy, and a separate $1,590 cap applies to physical therapy and speech therapy combined. The therapy caps were enacted in 1999, but Congress declared a moratorium on these therapy caps in both 2000 and 2001. CMS currently plans to implement these therapy caps in July 2003.

The therapy caps are intended to be per beneficiary. However when initially implemented in 1999, CMS did not have the systems capability to apply this cap if a beneficiary moved to a different provider in another venue. When therapy caps are re-implemented later this year, CMS systems are expected to be able to implement the caps as required by law.

Jason Kroll of Bear Stearns has not included the impact of therapy cap implementation in his financial estimates yet. However, "While this eventuality is not reflected in our projections, there is substantial likelihood, in our view, that the therapy caps could be implemented in July, in which case there would be downside to our estimates...."

Bad Debt Reimbursement

SNFs that provide care to Medicare beneficiaries sometimes incur bad debt because of beneficiaries' failure to pay deductibles. In February 2003, CMS issued a proposed rule to reduce SNF bad debt reimbursements from 100% to 70% over three-year period beginning October 1, 2003. By doing so, CMS would bring the bad debt reimbursement level in line with hospital rates, and hopes to further encourage collection of bad debt by SNFs and other affected providers. In total, this regulatory change will reduce bad debt payments by about $20 million in FY 2004 and $100M when fully implemented in 2006. Comments on the proposed rule were accepted through mid-April and will be considered in the final rule. Schwab/Washington Research Group believes the effect will be minimal on the major nursing facility chains. Schwab writes, "On average, the change will result in an approximately $1 a day reduction in reimbursements, though the effect may be greater for some companies." Schwab notes that the industry estimates the effect could rise to as much as $6 a day in 2006.

Nursing Home Quality Initiative

In November 2002 CMS released quality measures for all Medicare and Medicaid certified nursing homes. Measures are given for nearly 17,000 nursing homes in all 50 states, the District of Columbia, and some U.S. Territories. This quality initiative is a four-prong effort that consists of: 1) regulation and enforcement efforts conducted by state survey agencies and CMS; 2) improved consumer information on the quality of care in nursing homes; 3) continual, community-based quality improvement programs designed for nursing homes to improve their quality of care; and 4) collaboration and partnership to leverage knowledge and resources. Information on nursing home quality can be found on the Nursing Home Compare site at www.medicare.gov/NHCompare/Home.asp.

SUMMARY

- Profit margins for the large, publicly traded nursing facility chains continue to decline, although no dramatic drop-off has been observed after certain add-on provisions sunset on October 1, 2002.

- The effect of government spending reductions may not yet be fully realized as results for only six months have been reported since the Medicare add-on provisions expired and many new state budget cuts have not yet been implemented.

- Two additional nursing facility chains emerged from bankruptcy in 2002. However, some analysts worry how these chains will be able to weather the uncertain government payment environment. The facilities at greatest risk are those that heavily subsidize Medicaid revenue with Medicare payments.

- While Wall Street continues to watch Congress for signs of legislation that would restore Medicare add-on payments, investors are increasingly concerned by the risk of Medicaid payment cuts and rising liability costs.

- Rising insurance costs and aggressive litigation have led to the exit of many chains from states where liability costs are high.

- Most analysts believe that access to capital remains very limited for the sector in an uncertain payment environment. Access to capital for not-for-profit nursing facilities is particularly difficult.

- Investment analysts worry that some nursing facilities, recently emerged from bankruptcy, may need to re-enter bankruptcy protection. Three nursing facility chains have filed for bankruptcy since December 2002.

If you would like to receive the CMS Health Care Industry Market Update via email, please send a request to: capitalmarkets@cms.hhs.gov, Subject: Market Update Distribution

The CMS Health Care Industry Market Update is also available on the web at: www.cms.hhs.gov/marketupdate

From: Nancy Armentrout
To: peter.anderson@asm.ca.gov
Date: 4/26/2004 1:42:49 PM
Subject: AB 2791 - History of penaly enforcement legislation

Peter-

Sorry this has taken so long, but here is the chronology of penalty and enforcement bills levied against long-term care facilities. These bills all have raised penalties or added enforcement remedies, or have expanded the requirements for reporting/investigating abuse/neglect. They have all increased the level of scrutiny and the liability for any negligent act or "ommission" that happens in a facility, and have led to the liability crisis facilities face today:

AB 1133 (Gallegos) - Ch. 650, Statutes of 1998
- Increased civil penalties for violations affecting the health of patients in skilled nursing facilities.

AB 1731 (Shelley) - Ch. 451, Statutes of 2000
- Significantly increased civil penalties for skilled nursing facilities up to $100,000.
- Established a state remedy to allow for a temporary manager to be appointed by DHS to run a facility; made it easier for DHS to appoint a court-appointed receiver; and, allows DHS the authority to grant provisional licenses.
- Requires allegations of suspected abuse and neglect to be investigated by DHS within 24-hours.

AB 828 (Cohn) - Ch. 680, Statutes of 2001
- Requires DHS to establish a centralized consumer response unit to respond to complaints about resident care in long-term care facilities.

AB 1212 (Shelley) - Ch. 685, Statutes of 2001
- Clean-up bill to AB 1731 (Shelley) and, subject to penalties, the bill requires skilled nursing facilities to post a "Notice of Violation Remedies" form on all doors of the facility if specified remedies are imposed.

SB 333 (Escutia) - Ch. 301, Statutes of 2002
- Authorizes each county to establish an interagency elder death review team to assist local agencies in identifying and reviewing suspicious elder deaths.

AB 255 (Zettel) - Ch. 54, Statutes of 2003
- Makes changes to the individual mandated reporting requirements for reporting suspected or alleged elder abuse.

AB 1946 (Corbett) - Ch. 550, Statutes of 2003
- Requires each facility, upon admission of a resident, to ask the resident if s/he would like the facility to provide the resident's responsible party with materials regarding resident's rights and responsibilities.

SB 339 (Ortiz) - Ch. 242, Statutes of 2004
- Subject to penalties, the bill imposes new requirements upon long-term care facilities to carrying out a lengthy process of assessment and notification prio to transferring residents from the facility.

AB 634 (Steinberg) - Ch. 242, Statutes of 2004
Creates a statewide policy prohibiting confidential settlement agreements or agreements to keep information obtained during discovery confidential if the case includes a cause of action for elder abuse or neglect.

SB 577 (Kuehl) - Ch. 878, Statutes of 2004
- Expands the authority of Protection and Advocacy Inc to enter long-term care facilities to investigate any incident of abuse or neglect of any person with a disability.

SB 130 (Chesbro) - Ch. 750, Statutes of 2004
- Prohibits facilities from using any type of seclusion or restraint unless there is a behavioral emergency.

Nancy C. Armentrout
Director of Legislative Affairs
California Association of Health Facilities
ph. (916) 441-6400 ext. 213
fax: (916) 441-6441
e-mail: narmentrout@cahf.org

CC: Helmsin Dave

(A) A current nursing procedure manual.

(B) Provision for the inventory and identification of patients' personal possessions, equipment and valuables.

(C) Screening of all patients for tuberculosis upon admission. These procedures shall be determined by the patient care policy committee. A tuberculosis screening procedure may not be required if there is satisfactory written evidence available that a tuberculosis screening procedure has been completed within 90 days of the date of admission to the facility. Subsequent tuberculosis screening procedures shall be determined by the attending physician.

(D) Notification of physician regarding sudden or marked adverse change in a patient's condition.

(E) Conditions under which restraints are used, the application of restraints, and the mechanism used for monitoring and controlling their use.

(3) Infection control policies and procedures.

(4) Dietary services policies and procedures which include:

(A) Provision for safe, nutritious food preparation and service.

(B) A provision for maintaining a current dietetic service procedure manual.

(5) Pharmaceutical services policies and procedures.

(6) Activity program policies and procedures.

(7) Housekeeping services policies and procedures which include provision for maintenance of a safe, clean environment for patients, employees and the public.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72525. Required Committees.

(a) Each facility shall have at least the following committees: patient care policy, infection control and pharmaceutical service.

(b) Minutes of every committee meeting shall be maintained in the facility and indicate names of members present, date, length of meeting, subject matter discussed and action taken.

(c) Committee composition and function shall be as follows:

(1) Patient care policy committee.

(A) A patient care policy committee shall establish policies governing the following services: Physician, dental, nursing, dietetic, pharmaceutical, health records, housekeeping, activity programs and such additional services as are provided by the facility.

(B) The committee shall be composed of: at least one physician, the administrator, the director of nursing service, a pharmacist, the activity leader and representatives of each required service as appropriate.

(C) The committee shall meet at least annually.

(D) The patient care policy committee shall have the responsibility for reviewing and approving all policies relating to patient care. Based on reports received from the facility administrator, the committee shall review the effectiveness of policy implementation and shall make recommendations for the improvement of patient care.

(E) The committee shall review patient care policies annually and revise as necessary. Minutes shall list policies reviewed.

(F) The Patient Care Policy Committee shall implement the provisions of the Health and Safety Code, Sections 1315 and 1316.5, by means of written policies and procedures.

1. Facilities which choose to allow clinical psychologists to refer patients for admission shall do so only if there are physicians who will provide the necessary medical care for the referred patients.

2. Only physicians shall assume overall care of patients, including performing admitting history and physical examinations and issuing orders for medical care.

(G) The Patient Care Policy Committee shall implement the provisions of the Health and Safety Code, Section 1316, by means of written policies and procedures.

1. Facilities which choose to allow podiatrists to refer patients for admission shall do so only if there are physicians who will provide the necessary medical care for the referred patients.

2. Only physicians shall assume overall care of patients, including performing admitting history and physical examinations.

(2) Infection control committee.

(A) An infection control committee shall be responsible for infection control in the facility.

(B) The committee shall be composed of representatives from the following services; physician, nursing, administration, dietetic, pharmaceutical, activities, housekeeping, laundry and maintenance.

(C) The committee shall meet at least quarterly.

(D) The functions of the infection control committee shall include, but not be limited to:

1. Establishing, reviewing, monitoring and approving policies and procedures for investigating, controlling and preventing infections in the facility.

2. Maintaining, reviewing and reporting statistics of the number, types, sources and locations of infections within the facility.

(3) Pharmaceutical service committee.

(A) A pharmaceutical service committee shall direct the pharmaceutical services in the facility.

(B) The committee shall be composed of the following: a pharmacist, the director of nursing service, the administrator and at least one physician.

(C) The committee shall meet at least quarterly.

(D) The functions of the pharmaceutical service committee shall include, but not be limited to:

1. Establishing, reviewing, monitoring and approving policies and procedures for safe procurement, storage, distribution and use of drugs and biologicals.

2. Reviewing and taking appropriate action on the pharmacist's quarterly report.

3. Recommending measures for improvement of services and the selection of pharmaceutical reference materials.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code.

HISTORY

1. Amendment filed 2–8–83; designated effective 3–2–83 (Register 83, No. 7).

§ 72527. Patients' Rights.

(a) Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated. The facility shall establish and implement written policies and procedures which include these rights and shall make a copy of these policies available to the patient and to any representative of the patient. The policies shall be accessible to the public upon request. Patients shall have the right:

(1) To be fully informed, as evidenced by the patient's written acknowledgement prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(2) To be fully informed, prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or not covered under Titles XVIII or XIX of the Social Security Act.

(3) To be fully informed by a physician of his or her total health status and to be afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care including the identification of medical, nursing and psychosocial needs and the planning of related services.

(4) To consent to or to refuse any treatment or procedure or participation in experimental research.

(5) To receive all information that is material to an individual patient's decision concerning whether to accept or refuse any proposed treatment or procedure. The disclosure of material information for administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function shall include the disclosure of information listed in Section 72528(b).

(6) To be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment for his or her

stay and to be given reasonable advance notice to ensure orderly transfer or discharge. Such actions shall be documented in the patient's health record.

(7) To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

(8) To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept written delegation of this responsibility subject to the provisions of Section 72529.

(9) To be free from mental and physical abuse.

(10) To be assured confidential treatment of financial and health records and to approve or refuse their release, except as authorized by law.

(11) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.

(12) Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.

(13) To associate and communicate privately with persons of the patient's choice, and to send and receive personal mail unopened.

(14) To meet with others and participate in activities of social, religious and community groups.

(15) To retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the health, safety or rights of the patient or other patients.

(16) If married, to be assured privacy for visits by the patient's spouse and if both are patients in the facility, to be permitted to share a room.

(17) To have daily visiting hours established.

(18) To have visits from members of the clergy at any time at the request of the patient or the patient's representative.

(19) To have visits from persons of the patient's choosing at any time if the patient is critically ill, unless medically contraindicated.

(20) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

(21) To have reasonable access to telephones and to make and receive confidential calls.

(22) To be free from any requirement to purchase drugs or rent or purchase medical supplies or equipment from any particular source in accordance with the provisions of Section 1320 of the Health and Safety Code.

(23) To be free from psychotherapeutic drugs and physical restraints used for the purpose of patient discipline or staff convenience and to be free from psychotherapeutic drugs used as a chemical restraint as defined in Section 72018, except in an emergency which threatens to bring immediate injury to the patient or others. If a chemical restraint is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient and used only for a specified and limited period of time.

(24) Other rights as specified in Health and Safety Code, Section 1599.1.

(25) Other rights as specified in Welfare and Institutions Code, Sections 5325 and 5325.1, for persons admitted for psychiatric evaluations or treatment.

(26) Other rights as specified in Welfare and Institutions Code Sections 4502, 4503 and 4505 for patients who are developmentally disabled as defined in Section 4512 of the Welfare and Institutions Code.

(b) A patient's rights, as set forth above, may only be denied or limited if such denial or limitation is otherwise authorized by law. Reasons for denial or limitation of such rights shall be documented in the patient's health record.

(c) If a patient lacks the ability to understand these rights and the nature and consequences of proposed treatment, the patient's representative shall have the rights specified in this section to the extent the right may devolve to another, unless the representative's authority is otherwise limited. The patient's incapacity shall be determined by a court in accordance with state law or by the patient's physician unless the physician's determination is disputed by the patient or patient's representative.

(d) Persons who may act as the patient's representative include a conservator, as authorized by Parts 3 and 4 of Division 4 of the Probate Code (commencing with Section 1800), a person designated as attorney in fact in the patient's valid durable power of attorney for health care, patient's next of kin, other appropriate surrogate decisionmaker designated consistent with statutory and case law, a person appointed by a court authorizing treatment pursuant to Part 7 (commencing with Section 3200) of Division 4 of the Probate Code, or, if the patient is a minor, a person lawfully authorized to represent the minor.

(e) Patients' rights policies and procedures established under this section concerning consent, informed consent and refusal of treatments or procedures shall include, but not be limited to the following:

(1) How the facility will verify that informed consent was obtained or a treatment or procedure was refused pertaining to the administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability of the patient to regain the use of a normal bodily function.

(2) How the facility, in consultation with the patient's physician, will identify consistent with current statutory case law, who may serve as a patient's representative when an incapacitated patient has no conservator or attorney in fact under a valid Durable Power of Attorney for Health Care.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1320, 1599, 1599.1, 1599.2 and 1599.3, Health and Safety Code; and *Cobbs* v. *Grant* (1972) 8 Cal.3d 229.

HISTORY

1. Amendment of subsections (a) and (b), repealer of subsection (c), and new subsections (c), (d), and (e) filed 5-27-92; operative 5-27-92 (Register 92, No. 22).

§ 72528. Informed Consent Requirements.

(a) It is the responsibility of the attending physician to determine what information a reasonable person in the patient's condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure. Information that is commonly appreciated need not be disclosed. The disclosure of the material information and obtaining informed consent shall be the responsibility of the physician.

(b) The information material to a decision concerning the administration of a psychotherapeutic drug or physical restraint, or the prolonged use of a device that may lead to the inability of the patient to regain use of a normal bodily function shall include at least the following:

(1) The reason for the treatment and the nature and seriousness of the patient's illness.

(2) The nature of the procedures to be used in the proposed treatment including their probable frequency and duration.

(3) The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment.

(4) The nature, degree, duration and probability of the side effects and significant risks, commonly known by the health professions.

(5) The reasonable alternative treatments and risks, and why the health professional is recommending this particular treatment.

(6) That the patient has the right to accept or refuse the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time.

(c) Before initiating the administration of psychotherapeutic drugs, or physical restraints, or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function, facility staff shall verify that the patient's health record contains documentation that the patient has given informed consent to the proposed treatment or procedure. The facility shall also ensure that all decisions concerning the withdrawal or withholding of life sustaining treatment are documented in the patient's health record.

Confronting the New Health Care Crisis:

Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System

July 24, 2002

Prepared by
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Assistant Secretary for Planning and Evaluation

Confronting the New Health Care Crisis:
Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System

American health care is the envy of the world, but with rapidly rising health care costs, reforms are needed to make high-quality, affordable health care more widely available. These include new approaches to making employer-provided coverage more affordable, new initiatives to help states expand Medicaid and S-CHIP coverage for lower-income persons, and new policies including health insurance credits for persons who do not have access to employer or public health insurance. A critical element for enabling all of these reforms to provide real relief, and to help all Americans get access to better and more affordable health care, is curbing excessive litigation.

Americans spend proportionately far more per person on the costs of litigation than any other country in the world. The excesses of the litigation system are an important contributor to "defensive medicine"--the costly use of medical treatments by a doctor for the purpose of avoiding litigation. As multimillion-dollar jury awards have become more commonplace in recent years, these problems have reached crisis proportions. Insurance premiums for malpractice are increasing at a rapid rate, particularly in states that have not taken steps to make their legal systems function more predictably and effectively. Doctors are facing much higher costs of insurance, and some cannot obtain insurance despite having never lost a single malpractice judgment or even faced a claim.

This is a threat to health care quality for all Americans. Increasingly, Americans are at risk of not being able to find a doctor when they most need one because the doctor has given up practice, limited the practice to patients without health conditions that would increase the litigation risk, or moved to a state with a fairer legal system where insurance can be obtained at a lower price.

This broken system of litigation is also raising the cost of health care that all Americans pay, through out-of-pocket payments, insurance premiums, and federal taxes. Excessive litigation is impeding efforts to improve quality of care. Hospitals, doctors, and nurses are reluctant to report problems and participate in joint efforts to improve care because they fear being dragged into lawsuits, even if they did nothing wrong.

Increasingly extreme judgments in a small proportion of cases and the settlements they influence are driving this litigation crisis. At the same time, most injured patients receive no compensation. Some states have already taken action to squeeze the excesses out of the litigation system. But federal action, in

conjunction with further action by states, is essential to help Americans get high-quality care when they need it, at a more affordable cost.

Access to Care is Threatened

There are a number of obstacles that limit access to affordable health care in this country, including lack of affordable insurance and an outdated Medicare program. We now face another--the litigation crisis that has made insurance premiums unaffordable or even unavailable for many doctors, through no fault of their own. This is making it more difficult for many Americans to find care, and threatening access for many more.

- Nevada is facing unprecedented problems in assuring quick access to urgently needed care. The University of Nevada Medical Center closed its trauma center in Las Vegas for ten days earlier this month. Its surgeons had quit because they could no longer afford malpractice insurance.[1] Their premiums had increased sharply, some from $40,000 to $200,000. The trauma center was able to re-open only because some of the surgeons agreed to become county government employees for a limited time, which capped their liability for non-economic damages if they were sued. This is obviously only a temporary solution. If the Las Vegas trauma center closes again, the most severely injured patients will have to be transported to the next nearest Level 1 trauma center, five hours away. Access to trauma care is only one problem Nevada faces; access to obstetrics and many other types of care is also threatened.

- Overall, more than 10% of all doctors in Las Vegas are expected to retire, or relocate their practices by this summer.[2] For example, Dr. Cheryl Edwards, 41, closed her decade-old obstetrics and gynecology practice in Las Vegas because her insurance premium jumped from $37,000 to $150,000 a year. She moved her practice to West Los Angeles, leaving 30 pregnant women to find new doctors.[3]

- Dr. Frank Jordan, a vascular surgeon, in Las Vegas, left practice. "I did the math. If I were to stay in business for three years, it would cost me $1.2 million for insurance. I obviously can't afford that. I'd be bankrupt after the first year, and I'd just be working for the insurance company. What's the point?"[4]

- Other states are facing the same problem. A doctor in a small town in North Carolina decided to take early retirement when his premiums skyrocketed from $7,500 to $37,000 per year. His partner, unable to afford the practice expenses by himself, may now close the practice, and work at a teaching hospital.[5]

- Pennsylvania physicians are also leaving their practices. About 44 doctors at the height of their careers in Delaware County outside Philadelphia left the state in 2001 or stopped practicing medicine because of high malpractice insurance costs.[6]

- When Chester County (Pennsylvania) physicians were polled in January 2001, 65% said they were seriously considering moving their practice to another state. Many specialists (such as neurosurgeons) have already moved to less hostile medical-legal environments of surrounding states.[7]

- At Frankford Hospital's three facilities in Northeast Philadelphia and Bucks County, all twelve active orthopedic surgeons decided to lay down their scalpels after their malpractice rates nearly doubled to $106,000 each for 2001.[8]

- Many physicians in Ohio saw their malpractice premiums triple in 2001, and some are leaving their practice as a result. Dr. James Wilkerson, an Akron urologist, decided to retire. Had Dr. Wilkerson continued to practice, he would have spent seven months of his yearly income to cover the $84,000 premium. "I would have had to go back to working 90 hours a week and I didn't want to do that..."[9]

- West Virginia is also facing critical access problems for urgently needed care such as obstetrics. In rural areas, such as Putnam County and Jackson County, the sole community provider hospitals have closed their OB units because the obstetricians in those areas cannot afford malpractice insurance.[10]

- Many communities in Mississippi are losing access to needed medical care. Physicians who specialize in family medicine and obstetrics/gynecology in Indianola, and in other rural areas of the state, have stopped delivering babies because of skyrocketing insurance costs.[11] Ambur Peterson's obstetrician in Cleveland, Mississippi, stopped practicing three weeks before her due date, and she had to drive out of state, over a hundred miles, to Memphis, Tennessee, to get the care she needed.[12]

- Most of the cities with populations under 20,000 in Mississippi no longer have doctors who deliver babies.[13] Doctors in Natchez say they will relocate their practice across the Mississippi River to Louisiana because of the cost of insurance in Mississippi and runaway jury awards. They are planning a new $6 million medical office building in Vidalia, Louisiana.[14]

- In Georgia, the 80-bed Bacon County Hospital in Alma took out a loan to cover a premium that more than tripled.[15]

- Another Georgia hospital, Memorial Hospital and Manor in Bainbridge, that operates a hospital and a nursing home, was faced with a 600% increase.[16]

- In New Jersey, 65% of the hospitals report that physicians are leaving because of increased premiums (over 250% over the last three years).[17]

- In Tacoma, Washington, some doctors were faced with a tripling of their premiums. High premium rates and an inability to obtain insurance may force many physicians in the state to leave.[18]

- Doctors who would volunteer their time to provide care in free clinics and other volunteer organizations, or who would volunteer their services to the Medical Reserve Corps, are afraid to do so because they do not have malpractice insurance. This makes it more difficult for clinics to provide care to low-income patients. The clinics must spend their precious resources to obtain their own coverage, and have less money available to provide care to people who need it. The proportion of physicians in the country providing any charity care fell from 76% to 72% between 1997 and 1999 alone, increasing the need for doctors willing to volunteer their services.[19]

- Health Link Medical Center opened in March 2001 in Southampton, Pennsylvania, to provide free health care to the working poor. Dr. Theodore Onifer, a retired physician, volunteers his services on the board but is unable to volunteer to provide medical care because of the fear of lawsuits and the cost of insurance.

Patient Safety is Jeopardized

Because the litigation system does not accurately judge whether an error was committed in the course of medical care, physicians adjust their behavior to avoid being sued. A recent survey of physicians revealed that one-third shied away from going into a particular specialty because they feared it would subject them to greater liability exposure.[20] When in practice, they engage in defensive medicine to protect themselves against suit. They perform tests and provide treatments that they would not otherwise perform merely to protect themselves against the risk of possible litigation. The survey revealed that over 76% are concerned that malpractice litigation has hurt their ability to provide quality care to patients.

Because of the resulting legal fear:

- 79% said that they had ordered more tests than they would, based only on professional judgment of what is medically needed, and 91% have noticed other physicians ordering more tests;

- 74% have referred patients to specialists more often than they believed was medically necessary;

- 51% have recommended invasive procedures such as biopsies to confirm diagnoses more often than they believed was medically necessary; and

- 41% said that they had prescribed more medications, such as antibiotics, than they would based only on their professional judgment, and 73% have noticed other doctors similarly prescribing excessive medications.

Every test and every treatment poses a risk to the patient, and takes away funds that could better be used to provide health care to those who need it.

Physicians' understandable fear of unwarranted litigation threatens patient safety in another way. It impedes efforts of physicians and researchers to improve the quality of care. As medical care becomes increasingly complex, there are many opportunities for improving the quality and safety of medical care, and reducing its costs, through better medical practices. According to some experts, these quality improvement opportunities hold the promise of not only significant improvements in patient health outcomes, but also reductions in medical costs of as much as 30%.[21]

A broad range of experts on improving health care quality have developed strong evidence that the best way to achieve these needed improvements in quality of care is to provide better opportunities for health professionals to work together to identify errors, or practices that may lead to errors, and correct them. Many problems in the health care system result not from one individual's failings, but from complex system failings. These can only be addressed by collecting information from a broad range of doctors and hospitals, and encouraging them to collaborate to identify and fix problems. Already many health care systems are beginning to make these improvements:

- Intermountain Health Care and LDS Hospital in Utah improved quality and efficiency of the intensive care unit by applying quality improvement techniques and improving collaborative efforts.

- The Pittsburgh Regional Healthcare Initiative has brought together hospitals, health plans, physicians, and purchasers of health care in a collaborative effort to identify better ways to provide care. It has reduced blood infections in intensive care units by 20% in just two years, and it is encouraging reporting to reduce medication errors.

- The Baylor Medical Center in Dallas, Texas, has recently initiated an error reporting system and integrated it into care delivery to reduce medication and other errors.[22]

- Through the Northern New England Cardiovascular Disease Study Group, eight hospitals reduced mortality for cardiac bypass surgery by developing a collaborative patient registry, tracking how care is delivered and what the outcomes are, and sharing what they learn.

However, these efforts and other efforts are impeded and discouraged by the lack of clear and comprehensive protection for collaborative quality efforts. Doctors are reluctant to collect quality-related information and work together to act on it for fear that it will be used against them or their colleagues in a lawsuit. Perhaps as many as 95% of adverse events are believed to go unreported.[23] To make quality improvements, doctors must be able to exchange information about patient care and how it can be improved--what is the effect of care not just in one particular institution or of the care provided by one doctor--but how the patient fares in the system across all providers. These quality efforts require enhancements to information and reporting systems.

In its recent report, "To Err is Human," the Institute of Medicine (IOM) observed that, "[R]eporting systems are an important part of improving patient safety and should be encouraged. These voluntary reporting systems [should] periodically assess whether additional efforts are needed to address gaps in information to improve patient safety and to encourage health care organizations to participate in...reporting, and track the development of new reporting systems as they form."[24]

However, as the IOM emphasized, fear that information from these reporting systems will be used to prepare a lawsuit against them, even if they are not negligent, deters doctors and hospitals from making reports. This fear, which is understandable in the current litigation climate, impedes quality improvement efforts. According to many experts, the "#1 barrier" to more effective quality improvement systems in health care organizations is fear of creating new avenues of liability by conducting earnest analyses of how health care can be improved. Without protection, quality discussions to improve health care provide fodder for litigants to find ways to assert that the status quo is deficient. Doctors are busy, and they face many pressures. They will be reluctant to engage in health care improvement efforts if they think that reports they make and recommendations they make will be thrown back at them or others in litigation. Quality improvement efforts must be protected if we are to obtain the full benefit of doctors' experience in improving the quality of health care.

The IOM Report emphasized the importance of shifting the inquiry from individuals to the systems in which they work: "The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system." [25] But the litigation system impedes this progress--not only because fear of litigation deters reporting but also because the scope of the litigation system's view is restricted. The litigation system looks at the past, not the future, and focuses on the individual in an effort to assess blame

rather than considering how improvements can be made in the system. "Tort law's overly emotional and individualized approach...has been a tragic failure."[26]

Health Care Costs are Increased

The litigation and malpractice insurance problem raids the wallet of every American. Money spent on malpractice premiums (and the litigation costs that largely determine premiums) raises health care costs. Doctors alone spent $6.3 billion last year to obtain coverage.[27] Hospitals and nursing homes spent additional billions of dollars.

The litigation system also imposes large indirect costs on the health care system. Defensive medicine that is caused by unlimited and unpredictable liability awards not only increases patients' risk but it also adds costs. The leading study estimates that limiting unreasonable awards for non-economic damages could reduce health care costs by 5-9% without adversely affecting quality of care.[28] This would save $60-108 billion in health care costs each year. These savings would lower the cost of health insurance and permit an additional 2.4-4.3 million Americans to obtain insurance.[29]

The costs of the runaway litigation system are paid by all Americans, through higher premiums for health insurance (which reduces workers' take home pay if the insurance is provided by an employer), higher out-of-pocket payments when they obtain care, and higher taxes.

The Federal Government--and thus every taxpayer who pays federal income and payroll taxes--also pays for health care, in a number of ways. It provides direct care, for instance, to members of the armed forces, veterans, and patients served by the Indian Health Service. It provides funding for the Medicare and Medicaid programs. It funds Community Health Centers. It also provides assistance, through the tax system, for workers who obtain insurance through their employment. The direct cost of malpractice coverage and the indirect cost of defensive medicine increases the amount the Federal Government must pay through these various channels, it is estimated, by $28.6-47.5 billion per year.[30] If reasonable limits were placed on non-economic damages to reduce defensive medicine, it would reduce the amount of taxpayers' money the Federal Government spends by $25.3-44.3 billion per year.[31] This is a very significant amount. It would more than fund a prescription drug benefit for Medicare beneficiaries and help uninsured Americans obtain coverage through a refundable health credit.[32]

The Increasingly Unpredictable, Costly, and Slow Litigation System is Responsible

Insurance premiums are largely determined by the expensive litigation system. The malpractice insurance system and the litigation system are inexorably linked. The litigation system is expensive, but, at the same time, it is slow and provides little benefit to patients who are injured by medical error. Its application is unpredictable, largely random, and standardless. It is traumatic for all involved.

Most victims of medical error do not file a claim--one comprehensive study found that only 1.53% of those who were injured by medical negligence even filed a claim.[33] Most claims--57-70%--result in no payment to the patient.[34, 35] When a patient does decide to go into the litigation system, only a very small number recover anything. One study found that only 8-13% of cases filed went to trial; and only 1.2-1.9% resulted in a decision for the plaintiff.[36]

Although most cases do not actually go to trial, it costs a significant amount of money to defend each claim--an average of $24,669.[37] The most dramatic cost, however, is the cost of the few cases that result in huge jury awards. Even though few cases result in these awards, they encourage lawyers and plaintiffs in the hope that they can win this litigation lottery, and they influence every settlement that is entered into.

A large proportion of these awards is not to compensate injured patients for their economic loss—such as wage loss, health care costs, and replacing services the injured patient can longer perform (such as child care). Instead, much of the judgment (in some cases, particularly the largest judgments, perhaps 50% or more) is for non-economic damages. Awarded on top of compensation for the injured patient's actual economic loss, non-economic damages are said to be compensation for intangible losses, such as pain and suffering, loss of consortium, hedonic (loss of the enjoyment of life) damages, and various other theories that are imaginatively created by lawyers to increase the amount awarded.

Non-economic damages are an effort to compensate a plaintiff with money for what are in reality non-monetary considerations. The theories on which these awards are made however, are entirely subjective and without any standards. As one scholar has observed: "The perceived problem of pain and suffering awards is not simply the amount of money expended, but also the erratic nature of the process by which the size of the awards is determined. Juries are simply told to apply their 'enlightened conscience' in selecting a monetary figure they consider to be fair."[38]

Unless a state has adopted limitations on non-economic damages, the system gives juries a blank check to award huge damages based on sympathy, attractiveness of the plaintiff, and the plaintiff's socio-economic status (educated, attractive patients recover more than others).[39]

The cost of these awards for non-economic damages is paid by all other Americans through higher health care costs, higher health insurance premiums, higher taxes, reduced access to quality care, and threats to quality of care. The system permits a few plaintiffs and their lawyers to impose what is in effect a tax on the rest of the country to reward a very small number of patients who happen to win the litigation lottery. It is not a democratic process.

The number of mega-verdicts is increasing rapidly. The average award rose 76% from 1996-1999.[40] The median award in 1999 was $800,000, a 6.7% increase over the 1998 figure of $750,000; and between 1999 and 2000, median malpractice awards increased nearly 43%.[41] Specific physician specialties have seen disproportionate increases, especially those who deliver babies. In the small proportion of cases where damages were awarded, the median award in cases involving obstetricians and gynecologists jumped 43% in one year, from $700,000 in 1999 to $1,000,000 in 2000.[42]

The number of million dollar plus awards has increased dramatically in recent years. In the period 1994-1996, 34% of all verdicts that specified damages assessed awards of $1 million or more. This increased by 50% in four years; in 1999-2000, 52% of all awards were in excess of $1 million.[43] There have been 21 verdicts of $9 million or more in Mississippi since 1995--one of $100,000,000.[44] Before 1995 there had been no awards in excess of $9,000,000.[45]

These mega-awards for non-economic damages have occurred (as would be expected) in states that do not have limitations on the amounts that can be recovered, as shown in Table 1.

TABLE 1: Mega Awards In States Without Caps		
State	Jury Award	Year
Arizona	$ 3,000,000	1998
Kentucky	$ 13,000,000	1998
Mississippi	$100,000,000	2002
Nevada	$ 6,000,000	2001
	5,400,000	2001
	4,600,000	2001
North Carolina	$ 23,500,000	1997
	4,500,000	2001
	8,100,000	2001
Pennsylvania	$100,000,000	1999
Washington	$ 3,790,000	1998
Source: ASPE Review of Media Reports from The Advocate, Las Vegas Review, North Carolina Lawyers Weekly, and other select sources.		

Mirroring the increase in jury awards, settlement payments have steadily risen over the last two decades. The average payment per paid claim increased from approximately $110,000 in 1987 to $250,000 in 1999.[46] Defense expenses per paid claim increased by $24,000 over the same period.[47]

The winning lottery ticket in litigation, however, is not as attractive as it may seem at first blush. A plaintiff who wins a judgment must pay the lawyer 30-40% of it, and sometimes even more. Lawyers, therefore, have an interest in finding the most attractive case. They develop a portfolio of cases and have an incentive to gamble on a big "win." If only one results in a huge verdict, they have had a good payday. Thus, they have incentives to pursue cases to the end in the hope of winning the lottery, even when their client would be satisfied by a settlement that would make them whole economically. The result of the contingency fee arrangement is that lawyers have few incentives to take on the more difficult cases or those of less attractive patients.

One prominent personal injury trial lawyer explained the secret of his success: "The appearance of the plaintiff [is] number one in attempting to evaluate a lawsuit because I think that a good healthy-appearing type, one who would be likeable and one that the jury is going to want to do something for, can make your case worth double at least for what it would be otherwise and a bad-appearing plaintiff could make the case worth perhaps half..."[48]

For most injured patients, therefore, the litigation process, while offering the remote chance of a jackpot judgment, provides little real benefit, even for those who file claims and pursue them. Even successful claimants do not recover anything on average until five years after the injury, longer if the case goes to trial.[49]

The friction generated by operating the system takes most of the money. When doctors and hospitals buy insurance (sometimes they are required to buy coverage that provides more "protection" than the total amount of their assets), it is intended to compensate victims of malpractice for their loss. However, only 28% of what they pay for insurance coverage actually goes to patients; 72% is spent on legal, administrative, and related costs.[50] Less than half of the money that does go back to injured patients is used to compensate the patient for economic loss that is not compensated from other sources--the purpose of a compensation system.[51] More than half of the amount the plaintiff receives duplicates other sources of compensation the patient may have (such as health insurance) and goes for subjective, non-economic damages (a large part of which, moreover, actually goes to the plaintiff's lawyer).

The malpractice system does not accurately identify negligence, deter bad conduct, or provide justice. The results it obtains are unpredictable, even random. The same study that found that only 1.53% of patients who were injured by medical error filed a claim also found, on the flip side, that most events for which claims were filed did not constitute negligence.[52] Other studies show the same random results.[53] "The evidence is growing that there is a poor correlation between injuries caused by negligent medical treatment and malpractice litigation."[54]

Not surprisingly, most people involved in health care delivery on a day-to-day basis believe that the system does not accurately reflect the realities of health care or correctly identify malpractice. A recent survey indicated that 83% of physicians and 72% of hospital administrators do not believe the system achieves a reasonable result.[55]

With this randomness, the litigation system cannot be expected to deter error or set meaningful standards of care. That this is, in fact, the case is evidenced by the IOM's estimate that as many as 98,000 people die each year from medical error.[56] If so, the system is failing not only to compensate patients fairly, but even more importantly to ensure quality care.

Yet our current system forces injured patients to sue their doctors in order to obtain compensation and forces both patients and doctors to go through what is a traumatic process for all. Patients must wait years for recovery (if they ever win any). Doctors are subject to minute scrutiny of actions they took, often years before, and their actions are judged on the basis of hindsight and perhaps even on the basis of changed medical standards. The process consumes the time and energy of the doctor that could better be spent in patient care. It is essentially punitive in nature, yet random. Rather than helping doctors do better, it causes them to engage in defensive medicine. It is a process that benefits no one except those who live off it--trial lawyers, both those who represent plaintiffs and those who represent defendants.

Insurance Premiums are Rising Rapidly

The cost of the excesses of the litigation system shows up in the cost of malpractice insurance coverage. Premiums have increased rapidly over the past several years. Experts believe we are seeing just the tip of what will happen this year and next. Rates have escalated rapidly for doctors who practice internal medicine, general surgery, and obstetrics/gynecology (see Table 2 below). The average increases ranged from 11% to 17% in 2000, were about 10% in 2001, but are accelerating rapidly this year. A recent special report revealed that rate increases are averaging 20%.[57]

TABLE 2. Medical Malpractice Liability Average Premium Increases by Specialty, 2000-2001

	July 2000	July 2001	December 2001
Internists	17%	10%	22%
General Surgeons	14%	10%	21%
Obstetricians/ Gynecologists	12%	9%	19%
SOURCE: Medical Liability Monitor, 2001			

However, these increases have varied widely across states, and some states have experienced increases of 30-75%, although there is no evidence that patient care had worsened. As seen in Table 3, a major contributing factor to the most enormous increases in liability premiums has been rapidly growing awards for non-economic damages in states that have not reformed their litigation system to put reasonable standards on these awards.

TABLE 3. Premium Increases in Non-Reform States Between 2000-2001 or 2001-2002

State	Premium Increase
Nevada	30%
Mississippi	30-40%
North Carolina	50%
Pennsylvania	40%
Virginia	75%
Florida	30%
Ohio	30%
Illinois	Over 30%
Source: Survey of PIAA companies, July 2002 and ASPE Review of Articles, 2000-2002.	

Among the states with the highest average medical malpractice insurance premiums are Florida, Illinois, Ohio, Nevada, New York, and West Virginia.[58] These states have not reformed their litigation systems as others have. (Florida's caps apply only in limited circumstances. New York has prevented insurers from raising rates, and accordingly it is expected that substantial increases will be needed in 2003.) The comparison of the rates in these states

with those in California, which has reformed its litigation system, is shown in Table 4 below.

TABLE 4. States with High Annual Premiums in 2001 by Specialty Compared to California			
	OB/GYN	**Surgeon**	**Internists**
Florida	$143K-203K	$63K-159K	$27K-51K
Michigan	$87K-124K	$67K-94K	$18K-40K
Illinois	$89K-110K	$50K-70K	$16K-28K
Ohio	$58K-95K	$33K-60K	$11K-16K
Nevada	$60K-95K	$32K-57K	$9K-$16K
New York	$34K-115K	$19K-63K	$6K-22K
West Virginia	$63K-85K	$44K-56K	$8K-16K
California	**$23K-72K**	**$14K-42K**	**$4K-15K**
Source: Medical Liability Monitor's "Trends in 2001 Rates for Physicians' Medical Professional Liability Insurance," Vol. 25, No. 10, October 2001.			

The effect of these premiums on what patients must pay for care can be seen from an example involving obstetrical care. The vast majority of awards against obstetricians involve poor outcomes at childbirth. As a result, payouts for poor infant outcomes account for the bulk of obstetricians' insurance costs. If an obstetrician delivers 100 babies per year (which is roughly the national average) and the malpractice premium is $200,000 annually (as it is in Florida), each mother (or the government or her employer who provides her health insurance) must pay approximately $2,000 merely to pay her share of her obstetrician's liability insurance. If a physician delivers 50 babies per year, the cost for malpractice premiums per baby is twice as high, about $4,000. It is not surprising that expectant mothers are finding their doctors have left states that support litigation systems imposing these costs.

In addition to premium increases for physicians, nursing home malpractice costs are rising rapidly because of dramatic increases in both the number of lawsuits and the size of awards. Nursing homes are a new target of the litigation system. Between 1995 and 2001, the national average of insurance costs increased from $240 per occupied skilled nursing bed per year to $2,360. From 1990 to 2001, the average size of claims tripled, and the number of claims increased from 3.6 to 11 per 1,000 beds.[59]

These costs vary widely across states, again in relation to whether a state has implemented reforms that improve the predictability of the legal system. Florida ($11,000) had one of the highest per bed costs in 2001.[60] Nursing homes in Mississippi have been faced with increases as great as 900% in the past two years.[61] It has been recently reported that "nearly all companies that used to write nursing home liability [insurance] are getting out of the business."[62] Since the costs of nursing home care are mainly paid by Medicaid and Medicare, these increased costs are borne by taxpayers, and consume resources that could otherwise be used to expand health (or other) programs.

Insurers are Leaving The Market

The litigation crisis is affecting patients' ability to get care not only because many doctors find the increased premiums unaffordable but also because liability insurance is increasingly difficult to obtain at any price, particularly in non-reform states. Demonstrating and exacerbating the problem, several major carriers have stopped selling malpractice insurance.

- St. Paul Companies, which was the largest malpractice carrier in the United States, covering 9% of doctors, announced in December 2001 that it would no longer offer coverage to any doctor in the country.[63]
- MIXX pulled out of every state; it will reorganize and sell only in New Jersey.
- PHICO and Frontier Insurance Group have also left the medical malpractice market.[64, 65]
- Doctors Insurance Reciprocal stopped writing group specialty coverage at the beginning 2002.[66]

States that had not enacted meaningful reforms (such as Nevada, Georgia, Oregon, Mississippi, Ohio, Pennsylvania, and Washington) were particularly affected.[67] Fifteen insurers have left the Mississippi market in the past five years.[68]

States with Realistic Limits on Non-Economic Damages Are Faring Better

The insurance crisis is less acute in states that have reformed their litigation systems. States with limits of $250,000 or $350,000 on non-economic damages have average combined highest premium increases of 12-15%, compared to 44% in states without caps on non-economic damages, as shown in Table 5.

TABLE 6. Comparison of States with Caps to States without Meaningful Non-Economic Caps (Average Premium Increase)			
States with Caps ≤ $250,000		**States without Caps**	
California	20%	Arkansas	18%
Indiana	15%	Connecticut	50%
Montana	21%	Georgia	32%
Utah	5%	Nevada	35%
		New Jersey	24%
		Oregon	56%
		Pennsylvania	77%
		Washington	55%
		Ohio	60%
		West Virginia	30%
AVERAGE	**15%**	**AVERAGE**	**44%**
States with Caps ≤ $350,000		**States without Caps**	
California	20%	Arkansas	18%
Hawaii	0%	Connecticut	50%
Indiana	15%	Georgia	32%
Michigan	39%	Nevada	35%
Montana	21%	New Jersey	24%
New Mexico	13%	Oregon	56%
North Dakota	0%	Pennsylvania	77%
South Dakota	0%	Washington	55%
Utah	5%	Ohio	60%
Wisconsin	5%	West Virginia	30%
AVERAGE	**12%**	**AVERAGE**	**44%**

SOURCE: Medical Liability Monitor, 2001. Percentages represent the combined average of the highest premium increases for OB/GYNs, Internists, and General Surgeons among select states, 2000-2001. Average highest premium increase is derived from the highest potential premium increase among internal medicine, general surgery or obstetrics/gynecology specialists in that state during 2001. These combined averages are not weighted.

As Table 6 below shows, there is a substantial difference in the level of medical malpractice premiums in states with meaningful caps, such as California, Wisconsin, Montana, Utah and Hawaii, and states without meaningful caps.

TABLE 6. Malpractice Liability Rate Ranges by Specialty by Geography as of July 2001	Cap in Non-Economic Damages	Low	High
INTERNISTS			
State Wide Data			
Wisconsin	$350,000	$5,000	$6,000
Montana	$250,000	5,300	7,000
Utah	$250,000	5,900	5,900
Hawaii	$350,000	6,800	6,800
Connecticut	No cap	6,200	15,800
Washington	No cap	7,100	9,000
Metropolitan Area Data			
California (Los Angeles area)	$250,000	$7,900	$13,000
Pennsylvania (Urban Philadelphia area)	No cap	10,700	11,800
Nevada (Las Vegas area)	No cap	11,600	15,800
Illinois (Chicagoland area)	No cap	16,500	28,100
Florida (Miami and Ft. Lauderdale areas)*	No cap	17,600	50,700
GENERAL SURGEONS			
State Wide Data			
Wisconsin (state wide)	$350,000	$16,000	$17,500
Montana (state wide	$250,000	23,300	27,000
Utah (state wide)	$250,000	26,200	26,200
Hawaii (state wide)	$350,000	24,500	24,500
Connecticut (state wide)	No cap	26,200	45,800
Washington (state wide)	No cap	20,100	32,600
Metropolitan Area Data			
California (Los Angeles area)	$250,000	$23,700	$42,200
Pennsylvania (Urban Philadelphia area)	No cap	31,500	35,800
Nevada (Las Vegas area)	No cap	40,300	56,900
Illinois (Chicagoland area)	No cap	50,000	70,200
Florida (Miami and Ft. Lauderdale areas)*	No cap	63,200	126,600
OBSTETRICIANS/GYNECOLOGISTS			
State Wide Data			
Wisconsin (state wide)	$350,000	$23,800	$27,500
Montana (state wide	$250,000	36,000	38,600
Hawaii (state wide)	$350,000	40,900	40,900
Utah (state wide)	$250,000	44,300	44,300
Connecticut (state wide)	No cap	45,400	64,800
Washington (state wide)	No cap	34,100	59,300
Metropolitan Area Data			
California (Los Angeles area)	$250,000	$46,900	$57,700
Pennsylvania (Urban Philadelphia area)	No cap	45,900	66,300
Nevada (Las Vegas area)	No cap	71,100	94,800
Illinois (Chicagoland area)	No cap	72,500	110,100
Florida (Miami and Ft. Lauderdale areas)*	No cap	108,000	208,900

Source: Medical Liability Monitor, Vol. 26, No. 10, October 2001: Shook, Hardy, Bacon, L.L.P., October 9, 2001.
* Florida imposes caps of $250,000-350,000 unless neither party demands binding arbitration or the defendant refuses to arbitrate.

In the early 1970s, California faced an access crisis like that facing many states now and threatening others. With bi-partisan support, including leadership from then Governor Jerry Brown and now Congressman Henry Waxman, then chairman of the Assembly's Select Committee on Medical Malpractice, California enacted comprehensive changes to make its medical liability system more predictable and rational. The Medical Injury Compensation Reform Act of 1975 (MICRA) made a number of reforms, including:

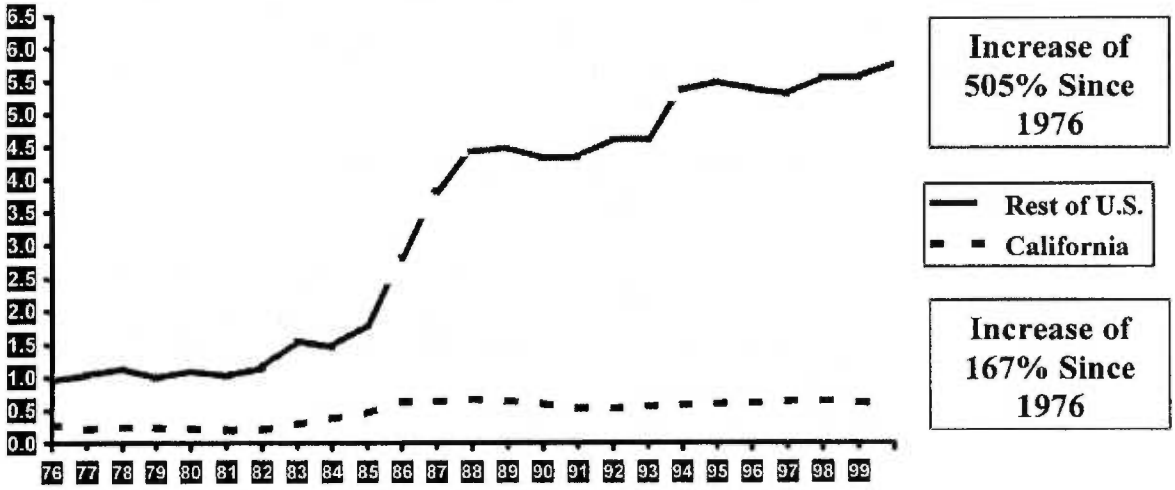
- Placing a $250,000 limit on non-economic damages while continuing unlimited compensation for economic damages.

- Shortening the time in which lawsuits could be brought to three years (thus ensuring that memories would still be fresh and providing some assurance to doctors that they would not be sued years after an event that they may well have forgotten).

- Providing for periodic payment of damages to ensure the money is available to the patient in the future.

California has more than 25 years of experience with this reform. It has been a success. Doctors are not leaving California. Insurance premiums have risen much more slowly than in the rest of the country without any effect on the quality of care received by residents of California. Insurance premiums in California have risen by 167% over this period while those in the rest of the country have increased 505%.[69] This has saved California residents billions of dollars in health care costs and saved federal taxpayers billions of dollars in the Medicare and Medicaid programs.

FIGURE 1. Premium Growth: California vs. U.S. Premiums 1976-2000 (billions of dollars)



SOURCE: NAIC Profitability Study, 2000.

The President's Framework for Improving the Medical Liability System

Federal and state action is needed to address the impact of the medical liability crisis on health care costs and the quality of care.

Achieving a Fair, Predictable, and Timely Medical Liability Process

As years of experience in many states have proven, reasonable limits on the amount of non-economic damages that are awarded significantly restrain increases in the cost of malpractice premiums. These reforms improve the predictability of the medical liability system, reducing incentives for filing frivolous suits and for prolonged litigation. Greater predictability and more timely resolution of cases means patients who are injured can get fair compensation more quickly. They also reduce health care costs, enabling Americans to get more from their health care spending and enabling federal health programs to provide more relief. They improve access to care, by making insurance more affordable and available. They also improve the quality of health care, by avoiding unnecessary "defensive" treatments and enabling doctors to spend significantly more time focusing on patient care. Congress needs to enact

legislation that would give all Americans the benefit of these reforms, eliminate the excesses of the litigation system, and protect patients' ability to get care.

The President supports federal reforms in medical liability law that would implement these proven steps for improving our health care system:

- Improve the ability of all patients who are injured by negligence to get quicker, unlimited compensation for their "economic losses," including the loss of the ability to provide valuable unpaid services like care for children or a parent.

- Ensure that recoveries for non-economic damages could not exceed a reasonable amount ($250,000).

- Reserve punitive damages for cases that justify them--where there is clear and convincing proof that the defendant acted with malicious intent or deliberately failed to avoid unnecessary injury to the patient--and avoid unreasonable awards (anything in excess of the greater of two times economic damages or $250,000).

- Provide for payment of a judgment over time rather than in one lump sum--and thus ensure that the money is there for the injured patient when needed.

- Ensure that old cases cannot be brought years after an event when medical standards may have changed or witnesses' memories have faded, by providing that a case may not be brought more than three years following the date or injury or one year after the claimant discovers or, with reasonable diligence, should have discovered the injury.

- Informing the jury if a plaintiff also has another source of payment for the injury, such as health insurance.

- Provide that defendants pay any judgment in proportion to their fault, not on the basis of how deep their pockets are.

The success of the states that have adopted reforms like these shows that malpractice premiums could be reduced by 34% by adopting these reforms.[70] The savings to the Federal Government resulting from reduced malpractice premiums would be $4 billion.[71]

Legislation such as H.R. 4600--a bill introduced by Congressman Jim Greenwood with almost 100 bipartisan cosponsors--is now pending in Congress. Enactment of this legislation with improvements to ensure that its meaningful standards will apply nationally, will be a significant step toward the goals of

affordable, high-quality health care for all Americans, and a fair and predictable liability system for compensating injured patients.

In addition, there are other promising approaches for compensating patients injured by negligence fairly and without requiring them to go through full-scale, time-consuming, and expensive litigation. Just as states like California have demonstrated the effectiveness of litigation reforms, they should also adopt and evaluate the impact of alternatives to litigation.

Early Offers is one innovative approach.[72] This would provide a new set of balanced incentives to encourage doctors to make offers, quickly after an injury, to compensate the patient for economic loss, and for patients to accept. It would make it possible for injured patients to receive fair compensation quickly, and over time if any further losses are incurred, without having to enter into the litigation fray. Because doctors and hospitals would have an incentive to discover adverse events quickly in order to make a qualifying offer, it would lead to prompt identification of quality problems. The money that otherwise would be spent in conducting litigation would be recycled so that more patients get additional recovery, more quickly, with savings left over to the benefit of all Americans. It may also be possible to implement an administrative form of Early Offers as an option for care provided under federal health programs.

A second innovative approach involves strengthening medical review boards. Boards with special expertise in the technical intricacies of health care can streamline the fact-gathering and hearing process, make decisions more accurately, and provide compensation more quickly and predictably than the current litigation process. As with Early Offers, incentives are necessary for patients and health care providers to submit cases to the boards and to accept their decisions.

The Administration intends to work with states on developing and implementing these alternatives to litigation, so that injured patients can be fairly compensated quickly and without the trauma and expense that litigation entails.

Encouraging Improvements in Health Care Quality and Patient Safety Through Litigation Reform

The best protection for patients can be provided by medical professionals, not lawyers. High quality care that achieves the best possible patient outcomes makes litigation unnecessary. The Administration is already taking many steps to improve quality of care.

The ability of Americans to work with their doctors to choose and control their own health care is an important ingredient of quality. The people who are most affected by the quality of care--patients and their families--should be the ones deciding how they obtain their health care. To do so, they need helpful information.

The Administration is undertaking a number of activities to promote quality by increasing and improving the information available to patients, and taking other steps to make the system safer and better. Some specific activities include:

- Developing the Consumer Assessment of Health Plans Survey (CAHPS) that provides information on consumers' descriptive ratings of health plans as well as evaluative ratings of care.

- Providing quality information about nursing homes on the Internet to enable families to make comparisons and informed judgments.

- Examining how information technology, such as decision support systems embedded in clinicians' personal digital assistants (PDAs), can improve safe patient care.

- Promoting the introduction and use of bar coding for dispensing prescription drugs to reduce errors.

- Developing voluntary standards necessary to make the creation of an electronic health care record possible; this would make a patient's medical records available across different care sites, and to the patient.

- Examining model disease management programs that can improve the quality of care for people with asthma and diabetes.

- Developing computer software that hospitals can use to identify quality problems, assisting in quality improvement activities.

- Developing a program called "Put Prevention into Practice" in order to assure that evidence-based recommendations for clinical prevention are actually translated into improved delivery of services.

The Administration will work to expand these efforts, to give patients and their doctors the information they need to make informed and appropriate medical decisions, while protecting the confidentiality of sensitive information from inappropriate uses.

One of the key ingredients to reducing errors is optimizing doctors' inherent ethical imperative to improve patients' health care. We must do a better

job of helping them and other experts to identify problems before they result in injury and to develop better ways of providing care.

Researchers have found that most errors are system failures, rather than individual faults. Doctors could do their job correctly, and most errors would still occur. In addition, since human error inevitably occurs, built-in systems should automatically prevent, detect and/or correct errors before they occur. Continuous quality improvement processes, which have been effective in many other "high-risk" sectors, focus on finding ways to design work processes so that better results and fewer errors can be achieved. This requires measurement and analysis of the ways health care is provided, and the results of care for patients. By encouraging the experts to work both inside their own organization and with outside groups to share information on how medical errors or "near misses" occur and ways to prevent them, health care organizations have begun to develop tools to prevent injury and increase knowledge of how errors occur.

Success in improving health care practices to prevent errors and deliver high-quality care, however, requires a legal environment that encourages health care professionals and organizations to work together to identify problems in providing care, evaluate the causes, and use that information to improve care for all patients.

A principal obstacle to taking these steps is the fear by doctors, hospitals, and nurses that reports on adverse events and efforts to improve care will be subject to discovery in lawsuits. As several distinguished physicians recently wrote, "for reasons that include liability issues and a medical culture that has discouraged open discussion of mistakes, the power of individual case presentation, so important in the physician's clinical medicine education, has not been harnessed to educate providers about medical errors."[73]

A number of states have enacted peer review statutes that protect the confidentiality of information reported to hospitals and other health care entities. States that have such laws have found that they improve reporting of adverse events, thereby facilitating efforts to identify problems and improve quality. These protections do not take away from the ability of plaintiffs to succeed in lawsuits: all of the medical information currently available to pursue a lawsuit is still available.

Confidentiality protections provided by law for specific activities also have proven successful in identifying problems and reducing medical errors:

- The National Nosocomial Infections Surveillance System, operated by the Centers for Disease Control, receives voluntary reports from hospitals on hospital-acquired infections. It has reduced these infections by 34%. The system works because federal law assures participating hospitals that information supplied by them will be kept confidential.

- MedWatch is a voluntary Medical Products Reporting System operated by the Food and Drug Administration. Adverse events concerning medical devices and drugs may be reported to it to identify problem areas. Names of the reporting doctors and hospitals, and the name of patients involved, are not releasable under the Federal Freedom of Information Act.

- The Department of Veterans Affairs maintains a Patient Safety Reporting System to learn about issues related to patient safety. To encourage reporting, federal law provides that reports relating to new safety ideas, close calls, or unexpected serious injury are confidential and privileged. This is based on the successful system operated by the National Aeronautics and Space Administration for aviation safety reporting.

- New York State operates the New York Patient Occurrence Reporting and Tracking System. Adverse events are reported to it. New York State law prevents disclosure of reports under the state's freedom of information law.

The IOM report "To Err is Human" noted that while many of the legal protections developed by states have promise, many current state peer review statutes do not go far enough. For example, these laws typically apply only to a single institution and do not reflect the systemic nature of health care as it is now provided. They do not provide a way to obtain data from various providers at one time and to compare results. Many states, moreover, do not have any peer review statutes at all. The IOM, therefore, recommended legislation to ensure that peer review proceedings and reports remain confidential.[74]

The President believes that new, good-faith efforts to improve the quality and safety of health care should be protected and encouraged, not penalized by new lawsuits. In his speech in Milwaukee on February 11, President Bush urged Congress to do something about this problem by enacting legislation that will give health professionals the confidence necessary to expand their reporting of problems in the health care system.

Following the President's request, and with assistance from the Administration, legislation was introduced in both Houses of Congress that would provide protection from discovery in lawsuits for reports made to Patient Safety Organizations and for their collaborative efforts to improve care. A tri-partisan Bill that reflects the President's goals, sponsored by Senators Jeffords, Breaux, Frist, and Gregg, has been introduced in the Senate (S. 2590). Chairwoman Johnson and others have introduced a similar Bill in the House (H.R. 4889). Enactment of this legislation will ensure that patient safety and quality reports are given the protection they deserve. Information developed or used as part of Patient Safety Organizations' activities would be protected, and would not be available for trial lawyers to exploit in order to find new opportunities for litigation.

The assurance of confidentiality is a proven approach to increase reporting by doctors, nurses, and other health care providers. With more information, quality experts will be better able to identify problems and recommend improvements in a proactive way. Rather than reacting to an avoidable injury or quality problem after it occurs, without benefit of careful and systematic review, medical professionals will be able to find system weaknesses and fix them before a patient is injured. Passage of the legislation will improve the quality of health care.

---

[1] Washington Post, July 4, 2002.

[2] Los Angeles Times, "Physicians Fold Under Malpractice Fee Burden," March 4, 2002.

[3] Los Angeles Times, March 4, 2002.

[4] Los Angeles Times, March 4, 2002.

[5] Senn, Dunn, Marsh, Roland Insurors, Personal Correspondence, July 2002.

[6] Allentown Morning Call, "Care crisis: Malpractice premiums crippling doctors," January 3, 2002.

[7] Philadelphia Inquirer, "Doctors and Patients are at Risk," January 19, 2001.

[8] Philadelphia Inquirer, "Rising Costs of Insurance Sends Doctors Scurrying," December 21, 2000.

[9] Akron Beacon Journal, January 2002.

[10] Advancing Health in America, June 12, 2002, Statement before the House Judiciary Subcommittee on Commercial and Administrative Law.

[11] Los Angeles Times, "Mississippi Doctors Give Up Obstetrics," November 19, 2001.

[12] Associated Press, "Exodus of doctors causing crisis for moms-to-be in Mississippi," July 11, 2002.

[13] Fox News, "Lawsuits Fueling Health Care Crisis," May 14, 2002.

[14] The Advocate, "Natchez Doctors Eye Vidalia," May 19, 2002.

[15] Bryant, Julie, "Malpractice Rates Sicken Hospitals," Atlanta Business Chronicle, March 25, 2002.

[16] Bryant, Julie, "Malpractice Rates Sicken Hospitals," Atlanta Business Chronicle, March 25, 2002.

[17] American College of Obstetricians and Gynecologists, "The Hot States," Red Alert Facts: The Professional Liability Insurance Crisis, May 2002.

[18] American College of Obstetricians and Gynecologists, June 12, 2002.

[19] Center for Health Systems Change, "An Update on the Community Tracking Study, A Focus on the Changing Health System," Issue Brief No. 18, February 1999.

[20] "Fear of Litigation Study," conducted by Harris Interactive, Final Report, April 11, 2002.

[21] Berwick, Donald M., "As Good As It Should Get: Making Healthcare Better in the New Millennium," National Coalition for Healthcare, 1998.

[22] Maulik, Joshi; Anderson, John; et al., "A Systems Approach to Improving Error Reporting," Journal of Healthcare Information Management, Vol. 16, No. 1.

[23] Maulik, Joshi; Anderson, John; et.al., "A Systems Approach to Improving Error Reporting," Journal of Health Care Information Management, Vol. 16, No. 1.

[24] Committee for Quality Health Care in America/Institute of Medicine, "To Err is Human: Building a Safer Health System," 2000.

[25] IOM Report, "To Err is Human: Building a Safer Health System," 2000.

[26] O'Connell, Jeffrey; Baldwin, Joseph, "Tort Law as Melodrama--Or Is It Farce?," forthcoming article in UCLA Review.

[27] A.M. Best, Statistical Study, July 16, 2001.

[28] Kessler, D.; McClellan, M, "Do Doctors Practice Defensive Medicine," Quarterly Journal of Economics, 111(2): 353-390, 1996.

[29] A recent health insurance study estimate that a 1% increase in health insurance premiums leads to a 0.31% reduction in employer-sponsored coverage. Gruber, J.; Lettau, M, "How elastic is the firm's demand for health insurance," National Bureau of Economic Research Working Paper, #8021, 2000.

[30] This amount includes $23.66-42.59 billion for the cost of defensive medicine; $3.91 billion in liability insurance paid to Medicare, Medicaid, Veteran's Affairs, and other federal programs; $246 million in liability insurance paid through health benefits for its employees and retired employees; and $778 million in lost tax revenue from self-employed and employer-sponsored health insurance premiums that are excluded from income.

[31] This amount includes $23.66-42.59 billion in savings from elimination of defensive medicine and $1.68 billion in reductions in liability insurance premiums paid by the Federal Government.

[32] The Administration's proposed Medicare prescription drug plan is estimated to cost $190 billion over ten years by the CBO. The Administration's proposed Health Insurance Tax Credit is estimated to cost $89 billion over ten years.

[33] Localio, A.R.; Lawthers, A.G.; et.al., "Relation between malpractice claims and adverse events due to negligence. Results of the Harvard Medical Practice Study III," New England Journal of Medicine, Volume 325:245-251, July 25, 1991.

[34] GAO, "Medical Malpractice: Characteristics of Claims Closed in 1984," GAO/HRD-87-55, April 1987, p. 18; PIAA.

[35] Subcommittee on Commercial and Administrative Law before the House Judiciary Committee, testimony presented by PIAA, June 12, 2002.

[36] O'Connell, Jeffrey, "An Alternative to Abandoning Tort Liability," 60 Minnesota: 501-506-509, 1976.

[37] PIAA Fact Sheet, Malpractice Insurance: The Basics, 2000.

[38] Weiler, Paul, "Medical Malpractice on Trial," 1991.

[39] O'Connell, Jeffrey; Kelly, Brian, "The Blame Game," p.125; Dodd, Christopher, "A Proposal for Making Product Liability Fair, Efficient, and Predictable," p.139; Statement of George Priest, "Punitive Damages: Tort Reform and FDA Defenses," Hearings before the Committee on the Judiciary of the United States Senate, Serial No. J-104016, April 4, 1995, p. 85. (Dealing with product liability litigation generally).

[40] Medical Malpractice, III Insurance Issues Update, March, 2002.

[41] Fox News Channel, "Lawsuits Fueling Health Care Crisis," May 14, 2002, source from American College of Obstetricians and Gynecologists (ACOG).

[42] Trends in Personal Injury by Jury Verdict Research, 2001.

[43] 2001 Current Award Trends in Personal Injury by Jury Verdict Research, 2002.

[44] Personal Communication from Rep. Chip Pickering, July 2002.

[45] Personal Communication from Rep. Chip Pickering, July 2002.

[46] Physician Insurers Association of America (PIAA), Trend Analysis of Claims by Close Year, 2000.

[47] PIAA in Health Care Financial Trends Report, April,2002.

[48] Quoted in Keeton, Robert; O'Connell, Jeffrey, "Basic Protection for the Traffic Victim," Little Brown, 1965.

[49] Subcommittee on Commercial and Administrative Law before the House Judiciary Committee, testimony presented by PIAA, June 12, 2002.

[50] O'Connell, Jeffrey, "An Alternative to Abandoning Tort Liability," 60 Minnesota: 501-506-509, 1976.

[51] O'Connell, Jeffrey, "An Alternative to Abandoning Tort Liability," 60 Minnesota: 501-506-509, 1976.

[52] Localio, A.R.; Lawthers, A.G.; et.al., "Relation between malpractice claims and adverse events due to negligence. Results of the Harvard Medical Practice Study III," New England Journal of Medicine, Volume 325:245-251, July 25, 1991.

[53] O'Connell, Jeffrey; Pohl, Christopher, "How Reliable is Medical Malpractice Law?," 359 Journal of Law and Health,1998. A Review of Vidmar, Neil, "Medical Malpractice and the American Jury: Confronting the Myths About Jury Incompetence, Deep Pockets, and Outrageous Damage Awards," University of Michigan Press, 1995.

[54] O'Connell, Jeffrey; Pohl, Christopher, "How Reliable is Medical Malpractice Law?," 359 Journal of Law and Health,1998. A Review of Vidmar, Neil, "Medical Malpractice and the American Jury: Confronting the Myths About Jury Incompetence, Deep Pockets, and Outrageous Damage Awards," University of Michigan Press, 1995.

[55] "Fear of Litigation Study," conducted by Harris Interactive, Final Report, April 11, 2002.

[56] IOM Report, "To Err is Human: Building a Safer Health System," 2000.

[57] Medical Liability Monitor, Vol. 27, No. 1, January 2002.

[58] American Tort Reform Association, December 2001--Non-Economic Damage Reform; Shook, Hardy & Bacon L.L.P, Liability Reform Laws, October 2001.

[59] Aon Risk Consultants, Inc., "Long Term Care General Liability: Professional Liability Actuarial Analysis," February 28, 2002.

[60] Aon Risk Consultants, Inc., "Long Term Care General Liability: Professional Liability Actuarial Analysis," February 28, 2002.

[61] Information supplied By Rep. Chip Pickering.

[62] A.M. Best Company, Inc., "As Nursing home liability losses soar, carriers stop writing business," February 7, 2000.

[63] Modern Healthcare, January 7, 2002; Medical Malpractice, III, Insurance Issues Update, March 2002.

[64] The Record (New Jersey), December 23, 2001.

[65] The New York Times, "Doctors Face a Big Jump in Insurance," March 22, 2002.

[66] The Clarion-Ledger, "Lloyd's of London Agrees to Insure Mississippi Doctors But 25-Member Group Will Pay Rates 400% Higher," December 22, 2001.

[67] HHS Analysis of PIAA and other source data, 2002.

[68] Best's Insurance News, "Mississippi Looks for Answers to Lack of Med-Mal Coverage," December 28, 2001.

[69] NAIC Profitability by Line by State, 2001, presented before House Judiciary Committee by PIAA June, 2002.

[70] Zuckerman, Stephen, Bovbjerg, Randall R., and Sloan, Frank, "Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums," Inquiry 27: 167-182, Summer 1990.

[71] Analysis from the Council of Economic Advisors, July, 2002.

[72] O'Connell, Jeffrey, "Offers that Can't be Refused," 1977 Northwestern University Law Review 589 (1982); Moore, Henson; O'Connell, Jeffrey, "Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss," 44 Louisiana Law Review 1267 (1984); Moore, Henson; Hoff, John, "H.R. 3084: A More Rational Compensation System for Medical Malpractice," 49 Law and Contemporary Problems 117 (Spring 1986). A Statement by the Committee for Economic Development, "Breaking the Litigation Habit," 2000. A Bill to implement this approach was first introduced by Rep. Henson Moore and Rep. Richard Gephardt in 1987, H.R. 5400, 98th Congress.

[73] "Learning from our Mistakes: Quality Grand Rounds, a New Case-Based Series on Medical Errors and Patient Safety," Annuals of Internal Medicine, Volume 136, Number 11, June 4, 2002.

[74] IOM Report, "To Err is Human: Building a Safer Health System," 2000.

The Rise of Nursing Home Litigation:
Findings From a National Survey of Attorneys

David G. Stevenson, M.S.

David M. Studdert, LL.B., Sc.D., M.P.H.

David Stevenson, S.M. Doctoral Candidate, Ph.D. Program in Health Policy, Harvard University, 17 Alden Road #1, Watertown MA 02472. 617-588-0349 (phone). Email: stevens@fas.harvard.edu.

Corresponding author: David Studdert, LL.B., Sc.D. Assistant Professor, Department of Health Policy and Management, Harvard School of Public Health, 677 Huntington Avenue, Boston MA 02115. 617-432-5209 (phone); 617-432-1494 (fax). Email: studdert@hsph.harvard.edu.

Funding/Support: Mr. Stevenson was supported in part by an Agency for Health Care Research and Quality National Research Service Award Training Grant. Dr. Studdert was supported in part by grant number KO2HS11285 from the Agency for Healthcare Research and Quality.

Word count: 3,794. **Originally Submitted:** July 8, 2002

Abstract

Lawsuits against nursing homes are a relatively recent phenomenon. Despite a growing sense of alarm among policy-makers, little is known about their scale, dynamics, or outcomes. To describe these characteristics at the national level, we conducted a web-based survey of attorneys from across the country who bring and defend this litigation. Respondents and their firms were involved, respectively, in 4,677 and 8,256 claims in 2001, over half of which were in Florida and Texas. Our data show that the costs of nursing home litigation are substantial on an aggregate and per-claim basis, especially in states where the litigation is most prevalent. These findings elevate concerns about nursing home quality of care, and they also indicate that litigation diverts substantial resources from resident care which may actually fuel quality problems.

Lawsuits against nursing homes are a new feature on the health law landscape. The legal system's traditional response to concerns about the quality of long-term care has been regulation, rendering nursing homes among the most highly regulated entities in American health care.[1] Although these laws generally preserve private rights to sue, the conventional wisdom is that the elderly face access problems in civil litigation.[2] This view holds that the elderly are not attractive clients to plaintiffs' attorneys, because the damages (and fees) recoverable for their injuries are relatively small due to the lack of associated economic losses.[3]

For reasons that are not clear, this situation began to change dramatically through the 1990s.[4] Nursing home litigation is now widely recognized as one of the fastest growing areas of health care litigation. In several states, most notably Florida, claims rates and nursing homes' liability insurance premiums have soared.[5] State statutes that set forth residents' rights, and permit third parties to bring lawsuits on behalf of residents for violations of those rights, appear to have provided a legal basis for many of these claims.[6] Citing concerns about the financial viability of long-term care facilities, the Florida legislature recently enacted sweeping reforms designed to stem the volume and cost of nursing home lawsuits.[7] Other states have passed similar measures.[8]

Despite a growing sense of alarm among policy-makers about lawsuits against nursing homes, little is known about their scale, dynamics, or outcomes. Previous studies of this litigation have focused primarily on the experience of nursing homes and insurers in Florida.[9] We surveyed a national sample of plaintiff and defense attorneys who practice in the area of nursing home litigation about the details of the claims they steward, including litigant characteristics and the volume, type, and outcomes of claims. We were particularly interested in what such descriptive statistics may imply about the relationship between litigation and quality of care in this sector.

Study Methods

Survey Sample

To identify plaintiff and defense attorneys who devote a substantial amount of time to nursing home litigation, we searched the Martindale-Hubbell legal directory, which is freely accessible on the internet.[10] Martindale-Hubbell is the standard national guide to lawyers and law firms, and has been used as a reference tool in previous studies of litigation practice. It provides a free basic listing for any individual who has been admitted to a state bar and lists approximately 90% of attorneys in private practice in the United States, including

contact information, individual and firm details, and areas of legal practice.[11]

We selected all attorneys who listed "nursing home" or "long-term care" law among their practice areas. We limited selections to one attorney per firm.[12] The final sample consisted of 464 attorneys from 43 states (Exhibit 1). More than one-third of the sample came from Florida (22%) or Texas (15%), states that together account for approximately 10% of nursing home residents nationwide. California, which accounts for approximately 7% of nursing home residents nationwide, had the next largest representation of attorneys (5%).

Survey Content and Administration

Using a web-based survey instrument, we elicited information from attorneys about their nursing home litigation practices, including volume, compensatory value, and outcomes of claims they handled. A "claim" was defined as a formal demand for compensation made orally or in writing, whether or not it involved a formal lawsuit.[13] The survey contained questions about the injuries alleged and the characteristics of plaintiffs and defendants.

We also asked about "primary initiators" of claims, defined as the person who took the most responsibility for taking the steps necessary to bring the claim, whether or not that person

was the injured party or the named plaintiff. In addition, we sought respondents' opinions about litigation trends over the past five years. A draft version of the instrument was pre-tested on a small sample of plaintiff and defense attorneys, as well as several academicians with relevant expertise.

We administered the survey in November 2001 by sending emails containing an internet link to a secure study website. To maximize response, we conducted intensive email and telephone follow-up over the subsequent two months. Survey participation was voluntary and uncompensated.[14]

Analysis

Descriptive statistics relating to the proportion of claims were weighted by the number of claims in which individual respondents were involved. We calculated national aggregates (practice, caseload, alleged injuries and claims disposition) as well as state-specific statistics for Florida and Texas because of their dominance in both the sample and respondent populations. We tested for statistically significant differences (t-tests) in alleged injuries and claims disposition by separately comparing Florida and Texas with national averages (exclusive of the comparator state). Finally, to investigate the potential for reporting bias, we tested for statistically

significant differences (t-tests) in practice, caseload, and disposition data across attorney type (plaintiff/defense).

Study Results

Attorney Respondents

We received responses from 278 attorneys in 37 states, a response rate of 60%. Florida and Texas were home to the practices of 23% (n=63) and 16% (44) of respondents, respectively.[15] California, the next most heavily represented state, accounted for 5% (14) of respondents.

Based on their client profile, we classified 61% (170) of respondents as plaintiff attorneys and 36% (100) as defense attorneys.[16] The vast majority (91%) acted exclusively for one side. Eight attorneys could not be classified due to an even split in their practices or missing data.

Practice and Caseload Characteristics

Exhibit 2 summarizes respondents' practice and caseload characteristics. Respondents reported personally handling a total of 4,677 nursing home claims in the 12 months prior to the survey. Respondents' firms were involved in 8,256 claims, more than half of which were in Florida (40%) and Texas (21%).

Defense attorneys, on average, practiced at larger firms (54 vs. 5 attorneys per firm), devoted more of their personal

practice to nursing home litigation (41% vs. 32%), and were involved in more nursing home claims on an annual basis than plaintiff attorneys, especially at the firm level (50 vs. 19 claims). The total number of claims personally handled by plaintiff (2,327 claims) and defense (2,247 claims) attorneys were similar, but the firm level aggregates differed (3,172 and 4,971 claims, respectively).

Types of Claims

State statutes (49%) and common law causes of action (36%) figured prominently as the primary legal bases of claims nationwide, although these bases varied across states. For instance, most claims in Florida (83%) relied on the nursing home residents' rights statute in that state as the primary basis of the claim.[17] Attorneys in other states, including Arkansas, Georgia, Kentucky, Louisiana, Maine, Ohio, and Texas cited residents' rights statutes, but less frequently than their counterparts in Florida.

Recognizing that claims may allege multiple injuries, more than half (52%) of claims nationwide involved deaths (Exhibit 3). The next most frequent harms alleged were pressure ulcers/bed sores (49%), dehydration/weight loss (34%), and emotional distress (32%). The leading injury types in Florida and Texas were similar to those at the national level, with

three exceptions. In Texas, the proportions of claims that alleged death and pressure ulcers/bedsores were significantly higher than the national average; in Florida, the proportion of claims that alleged falls was significantly higher than the national average.

Resident & Plaintiff Characteristics

Children of nursing home residents were the primary initiators of the majority (64%) of claims, followed by residents' spouses (22%) and residents themselves (8%) (Exhibit 4). A large proportion of the litigation involved chronic, long stay nursing home residents. Claimants also were commonly Medicaid beneficiaries and individuals with dementia or Alzheimer's disease. Fewer claims involved individuals in nursing homes for post-acute care and individuals under the age of 65.

Virtually all claims (99%) named the nursing home itself as a defendant. Other professional staff were also frequent targets of the litigation. Nursing home administrators were named in 28% of claims. Nearly one in five claims named physicians, and approximately the same proportion named nurses. However, the proportion of claims in which professional staff members were sued varied considerably across states. For

example, physicians were named as defendants in 8% of Florida claims and 24% of Texas claims.

Disposition of Claims

Attorneys reported that approximately 8% of claims reached trial, and that nearly one half (46%) of these resulted in verdicts for the plaintiff (Exhibit 5). The trial rate was significantly lower among Florida claims (2%). Plaintiff attorneys reported higher trial rates on average than their defense counterparts, although the difference was not statistically significant. With respect to trial outcomes, on the other hand, the divergence was statistically significant: plaintiff attorneys estimated winning 61% of trials, compared to defense attorneys' estimate of 32% for plaintiff wins.

Among claims resolved out of court, 88% involved compensation payment to the plaintiff; this is nearly three times the rate of payment typically observed among medical malpractice claims (33%). There was much closer agreement among attorneys about this figure, with no statistically significant variation between plaintiff (90%) and defense (85%) attorneys.

Finally, the average recovery amount among paid claims—whether resolved in or out of court—was approximately $406,000 per claim, nearly twice the size of compensation in a typical medical malpractice claim ($207,000). Average recovery amounts

in Florida ($464,000) and Texas ($553,000) were higher than the national average ($311,000, exclusive of Florida and Texas). Plaintiff attorneys nationwide reported a higher level of payment ($432,000) than defense attorneys ($384,000), but they agreed that approximately 17% of payments included punitive damages. In Texas, punitive damages were significantly more common than they were elsewhere in the country, forming part of the compensation package in 30% of paid claims.

Litigation Trends

Attorneys reported substantial increases over the last 5 years in both the number of nursing home claims they handled and the average size of recoveries. On a 5-point Likert scale (1=decreased substantially; 3=stayed about the same; 5=increased substantially), the average score for trends in claims volume was 4.2, with approximately one half of all respondents selecting the highest possible response category. With respect to damages payments, the average score was 4.0, and just over 40% of attorneys selected the highest possible response category. Despite the much higher volume and cost of claims in Florida and Texas, attorneys in these states reported rates of increase that were slightly lower than the national average.

DISCUSSION

Scale of the Litigation

This study provides new evidence about the dimensions of nursing home litigation in the United States. The attorneys we surveyed were personally involved in litigating nearly 4,700 claims in the preceding 12 months. Their firms handled approximately 8,300 claims. Respondents' individual case histories suggest that 85% of these claims would recover damages at an average of $406,000 per claim.

The implications of these data in terms of the volume and cost of nursing home litigation are staggering. Using the conservative assumption that plaintiff and defense attorneys who responded to our survey represent opposite sides of the same disputes, their firms were involved in litigating claims in 2001 estimated to be worth approximately $1.4 billion. If non-respondents had similar litigation experiences to respondents, our data imply compensation payments of $2.3 billion to plaintiffs nationwide, with claims in Florida and Texas accounting for $1.1 billion and $654 million, respectively.

These figures should be interpreted as a type of "unfunded liability," rather than as strictly annualized estimates of litigation costs. Because of the time lag associated with resolution of claims, a portion of the reported claims would have closed in 2001; the rest will close in future years (and,

of course, be joined along the way by new claims). Nonetheless, to put the estimated worth of the open claims we analyzed in context, they represent 2.5% of the $92 billion spent on nursing home care nationwide in 2000 (60% of which came from Medicaid and Medicare).[18] In Florida and Texas, they represent 23% and 15%, respectively, of annual nursing home expenditures in those states.

Several previous studies have attempted to measure the volume and costs of nursing home litigation in Florida. Using survey data from 442 facilities and detailed claims information from one county, researchers at the University of South Florida and the University of Florida estimated 1,723 open claims statewide in 2001 and an average out-of-court settlement amount of $462,000.[19] These are remarkably close to our Florida estimates of 1,651 claims and $464,000, respectively.

A survey of facilities conducted by the Florida for-profit nursing home association estimated 1,621 open claims statewide worth approximately $970 million, a cost figure slightly lower than our extrapolation of $1.1 billion for the state.[20] Direct comparison of our results to those of a two other surveys sponsored by the for-profit nursing home industry, one focused on Florida and one at the national level, are difficult because of methodological discrepancies.[21] However, the main estimates are broadly consistent.

Growth and Dynamics of the Litigation

Besides highlighting its scale, our results indicate that nursing home litigation is a new and growing industry. The average respondent had practiced law for 17 years but had been involved in nursing home litigation for only 8 years, suggesting a mobilization of attorneys into this area in the mid-1990s. There was also a strong consensus among survey respondents from nearly every state about its substantial growth over the past 5 years. Among states with a significant representation in the study sample, attorneys from Arkansas, Georgia, Louisiana, and Oklahoma reported increases in both claims volume and average recovery amounts that were considerably higher than Florida, Texas, and the national average, highlighting these geographically-proximate states as emerging strongholds.

Several features of the litigation are distinctive. First, residents' children are the prime movers behind more than 60% of claims, a logical result given the high proportion of claims involving death and the prevalence of cognitive impairments among residents for whom claims were filed. Second, the average payment rate of 85% is remarkably high by civil litigation standards. It is nearly triple the average rate observed in medical malpractice litigation nationwide.

Third, average payments are large relative to medical malpractice and other types of personal injury litigation, a striking result given the absence of wage losses and financial dependents in a typical nursing home claim. The high rate of punitive damages, particularly in Texas, and the proportion of claims reportedly involving death would certainly buoy recovery amounts.[22] Fourth, nearly half of all nursing home claims involved wrongful death and/or pressure ulcers/bedsores; smaller proportions alleged dehydration/weight loss, improper use of restraints, and falls. These findings are consistent with previous analyses of litigation against Florida nursing homes and with key problems identified in a recent review of the nursing home quality literature.[23]

The Litigation and Quality Debate Revisited

The factors driving the recent trends in nursing home litigation are unclear. Public discussion often centers on two competing drivers: trial attorneys, who seek to maximize their incomes; and consumers, who are responding to unacceptable care in nursing homes and potential failures of regulatory oversight in this sector. Such polarized explanations must be situated in the context of the broader, ongoing debate about the relationship between litigation and quality.[24]

Consumer advocates and the plaintiffs' bar have long argued that lawsuits are essential to ensuring high quality care. Yet, providers and defense attorneys state, with some empirical justification, that lawsuits are haphazard, do little to improve quality, and impose significant financial burdens. In the nursing home sector, the battle lines are very sharply drawn. Proponents of litigation can point to plentiful reports of substandard care as substantiating the need for the deterrent influence of tort law.[25] Nonetheless, critics counter that, in a system that is already fiscally strained, litigation diverts scarce resources that could be used to address such problems away from resident care.

What do our findings add to this important ongoing debate? The large body of litigation we detected elevates existing concerns about the current standard of care in nursing homes across the country, as does the high rate of claim payments.[26] However, several important caveats are appropriate.

First, considerations other than fault, such as the costs of running litigation, the risk of large awards, and the empathy jurors may have for particular types of plaintiffs, influence the decisions insurers, defense attorneys, and defendants make about whether to pay claims. Second, available quality indicators, such as On-Line Survey, Certification, and Reporting (OSCAR) deficiencies and staffing levels, do not flag Florida

EXHIBIT 1C

EXHIBIT 3C

and Texas, in the aggregate, as performing markedly worse than other states.[27] Similarly, an in-depth, facility-level study of claims in one Florida county found no relationship between OSCAR deficiencies (including citations for insufficient staffing) and lawsuits.[28] Third, the recent rise in nursing home litigation does not appear to track any clearly documented, general deterioration of quality in this sector. On the contrary, although substantial problems are known to exist, the health services literature has painted a cautiously optimistic picture about quality improvement over the last two decades.[29] Of course, at least part of a discrepancy between litigation and quality trends is likely due to plaintiff attorneys gaining ground on a reservoir of substandard care.

Regardless of the extent to which nursing home litigation effectively highlights and provides redress for problems with care, its sheer scale raises policy concerns about its net impact on quality. This is particularly true in Florida and Texas, where significant portions of nursing home resources are being channeled toward litigation. Many litigants may need and deserve the compensation that such litigation provides. However, liability insurance premiums and payments may create a "death spiral" if their fiscal impact on defendant facilities feeds further quality problems and increases the probability of future lawsuits.

Representatives of the nursing home industry claim that the costs of litigation threaten the already tenuous financial solvency of many facilities.[30] There is also reasonable evidence of volatility in liability insurance markets across the country, especially Florida.[31] Premiums for nursing home coverage in Florida were eight times higher than the national average, and several of the largest carriers have terminated this product line altogether.[32] Before the Florida legislature mandated coverage in January 2002, approximately one in five nursing facilities in the state were operating uninsured.[33]

Study Limitations

One limitation of our study is that attorneys would be expected to bring their professional biases to bear on survey questions. They also may have had problems recalling and estimating specific details of their cases, such as average payment amounts. Our survey does not validate their reports, nor does it capture the perceptions of nursing home residents and their families, nursing home providers, liability insurance companies, or policymakers. Another limitation is that our cost and volume extrapolations involve generalizing respondents' experiences for non-respondents; the latter's practice profile may have been systematically different, particularly if plaintiff and defense attorneys had different response rates.

We cannot directly compare these response rates because we had no basis, independent of survey response data, for classifying practice orientation.

Nonetheless, several considerations bolster our estimates. First, a crude check of response rates within attorney types is firm size: average firm size for respondents and the full study sample are 23 and 26 attorneys, respectively. Since average firm size for plaintiff and defense attorneys differs considerably (5 attorneys per firm for plaintiffs vs. 54 attorneys per firm for defense), this suggests that non-response may not be markedly different for plaintiff and defense attorneys. Second, breakdowns of the main results by attorney type show fairly good internal consistency.[34] Third, our findings and extrapolations are very consistent with other Florida studies that relied on different data sources.

On the other hand, a few study design features suggest that total claims are higher than our extrapolations. Attorneys who did not list relevant practice expertise in Martindale-Hubbell were excluded from the sample. In addition, our cost estimates are tied only to compensation, omitting the costs of defense attorneys, the judicial system, and the non-monetary or uninsurable costs (e.g. litigants' time) associated with lawsuits. Similarly, the costs of any reactive measures to the

threat of litigation that did not cost-effectively improve the quality of care would not be included in our estimates.

Conclusion and Policy Implications

Our findings about the rates and outcomes of nursing home litigation highlight persistent questions about quality of care in this sector. We can only speculate about the mix of salutary and damaging effects on care generated by the body of claims we identified, since we did not measure litigation performance directly—in particular, the extent to which the litigation reliably tracks negligence, deters substandard care, and compensates worthy residents. Yet, the overall scale of the litigation is extremely sobering. In high volume litigation states, the diversion of substantial resources currently required to defend and pay nursing home lawsuits is likely to have an independent, negative impact on quality.

How can policy-makers respond? One response is to enact tort reform of the kind recently attempted in Florida and currently being considered by other state legislatures. The goal of such reforms is to stabilize the nursing home and liability insurance markets without eliminating the incentives litigation may provide to deliver high quality care. Yet, fiercely competing political interests make these reforms difficult to advance. In particular, the main stakeholders in

tort reform debates have sharply divergent opinions about the wisdom of caps on damages awards and attorney fees, the two most prominent reform measures.

An alternative approach to curbing litigation rates—one that is more attractive in theory—is to rely on redoubled quality improvement and assurance efforts to remove the basis of lawsuits. In contrast to tort reforms, whose litigation-reducing capacities have been documented, the impact of a quality-oriented approach to litigation is less certain.[35] Its effectiveness clearly hinges on both the extent to which quality gains can be realized and the extent to which litigation rates will then respond to such gains. There are considerable uncertainties associated with each of these elements.[36]

But perhaps the greatest obstacle to the quality improvement approach is that increased staffing ratios and other favored strategies call for substantial investments, a difficult sell in the current fiscal climate.[37] The recent, government-led *Nursing Home Quality Initiative* is a comparatively inexpensive intervention, emphasizing access to information and its potential to spur consumer empowerment and competition on quality.[38] Although it is too soon to evaluate the impact of this particular effort, policymakers should include a broad range of potential benefits when considering the affordability of such interventions. Quite apart from the ability of these

investments to improve nursing home residents' quality of care and quality of life, their potential to reduce the number and severity of lawsuits should be an important consideration in evaluating their cost-effectiveness.

Acknowledgements

The authors thank Troyen Brennan, Susan Eaton, Christopher Johnson, Marshall Kapp, Michelle Mello, Joseph Newhouse, and Alan Zaslavsky for their comments on an earlier draft of this article.

References

1. Institute of Medicine (IOM) Committee on Nursing Home Regulation, Improving the Quality of Care in Nursing Homes (Washington, D.C.: National Academy Press, 1986); 42 U.S.C. Sec. 1395; 42 U.S.C. U.S.C. Sec. 1396r; M. B. Kapp, "Quality of Care and Quality of Life in Nursing Facilities: What's Regulation Got to Do with It?," McGeorge Law Review 31, no. 3 (2000): 707-731.

2. D. M. Studdert et al, "Negligent Care and Malpractice Claiming Behavior in Utah and Colorado," Medical Care 38, no. 3 (2000): 250-260.

3. D. Bragg, "Dealing with Nursing Home Neglect: The Need for Private Litigation," Southern Texas Law Review 39, no.1 (1997): 1-22; S. J. Hemp, "The Right to a Remedy: When Should an Abused Nursing Home Resident Sue?," Elder Law Journal 2, no. 2 (1994): 195-224.

4. S. J. Hemp, "The Right to a Remedy: When Should an Abused Nursing Home Resident Sue?;" M. B. Kapp, "Malpractice Liability in Long-Term Care: A Changing Environment," Creighton Law Review 24, no. 4 (1991): 1235-1253; D. Keville, B. Landsberg, K. L. Breuner and J. F. Libby, "Recent Developments in Long-Term Care Law and Litigation," Whittier Law Review 20(Winter 1998): 325-

344; T. D. Begley, "Nursing Home Law and Litigation," New Jersey Law Journal 32(April 1999): 120-156; D. Gill, "Elder Law Practices Come of Age," Chicago Lawyer, November 1997; G. D. Cox, "End of Life Valued," National Law Journal, March 2, 1998.

5. T. Bourdon and S. Dubin, "Long Term Care: General Liability and Professional Liability, Actuarial Analysis," (New York, NY: Aon Actuarial Solutions, 2002); T. Bourdon and S. Dubin, "Florida Long-Term Care: General Liability and Professional Liability Actuarial Analysis" (New York, NY: Aon Actuarial Solutions, 2001); J. Williamson, "The Siren Song of the Elderly: Florida's Nursing Homes and the Dark Side of Chapter 400," American Journal of Law and Medicine 25, nos. 2 and 3 (1999): 423-443; L. Polivka-West, H. Tuch and K. Goldsmith, "A Perfect Storm of Unlimited Risks for Florida Nursing Home Providers," Ethics Law and Aging Review 7(2001): 81-99.

6. J. Spitzer-Resnick and M. Krajcinovic, "Protecting the Rights of Nursing Home Residents: How Tort Liability Interacts with Statutory Protections," Nova Law Review 19(Winter 1995): 629-646.

7. Florida Senate Bill 1202, signed into law in May 2001. In addition to tort reforms, the bill also included provisions to increase nursing home staffing and tighten regulatory standards.

8. Ohio House Bill 412, passed in August 2002. The Ohio bill focuses more narrowly on tort reforms than Florida Senate Bill 1202. In addition to Ohio's and Florida's nursing home-centered statutes, other states such as Mississippi, Nevada, and Pennsylvania have recently passed more general malpractice reforms. The U.S. House of Representatives also recently passed HR 4600 restricting medical malpractice lawsuits.

9. Bourdon and Dubin, "Florida Long-Term Care: General Liability and Professional Liability Actuarial Analysis;" D. Hedgecock and J. Salmon, "Lawsuits and Liability Insurance Experience of Florida Nursing Facilities," (Tampa, FL: Florida Policy Exchange Center on Aging, University of South Florida, 2001); Florida Association of Homes for the Aging and The Florida Health Care Association, "Nursing Home Tort Survey Results," Available at: http://www.fhca.org/fhca/news/tortsurvey_files/frame.htm. (March 2002); M. Oakley and C. E. Johnson, "Liability and Long-Term Care Viability," in Informational Report of the Task Force on Availability and Affordability of Lon-Term Care for the

Florida Legislature in Response to House Bill 1993 (Tampa, FL: Florida Policy Exchange Center on Aging, University of South Florida, 2001).

10. Martindale-Hubbell: http://www.martindale.com (March 2002).

11. Personal communication on 10/23/01 with Chris Pelzer, Assistant Marketing Manager, Martindale-Hubbell.

12. At firms with multiple attorneys practicing in the areas of interest, we chose the senior lawyer. We also limited the sample to attorneys with email addresses listed, which excluded 42 otherwise eligible attorneys. In addition, because our practice specifications were not unique to litigators-for example, some attorneys' nursing home practices were confined to regulatory or corporate work-we further refined our sample through confirmatory telephone contacts with the subsample for whom area of specialization was unclear.

13. This definition of a "claim" comes from the Harvard Medical Practice Study. For more information, see P. C. Weiler et al, A Measure of Malpractice: Medical Injury, Malpractice Litigation,

and Patient Compensation (Cambridge, Mass.: Harvard University Press, 1993).

14. The study design and the survey instrument were approved by the human subjects committee at the Harvard School of Public Health.

15. Response rates in Florida (61%) and Texas (63%) were comparable with the overall response rate.

16. We are unable to calculate precise response rates for plaintiff and defense attorneys, as these characteristics were not identified in the initial attorney listings. However, based on firm size characteristics of the full sample and of respondents, we believe that response rates for plaintiff and defense attorneys are quite similar. See our discussion of potential study limitations for more detail.

17. Florida Statutes § 400.022 - 400.023.

18. U.S. Centers for Medicare and Medicaid Services (CMS), "National Health Expenditures: Nursing Home Care Expenditures Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1980-2000," Available

at: http://www.hcfa.gov/stats/nhe%2Doact/tables/t7.htm (March 2002).

19. Hedgecock and Salmon, "Lawsuits and Liability Insurance Experience of Florida Nursing Facilities;" Oakley and Johnson, "Liability and Long-Term Care Viability."

20. Florida Association of Homes for the Aging and The Florida Health Care Association, "Nursing Home Tort Survey Results."

21. Bourdon and Dubin, "Florida Long-Term Care: General Liability and Professional Liability Actuarial Analysis;" Bourdon and Dubin, "Long Term Care: General Liability and Professional Liability, Actuarial Analysis."

22. Because attorneys were asked to report averages only, we cannot determine the extent to which very high worth claims drive the average payment amount. See, for example, "Trial Judge Affirms $78 Million Verdict In Elder Abuse Case," Nursing Home Litigation Reporter, August 24, 2001. However, based on our pilot work, we believe it is likely that many respondents reported dollar amounts that more closely resembled medians (i.e., typical claims) than means.

23. Hedgecock and Salmon, "Lawsuits and Liability Insurance Experience of Florida Nursing Facilities;" IOM Committee on Improving Quality in Long-Term Care, G. S. Wunderlich and P. O. Kohler, Improving the Quality of Long-Term Care (Washington, D.C.: National Academy Press, 2001).

24. P. C. Weiler, Medical Malpractice on Trial (Cambridge, Mass.: Harvard University Press, 1991).

25. A recent U.S. Government Accounting Office (GAO) report, for example, found that more than one-fourth of the nursing homes it studied had deficiencies causing actual harm to residents or placing them at risk of serious injury, and that 40% of these facilities were repeat offenders. GAO, Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards, (Washington, D.C.: GAO, 1999). See, also: R. Pear, "Unreported Abuse Found at Nursing Homes," New York Times, March 2, 2002; M. Thompson, "Fatal Neglect," Time Magazine, October 27, 1997; GAO, California Nursing Homes: Care Problems Persist Despite Federal and State Oversight, (Washington, D.C.: GAO, 1998); GAO, Nursing Homes: More Can Be Done to Protect Residents from Abuse, (Washington, D.C.: GAO, 2002).

26. In addition, these findings highlight the potential for claims information to provide a valuable repository of data for informing and targeting quality improvement efforts. See, for example, B. LaMendola and G. Groeller, "Quality Violations Often Lead to Suits - Even the Best Home Can End up in Court. Series: Special Report: Nursing Homes on Trial," South Florida Sun Sentinel, March 6, 2001.

27. C. Harrington et al, "Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1992-1998," (San Francisco: University of California at San Francisco, 2000).

28. Oakley and Johnson, "Liability and Long-Term Care Viability."

29. Institute of Medicine, Improving the Quality of Long-Term Care (Washington, D.C.: National Academy Press, 2001); C. Hawes, Assuring Nursing Home Quality: The History and Impact of Federal Standards in OBRA-87, (New York, NY: The Commonwealth Fund, 1996).

30. L. Polivka-West et al, "A Perfect Storm of Unlimited Risks for Florida Nursing Home Providers;" Florida Health Care Association, "Nursing Home Litigation Reform Will End The Crisis

that Threatens Florida's Elderly," (Tallahassee, FL: FHCA, March 2001). One large nursing home chain recently cited these costs as a primary reason for selling its more than 50 facilities in Florida. V. Galloro, "Beverly to Sell Florida Properties," Modern Healthcare 31, no. 20 (July 23, 2001): 28.

31. Associated Press, "Pickens Says Nursing Home Insurance Not Reasonably Available," AP and Local Wire, October 1, 2001; "Higher Insurance Rates Raise Nursing Home Costs," The State, September 17, 2001; Texas Department of Insurance, "Best Practices Adopted to Curb Nursing Home Claims," Available at: http://www.tdi.state.tx.us/commish/nr12041a.html (March 2002); K. Stefanova, "Suits Boost Nursing Homes' Premiums," The Washington Times, September 4, 2001.

32. Bourdon and Dubin, "Florida Long-Term Care: General Liability and Professional Liability Actuarial Analysis;" L. W. Hann, "Driven Out: As Nursing Home Liability Costs Soar, Exiting Carriers Spur Market Crisis," Best's Review, March 2000.

33. Hedgecock and Salmon, "Lawsuits and Liability Insurance Experience of Florida Nursing Facilities."

34. The exception was the percent of trial verdicts for the plaintiff. However, because few claims proceed to trial, this difference has a negligible impact on our estimates of scale.

35. R.R. Bovbjerg, "Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card," U.C. Davis Law Review 22, no. 2 (1989): 499-566; F.A. Sloan, P.M. Mergenhagen, and R.R. Bovbjerg, "Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis," Journal of Health Politics, Policy and Law 14, no.4(1989): 663-89; S. Zuckerman, R.R. Bovbjerg, F.A. Sloan, "Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums," Inquiry 27, no. 2(1990):167-82; P.M. Danzon, "The Frequency and Severity of Medical Malpractice Claims: New Evidence," Law and Contemporary Problems 49, no. 2 (1986): 57-84. But compare with: W.P. Gronfein and E.D. Kinney, "Controlling Large Malpractice Claims: The Unexpected Impact of Damage Caps," Journal of Health Politics, Policy, and Law 16, no. 3 (1991): 441-64.

36. There is considerable debate about the most effective way to improve nursing home quality. See IOM, Improving the Quality of Long-Term Care for more detail. For the question of whether litigation responds to changes in quality, see D. M. Studdert,

T. A. Brennan and E. J. Thomas, "Beyond dead reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado," Indiana Law Review 33, no. 4 (2000): 1643-1686.

37. R. Pear, "9 of 10 Nursing Homes Lack Adequate Staff, Study Finds," New York Times, February 18, 2002.

38. The CMS-sponsored Nursing Home Quality Initiative and Nursing Home Compare website allow consumers and their families to compare the performance of specific nursing facilities along selected dimensions of quality. For more information, see http://cms.hhs.gov/providers/nursinghomes/nhi/ and http://www.medicare.gov/nhcompare/home.asp.

EXHIBIT 1: SAMPLE OVERVIEW AND CONTEXT

	Florida	Texas	National
Population			
Population Age 75+[a]	1,355,421	929,924	16,600,767
Nursing Home Residents[b]	69,122	87,299	1,490,155
Nursing Home Residents per 1,000 age 75+	51.0	93.9	89.8
Attorneys			
Nursing Home Lawyers in Sample	103	70	464
Nursing Home Lawyers per 1,000 Nursing Home Residents	1.5	0.8	0.3

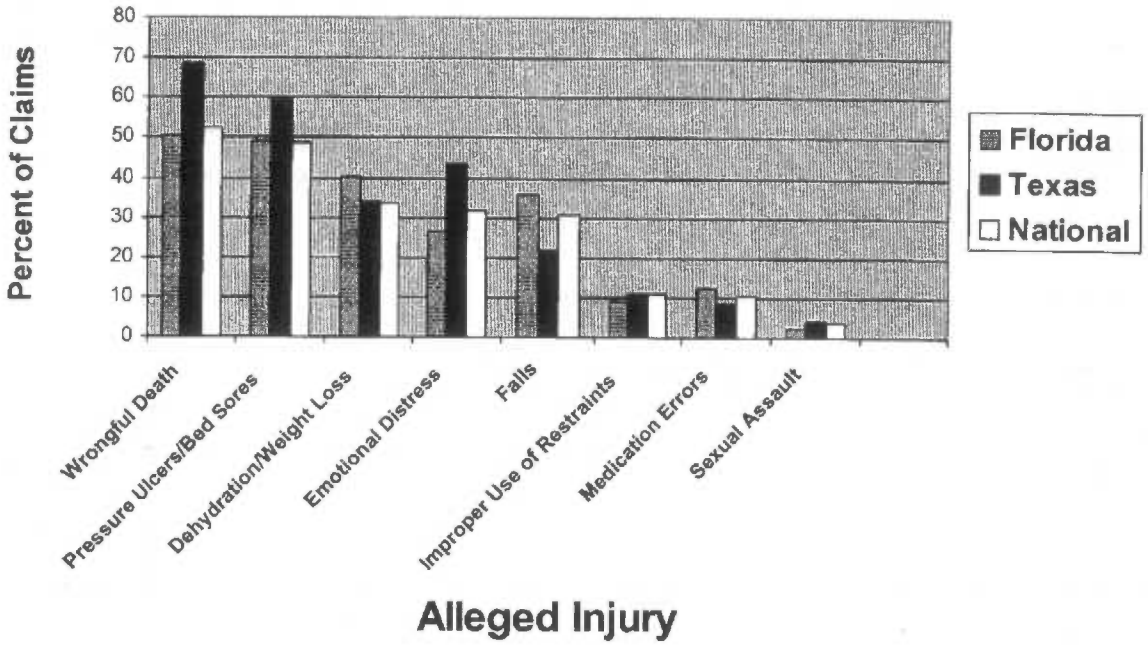
[a]United States Bureau of the Census. Available at http://www.census.gov. Accessed in February 2002.
[b]American Health Care Association. *Facts and Trends: The Nursing Facility Sourcebook, 2001.* Washington, D.C.: The American Health Care Association; 2001.

EXHIBIT 2: PRACTICE AND CASELOAD CHARACTERISTICS OF ATTORNEYS CONDUCTING NURSING HOME LITIGATION

	Florida (n=63)	Texas (n=44)	National (n=278)	Plaintiff[a] (n=170)	Defense[a] (n=100)
Practice					
Firm Size (mean)	15.4	34.6	22.7	5.1	54.1
Nursing Home Litigation as Share of Practice (mean)	38.7%	36.0%	35.2%	31.7%	41.2%
Caseload					
Claims,[b] by Individual (mean)	25.0	18.8	16.8	13.7	22.5
Claims, by Firm (mean)	52.3	40.1	29.7	18.7	49.7
Total Claims, by Individual	1,576	827	4,677	2,327	2,247
Total Claims, by Firm	3,298	1,765	8,256	3,172	4,971
Years in Practice (mean)	16.1	17.2	16.9	16.8	17.1
Years Doing Nursing Home Litigation (mean)	9.0	8.5	8.0	7.4	9.2

[a] 'Plaintiff' is defined as any attorney who reported practicing plaintiff work more than 50 percent of the time; 'Defense' is defined as any attorney who reported practicing defense work more than 50 percent of the time. Lawyers who did not respond to this question or who indicated that their practice broke out evenly were not classified as either plaintiff or defense.
[b] A claim is defined as a formal demand for compensation made orally or in writing; it will often, but not necessarily, involve the formal filing of a lawsuit. All claims volume statistics relate to claims reported as being open in 2001.

EXHIBIT 3: NURSING HOME LITIGATION BY TYPE OF ALLEGED INJURY[a,b,c,d]



[a]Weighted by number of claims of individual respondent.
[b]Does not add to 100 percent because multiple injuries might be alleged in a single claim.
[c] "Other" alleged injuries identified by respondents included assault/battery, wandering/elopement, and inadequate care/supervision.
[d]The proportions of alleged injuries involving death and pressure ulcers or bed sores are significantly higher in Texas than the national average excluding Texas ($p<0.01$). The proportion of alleged injuries involving falls is significantly higher in Florida than the national average excluding Florida ($p<0.01$).

EXHIBIT 4: LITIGANT CHARACTERISTICS

Resident Characteristics	Frequency among Claims (1-5 scale)[a]	Primary Initiator of Claim	Percent of Claims[b,c]	Named Defendant	Percent of Claims[b,c]
Chronic, long stay nursing home residents	4.4	Child of resident	63.5%	Nursing home/nursing home ownership	99.4%
Medicaid recipients	4.2	Spouse of resident	21.7%	Administrator/ Executive Director	28.2%
Individuals with dementia or Alzheimer's disease	4.0	Nursing home resident herself/him self	7.7%	Nurse	19.7%
Post-hospital, short stay residents	2.6	Other	4.1%	Physician	18.8%
Individuals Aged <65 years	1.9	Corporate guardian	2.6%	Nurse aide	7.2%
				Other	3.0%

[a]Scores are averages on a 5-point Likert scale with 1 indicating "very rare" and 5 indicating "very common."
[b]Weighted by number of claims of individual respondent.
[c]Primary initiator of claim category adds to 100%; named defense party does not.

EXHIBIT 5: DISPOSITION OF CLAIMS[a]

	Florida	Texas	National	National malpractice data[b]	Plaintiff	Defense
Process						
Percent to Mediation	92.0%[c]	83.1%[c]	74.6%	--	72.2%	77.3%
Percent to Arbitration	1.8%	0.6%[c]	2.3%	--	2.0%	2.5%
Percent to Trial	2.4%[c]	9.7%	7.9%	5.3%	9.4%	6.3%
Outcomes						
Percent Trial Verdicts for Plaintiff	44.3%	43.7%	46.2%	30.1%	61.4%[d]	31.6%[d]
Percent Out of Court Settlements with Plaintiff Compensation	91.7%[c]	89.1%	87.8%	33.1%	90.0%	85.3%
Damages						
Average Recovery Amount	$464,300	$552,700	$406,000	$207,000	$436,000	$384,000
Percent of Recoveries Including Punitive Damages	12.9%	30.3%[d]	17.5%	--	17.6%	16.9%

[a]Weighted by number of claims of respondent.
[b]Data from medical malpractice claims closed between 1993 and 1999 are presented for comparative purposes. They come from a database of 45,100 claims from 19 insurers operating in 27 states, including Florida and Texas.
[c]$p<0.01$. State comparisons are to national average, excluding that state. Plaintiff estimate compared to defense estimate.
[d]$p<0.05$. State comparisons are to national average, excluding that state. Plaintiff estimate compared to defense estimate.

NORCAL Mutual Insurance Company
CLAIMS Rx
March/April 2001

Institutional Elder Abuse

A Litigation Trend Physicians Need to Know

Observing a significant rise in elder abuse and dependent adult litigation during 1999 and 2000, NORCAL evaluated elder abuse case trends, taking into account the social, statutory and regulatory forces that generate these claims. This *Claims Rx* introduces elder abuse litigation trends, explores the physician's role in potential litigation, presents data on the NORCAL elder abuse cases and offers risk management strategies for appropriately approaching care of this unique patient population.

Litigation Trends

Several factors contribute to the rise in elder abuse/nursing home litigation:

- increased activity of various state and federal oversight agencies who have produced regulations to protect the rights of elderly and dependent adult inpatients;
- incentives for financial recovery by plaintiffs; and
- public mistrust of nursing home care.

These factors are set against the backdrop of an aging population and the perception that baby boomers do not have the time or financial resources to hire help to care for aging relatives at home.

Effect of Statutory and Regulatory Requirements

Historically, litigation of elder abuse cases has been limited. Plaintiff attorneys have not always been willing to accept medical malpractice cases involving elder claimants in which recovery for economic damages has been minimal and general damages have been arguably reduced by the age of the patients and their overall medical condition. However, the enactment of laws such as California's Elder Abuse and Dependent Adult Civil Protection Act (California Welfare and Institutions Code §15600 *et seq.*),[1] which essentially specifies the standard of care to which nursing homes are held, have significantly changed the litigation climate in favor of plaintiff attorneys. The requirements under this statute, as well as those from other state and federal guidelines, have provided plaintiffs in

continued on page 2...

NORCAL Elder and Dependent Adult Abuse Claims Study

NORCAL studied the characteristics of its claims experience in elder and dependent care, primarily through responses to questionnaires submitted by Claim's department supervisors. Fifty cases of elder and dependent care abuse, all from California, were identified. Forty-six of the cases involved elder adults, while the remaining four involved dependent adults. The information and data generated will help both physicians who treat elderly patients and those who serve as medical directors for SNFs to decrease their liability.

Closed Case Dispositions

Roughly half of the 50 cases are now closed, 13 of these due to dismissals, eight cases were settled and three resulted in defense verdicts. No plaintiff verdicts have been rendered against NORCAL defendants so far.

Of the eight cases that settled, six involved substandard care. The other two cases involved physicians who were poor witnesses. Two physicians requested settlement. Settlements by

continued on page 6...

continued from page 1...

California with a blueprint for establishing breaches of care and proving neglect and/or abuse.

Federal regulations under The Omnibus Budget Reform Act (OBRA) also provide an extensive recitation of standards that MediCare/MediCaid funded institutions must meet in order to maintain funding eligibility.[2]

While some skilled nursing facilities (SNFs) may fail to comply with these mandates either through indifference or neglect, the sheer volume of regulations virtually guarantees that even a fully-funded, fully-staffed and well-intentioned facility could fall short of compliance in a number of areas.

Financial Recovery as an Incentive for Plaintiffs

In states where there are limitations or caps on non-economic damages, such as California, the caps may no longer apply. Because the caps apply only to allegations of medical negligence, some allegations in these cases are not subject to limitations. For example, decisions in California elder abuse cases have generally broadened the scope of recovery making them more appealing to plaintiff attorneys. Therefore in California, the $250,000 cap on pain and suffering does not apply in many instances.

Public Mistrust of Nursing Homes

With increasing advocacy by organizations dedicated to defending the rights of nursing home patients, a tremendous amount of media attention has been focused on reporting horror stories generated by abuse and neglect of elderly victims confined to holding pens. It is not uncommon to hear people express a belief that they would rather die than have to live the remainder of their lives in a nursing home. Plaintiff attorneys specializing in these cases take full advantage of these preconceptions and can be virtually assured of a sympathetic jury in almost any venue.

The Physician's Role in Elder Care and Elder Abuse Cases

Lawsuits for medical negligence against physicians who treat elders and dependent adults must include allegations of substandard care. Although

OIG Definition of Elder Abuse

The Office of the Inspector General (OIG) of the Department of Health & Human Services has identified seven types of elder abuse for nursing home residents.[1,2]

1. *Physical Abuse*
   Infliction of physical pain or injury, including sexual abuse.
2. *Misuse of Restraints*
   Chemical or physical control of a resident beyond the physician's orders or not in accordance with accepted medical practice; e.g., staff failing to loosen restraints within adequate time frames or attempting to cope with a patient's behavior by inappropriate drug use.
3. *Verbal/Emotional Abuse*
   Infliction of mental/emotional suffering; e.g., demeaning statements, harassment, threats, humiliation or intimidation of the patient.
4. *Physical Neglect*
   Disregard for the necessities of daily living; e.g., failure to provide necessary food, clothing, clean linens or daily care of the patient's necessities (bathing and grooming assistance).
5. *Medical Neglect*
   Lack of care for existing medical problems; e.g., ignoring a necessary special diet, not calling a physician when necessary, being unaware of the potential side effects of medication or not taking action on a medical problem.
6. *Verbal/Emotional Neglect*
   Creating situations in which the resident's needs for verbal and emotional contact are not met; e.g., not considering the patient's wishes, restricting contact with family, friends or other residents.
7. *Personal Property Abuse*
   Illegal or improper use of a resident's property by another for personal gain; e.g., theft of a resident's private television, false teeth, clothing, jewelry or money.

the standard of care for physicians is set by the medical community in which they practice, state and federal regulations governing nursing homes are becoming a more important player in elder care lawsuits.

Treating Physician

Liability Risks Due to Communication Gaps Between Physician and Nursing Staff

Treating physicians should be aware of nursing home care scenarios that invite communication gaps and thus compromise patient well-being.[6] Physician visits may only occur every 30 days, thus reducing the number of face-to-face encounters between physicians and nurses, and physicians and patients. Nursing staff often contact physicians who provide orders so that the nursing staff may formulate care plans and provide care. This usually occurs by phone or fax. This mode of communication requires clear instructions and clear documentation to ensure accuracy and safety.

If more serious conditions that are normally treated in acute care settings develop at the nursing home, the nurse may be responsible for reporting on the patient's condition and carrying out a complex set of physician orders before a physician has even seen the patient. In addition, because fulfillment of state and federal regulations are the facility's responsibility, nurses may feel pressured to reformulate physician orders in order to comply with those regulations. In scenarios such as these, nurses and physicians need to communicate extremely well to ensure a prompt and appropriate response that ensures patient safety and minimizes liability and regulatory problems.

Other Factors That Increase Risk—Punitive Damages

Even if a treating physician has provided appropriate and acceptable treatment—which includes telephone consultation, and up to 30 days between patient visits (unless an emergency occurs)—it is important to note that, in the eyes of a lay jury, the negative preconceptions that apply to a nursing home may also overflow onto the treating physician. This is even more likely if the facts of the case are particularly tragic. The most burdensome and unpleasant possibility

continued on page 5...

Role of the Treating Physician

The following duties are based on California law; however, they could be helpful in providing guidance to any physician treating elderly patients:

- Perform a patient evaluation and write a report of a physical examination within five days prior to admission or 72 hours following admission.
- Evaluate the patient as needed and at least every 30 days, unless there is an alternate schedule, and document these evaluations in the patient's medical record.
- Evaluate the patient and review orders and treatment upon any change of physicians.
- Determine the patient's diagnoses.
- Provide advice and treatment, and determine the appropriate level of care for each patient.
- Write and sign orders for diet, care, diagnostic tests and treatment of patient by others.
- Obtain informed consent for the use of restraints and psychotropic medications.
- Obtain informed consent in situations where a reasonable patient could not, or would not be aware of the consequences of a given treatment decision without obtaining specific information from the physician. Determine what information is needed by the patient in order to make the consent meaningful.
- Ensure that all care rendered by non-physician practitioners is legally authorized and that they are appropriately supervised.
- Write progress notes and other appropriate entries in the patient's chart.
- Provide for alternate physician coverage if the attending physician is not available.

When it is necessary to obtain consent, it is the physician's responsibility to do so and to determine what information is needed by the patient in order to make the consent meaningful.[7]

Risk Management Tips to Avoid an Allegation of Elder Abuse

- Become familiar with the state and federal guidelines that govern the quality of care in SNFs. If a treatment, medication or response is inadvisable, improper or untimely under the regulations and standards, the odds are great that the plaintiff will allege that it fell below the community standard of care as well.
- Reassess the patient when the patient's condition changes. This may warrant more frequent on-site evaluations.
- Alert SNF staff that the treating physician should be notified of a patient's change in condition, including any unexpected event, injury or illness (such as a significant drop in blood pressure, a fall, a skin tear, refusal of care, a bruise, a medication error).
- Objectively document problems, responses and plans discussed in phone calls with SNF staff. This information is critical to continuity of care and for defense in the event that an adverse event follows a change in condition.
- Become familiar with drug regimens, dosages and potential adverse interactions before altering a patient's medication schedule.
- Refrain from publicly discussing potential or actual patient safety concerns without advice from defense counsel. Be mindful of statements given to anyone prior to litigation. Opinions or statements rendered in the context of internal facility evaluations, such as quality assurance or incident reports, are protected and privileged and should not be discoverable by the plaintiff's attorney. However, these proceedings lose their privilege if discussed outside the confines of the quality assurance review.
- Fully evaluate the cause of weight loss and develop and implement a plan to address the weight loss. (If artificial feeding is withheld, the nursing home is not relieved of its obligation to prevent malnutrition and dehydration).
- Predict and prevent pressure ulcers that are medically avoidable. Recognize that the primary issue with pressure ulcers seems to be whether the ulcer was medically avoidable. If an unavoidable pressure ulcer develops, ensure that all staff agree that the ulcer was unavoidable and document the circumstance. The Agency for Health Care Policy and Research (AHCPR) published guidelines in 1992 for the prediction and prevention of pressure ulcers, and guidelines for pressure ulcer treatment in 1994. These guidelines can be accessed online at the AHCPR's Web site at www.ahcpr.gov/clinic/cpgonline.htm.
- Be aware of the standard of care for both physical and chemical restraints, which are set by the Health Care Financing Administration (HCFA), state law and individual hospital policies. The assumption underlying all standards is that restraints pose significant risks for patients, and should only be used when other measures prove inadequate. Standards for restraints are contained in the HCFA Hospital Conditions of Participation for Patient's Rights (COP). Interpretative Guidelines for the COP can be accessed at www.hcfa.gov/quality/4b2.htm.
- Implement an evidence-based fall risk assessment tool, such as the Morse Fall Scale, which is designed to predict fallers and non-fallers.[10] Once fallers are identified, develop interventions to prevent falls and resulting fractures. For more information on the Morse Fall Scale refer to *Preventing Patient Falls*,[11] which can be ordered online from Sage Publications at www.sagepub.co.uk.
- Recognize that the medical management of an elder or dependent in a nursing facility will be scrutinized in a highly-charged emotional context.

continued from page 3...

for the treating physician relative to elder abuse litigation is the potential exposure to punitive damage claims. Under California law, exemplary or punitive damages cannot be covered by insurance. In other states such as Rhode Island where no such law exists, malpractice carriers usually exclude payment of these exemplary or punitive damages. In either case, any award would potentially subject a physician's personal assets to exposure. In NORCAL's evaluation of elder abuse cases, punitive damages were allowed in 46% of the cases. This is a significant number when viewed in the context of traditional medical malpractice litigation, in which punitive damages are awarded in less than 1% of cases.

Physician as Medical Director

Advisor to the Facility's Administrators

Generally speaking, the medical director has no direct administrative role in running the SNF. For the most part, the medical director acts as an advisor to the administrator or director of nursing services. Most contracts between physicians and nursing facilities for medical director services contain indemnity clauses that protect the doctor when performing such administrative duties. Medical directors should contact their professional liability insurance carriers to determine if there is a need for Director's and Officer's (D&O) coverage.

Responsibility for Medical Care

Even though the facility is responsible for ensuring that physician orders conform to state and federal regulations, it is the responsibility of the medical director to be familiar with the regulations that govern the facility. A physician in the capacity of medical director should be aware of the following key components of this position.[8,9] The medical director is responsible for:

- ensuring that all residents receive adequate medical care. As such, the medical director may be called upon to provide treatment if the attending or covering physician is not available.
- ensuring OBRA compliance of all physician services and orders.
- overseeing the facility's overall quality of care. This function is usually fulfilled by attending various quality assurance meetings, and by reviewing policies and procedures and incident reports.

Conclusion

Although the number of elder abuse cases reported to NORCAL appeared to decline in 2000, this litigation represents an increasingly lucrative field for plaintiff attorneys. Litigation is facilitated by statutory and regulatory requirements for elder care and facility administration, statutory provisions that allow extraordinary financial recovery for plaintiffs, and a negative public perception of nursing homes. Further, the continued aging of the U.S. population places large burdens on health care resources and SNFs, which are not only vulnerable to increased regulation, but decreased funding. Physicians working with nursing homes in treatment or administrative capacities have become targets in these cases, as state and federal regulations governing nursing homes set the standard of care, rather than the community standard by which physician care is usually judged.

It is clear that health care professionals involved in both patient care and facility administration must maintain an awareness of these trends and implement sound strategies that not only provide quality care to elders, but demonstrate that care was coordinated and documented appropriately among caregivers. ■

continued from page 1...

co-defendants in 11 cases totaled $2.8 million, which underscores the trend toward settlement by nursing homes in cases they perceive as impossible to win.

Incident/Claims Reporting Years

Thirty-six of the 46 elder abuse incidents examined in our study occurred between1997 and 1999, paralleling the increased focus on elder care and abuse issues in legislatures and regulatory bodies discussed earlier in this article. Since 1996, there has been one dependent adult case per year, for a total of four. All cases were reported in 1999 and 2000.

Only eight policyholders were sued in their capacities as medical directors; however, the allegations against all of them were due to their role as treating physicians, and involved medical negligence, not medical director shortcomings.

Media Coverage

Seven of the 50 cases received media coverage. Most of the local coverage occurred in Sacramento (CA) newspapers. The patient in one Sacramento case appeared on a national news show as an advocate against nursing home abuse. Another Sacramento case involved a police investigation into manslaughter charges and the arrest of the SNF owners for unauthorized use of the decedent's credit cards. A San Diego trial judge permitted television coverage of one of the cases.

Although there was no analysis in our study of the role that media coverage played in the decision to settle a case, it remains a significant consideration in NORCAL's ongoing evaluation of these types of claims.

Outcomes, Events or Conditions Associated with Elder Abuse Allegations

Despite the limited size and scope of the study, it is possible to identify certain outcomes, events or conditions that are associated with elder abuse allegations. Heightened awareness of the conditions associated with elder abuse allegations can help focus quality assurance and risk management efforts, thereby enhancing patient safety and reducing liability. The presence of one of the following outcomes, events or conditions should

continued on page 7...

Claimant Age and Gender

Elder Abuse: 28 women, 18 men

Age Range	Case Distribution
55-59	1
60-64	2
65-69	9
70-74	6
75-79	9
80-84	5
85-90	14

Dependent Adult Abuse: 1 woman, 3 men

Age Range	Case Distribution
25-29	1
30-35	0
35-39	0
40-44	1
45-49	2

Specialty

Specialty	Case Distribution
Internal Medicine	32
Family Practice	9
Facility	6
General Practice	3
Psychiatry	2
Emergency Medicine	1
Gastroenterology	1
Cardiology	1
Orthopedics	1
General Surgery	1
Neurology	1

Role

Role	Case Distribution
Treating/Primary Care	39
Medical Director	8
Consulting Physician	3

continued from page 6...

also signal the need for effective communication between the physician and the patient and/or family about the diagnosis, treatment, and prognosis in order to prevent misunderstandings and misperceptions:

- Death
- Decubitus ulcers
- Falls
- Hip fractures
- Adverse reactions to medications
- Cardiopulmonary arrest (especially failure to resuscitate without a Do Not Resuscitate (DNR) order)

Most Prevalent Allegations in NORCAL Elder Abuse Claims

- Failure to respond to a critical situation
- Medication error
- Fall and negligent management of resulting hip fracture (Typically, the fall involved inadequate supervision by the SNF staff and the physician was implicated as providing inadequate or improper follow-up.)
- Improper treatment of infection, particularly a urinary tract infection or a decubitus ulcer. (Generally speaking, the treating physician was accused of a failure to appreciate the significance of the infectious process or the severity of pressure sores. Most of the cases, which came to suit, ultimately resulted in the patient's death.)

While these conditions and outcomes are common in elderly patient populations in acute care facilities, they take on a different significance in the nursing home. Elderly patients are usually placed in nursing homes for more routine, long-term maintenance, which the patient or the patient's family is unable to provide in the home. Placement in a SNF as opposed to a hospital may lead to the belief that patients are not really sick, and to feelings of guilt, especially if the patient preferred to stay at home. Patients and families may have more difficulty accepting outcomes such as death, a fall resulting in a fracture, or a decubitus ulcer as well as their resulting feelings. These outcomes provide a fertile ground for lawsuits. ■

Special thanks to Charles Lyde of NORCAL's Claims department for contributing to this article.

Common Medical Issues in Nursing Homes

These medical issues are commonly cited in nursing home litigation and mirror the most prevalent issues that arose in NORCAL elder abuse claims. (See summary of Most Prevalent Allegations in NORCAL Elder Abuse Claims at left). These issues are generally associated with a failure to meet the standard of care as defined by federal regulations.[6]

- Dementia (Alzheimer's dementia is the most common type, followed by vascular dementia.)
- Depression
- Incontinence
- Impaired physical function
- Gait problems, paralysis from stroke, arthritis, contractures, or generalized weakness
- Polypharmacy
- Malnutrition and dehydration
- Falls and fractures
- Pressure ulcers
- Physical and chemical restraints

References

1 California Welfare & Institutions Code §15600 *et seq.*

2 42 CFR §483.1 *et seq.*

3 22 CCR §72303

4 22 CCR §72307

5 22 CCR §72528

6 Locatell K. *A Physician's Perspective: Medical Management of the Nursing Home Patient.* In: Brown SH, Cicala A, Horowitz SI, Kahn RP, Locatell K, editors. *California Nursing Home Negligence* 2000; Section IV:1-12. Eau Claire (WI): Professional Education Systems, Inc.

7 22 CCR §72311

8 22 CCR §72305

9 47 CFR §483.75(l)(1)

10 Rutledge, DN, Donaldson, NE, Pravikoff, DS. *Fall risk assessment and prevention in healthcare facilities.* The Online Journal of Clinical Innovations, December 15, 1998; 1(9): 1-33.

11 Morse, J.M. *Preventing patient falls.* Thousand Oaks (CA): Sage Publications, (1997).

12 McDaniel CL. Elder abuse in the institutional setting [KELN Bibliography]. May 1997, from http://www.keln.org/bibs/mcdaniel2.htm

Direct inquiries to:
NORCAL Mutual Insurance Company
Risk Management Department
560 Davis Street, 2nd Floor
San Francisco, CA 94111-1902
1-800-652-1051

The information in this newsletter is obtained from sources generally considered to be reliable; however, accuracy and completeness are not guaranteed. The information is intended as risk management advice. It does not constitute a legal opinion, nor is it a substitute for legal advice. Legal inquiries about topics covered in this newsletter should be directed to your attorney.

Guidelines and/or recommendations contained in this publication are not intended to determine the standard of care, but are provided as risk management advice. Guidelines presented should not be considered inclusive of all proper methods of care or exclusive of other methods of care reasonably directed to obtain the same results. The ultimate judgment regarding the propriety of any specific procedure must be made by the physician in light of the individual circumstances presented by the patient.

Visit NORCAL Mutual on the Internet at http://www.norcalmutual.com

NORCAL
Mutual Insurance Company
Risk Management Department
560 Davis Street
San Francisco, CA 94111-1902

MEALEY'S
Emerging Insurance Disputes
Published by LexisNexis™

An Overview:

The Insurance Crisis For Long Term Care Facilities:

Where To Go Next?

by
Ira M. Gottlieb, Esq.

McCarter & English, LLP
Newark, New Jersey

A commentary reprinted from the March 12, 2002 issue of Mealey's Emerging Insurance Disputes.

P.O. Box 62090 • King Prussia, PA 9406-0230 • (610) 768-7800 • fax (610) 962-499 • WWW.MEALEYS.COM

MEALEY'S Emerging Insurance Disputes
Vol. 7, #5 March 12, 2002

Commentary

An Overview: The Insurance Crisis For Long Term Care Facilities: Where To Go Next?

By
Ira M. Gottlieb

[Editor's Note: Ira M. Gottlieb is a Senior Associate in the law firm of McCarter & English, LLP. The law firm of McCarter & English, LLP specializes in — among other things — insurance coverage issues and litigation. Mr. Gottlieb represents policyholders ranging from fortune 50 corporations to individuals in a wide array of commercial and insurance matters. He lectures on a variety of topics concerning insurance coverage issues. Responses to this commentary are welcome. Copyright 2002 by the author.]

Introduction

Obtaining affordable liability insurance policies for long-term care facilities (Skilled Nursing Facilities, or "SNFs") was once an easy task to accomplish. In the past the market place for such insurance was marked by its sleepiness and by the simplicity of the basic information needed to write coverage for multiple perils at SNFs. But today, those times are a distant memory for the long-term care industry. The industry is confronted by a variety of convergent economic factors, not the least of which is the inability to obtain suitable insurance at affordable rates, which threaten its financial well being right to the very core of its existence. With the rising tide of baby boomers heading for age sixty-five starting in 2010, and with estimates that there are nearly 2,000,000 people already residing in almost 15,000 nursing homes today — not to mention the assisted living facility population — the industry's financial well-being must be secured. This means, in part, getting a grip on the tail of the insurance tiger that is threatening the industry so that future risks can be controlled and affordably transferred to insurance mechanisms.

In today's insurance market premiums have jumped from generally $100 per bed to approximately $800 to $1000 per bed, depending on the size and location of a facility. In the past, it was not uncommon to obtain policies with limits of liability of $1 million per claim (or occurrence) and $3 million in the aggregate, but now even at increased rates, such limits, if available, will apply to both errors and omissions (professional liability) and general liability together. The effect is a dilution of actual limits. It has also become more difficult for owners with multiple facilities, or systems, to obtain separate per-location claim/occurrence limits and aggregates. To make matters worse, the situation is aggravated by some carriers imposing lower policy limits of liability, while requiring higher self-insured retentions, deductibles and adding sub-limits for certain occurrences such as molestation, abuse and employment related claims. A coincidental hardening of both the errors and omissions market compounds this situation for health care professionals (*e.g.*, medical malpractice insurance for physicians) as well as a similar toughening of the property and casualty market place. The net effect is that facilities are paying more, but getting much less bang for their buck and far less in real coverage.

A. The Problem Today

What caused insurance premiums to skyrocket? There is no one universal answer to this question. Certainly the enactment of elder abuse statutes in a number of States and the incredible surge of lawsuits against facilities, followed by breath taking verdicts, are major causes, but other factors are also at work. Reimbursement cut-backs and other funding constraints affecting qual-

ity of care, as well as historic problems at poorly maintained facilities, stepped-up federal and state agency inspections and new legal claims have also contributed to the industry-wide problem. Although risk analysis is a keystone of the insurance industry, carriers previously failed to fully anticipate these risks, and are now either completely pulling out of the market, or over-compensating by charging enormous premiums. The pendulum has swung from one extreme to the other, thus causing a crisis in the industry and resulting in some extreme cases in smaller facilities going bare (*i.e.*, running the risk of operating without any insurance whatsoever), or worse closing their doors, while leaving others searching for creative solutions to minimize risks, liabilities and insurance costs.

B. Risks Facilities Face

In the past, facilities faced some of the same types of claims they face today; however, in the absence of elder abuse laws (enacted in part as a result of the poor practices of some), these claims received less attention and were not the subject of astronomical verdicts. Such claims included common place falls, elopements and quality of care issues arising from such ailments as decubitus skin ulcers. Today, not only do facilities face many more claims, but the claims they face are much more varied. In addition to actions based on elder abuse statutes, claims range from quality of care issues to employee relations to allegations of deceptive business practices. For example, some recent lawsuits involve claims of wrongful death; physician liability; medication errors; improper nutrition; misappropriation of resident property; deceptive advertising; abuse and neglect of residents, including molestation; negligent supervision and hiring all of which are being asserted against facilities and their principals and employees. Indeed, some cases are not only filed against long term care facilities, but are also directed against their principals, officers and sometimes their directors. In such instances, a wide range of insurance coverage is implicated (*e.g.*, insurance for professional errors and omissions, employment related practices and the fiduciary responsibilities of officers and directors).

C. Risk Management And Reduction

As in the past, solid risk management, proactive and competent employee in-service training, as wells as records control and accurate data input, can reduce incidents and possibly lead to deficiency free surveys, thus making a facility a better insurance risk. A facility should have an experienced risk manager, together with a comprehensive employee training program, and a plan in place that is stringently followed and enforced. Similarly, facilities must be mindful of how they manage information for minimum data set reporting. This will not only reduce incidents and liability risks, but may also assist in avoiding unexpected and unintended injuries and damages. Thus, as a consequence, when federal and state surveys occur, fewer, or at least less serious, deficiencies may be cited. In turn this makes a facility overall a more attractive risk when it comes time to obtain insurance coverage.

Careful attention to records and paper work is also essential to risk reduction, placement of insurance and, eventually, supporting claims for insurance coverage. There was a time when simple forms could be completed to place insurance, or to submit claims. Today, insurance companies that will still write coverage, require much more information before they will write a policy. For example, carriers may request loss runs for the last three to five years preceding an application for insurance, they may request financial statements (or Medicaid cost reports) and they may request copies of licenses and copies of previous federal and state survey reports. Thus, careful risk management that leads to fewer losses and better surveys with fewer, or no deficiencies will hopefully result in somewhat less expensive coverage.

In addition, proper records maintenance will be of great assistance when it comes time to submit claims for coverage (See discussion below in Section E). As coverage tightens, facilities may find carriers much more difficult to deal with on claims. Carriers will likely require far more documentation in support of claims, and may be more prone to citing policy exclusions to deny cov-

erage. In such situations, good record keeping may prove to be a useful arsenal in combating a carrier's decision to decline a defense or deny coverage of a claim. In fact, careful presentation of a well-documented claim may mean the difference between receiving insurance coverage and its denial by a carrier.

D. Possible Steps For The Future

Simple risk reduction, better management of information and better claims handling practices may ameliorate the problem of obtaining affordable coverage to some degree, but they are not likely to cure the problem completely. More creative and innovative solutions must be contemplated, proposed and pursued. These solutions can range from simple measures to whole paradigm shifts in the manner that insurance is placed, by whom it is offered and with regard to who acts as an insurer of a long term care facility's risks. Such solutions may come in at least the following forms: legislation; cooperative efforts within the long term care industry; insurance industry (carriers, brokers and agents) innovations; creation of other mechanisms for transference of risks; and, simple measures taken by facilities themselves to ensure that there are fewer risks and perils. This last option may have the positive, and possibly unintended, result of boosting a facility's good-will and reputation and, in turn, a facility's census, which may result in a greater realization of economies of scale in the calculation of cost-based reimbursement rates by government payors.

Although the long-term care industry is widely diverse in its make-up, and ranges from single facility family-owned businesses to multi-state, multi-facility systems that are publicly held ventures, the industry must find a way to pull together to address the causes of rising insurance costs (some of these causes were mentioned above). The industry as a whole faces this problem, and while some within the industry have the ability and resources to address the symptoms of the problem (*e.g.*, monumental premium increases), they will always be effected by the situation of others because the causes of the problem are industry wide. Thus, the causes of the problem must be addressed and not just its effects (*e.g.*, withdrawal of carriers from certain markets or escalating premiums). By banding together to eliminate, or at least to mitigate the causes, the net effect may be a reduction in liabilities and associated costs, which in turn may lead to relatively more affordable insurance coverage. Even, if the industry cannot effectively coalesce on solving these problems, leaders must emerge and come forward to solve these problems for the good of all.

There are a variety of possible actions that might be fruitful in mitigating the impact of the current shortage and high cost of insurance. Indeed, there is no one single thing that will operate as a fix-all for this problem. This article will not discuss possible risk management and data management solutions, although they are an important part of any overall solution. The following list is intended to provide some overall examples of areas where other efforts might yield positive results. Some of these suggestions involve complicated legal, insurance and financing issues that should be thoroughly explored with competent professionals taking into account particular situations, before efforts are undertaken.

Legislative Reforms

There are already a number of efforts underway to persuade State legislators to enact new legislation, or amend existing laws, capping long term care facilities' liabilities. These efforts should be continued and should similarly ensure that existing laws that cap punitive damage awards, which in many, but not all, states are not recoverable under insurance policies, are utilized to stop run-away verdicts.

The long term care industry, through its various trade associations, should carefully consider lobbying efforts to encour-

MEALEY'S Emerging Insurance Disputes
Vol. 7, #5 March 12, 2002

age legislators to refine the scope of existing elder abuse statutes and to strengthen burden of proof requirements before liability may be imposed on facilities. While such an effort must naturally recognize the delicate balance of constituent interests that legislators will consider, the point must be made clear that continuing economic stress on the industry does not serve the best interests of the aged, infirm, or the community as a whole. Legislators should be reminded that continued bankruptcies, diversion of resources and pressure on Federal and State agencies to act as microscopic watch dogs, in the end serves no one's best interests and leads to less availability of services at, of course, higher costs to the private and public sector.

Insurance costs should be reimbursable under Medicaid rates, similar to other business expenses such as legal fees, utilities and the indirect cost of doing business. It is possible that existing rate components already afford reimbursement if such costs are properly characterized and substantiated. In many states reimbursement rates are based on a *per diem* number of residents/number of beds calculation. Insurance rates sometimes follow a similar cost premium per bed calculation. Federal and State regulators should be made to understand the gravity and scope of the insurance crisis, and its consequential effect on quality of care issues so that Medicaid State Plans allow such costs within the Plan's rate structure. Similarly, where insurance costs are deemed reimbursable, efforts should be made to adjust Medicaid rate screens so as to establish a higher means for such costs.

For less attractive insurance risks legislatures may establish Joint Insurance Underwriting Associations ("JUAs"). Such statutory mechanisms have been set up in the past, with mixed results, to separate higher risk insureds from those who deserve the benefit of insurance based upon their better risk loss experiences and other favorable attributes. The use of JUAs may be particularly useful in an industry where insurance coverage is a practical necessity, if not mandatory. Certain States (*e.g.*, Florida) have recently mandated insurance, or are considering such mandates as a condition to licensure.

Insurance Alternatives

At this moment creative insurance professionals are hard at work devising suitable alternatives to fill the gap of dwindling insurance availability and ballooning costs. Several of these alternatives are well known to the insurance industry, but need to be further explored for specific application to the long term care industry.

Captive Insurance Companies/Risk Retention Groups — Captive insurance companies may be formed by facilities, or health care systems, to write harder to place primary coverage. Similarly, Risk Retention

MEALEY'S Emerging Insurance Disputes
Vol. 7, #5 March 12, 2002

Groups ("RRGs") may be formed by a homogenous group of companies wishing to establish a liability insurance company. Recently, a group of Florida based facilities joined together to form the Long Term Care Risk Retention Group, which will pool their nursing homes risks and resources, and provide affordable coverage to members of the group. The formation of such captive insurance companies or RRGs, however, poses some problems. First, significant capital (many millions of dollars) must be raised to fund captives or RRGs. Second, members of the group may need to share financial information with co-members who are also competitors. Third, licensing of the venture will be required and may present special problems. Fourth, captives and RRGs must be selective about who can be insured and a member of the group; *i.e.*, this situation presents the same problem traditional insurers face with excluding bad risks. Finally, captives and RRGs still need to obtain reinsurance and excess (catastrophe) insurance, which may still be very expensive. At a minimum reinsurers and excess carriers may impose stringent requirements beyond what the captive or RRG wishes to impose on its members. These problems aside, for more well heeled facility owners, especially for those whose finances are public information, formation of captives or RRGs may be a good alternative.

Rent-a-Captives — Rent-a-captives are usually captive insurance companies that are organized to essentially rent out their capital to third parties for purposes of insurance coverage. The owners of a rent-a-captive will issue policies, usually through another entity, collect premiums and invest capital until claims are paid. Sometimes a rent-a-captive will offer a return of underwriting and investment income. The use of a rent-a-captive allows insureds to effectively rent the capital and services (*e.g.*, claims handling) of another entity. Use of a rent-a-captive may be preferable to the organization of a captive insurance company inasmuch as it does not require as much commitment of capital or any significant managerial effort. Rent-a-captives are often offshore entities (or are sometimes domiciled in Vermont) that frequently act as reinsurers of domestic fronting insurance carriers. In this situation, which is common, the parties seeking to use a rent-a-captive will need to find a domestic admitted carrier that is willing to at least front the policy to be reinsured by the rent-a-captive. The use of a rent-a-captive is unlikely to address the need for excess umbrella catastrophe coverage. Moreover, the use of rent-a-captives requires sizeable premiums that can be shared and defrayed by groups, but this requires exchanges

MEALEY'S Emerging Insurance Disputes

Vol. 7, #5

March 12, 2002

of financial information and cooperation that some might find undesirable.

Purchasing Groups — As distinguished from a RRG, a Purchasing Group, as the name implies, pools its resources to purchase affordable insurance from other entities (*e.g.*, traditional admitted or surplus line carriers, Captives, RRGs, or Rent-a-Captives). Once again the suitably of each member as a good insurance risk is an issue, as is the sharing of information about facilities loss runs, that may make this option unattractive. Still in certain situations, this may be a suitable alternative to facilitate affordable coverage.

Alternative Risk Transfer Vehicles — For more sophisticated and financially sound facilities, there may be other forms of unconventional risk transfer mechanisms (*e.g.*, securitization, bonding, private indemnity agreements) that may be available.

Other Forms Of Indemnification And Releases From Liability

There are other ways for facilities to attempt to shield themselves from liability and to transfer risks.

Facility operators may require physicians and other health care professionals to carry their own insurance with the facility named as an additional named insured.

Facility operators may require vendors (*e.g.*, food suppliers, pharmacists, nursing staff providers, pharmaceutical and medical device suppliers) to carry insurance that lists the facility as an additional named insured. Use of preferred provider agreements might also create economies of scale and facilitate better insurance coverage and transfer of risks.

Use of reliable and competent staffing services, including ones that provide Certified Nurse Aides, which provide their own insurance coverage, and name the facility as an additional named insured, used in conjunction with regular and supervisory facility staff.

Careful use of liability disclosure statements and waivers, combined with diligent initial and in-service training, together with good record keeping, may undercut some claims. While responsible facilities are sensitive to the needs of their residents, the potential risk of accidental occurrences should be made known to incoming residents whenever possible.

E. Making Claims To Carriers

While obtaining an appropriate and affordable insurance policy is crucial, the moment of truth arrives when you submit a claim and actually need the benefit of the coverage. With the tight-

ening of the insurance market, it is likely that insurance carriers may scrutinize claims much more closely then in the past and decline coverage more frequently. It is therefore essential that claims submission be undertaken carefully. This will make for a claim that is more likely to be well received and covered without delay. Insurance issues can be complicated and dependent on circumstances peculiar to a particular claim, including disparities in different states' laws. Therefore, counsel should be consulted before going forward with claims. The following are some general rules of thumb that may enhance the chances of your claim be honored expeditiously:

1 Submit all claims to your insurance carriers as soon as possible after receipt. (Although it is beyond the scope of this article, bear in mind that some policies are "claims made" policies. Such policies are usually plainly marked to indicate they are "claims made" policies. This usually materially affects notice requirements). Notice may be accomplished by either writing directly to your carrier, or through your insurance agent. If you choose to have your agent provide notice, be sure that you receive a copy of the notice, and that you are satisfied that notice sets forth your full claim. Also, be sure that all potential insurance carriers who may be obligated under various policies are put on notice — do not unnecessarily limit yourself unless you are certain a policy will not cover a claim. Many insurance carriers will deny coverage by asserting that notice is untimely. In some states, even a short delay may bar your claim. Inasmuch as you may face a lawsuit, contact your counsel to discuss appropriate action, including which carriers should be sent notice. With regard to insurance coverage, you may wish to confer with counsel who specializes in such matters;

2. Be sure your notice includes a copy of the complaint, or other documents informing you of the claim. Some policies require specific information be included in your notice. If this is the case, then be sure all such available information is provided;

3. Retain all of your insurance policies and not just notices of renewals or declaration pages. An insurance policy is a contract that should be kept in a safe place and in orderly condition;

Keep all your records in good order. Once you receive a claim, organize all the records that are pertinent to the claim, and confer with counsel regarding what further steps may need to be taken;

5. Your insurance carrier may write to you with many questions about your claim, or may have an adjuster make contact with you. If you receive a request for further information, having your records organized will facilitate a quick and cogent response, which may facilitate a favorable claims determination. If an adjuster contacts you, you may wish to have counsel involved. Sometimes carriers contact counsel for adverse parties to obtain information, you should request that all contact from your insurance carriers be directed to your counsel;

MEALEY'S Emerging Insurance Disputes

Vol. 7, #5

March 12, 2002

6. In some instances a carrier will undertake a defense of your claim, subject to a reservation of rights as to both defense and indemnity. This means a carrier may withdraw its defense at some point in the future, or decline to ultimately indemnify you if a settlement or judgement is reached. It is essential that you understand the terms of the carrier's reservation of rights as it may have important consequences down the road. Thus, conferring with an experienced insurance attorney may be a prudent investment of resources;

7. If a carrier denies your claim, you should carefully consider its reasons for denial in light of your policy's requirements and the facts of your claim. Insurance policies can be complicated documents, and often contain terms of art, that do not always have obvious meanings and effects. Therefore, a review of the situation should be done with competent counsel. If there are any real bases for disagreement, the carrier should be contacted in writing with a formal explanation of your position, and a reservation of your rights. Thereafter, you may wish to evaluate the situation and take further action as warranted.

Insurance is a valuable resource. Claims handling is a serious matter that should be approached in a careful and considered manner. After all, you have probably paid a substantial amount in premiums, and you should certainly expect your claims to receive fair treatment, and whenever possible, be paid.

Conclusion

As with other industries, procurement of insurance policies and related claims handling has become a thorny business for owners and operators of long term care facilities. This may be a transitory period. In the mean time, facility owners and operators should carefully consider their alternatives, and when possible, they should pool their resources and knowledge — through associations and other working groups — to get through this current difficult time. ■

Long Term Care

General Liability and Professional Liability

2004 Actuarial Analysis

Submitted by:

Aon Risk Consultants, Inc.

Theresa W. Bourdon, FCAS, MAAA
Sharon C. Dubin, ACAS, MAAA

February 4, 2004

Table of Contents

In

At the
Inc. (
profes
State

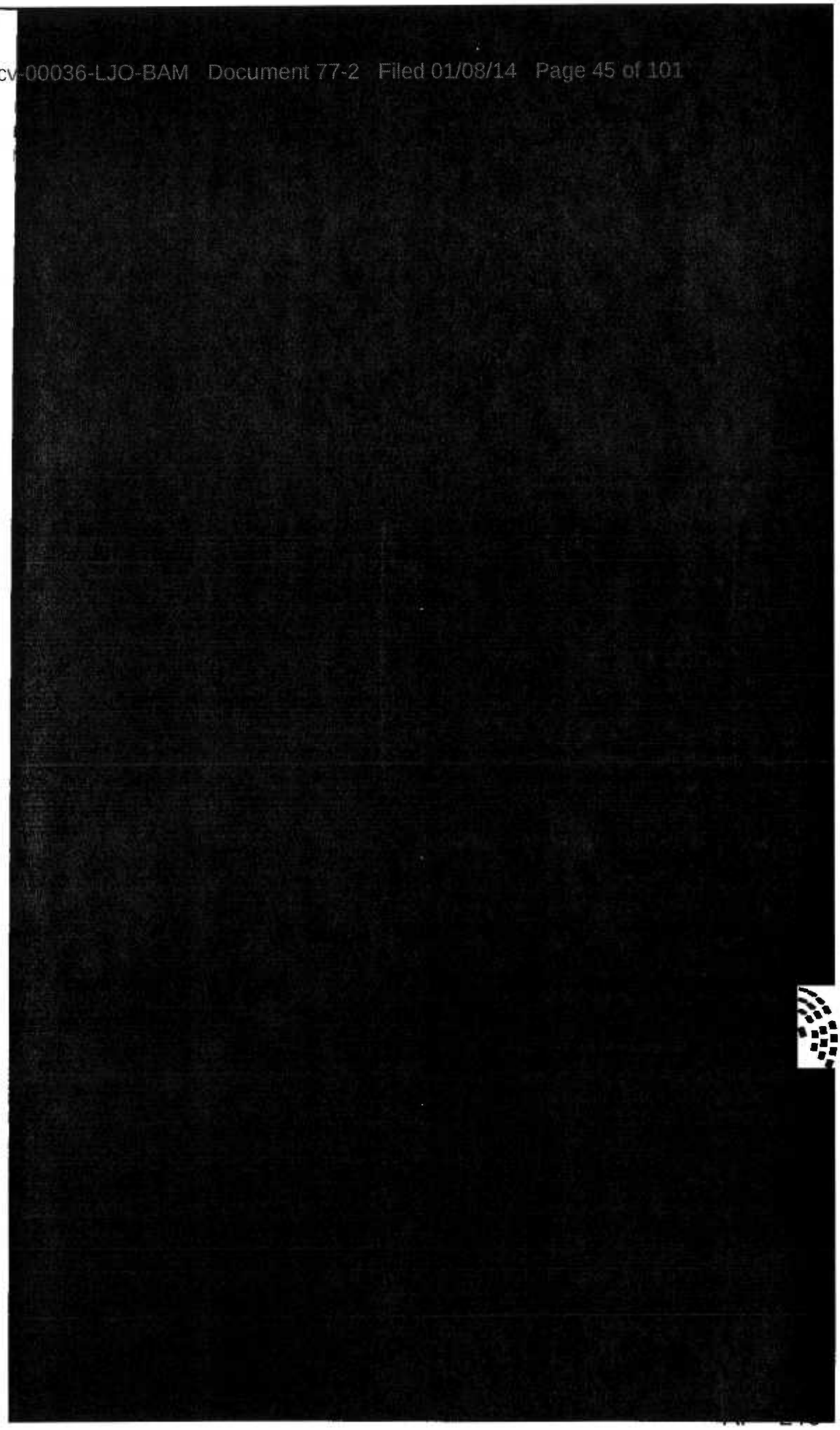
The s

1. **Id**
   in
   cl
   ex

2. **Id**
   fu
   ar
   C
   Te
   ac

3. **Id**
   tre
   le
   lia

4. **Es**
   ve
   th
   cc



on the average of the claim data provided to us. Plaintiff attorney costs are estimated as a portion of the indemnity payment to the plaintiff.

5. **Identify the distribution of losses by size of loss.** A histogram depicting the number of reported losses in incremental size of loss bands provides an indication of the variance of loss sizes, the magnitude of the large losses and the number of claims excess of $1 million.

In an effort to present a comprehensive analysis from the perspective of all long term care providers, the American Health Care Association, through its various constituencies disseminated a request for data to independent providers, regional multi-facility providers, non-for-profit providers, national multi-facility providers, and the National Center for Assisted Living. In addition, AHCA contacted state executives of long term care associations and other stake holders and encouraged them to share the data request with their membership in order to encourage greater participation by independently owned facilities.

Using a web-based data survey instrument, long term care providers were given a list of data requirements and instructed to submit their data directly to Aon Risk Consultants, Inc. Among the data elements requested were detailed individual general and professional liability claim information for all claims occurring over the past five to ten years, corresponding historical exposure estimates in the form of occupied beds, and specifics regarding insurance coverage terms during the latest two policy years. Data was collected and compiled between the end of September 2003 and early December 2003. In order to ensure the quality of each data submission, there was extensive correspondence with providers via email, telephone, fax, and written correspondence during this period.

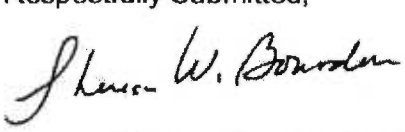
The results presented in this study are based on the ensuing comprehensive database of long term care general/professional liability losses and allocated loss adjustment expenses (ALAE) as reported to us by 108 long term care providers operating around the country. Approximately 28,000 individual non-zero claims from long term care facilities were aggregated to perform this study. The facilities included in this database combined currently operate approximately 470,000 long term care beds, consisting

primarily of skilled nursing facility beds but also including a number of independent living, assisted living, home health care and rehabilitation beds. They represent approximately 24% of the beds in the United States.

An executive summary containing our conclusions and recommendations can be found in this report. It is provided to give an overview of our national findings. More detailed benchmarks highlighting the national trends and identifying the state trends underlying the national increases are provided after the executive summary. Following the presentation of national and state specific loss trends is a section on the effects these trends are having on commercial insurance premium and coverage terms. Sections describing the data sources and defining common actuarial terms follow.

Should there be any questions regarding this report, we will be available to discuss them with you.

Respectfully Submitted,



Theresa W. Bourdon, FCAS, MAAA
Managing Director and Actuary

Sharon C. Dubin, ACAS, MAAA
Assistant Director and Actuary

Executive Summary

National trends in GL/PL losses continue to increase at rates well ahead of average inflation. The rate of claim cost inflation varies dramatically by state and there are some signs that costs are no longer increasing in some areas. States with the highest average GL/PL cost per bed are showing signs of flattening trend, and in some cases, reduced cost levels. However, many states with historically low GL/PL costs per bed are experiencing dramatic annual increases in the number and size of claims.

Claim Cost Trends

Based on our actuarial analysis of the long term care industry data provided to us, which represents 24% of the U.S., we find the following:

- The average long term care GL/PL cost per annual occupied skilled nursing bed has increased from $310 in 1992 to $2,290 in 2003. National costs are now seven times higher than they were in the early 1990's. On a cost of care basis this means $6.27 per day needs to be set aside per long term care resident to cover the cost of patient care litigation.
- The long term care operators represented in this study report $3.1 billion in GL/PL liability claims incurred from 1992 to 2003. The expected ultimate cost of claims incurred in this period is $5.2 billion, taking into consideration the claims in the pipeline and the as yet to be determined outcomes of open cases.
- These same providers, which represent only 24% of the providers in the United States, are projected to incur $1 billion in GL/PL claims in 2004 alone. Extrapolated to a national basis this exposure is a multi-billion dollar a year cost to the nursing home industry.
- The average size of a GL/PL claim has more than doubled from $65,000 in 1992 to just under $150,000 in 2003.
- Countrywide, long term care operators now incur 15.3 claims per year for every 1,000 occupied skilled nursing care beds. This is three times higher than the 1992 frequency rate of 4.8 claims per 1000 beds.
- Florida and Texas were leaders in driving the increase in GL/PL costs for the long term care industry. With trends during the 1990's in the range of 25% to 35% a year, costs in Florida appear to have peaked at $11,000 per bed in 2000 and have since dropped to $8,200. Texas loss costs are projected to have peaked at $5,500 in 2003 and are expected to decrease following the significant tort reform (most notable the $250,000 cap on non-economic damages) that was passed in 2003.
- Numerous states across the country are still experiencing increasing trends and are seeing their loss cost per bed head towards levels similar to those in Florida and Texas. Most notable are Arkansas ($5,760), Mississippi ($4,070), Alabama ($3,310), Tennessee ($2,980), and California ($2,790).

- In 2003 GL/PL claim costs are projected to absorb 5% of the countrywide average Medicaid reimbursement rate for long term care providers.
- Almost half of the total amount of claim costs paid for GL/PL claims in the long term care industry is going directly to attorneys.

Key Factors Affecting Trends

The factors affecting the above trends are multiple and highly correlated to the states in which facilities are located. In the opinion of the authors of this study, the following general observations may have an impact on these trends.

- The nursing home industry continues to be a key target of professional liability litigation. There is a correlation between the presence of law firms specializing in long term care litigation in a given state and the number and size of claims.
- Large multi-state providers, who have historically incurred the greatest number of claims and the largest value claims, are aggressively exiting high cost states such as Florida, thereby reducing the average frequency, severity and loss cost of these states.
- These same providers are implementing improved claims management processes, including faster investigation and claim resolution, and more effective litigation strategies, which in turn are lowering the average severity of claims. These strategies are being targeted first and foremost in the highest cost states such as Florida and Texas.
- Small to medium sized providers are carrying lower limits of liability, due to the lack of insurance availability. This has the effect of lowering average severity and its impact is strongest in states like Florida where capacity is most restricted.
- All providers are reporting an increase in the number of smaller value claims than in past years. This increase appears to be driven by greater interest in early tracking of any event or incident that may evolve into a lawsuit. Such early tracking and reporting can help mitigate large awards. In addition, under claims-made policy forms, which are the only forms generally being offered to the long term care industry these days, early reporting of claims is critical to triggering coverage for the appropriate policy period. The impact of this increase in event reporting is an increase in claim frequency and a corresponding decrease in the indicated average claim severity.
- Tort reform has been passed in a handful of states over the last few years, which for some states (Florida, Mississippi and Texas) triggered a higher than expected frequency level in the years just prior to the reform. However, while it is still too early to determine from the data reported in this study, it is anticipated that post reform severity will be lower in those states that included strongly worded non-economic caps of $500,000 or less.

The effect of these factors on a state by state basis is presented in the state analyses contained in this report.

Insurance Coverage Trends

Insurance markets have continued to offer only limited capacity to write long term care GL/PL insurance. As with the trends in claim costs, the availability varies by state. In some states, such as Florida, insurance capacity continues to be essentially non-existent for long term care patient care liability. In other states, only a very limited number of insurance companies are writing policies and doing so on a very selective underwriting basis. Where coverage has been available, based on the commercially insured respondents to our study, the following trends are indicated:

- Annual commercial insurance premium levels increased dramatically for the third straight year in a row. The average reported increase is 51% between 2002 and 2003. This follows average reported increases of 143% in 2002 and 131% in 2001. A comparison of the average reported increase and the median reported increase over the last three years is shown in the following table.

Historical Premium Increases – 2001 to 2003

	2001	2002	2003
Median Increase over Prior Year's Premium	74%	82%	25%
Average Increase over Prior Year's Premium	131%	143%	51%

- Smaller providers were the hardest hit by the premium increases in 2003. A comparison of premium changes by provider size (based on number of licensed beds) is provided in the chart below.

Change in Annual Premium by Provider Size – Policy Year 2002 to 2003

Provider Bed Count	Number of Respondents	Total Percentage Premium Change	Median Percentage Premium Change	Average Percentage Premium Change
0-100	27	33.9%	37.1%	73.7%
100-250	18	46.4%	30.4%	77.2%
250-500	6	27.9%	34.5%	61.6%
500-1000	4	-42.6%	-28.4%	-29.4%
1000-5000	22	8.1%	26.5%	32.6%
5000-10,000	8	24.5%	10.4%	21.4%
>10,000	1	-9.4%	-9.4%	-9.4%

- Both per occurrence and annual aggregate limits of liability available from the commercial insurance marketplace were reduced in 2003, following two years of severe capacity restrictions. The average reductions were $108,537 and $68,452, respectively. Overall, the commercial insurance industry provided $8.9 million less capacity to the 96 providers responding to this section of our survey.

Historical Limits of Liability Reductions – 2001 to 2003

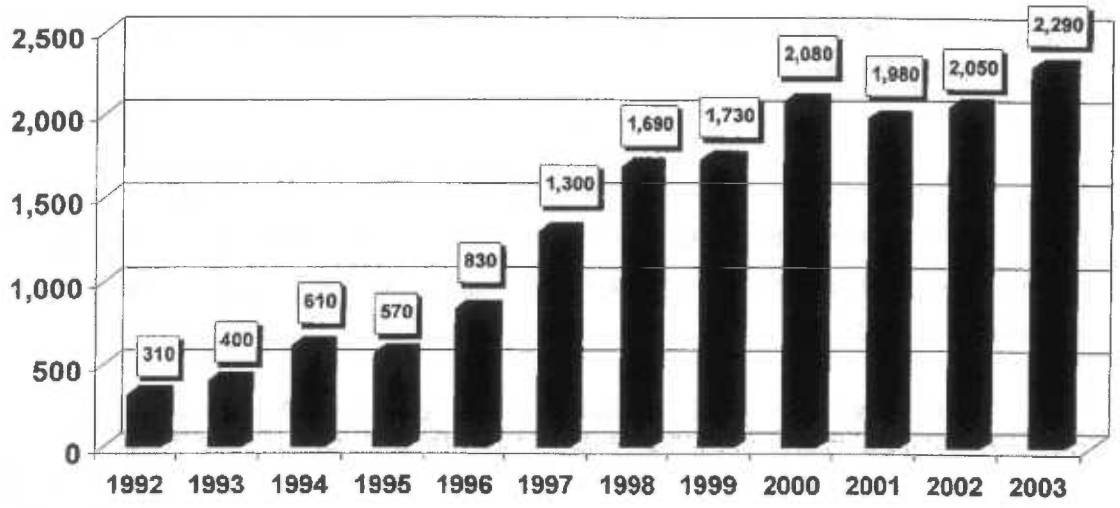
	2001	2002	2003
Average Decrease in Per Occurrence Limit from Prior Year	($474,074)	($488,679)	($108,537)
Average Decrease in Aggregate Limit from Prior Year	($2,311,111)	($624,000)	($68,452)

Countrywide Long Term Care GL/PL Trends

GL/PL Loss Costs in the United States are Significantly Increasing

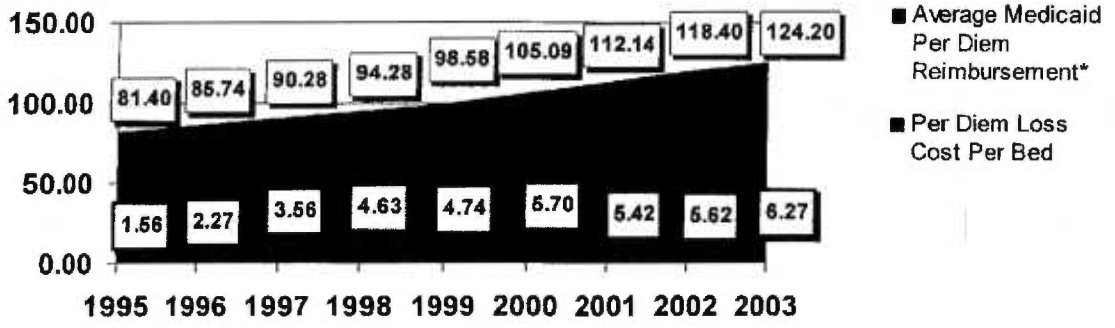
The cost per occupied long term care bed of GL/PL losses has increased 600% in the last decade, growing from $310 in 1992 to $2,290 in 2003, as the following graph shows:

Countrywide Loss Cost Per Occupied Bed



Because the majority of nursing home beds are funded by either Medicaid or Medicare (77% based on CMS OSCAR Survey data as of June, 2003: split 11% Medicare, 66% Medicaid), the increases in patient care liability are largely being funded by taxpayer dollars. On a per diem basis, the loss cost is increasing as a percent of Medicaid reimbursements, from 2% in 1995 to 5% in 2003 as shown in the graph below.

Countrywide Per Diem Loss Cost Versus Medicaid Reimbursement

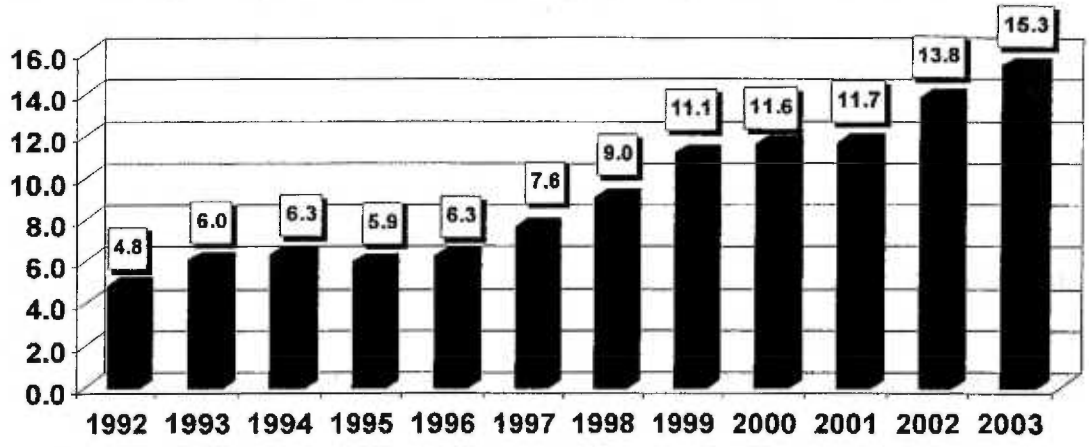


*2003 Projected

The Long Term Care Industry is Incurring More Claims Per Bed Every Year

The annual number of GL/PL claims per 1,000 beds in this country has been increasing over the last twelve years and currently is more than 3 times higher than the 1992 frequency per bed. Since 1995, the number of claims per bed has been increasing at an annual rate of 13%.

Countrywide Annual Number of Claims per 1,000 Occupied Beds

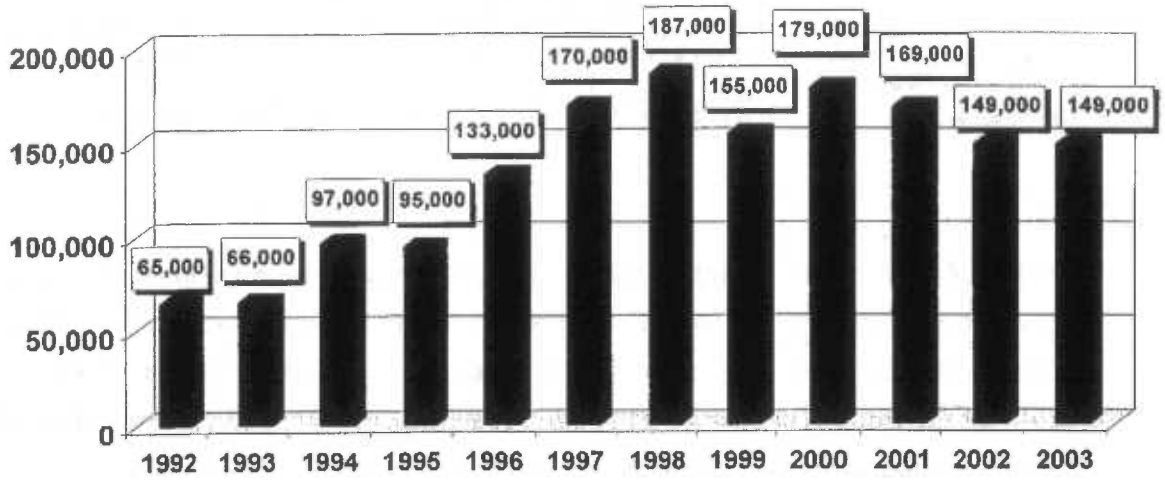


AON

Larger Jury Verdicts and Claim Settlements are Driving Up the Average Size of Losses

Current average GL/PL claim sizes are more than double the average size at the beginning of the last decade. The majority of this increase occurred from 1992 through 1998. Stabilization in the average severity in the states with the greatest amount of patient care litigation has directly affected the national average trends:

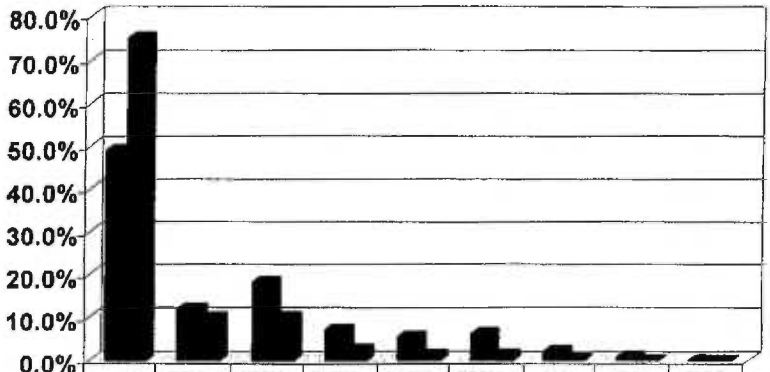
Countrywide Severity per Claim



A key factor affecting average severity is the number of extremely large claims. The distribution of GL/PL losses by size indicates that approximately 42% of the claims reported from 1995 to 2001 are greater than $50,000.

This distribution differs dramatically by state as the following graph demonstrates. For the thirteen states individually reviewed in this report (Alabama, Arizona, Arkansas, California, Florida, Georgia, Kentucky, Mississippi, North Carolina, Ohio, Tennessee, Texas and West Virginia), the percentage of claims greater than $50,000 is 50.9%. This compares to only 24.8% for all other states combined.

Percentage of Claims Reported by Size of Loss

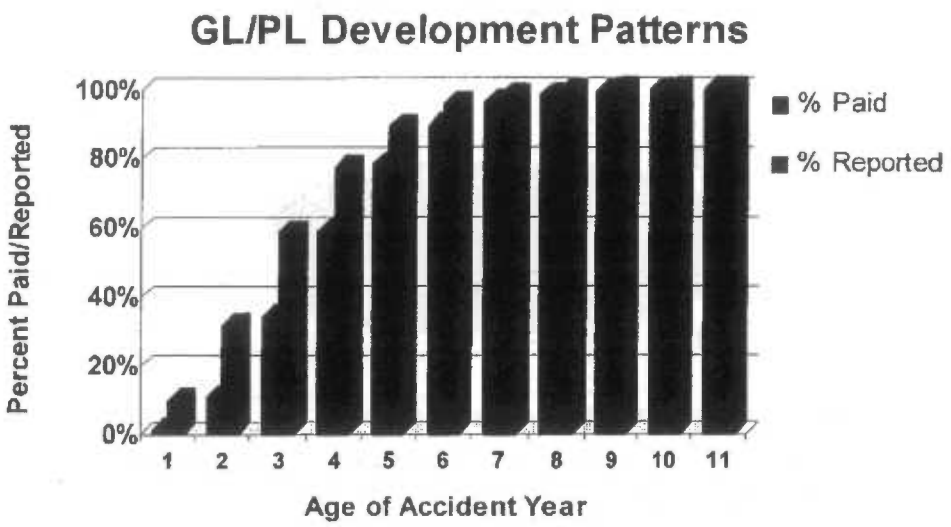


	0 - 50K	50K - 100K	100K - 250K	250K - 350K	350K - 500K	500K - 1M	1M - 2M	2M - 5M	5M & Up
AL, AZ, AR, CA, FL, GA, KY, MS, NC, OH, TN, TX & WV	49.1%	11.9%	18.1%	6.9%	5.2%	6.2%	2.0%	0.5%	0.1%
Remaining States	75.2%	10.0%	10.0%	2.3%	1.3%	1.0%	0.3%	0.1%	0.0%

Including all years (1992 through 2003), a total of 403 claims reported in our survey are greater than or equal to $1 million. Of these, 15 claims are in excess of $5 million. These counts represent only currently reported claims at company estimated case reserve levels. By the time many of these claims are taken to trial and/or settled, the number expected to exceed $1 million will increase significantly.

GL/PL Loss Development Extends Eleven Years

For the long term care industry, it takes approximately ten years before all claim cost estimates related to incidents from a particular period of time are reported. It takes approximately eleven years before all claims from incidents occurring during a year of operations are closed and the actual costs are known. The following graph shows the percentage reported and paid at each age until all claims are closed:

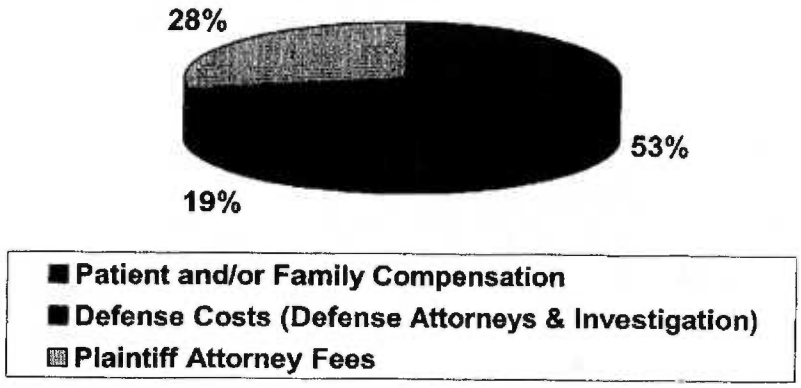


Almost Half of the Total Claim Dollars are Litigation Costs

It is estimated that 47% of the total amount of claim costs paid for GL/PL claims of the long term care industry are covering litigation costs. Based on the database of claims used in this study, 19% of total losses are allocated loss adjustment expenses, which represent defense costs such as investigation and attorney fees. The remaining 81% represent the amount paid in total to the plaintiff, including amounts retained by the plaintiff's attorneys. Of this amount, based on state Bar standards for contingency fees*, it is estimated that the plaintiff's attorneys retain approximately 35%. Of the total loss dollars, this represents 28%. Consequently, 47%, or almost half, of total long term care industry GL/PL losses are litigation costs.

* Insurance claim data does not break down the indemnity component of loss between plaintiff and attorney because this is privileged information. However, state Bar rules provide some guidelines. For example, the Florida Bar Rules of Professional Conduct, Section 4.1, Client – Lawyer Relationship, provides a standard of contingency fees that, if exceeded, would be considered to be clearly excessive. The fee schedule shown in this section varies depending on the timing of filing for arbitration or the entry of judgment, but generally ranges from 33 1/3% to 40% for any recovery up to $1 million. Lower contingency fees are recommended for the portion of recoveries above $1 million.

Distribution of Compensation



The Impact of Patient Rights Laws

Depending on individual state laws, lawsuits against nursing homes often include allegations beyond the traditional causes of action against acute care providers. Patient care lawsuits filed against hospitals and physicians typically are based on allegations of medical malpractice and fall under the corresponding state statutes. Allegations against nursing homes may include causes of action based upon nursing home patient protection laws or elder abuse laws. Based upon a review of the patient protection laws applicable to long term care residents in each of the 50 states, we find the following:

The two states with notably high per bed loss costs both have had strong patient rights statutes for a significant portion of the period under review in this study. Florida's Patient's Bill of Rights (Statute 400.002), which applied to Florida resident care liability claims up until May 15, 2001, guaranteed the patient's right to be informed, provided adequate care, and treated with dignity, among many other rights. The violation remedies provided under this statute include actual damages, punitive damages and attorney's fees.

Texas' Patients' Bill of Rights (Chapter 247 of the Texas Health and Safety Code)

itemizes 14 rights including, "the right to ... a safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of the resident." While the Texas statute does not specifically provide for punitive damages as a remedy for violations, cases involving injury to the elderly were specifically exempt from the 1995 Texas tort reform punitive damage cap. (This exemption was repealed when Texas passed significant healthcare tort reform effective September 1, 2003.)

In addition to Florida and Texas, several other states we have identified as having higher than average loss cost trends have patients' bill of rights statutes specific to the long term care industry. These include Arkansas and California.

Despite the correlation in these states, not all states with patient rights statutes have experienced the same trends in the cost of GL/PL claims. More than half of the states in the United States have some form of a patients' bill of rights. However, states vary on issues such as enforcement by lawsuit, reimbursement of attorney's fees, limits of liability, statute of limitations and damage caps.

Similarly, not all states identified as having higher than expected loss costs have patients' bill of rights. For example, neither Alabama nor Mississippi currently has a long term care specific patients' rights statute.

The Impact of Tort Reform Laws

Several state legislatures have recently passed tort reform to address the rising cost of patient care liability and medical malpractice claims. The impact of these reforms will be dependent upon the specific provisions of each and can only be fully measured once the applicable statute's effect has worked its way through an entire year of reported claims from incident date to the closure of all claims, whether settled or taken to trial. However, there are some early indications that can be gleaned from the post reform reported data or estimated based on how specific provisions would have affected past claims.

Florida

Effective with claims that occur on or after May 15, 2001, Florida resident's rights claims fall exclusively under Senate bills 1200 and 1202. These bills were passed with the intention of providing some tort reform to the nursing home patient care liability crisis. Based on our current study it appears that the bills have had little to no effect on reducing claim frequency in Florida. First of all, an increase in Florida claim frequency for incidents occurring prior to May 15, 2001 is evident, most likely triggered by the October 4, 2001 cut-off for filing claims under the old Statute 400 punitive damage provisions. Secondly, the frequency levels for 2002 and 2003 appear to be higher than the average level of the three years leading up to the tort reform. The impact of Senate bills 1200 and 1202 on claim severity is inconclusive at this time. The average severity of Florida GL/PL claims appears to have peaked in 1998 (three years before tort reform) and has been steadily decreasing at about 2% a year since then. While the decrease has continued post reform, it is difficult to differentiate the impact of tort reform from the impact of large providers leaving Florida and the reduced availability of insurance. Most importantly, the Florida tort reform did not provide any caps on non-economic damages, which actuarially are the most effective tort reform policy provision for reducing long term care patient care liability claim severity.

Mississippi

Like Florida, Mississippi passed legislation recently with the intent of curbing the rising cost of patient care liability claims. House Bill No. 2 became effective January 1, 2003 and included revisions to the Mississippi medical malpractice code that, among other things, brought long term care providers under the act and limited non-economic damages to $500,000 (stepping up to $750,000 on July 1, 2011 and $1,000,000 on July 1, 2017). As has occurred in other states, the passage of this reform initially caused a significant spike in the number of claims, most alleging events in years 2000, 2001, and, to a lesser extent, 2002. The impact of the tort reform on severity is not yet evident, due to the fact that the law has only been in effect a year and most post reform claims are still open. However, the $500,000 cap on non-economic damages is expected to have some affect on reducing average severity in years 2003 and later.

Ohio

Ohio passed tort reform in January of 2003 that included a cap on non-economic damages of $250,000 or 3 times economic loss to a maximum of $350,000 per plaintiff or $500,000 per occurrence. However, the exceptions are so broad that its potential impact on reducing long term care patient care liability is uncertain at this time. These exceptions include permanent and substantial physical deformity, loss of limb or bodily function, and permanent physical functional injury limiting activities of daily living. In the case of exceptions, the caps increase to $500,000 per plaintiff or $1,000,000 per occurrence.

Texas

Texas passed comprehensive tort reform for the healthcare industry with House Bill 4, which became effective September 1, 2003 and applies to all cases filed on or after this date. This reform brings nursing homes under the Texas punitive damage cap of $750,000 and imposes a $250,000 cap on non-economic damages for any single healthcare institution sued. This bill also provides a total limit on all damages in a wrongful death claim of approximately $1.4 million ($500,000 indexed for inflation since 1977). Further strengthening the Texas reform was the passage in September 2003 of a Texas medical malpractice ballot initiative, called Proposition 12, that amends the Texas Constitution to allow caps on non-economic damages in medical malpractice lawsuits. As has occurred in other states, the passage of this bill had no immediate effect on reducing frequency, and likely is a reason the indicated Texas frequency for years 2001 through 2003 continues to be increasing at an annual rate of close to 20%. However, the impact on severity, while several years from being evident in the data, is expected to be significant due to the strong language defining the provisions for caps on non-economic damages, punitive damages and wrongful death claims.

West Virginia

In March 2003 legislators in West Virginia enacted House Bill 2122 that contains caps on non-economic damages and other provisions intended to address the increase in patient care and medical malpractice liability. Under the new law the maximum award

for non-economic loss is $250,000 per occurrence. However, the maximum increases to $500,000 per occurrence for wrongful death, permanent and substantial deformity, and loss of limb or bodily function. In addition, there is an inflation adjustment that will begin January 1, 2004 with an eventual maximum of $1,000,000. Due to the fact that the current average severity of West Virginia GL/PL claims is below the countrywide average, the impact of these caps is not expected to have a significant effect on reducing severity. However, these provisions should help mitigate future increases in claims severity and average loss cost.

State Specific Long Term Care GL/PL Trends

The countrywide increases in long term care GL/PL costs are the result of an explosion in litigation that started in a handful of states and is spreading to a multitude of regions throughout the country. This increase in litigation is raising the number of claims individual long term care operators are incurring each year. In addition, the average size of each claim is going up in many states across the country at annual increases well ahead of inflation. In many states, the increase in liability costs is largely offsetting annual increases in Medicaid reimbursements.

The following sections highlight the range of litigation activity across the country on a state by state basis for all states for which there were a credible percentage of nursing homes participating from the state. These states include, in order of highest to lowest loss cost, Florida, Arkansas, Texas, Mississippi, Alabama, Tennessee, California, Georgia, Ohio, Kentucky, West Virginia, North Carolina and Arizona. Due to the credibility criterion, it should be recognized that these states do not represent the thirteen worst states with respect to patient care liability costs. While several of the most costly states are included, there may be states with higher loss costs that we have not included due to lack of data.

A review of these thirteen states shows a disturbing pattern that is repeating itself throughout the country. This pattern is a combination of increases in the number of claims and increases in the average claim size. This pattern continues until claim sizes reach an average level of between $200,000 to $300,000. At these levels it appears there is some tapering off of the average claim size. But, the frequency rate keeps trending up, creating no cap to the rising cost per bed.

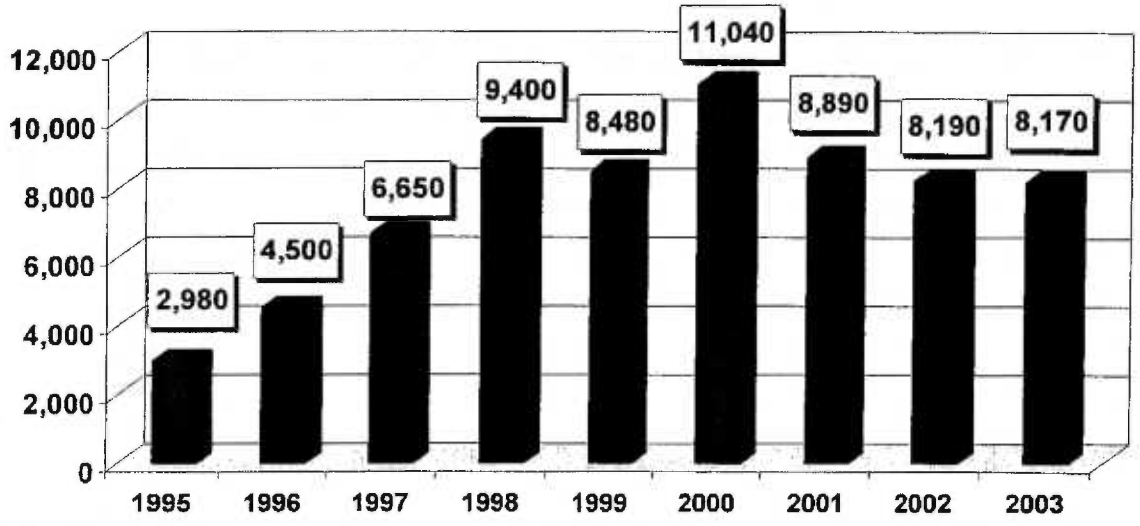
An analysis at the end of this section presents the loss cost trends for all other states combined, which indicates trends well in excess of normal tort liability inflation.

Florida

The participants in this study represent approximately 44,000 licensed beds in the state of Florida. This is approximately 47% of Florida nursing home beds.

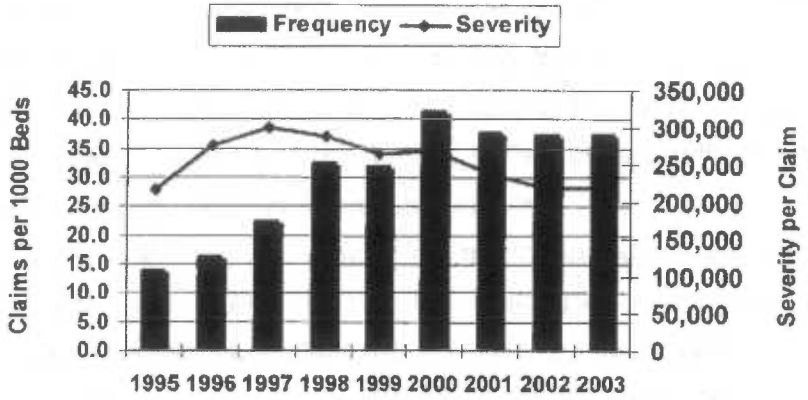
The cost per bed of GL/PL losses is materially higher in Florida than the rest of the United States as the following graph shows:

Florida Loss Cost per Occupied Bed



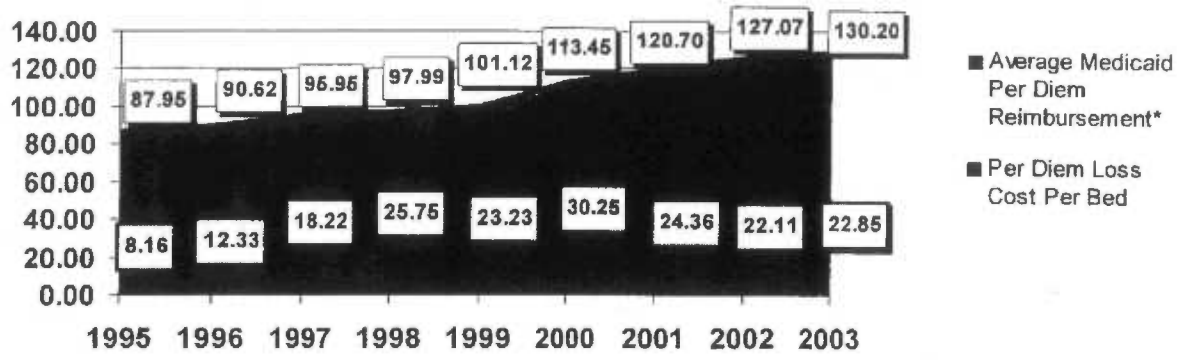
Underlying the loss cost increases are higher than average numbers of claims filed and significantly higher than average sizes of claims. For incidents occurring during 2003, Florida facilities will report approximately 38 claims for every 1,000 occupied beds. The average size of these claims is projected to be $218,000.

Florida Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Florida Medicaid reimbursements, from 9% in 1995 to 17% in 2003 as shown in the graph below.

Florida Per Diem Loss Cost Versus Medicaid Reimbursement



*2003 Projected

A strong patient rights statute was in effect from the late 1980's until May 15, 2001. Effective with claims that occur on or after May 15, 2001, Florida resident's rights claims fall exclusively under recently enacted Senate bills 1200 and 1202. Based on our

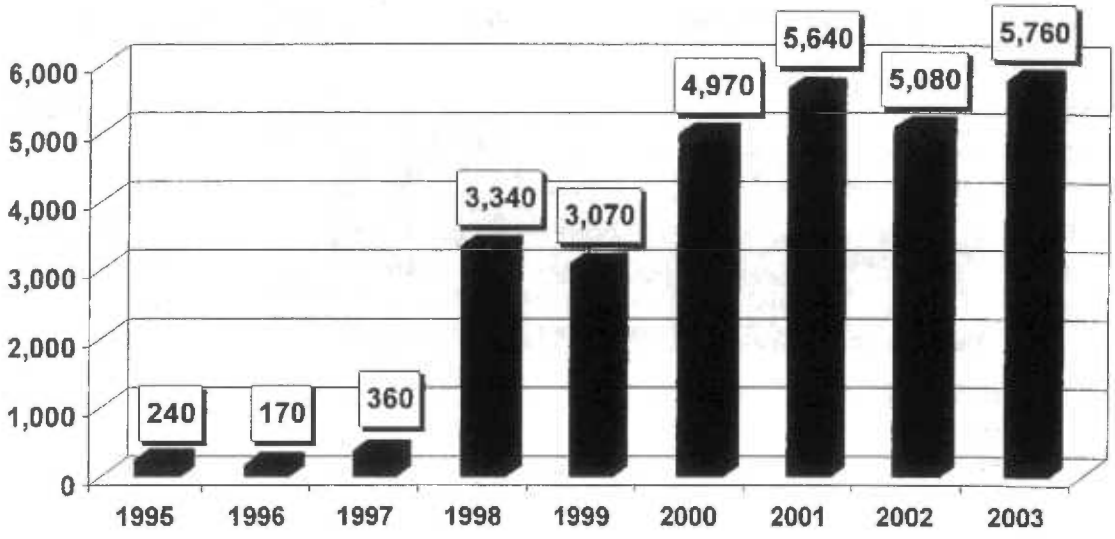
current study it appears that the bills have had no effect on reducing claim frequency in Florida. First of all, an increase in Florida claim frequency for incidents occurring prior to May 15, 2001 is evident, possibly triggered by the October 4, 2001 cut-off for filing claims under the old Statute 400 punitive damage provisions. Secondly, the frequency levels for 2002 and 2003 appear to be higher than the average level of the three years leading up to the tort reform. The impact of Senate bills 1200 and 1202 on claim severity is inconclusive at this time. The average severity of Florida GL/PL claims appears to have peaked in 1998 (three years before tort reform) and has been steadily decreasing at about 2% a year since then. While the decrease has continued post reform, it is difficult to differentiate the impact of tort reform from the impact of large providers leaving Florida and the reduced availability of insurance. Most importantly, the Florida tort reform did not provide any caps on non-economic damages, which actuarially are the most effective tort reform policy provision for reducing long term care patient care liability claim severity.

Arkansas

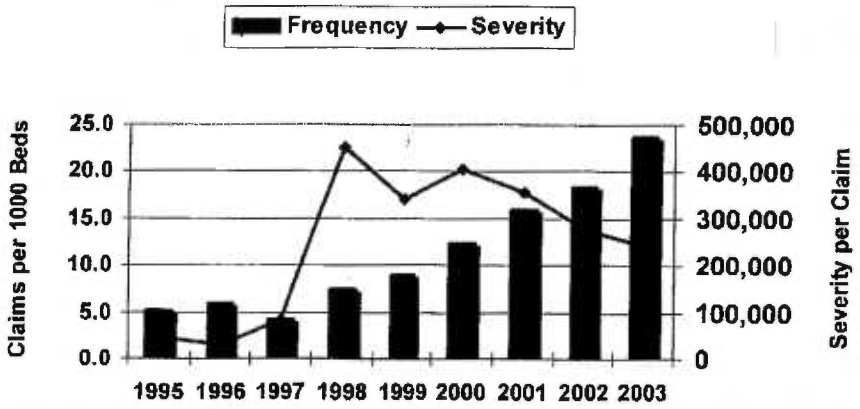
The participants in this study represent approximately 6,100 licensed beds in the state of Arkansas. This is approximately 20% of Arkansas nursing home beds.

Arkansas GL/PL costs are the second highest in the country due to significant increases in the last six years. Prior to 1998 Arkansas long term care providers incurred an average GL/PL cost per bed of around $120 - $360. In 1998 the number of claims incurred started increasing dramatically over prior years and several resulted in multi-million dollar payments. Since 1998 the number of claims has continued to climb and the average size is expected to continue at post 1998 levels. Of particular concern is that Arkansas appears to have the highest average severity in the country, with average per claim costs in the $250,000 to $450,000 range.

Arkansas Loss Cost per Occupied Bed

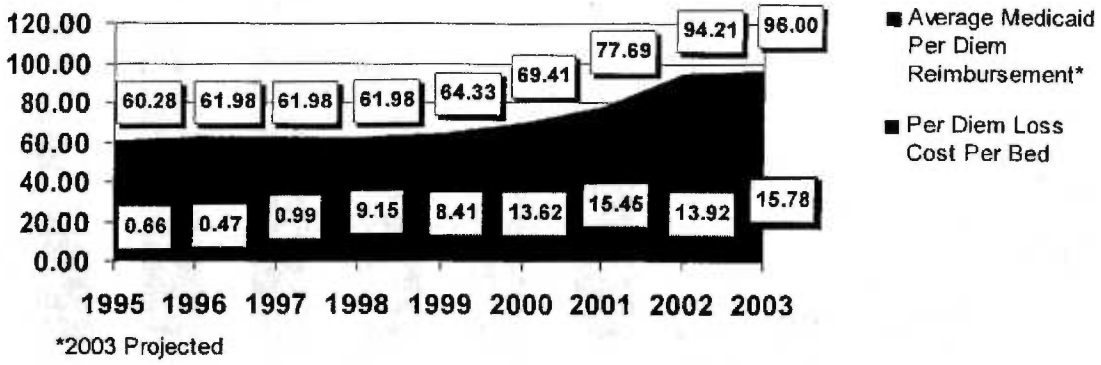


Arkansas Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Arkansas Medicaid reimbursements, from 1% in 1995 to 16% in 2003 as shown in the graph below.

Arkansas Per Diem Loss Cost Versus Medicaid Reimbursement



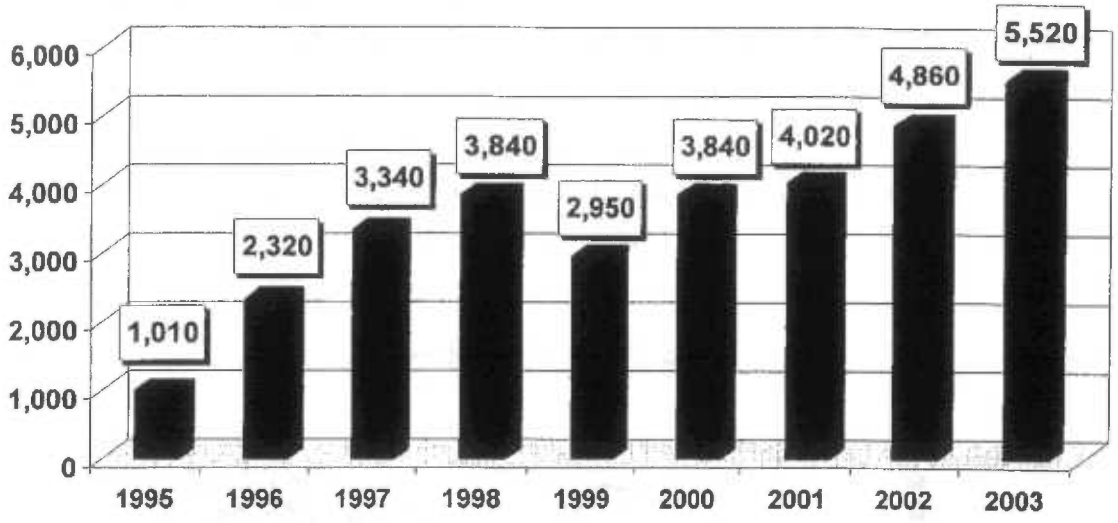
*2003 Projected

Texas

The participants in this study represent approximately 29,000 licensed beds in the state of Texas. This is approximately 21% of Texas nursing home beds.

Texas GL/PL loss costs are the third highest in the country. The Texas average cost per bed has increased from $1,010 in 1995 to $5,520 in 2003 as the following graph shows:

Texas Loss Cost per Occupied Bed

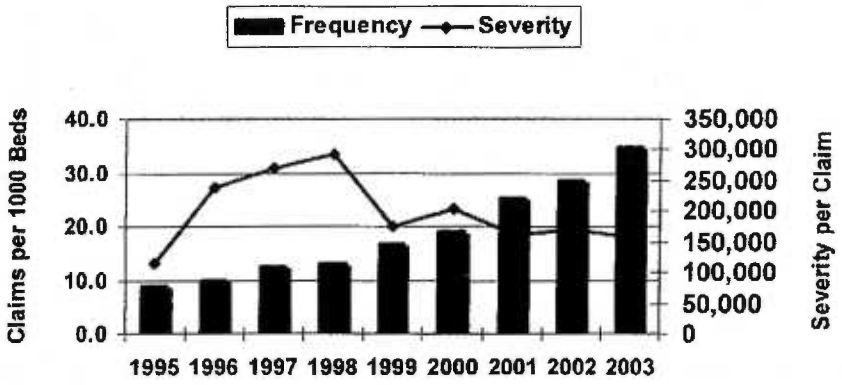


Like Florida, an increase in the number of claims per bed per year is a driving force behind the Texas loss cost increases. The number of claims Texas long term care providers incur per year has shot up to 35 per 1,000 occupied beds. The average size of claims in Texas, however, has been trending downward at approximately 2% since 1995, and noticeably reduced from a high of close to $300,000 in 1998.

Recent tort reform in Texas is likely to have an impact on future trends. Texas passed comprehensive tort reform for the healthcare industry with House Bill 4, which became effective September 1, 2003 and applies to all cases filed on or after this date. This reform brings nursing homes under the Texas punitive damage cap of $750,000 and

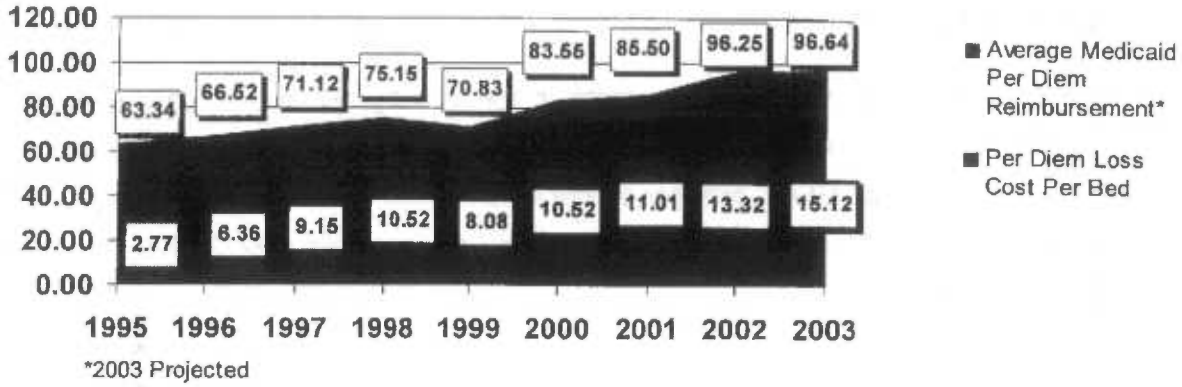
imposes a $250,000 cap on non-economic damages for any single healthcare institution sued. This bill also provides a total limit on all damages in a wrongful death claim of approximately $1.4 million ($500,000 indexed for inflation since 1977). Further strengthening the Texas reform was the passage in September 2003 of a Texas medical malpractice ballot initiative, called Proposition 12, that amends the Texas Constitution to allow caps on non-economic damages in medical malpractice lawsuits. As has occurred in other states, the passage of this bill had no immediate effect on reducing frequency, and likely is a reason the indicated Texas frequency for years 2001 through 2003 continues to be increasing at an annual rate of close to 20%. However, the impact on severity, while several years from being evident in the data, is expected to be significant due to the strong language defining the provisions for caps on non-economic damages, punitive damages and wrongful death claims.

Texas Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Texas Medicaid reimbursements, from 4% in 1995 to 16% in 2003 as shown in the graph below.

Texas Per Diem Loss Cost Versus Medicaid Reimbursement



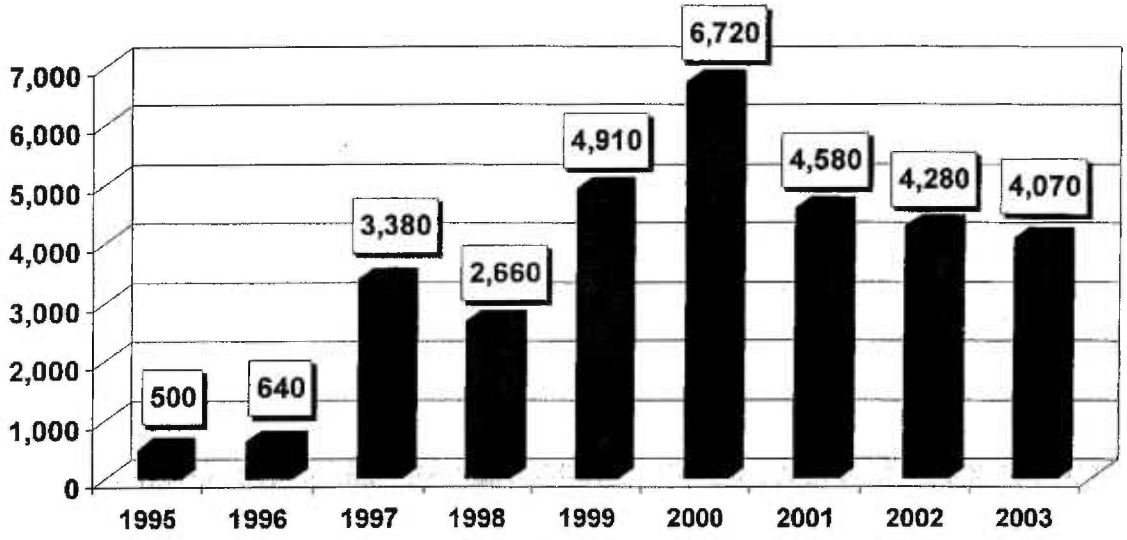
*2003 Projected

Mississippi

The participants in this study represent approximately 9,200 licensed beds in the state of Mississippi. This is approximately 50% of Mississippi nursing home beds.

While currently the fourth highest state in the country, Mississippi loss costs have recently shown some stabilization. Prior to 1997, Mississippi long term care providers incurred an average GL/PL cost per bed of around $400 - $600. But costs jumped up to $3,400 in 1997, peaked at $6,720 in 2000 and are now just over $4,000 per bed for 2003 occurrences.

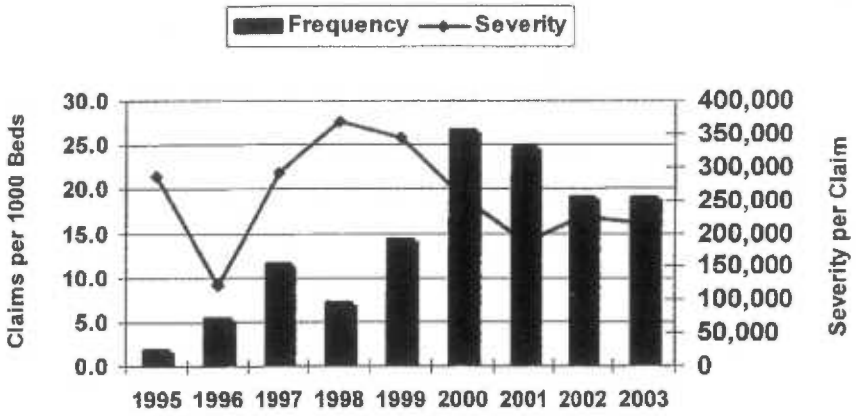
Mississippi Loss Cost per Occupied Bed



Fueling the rise in Mississippi loss costs is a huge spike in the frequency rate between 1995 and 2000 from 2 claims per 1,000 beds to 27 claims per 1,000 beds. Mississippi severity during this period also peaked at approximately $380,000 per claim and seems to be leveling off at approximately $215,000 per claim in 2003.

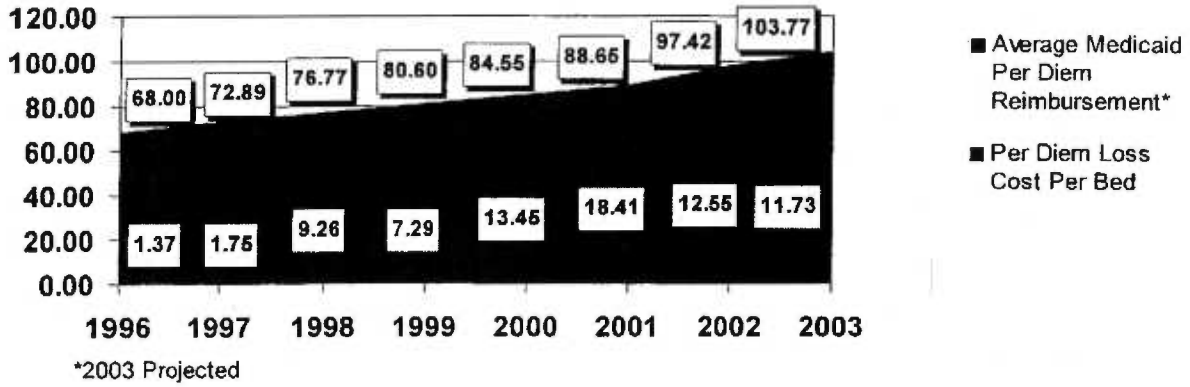
Like Florida, Mississippi passed legislation recently with the intent of curbing the rising cost of patient care liability claims. House Bill No. 2 became effective January 1, 2003 and included revisions to the Mississippi medical malpractice code that, among other things, brought long term care providers under the act and limited non-economic damages to $500,000 (stepping up to $750,000 on July 1, 2011 and $1,000,000 on July 1, 2017). As has occurred in other states, the passage of this reform initially caused a significant spike in the number of claims, most alleging events in years 2000, 2001, and, to a lesser extent, 2002. The impact of the tort reform on severity is not yet evident, due to the fact that the law has only been in effect a year and most post reform claims are still open. However, the $500,000 cap on non-economic damages is expected to have some affect on reducing average severity in years 2003 and later.

Mississippi Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Mississippi Medicaid reimbursements, from 2% in 1996 to 11% in 2003 as shown in the graph below.

Mississippi Per Diem Loss Cost Versus Medicaid Reimbursement



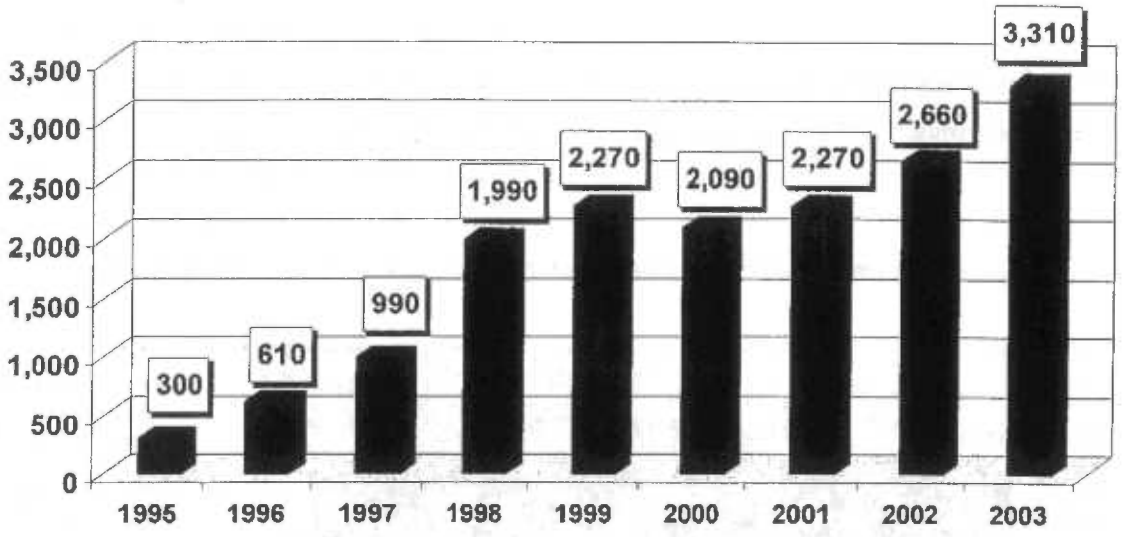
*2003 Projected

Alabama

The participants in this study represent approximately 19,700 licensed beds in the state of Alabama. This is approximately 72% of Alabama nursing home beds.

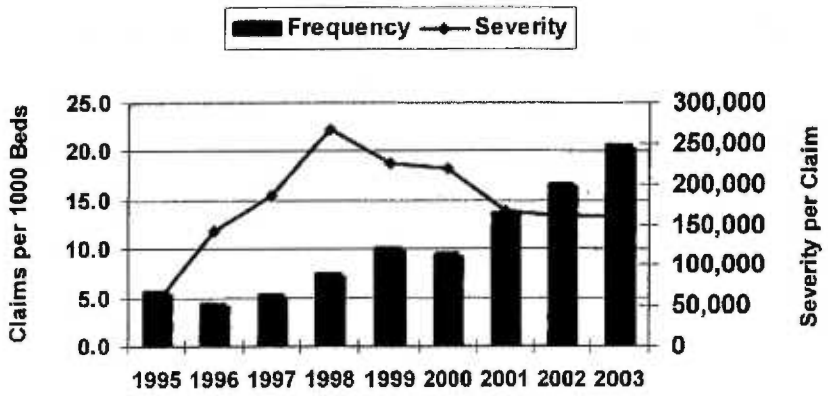
Like Arkansas, Alabama loss costs took a dramatic increase in 1998, although the increasing trends started a few years earlier. Alabama loss costs have steadily increased from $300 per bed in 1995 to an estimated $3,310 in 2003, resulting in an average annual increase of 29% per year.

Alabama Loss Cost per Occupied Bed



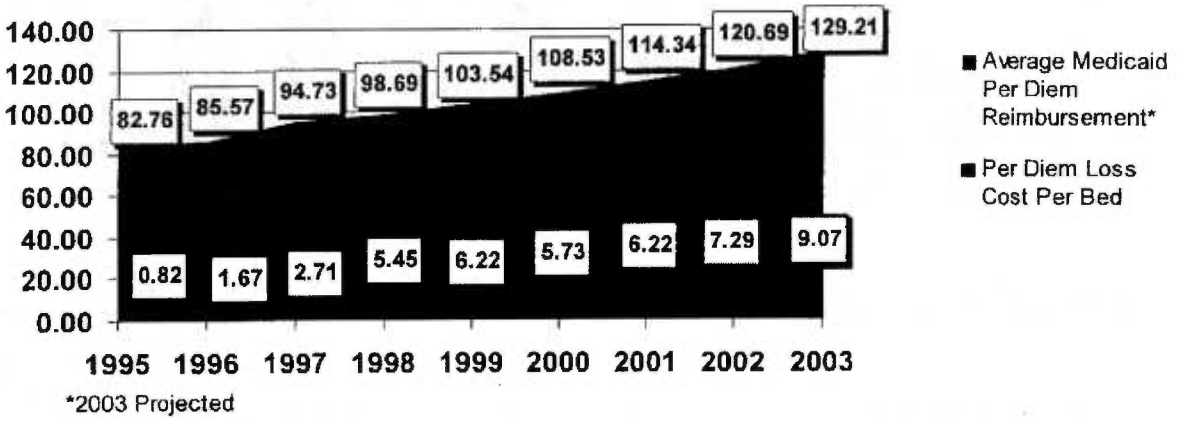
Frequency, while steadily increasing at an annual increase of 22% a year, is not yet as high as Florida, Arkansas or Texas. However, the average size of a PL/GL claim in Alabama is comparable to Texas, having increased dramatically between 1995 and 1998.

Alabama Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Alabama Medicaid reimbursements, from 1% in 1995 to 7% in 2003 as shown in the graph below.

Alabama Per Diem Loss Cost Versus Medicaid Reimbursement



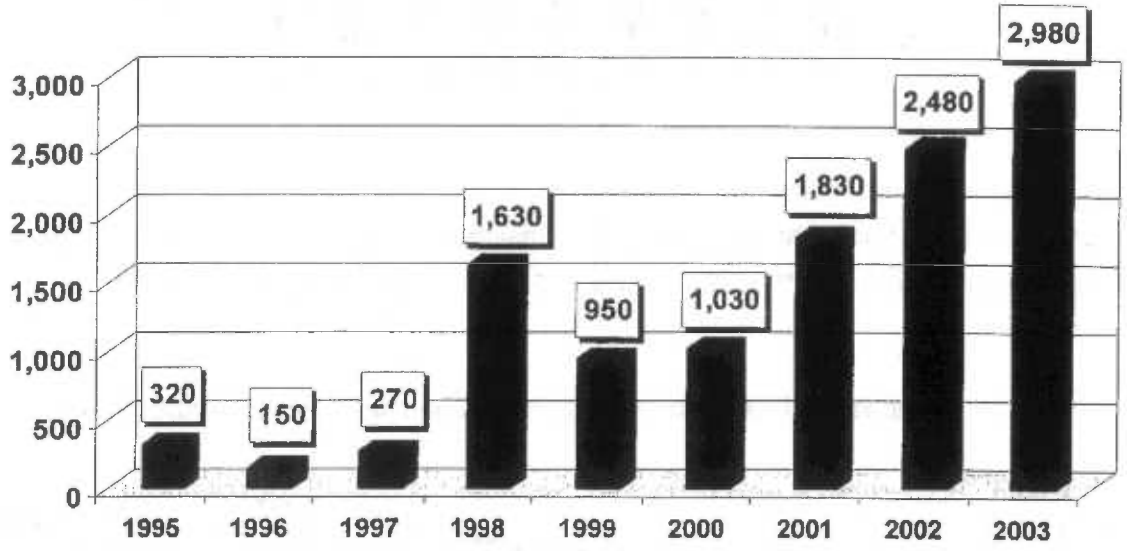
*2003 Projected

Tennessee

The participants in this study represent approximately 11,500 licensed beds in the state of Tennessee. This is approximately 29% of Tennessee nursing home beds.

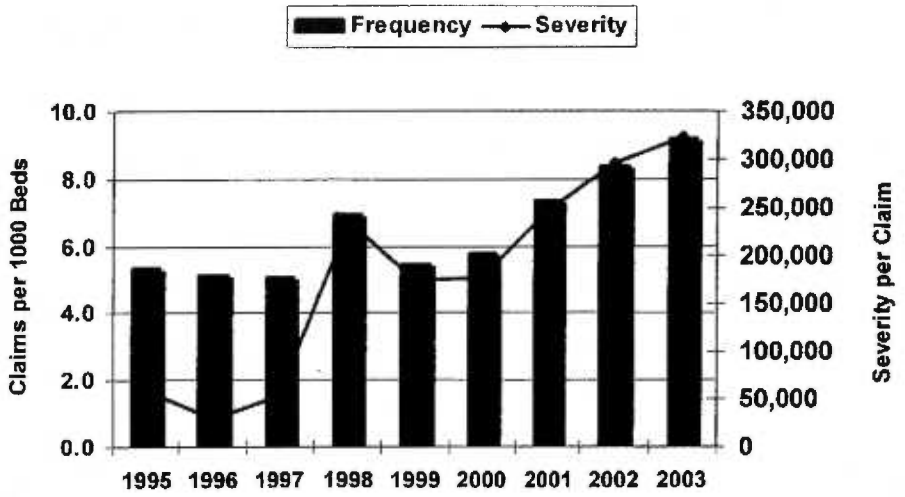
Tennessee loss costs also took a dramatic increase in 1998. The Tennessee average cost per bed has increased from $320 per bed in 1995 to an estimated $2,980 in 2003 as the following graph shows:

Tennessee Loss Cost per Occupied Bed



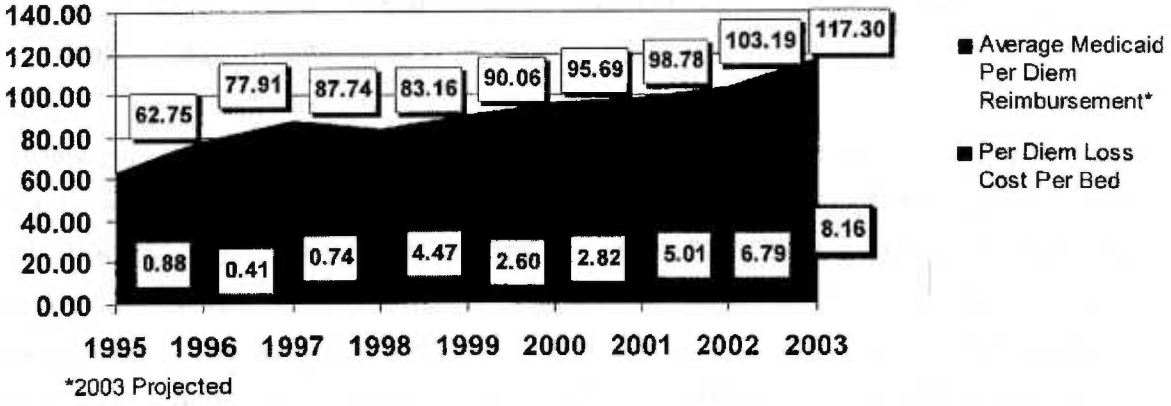
Like Florida and Texas, an increase in the number of claims per bed per year is contributing toward the Tennessee loss cost increase. The number of claims has increased from 5 claims per 1,000 occupied beds in 1995 to 9 in 2003. However, the average size of a PL/GL claim in Tennessee dramatically increased in 1998 to approximately $235,000 from an approximate average size of $50,000 in prior years. Unlike other states, where severity seems to be leveling off, the Tennessee average severity is increasing 32% a year and is projected to reach $325,000 for claims occurring in 2003.

Tennessee Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Tennessee Medicaid reimbursements, from 1% in 1995 to 7% in 2003 as shown in the graph below.

Tennessee Per Diem Loss Cost Versus Medicaid Reimbursement



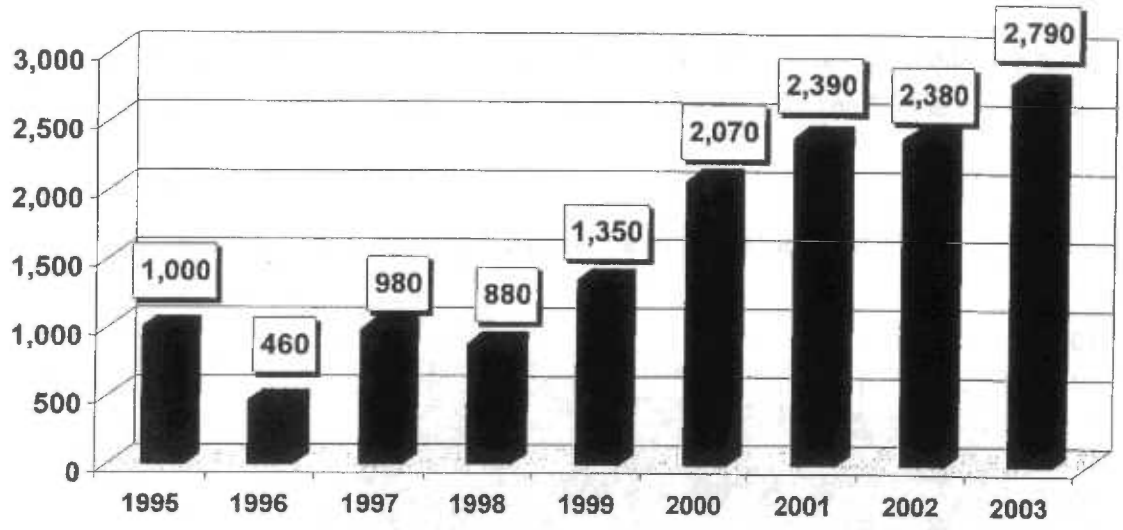
*2003 Projected

California

The participants in this study represent approximately 30,000 licensed beds in the state of California. This is approximately 21% of California nursing home beds.

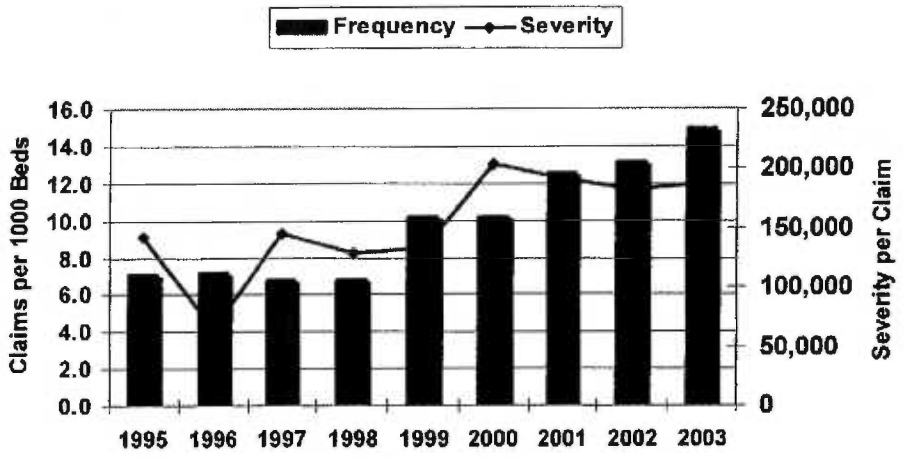
Similar to many of the southern states presented above, California loss costs in the early part of the last decade hovered in the $100 to $300 range per bed. In 1994 the number of claims per bed started creeping up and in 1995 the average size of California patient liability claims jumped dramatically. Since 1995 California claims costs have increased on average 29% a year. Loss costs are now projected to be $2,790.

California Loss Cost per Occupied Bed



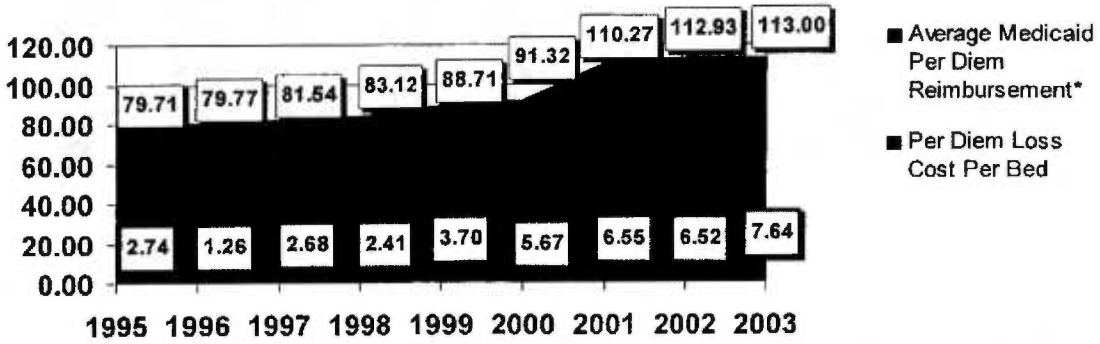
In California, while frequency continues to increase at an average rate of 13% a year, severity appears to be leveling off in recent years at a level just under $200,000.

California Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of California Medicaid reimbursements, from 3% in 1995 to 7% in 2003 as shown in the graph below.

California Per Diem Loss Cost Versus Medicaid Reimbursement



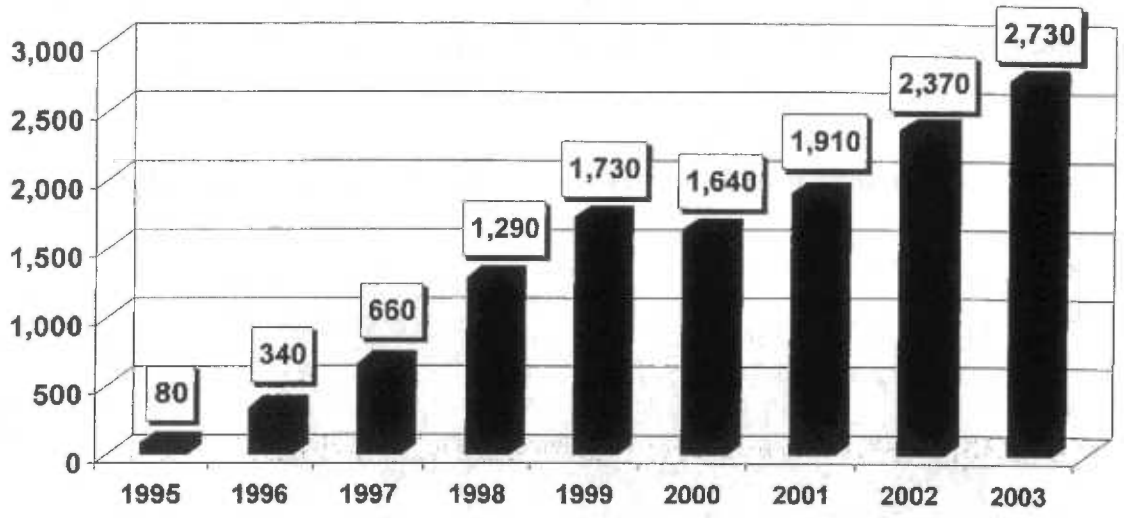
*2003 Projected

Georgia

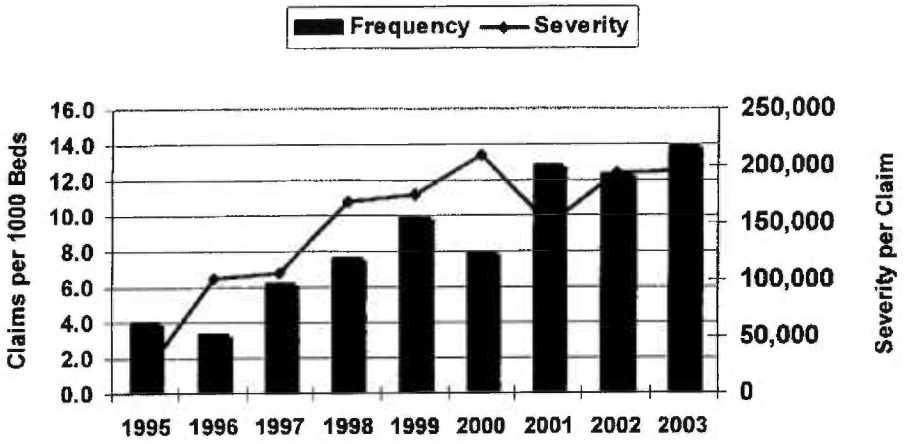
The participants in this study represent approximately 10,700 licensed beds in the state of Georgia. This is approximately 26% of Georgia nursing home beds.

Georgia loss costs have increased dramatically in the last five years from $80 in 1995 to $2,730 in 2003 at an annual trend rate of approximately 46%. Fueling the rise in Georgia loss costs is the dramatic increase in the frequency rate between 1995 and 2003 from 4 claims to 14 claims per 1,000 beds. The average claim severity in the same period has also grown from $20,000 to almost $200,000.

Georgia Loss Cost per Occupied Bed

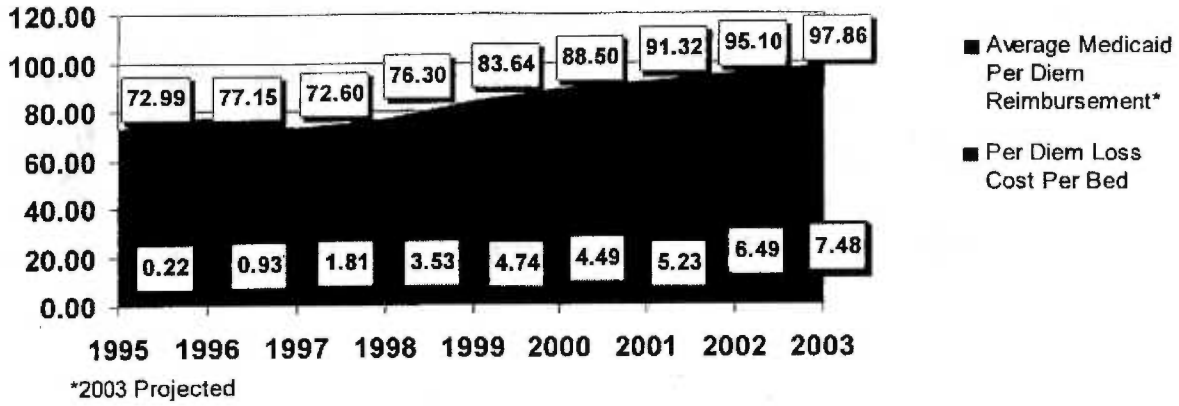


Georgia Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Georgia Medicaid reimbursements, from 0.3% in 1995 to 8% in 2003 as shown in the graph below.

Georgia Per Diem Loss Cost Versus Medicaid Reimbursement



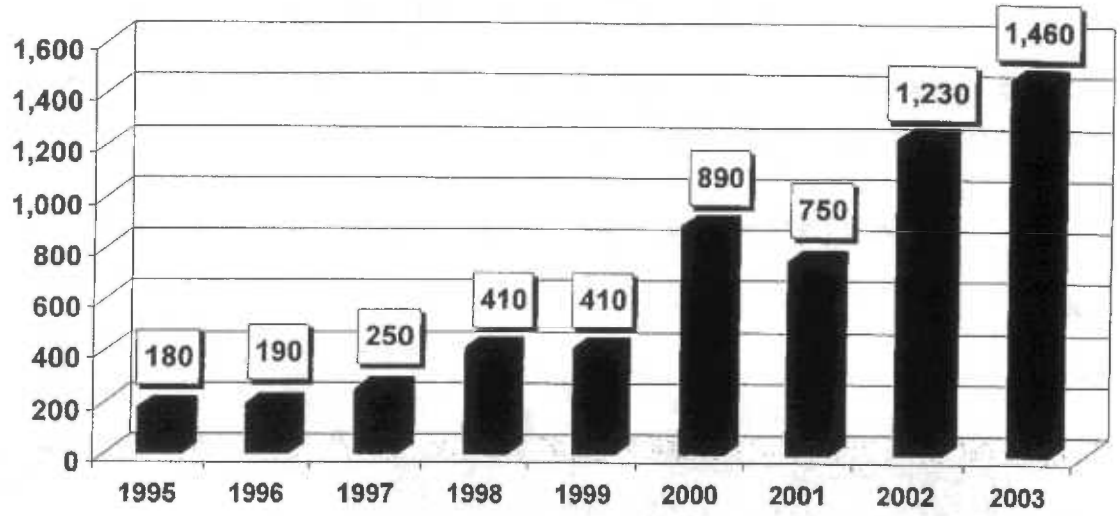
*2003 Projected

Ohio

The participants in this study represent approximately 26,000 licensed beds in the state of Ohio. This is approximately 20% of Ohio nursing home beds.

Prior to 2000, Ohio long term care providers incurred an average GL/PL cost per bed of around $100 - $400. But costs started climbing in 2000 and are projected to reach almost $1,500 per bed for 2003 occurrences. While frequency rates have been increasing, the noteworthy increase has been in severity. The average claim size has steadily grown from approximately $50,000 in 1995 to a projected $192,000 in 2003.

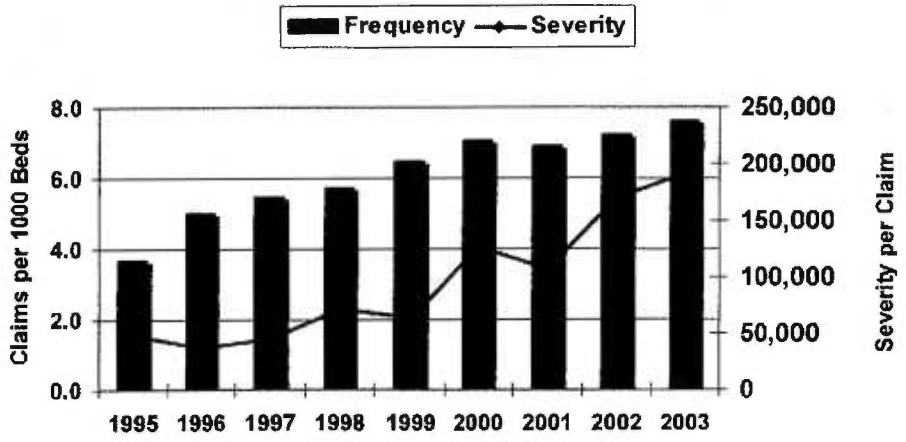
Ohio Loss Cost per Occupied Bed



Ohio passed tort reform in January of 2003 that included a cap on non-economic damages of $250,000 or 3 times economic loss to a maximum of $350,000 per plaintiff or $500,000 per occurrence. However, the exceptions are so broad that its potential impact on reducing long term care patient care liability is uncertain at this time. These exceptions include permanent and substantial physical deformity, loss of limb or bodily

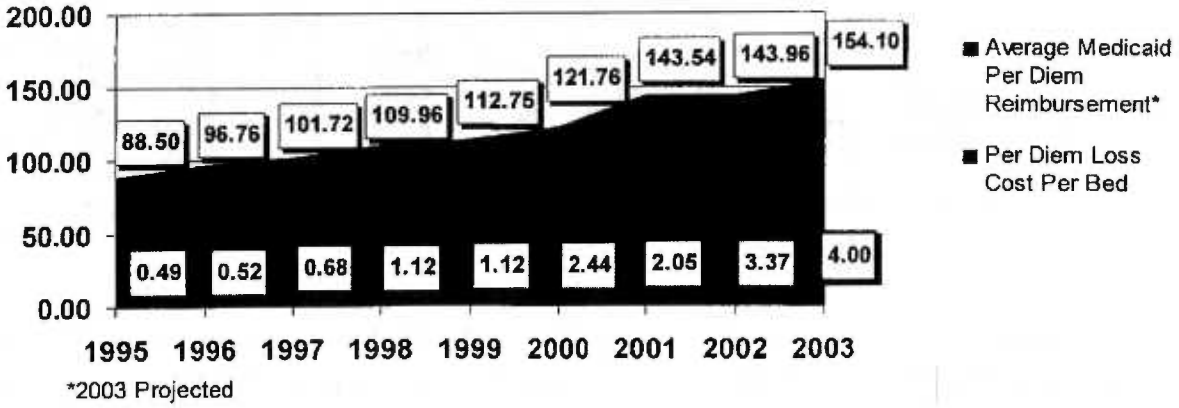
function, and permanent physical functional injury limiting activities of daily living. In the case of exceptions, the caps increase to $500,000 per plaintiff or $1,000,000 per occurrence.

Ohio Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Ohio Medicaid reimbursements, from 1% in 1995 to 3% in 2003 as shown in the graph below.

Ohio Per Diem Loss Cost Versus Medicaid Reimbursement



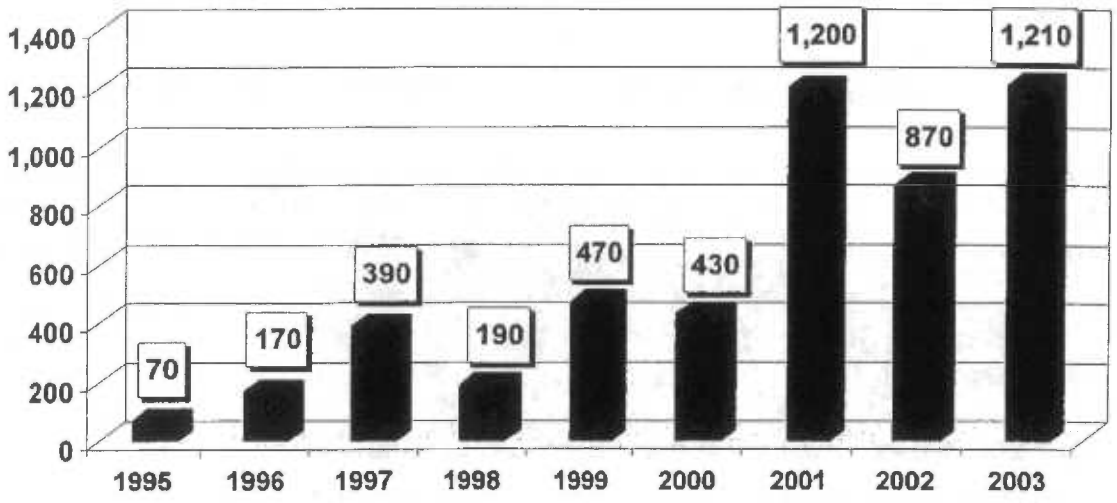
*2003 Projected

Kentucky

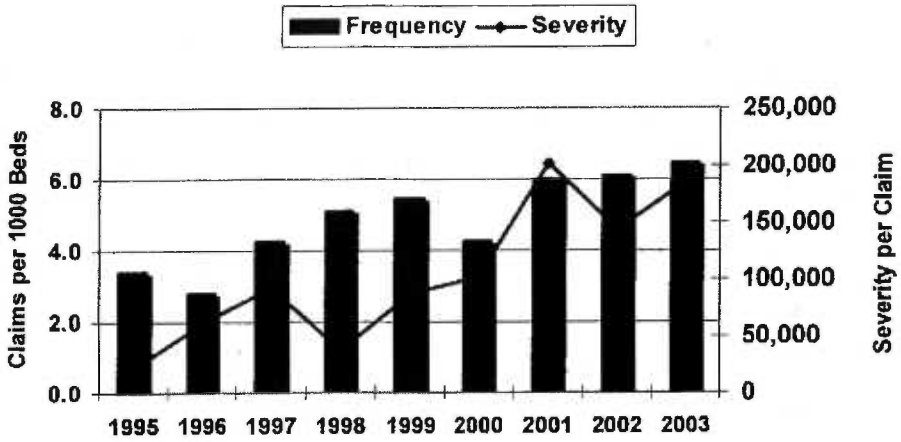
The participants in this study represent approximately 8,100 licensed beds in the state of Kentucky. This is approximately 31% of Kentucky nursing home beds.

Like Ohio, Kentucky seems to be a more recent victim to the increased trends we have seen countrywide. Prior to 2001, Kentucky long term care providers incurred an average GL/PL cost per bed of around $50 - $400. But costs started climbing in 2001 and are projected to reach $1,210 per bed for 2003 occurrences. While frequency rates have been increasing, the noteworthy increase has been in severity. The average claim size has steadily grown at an annual trend rate of 25% from approximately $22,000 in 1995 to a projected $186,000 in 2003.

Kentucky Loss Cost per Occupied Bed

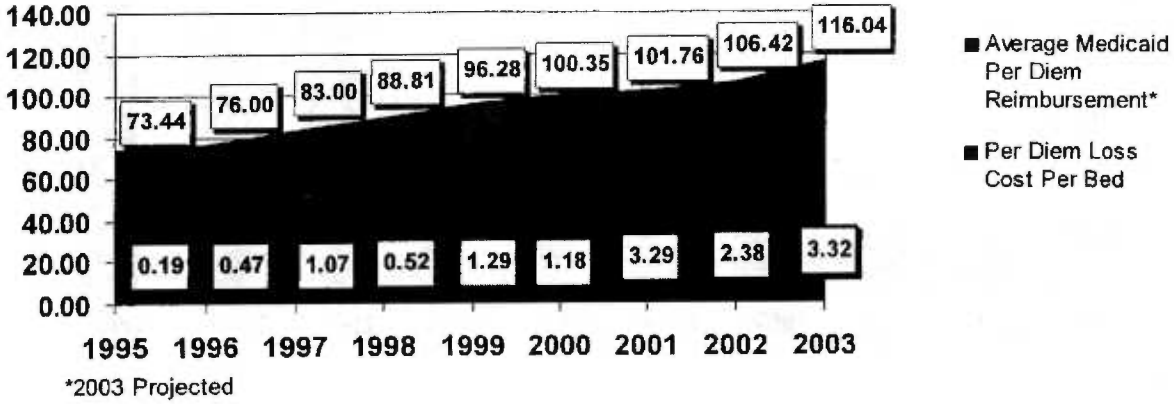


Kentucky Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Kentucky Medicaid reimbursements, from 0.3% in 1995 to 3% in 2003 as shown in the graph below.

Kentucky Per Diem Loss Cost Versus Medicaid Reimbursement



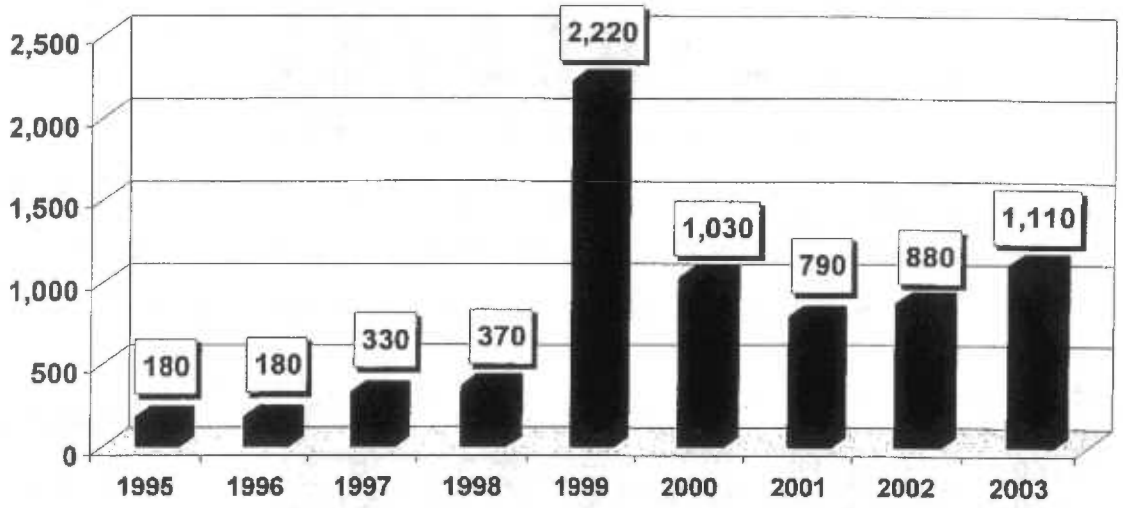
*2003 Projected

West Virginia

The participants in this study represent approximately 5,300 licensed beds in the state of West Virginia. This is approximately 46% of West Virginia nursing home beds.

West Virginia loss costs have increased in the last five years from $180 in 1995 to $1,110 in 2003. Fueling the rise in West Virginia loss cost is the dramatic, yet highly volatile, increase in the frequency rates between 1995 and 2003. The number of claims has ranged from 1 claim per 1,000 beds in 1995 to a high of 14 in 1999 and leveling off at approximately 8 claims per 1,000 beds in 2003. The average claim severity in the same period has hovered around $150,000.

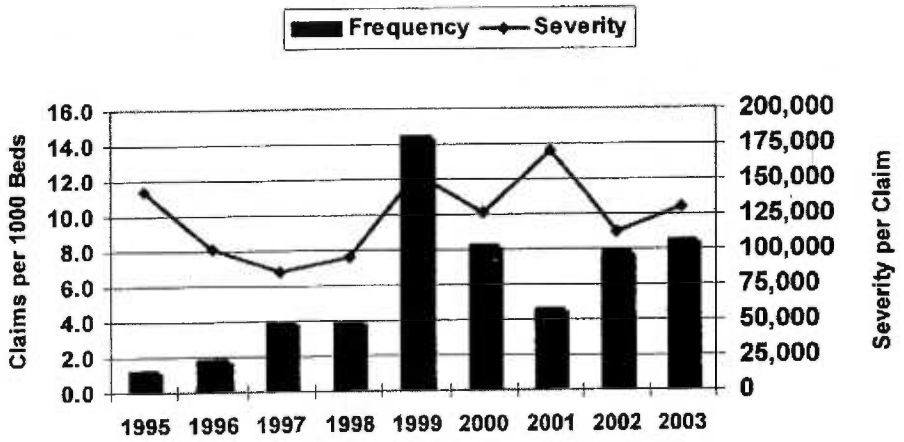
West Virginia Loss Cost per Occupied Bed



In March 2003 legislators in West Virginia enacted House Bill 2122 that contains caps on non-economic damages and other provisions intended to address the increase in patient care and medical malpractice liability. Under the new law the maximum award for non-economic loss is $250,000 per occurrence. However, the maximum increases to $500,000 per occurrence for wrongful death, permanent and substantial deformity, and loss of limb or bodily function. In addition, there is an inflation adjustment that will

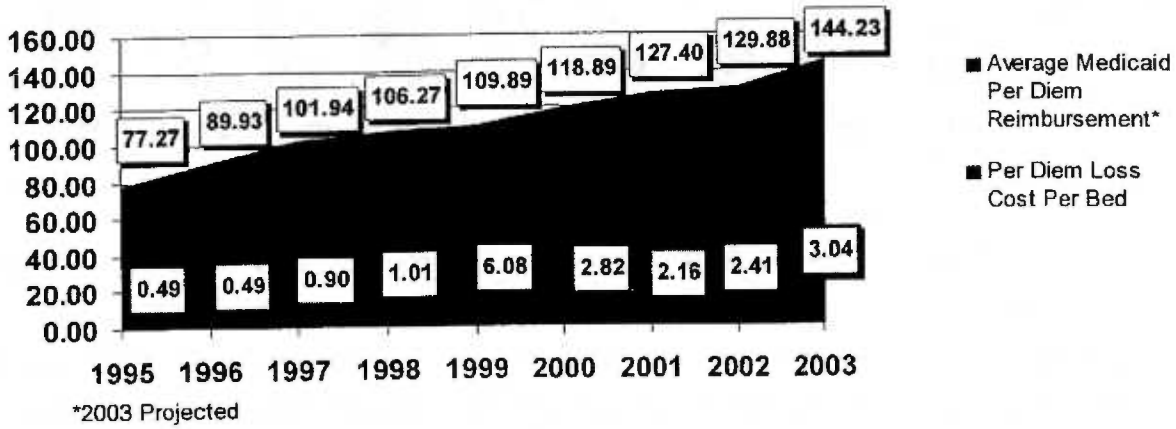
begin January 1, 2004 with an eventual maximum of $1,000,000. Due to the fact that the current average severity of West Virginia GL/PL claims is below the countrywide average, the impact of these caps is not expected to have a significant effect on reducing severity. However, these provisions should help mitigate future increases in claims severity and average loss cost.

West Virginia Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost as a percent of West Virginia Medicaid reimbursements, from 1% in 1995 to 2% in 2003 as shown in the graph below.

West Virginia Per Diem Loss Cost Versus Medicaid Reimbursement



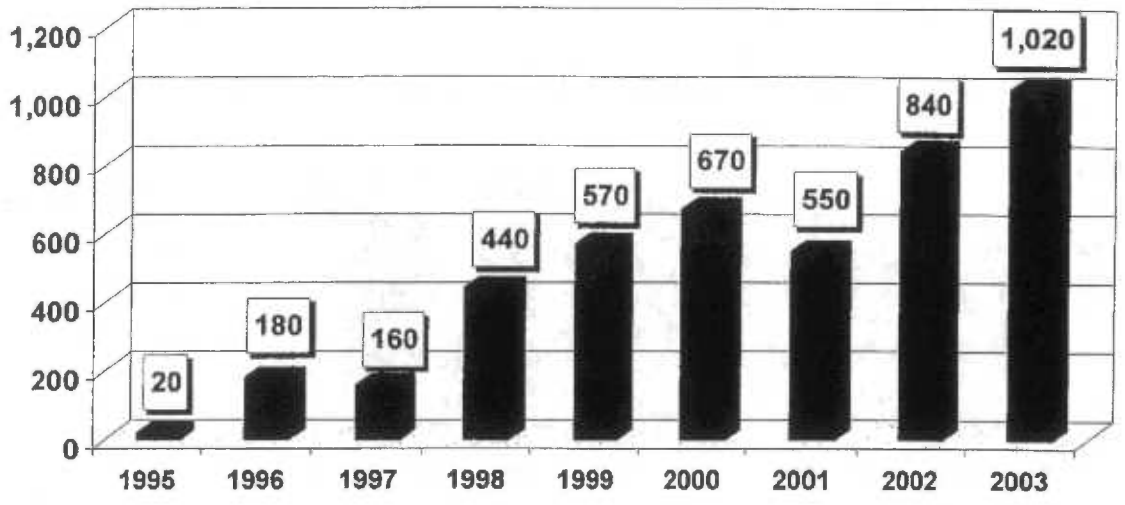
*2003 Projected

North Carolina

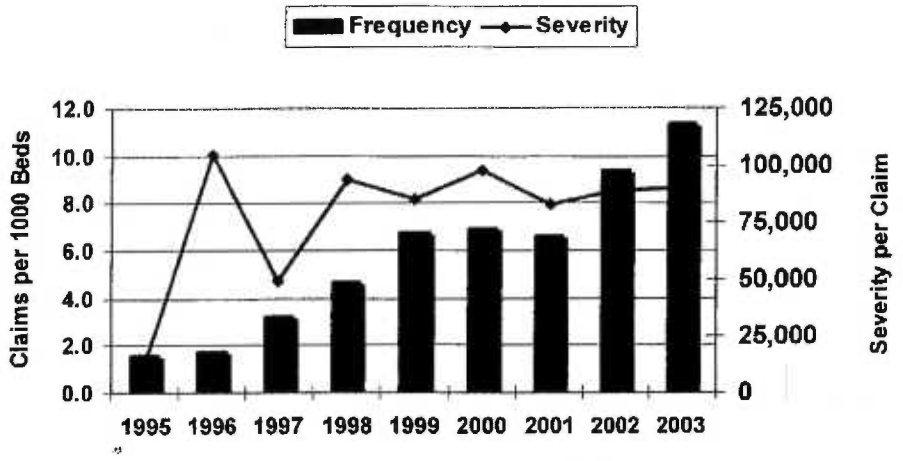
The participants in this study represent approximately 23,200 licensed beds in the state of North Carolina. This is approximately 51% of North Carolina nursing home beds.

North Carolina loss costs have steadily increased since 1995 at an annual trend rate of approximately 29%. While the projected average loss cost in 2003 of $1,020 does not rival the likes of Florida, Arkansas and Texas, the number of claims incurred has increased dramatically since 1996. The number of claims was 2 per 1,000 beds in 1995 and is now projected to be 11 per 1,000 beds in 2003. Also in 1996, the average claim size jumped considerably to an unprecedented $105,000 per claim. However, the average claim size has remained relatively stable at approximately $90,000 since 1996.

North Carolina Loss Cost per Occupied Bed

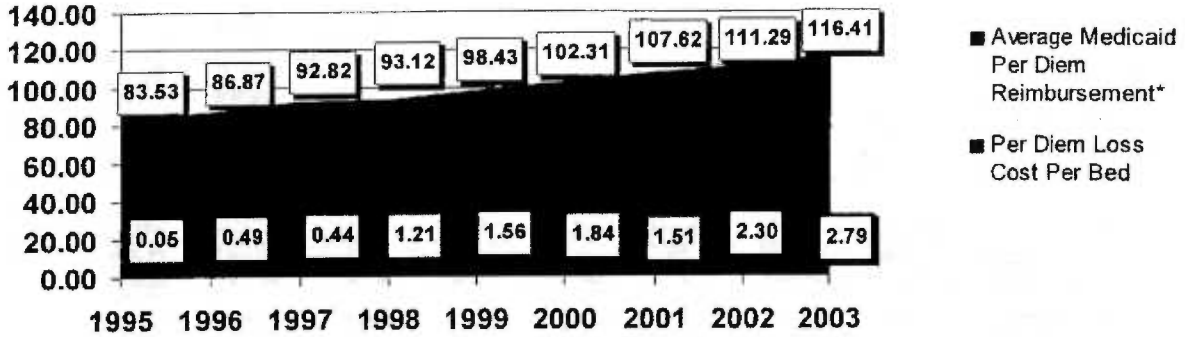


North Carolina Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of North Carolina Medicaid reimbursements, from 0.1% in 1995 to 2% in 2003 as shown in the graph below.

North Carolina Per Diem Loss Cost Versus Medicaid Reimbursement



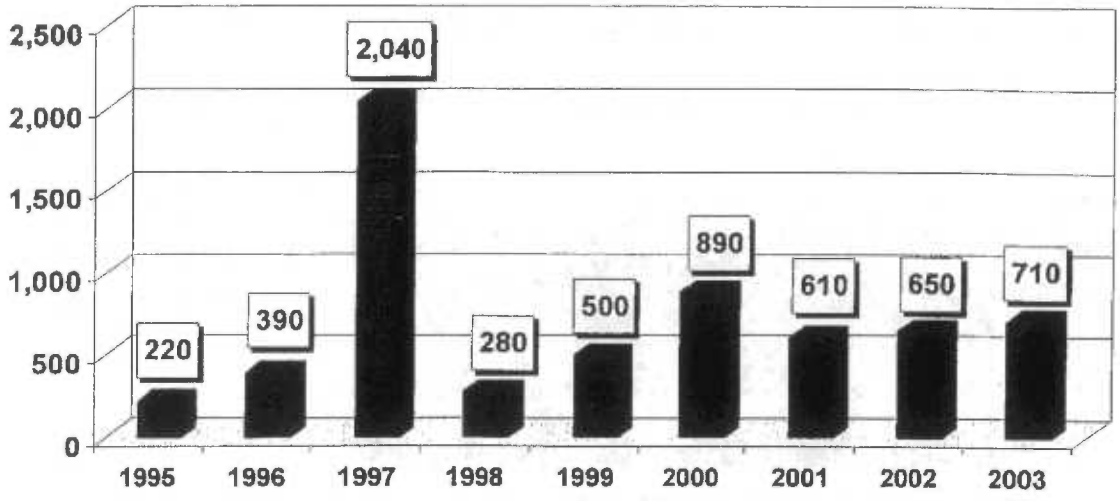
*2003 Projected

Arizona

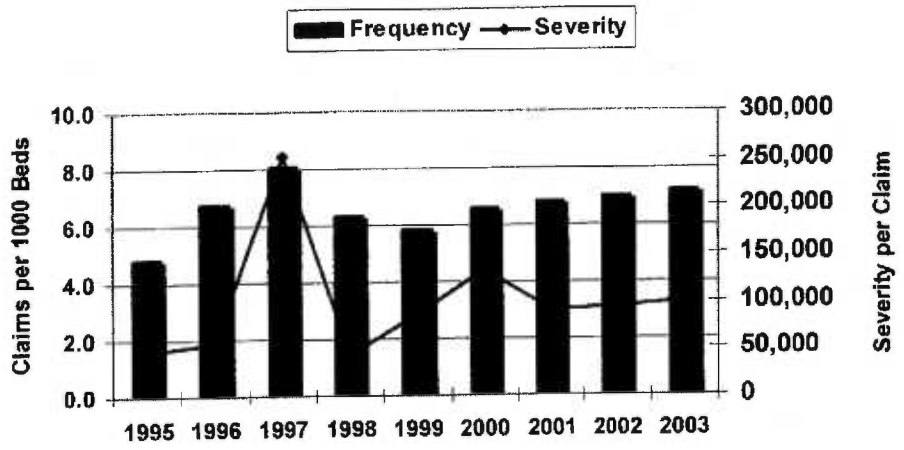
The participants in this study represent approximately 6,400 licensed beds in the state of Arizona. This is approximately 30% of Arizona nursing home beds.

Arizona loss costs have increased from $220 in 1995 to a projected $710 in 2003. The spike seen in 1997, due to both an increase in the number of claims and the average claim size did not have a continuing effect in this state. Overlooking this spike, the number of claims per 1,000 occupied beds has gone from 5 in 1995 to only 7 in 2003. Severity, on the other hand, has doubled from $47,000 in 1995 to $100,000 in 2003.

Arizona Loss Cost per Occupied Bed

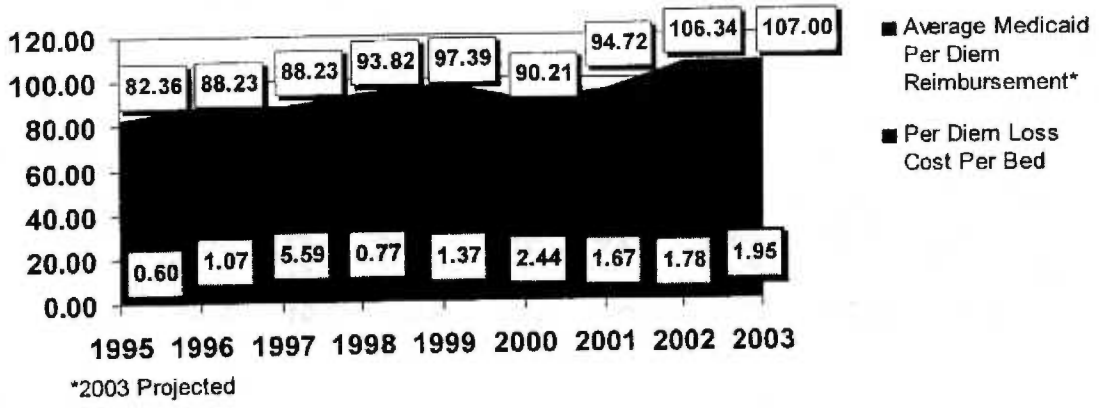


Arizona Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost has doubled as a percent of Arizona Medicaid reimbursements, from 1% in 1995 to 2% in 2003 as shown in the graph below.

Arizona Per Diem Loss Cost Versus Medicaid Reimbursement



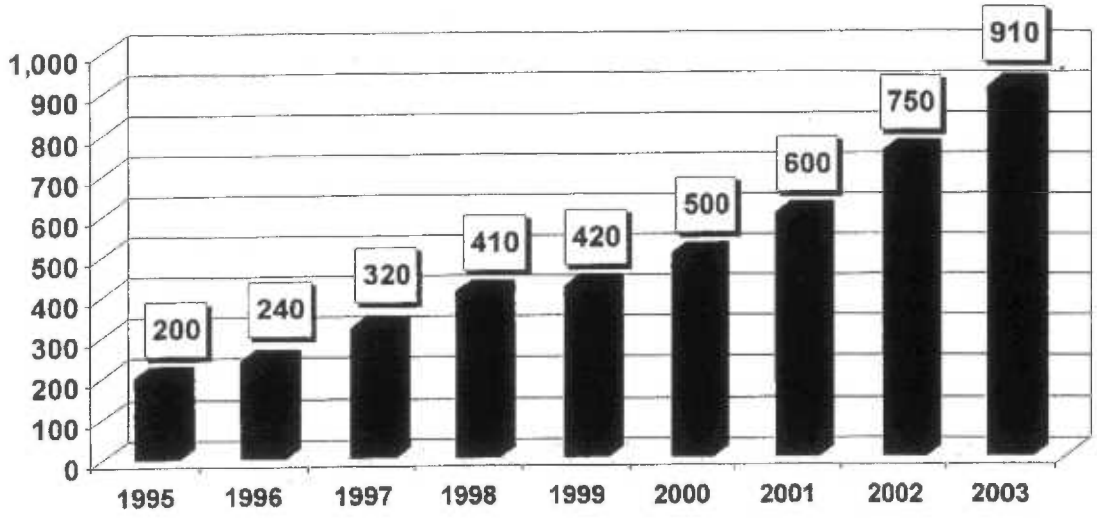
*2003 Projected

All Other States Combined

The participants in this study represent approximately 240,000 licensed beds in the remainder of the country (that is, excluding Florida, Arkansas, Texas, Mississippi, Alabama, Tennessee, California, Georgia, Ohio, Kentucky, West Virginia, North Carolina and Arizona). This is approximately 20% of all nursing home beds in the remaining states.

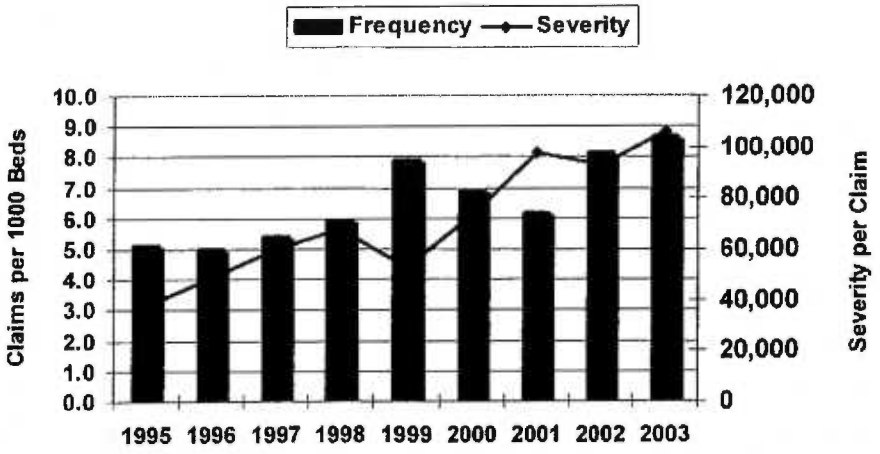
Even excluding the thirteen states noted above, which include some of the highest cost states in the country, GL/PL loss costs are increasing at an annual rate of 20% a year. This is well ahead of inflation and much higher than typical GL/PL claim cost increases for other industries, which tend to be in the 5% to 15% range a year. Our analysis of claims in all other states indicates that loss costs have risen from $200 in 1995 to $910 in 2003.

All Other States Loss Cost per Occupied Bed



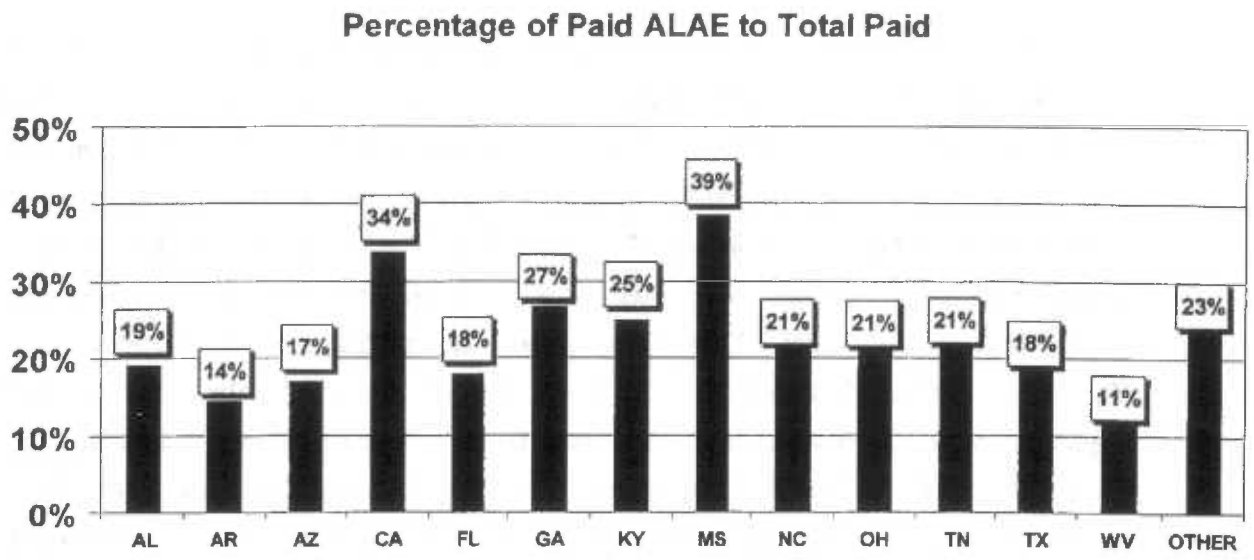
The 20% annual loss cost increase is the result of a 7% annual increase in the number of claims, combined with a 12% annual increase in the average size of a claim.

All Other States Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



ALAE

The component of total claim dollars used to defend claims, referred to as allocated loss adjustment expenses or ALAE varies by state as follows:



Insurance Premium and Coverage Analysis

Insurance premium has continued to increase and coverage terms have been further restricted for those survey respondents who have been commercially insured for their GL/PL exposure. Of the 108 total participants in this study (a 37% increase over last year's participation rate), 96 provided insurance premium and coverage terms for policy years 2002 and 2003 (a 71% increase over last year). These respondents are primarily comprised of the smaller, independent and regional providers. On average, the respondents to this section of the survey operate approximately 1,984 licensed beds. The median size of respondents is closer to 253 beds. In total, they operate approximately 120,000 beds, or one quarter of the total beds included in this study. The large national chains are, for the most part, self-insured and did not report commercial insurance coverage information. The following sections provide details on the impact to the survey respondents of premium and coverage changes. The key findings in this year's survey are continued premium increases, higher deductibles (insured retentions), and a shift from occurrence based policy forms to the more restrictive claims-made form.

Premium Increases

On average, annual commercial GL/PL insurance premiums increased $70,000 over the past year. For participants who were able to give a comparison of 2002 to 2003 coverage terms, the average percentage increase was 51%. This follows two years of substantial increases in GL/PL insurance premiums, as documented in prior Aon studies and summarized in the below chart.

Historical Premium Increases – 2001 to 2003

	2001	2002	2003
Median Increase over Prior Year's Premium	74%	82%	25%
Average Increase over Prior Year's Premium	131%	143%	51%

Smaller providers, those with less than 500 beds, incurred higher percentage increases than larger providers.

Change in Annual Premium by Provider Size – Policy Year 2002 to 2003

Provider Bed Count	Number of Respondents	Total Percentage Premium Change	Median Percentage Premium Change	Average Percentage Premium Change
0-100	27	33.9%	37.1%	73.7%
100-250	18	46.4%	30.4%	77.2%
250-500	6	27.9%	34.5%	61.6%
500-1000	4	-42.6%	-28.4%	-29.4%
1000-5000	22	8.1%	26.5%	32.6%
5000-10,000	8	24.5%	10.4%	21.4%
>10,000	1	-9.4%	-9.4%	-9.4%

The amount of premium change varied widely, however, the majority (74 of 85 respondents) reported increases. The maximum percentage premium increase was incurred by a 129 bed independent facility whose premium increased from under $100,000 to over $500,000, and whose coverage was reduced from occurrence based with no deductible to claims-made with a $50,000 deductible.

Change in Annual Premium - Policy Year 2002 to 2003

Amount of Change	Number of Respondents	Total Dollar Amount of Change	Average Dollar Amount
Less than $0	11	($3,376,988)	($306,999)
$0 - $50,000	45	$846,754	$18,817
$50,001 - $100,000	10	$719,892	$71,989
$100,001 - $500,000	17	$4,885,352	$287,374
$500,001 - $1,000,000	1	$650,000	$650,000
Greater than $1,000,000	1	$2,222,800	$2,222,800
Total	85	$5,947,811	$69,974

Limits of Liability Reductions

On average, survey respondents continued to report a reduction in available limits, although the contraction in capacity is materially reduced from prior years, as reported in previous Aon studies and summarized below.

Historical Limits of Liability Reductions – 2001 to 2003

	2001	2002	2003
Average Decrease in Per Occurrence Limit from Prior Year	($474,074)	($488,679)	($108,537)
Average Decrease in Aggregate Limit from Prior Year	($2,311,111)	($624,000)	($68,452)

Between 2002 and 2003 the majority of respondents (69 of 82 providing limits of liability comparisons) reported no change in their annual limits of liability. Five respondents reported increases in their limits of liability and eight reported decreases. Overall, the commercial insurance industry provided $8.9 million less capacity to the 82 providers responding to this section of our survey.

Change in Occurrence Limits - Policy Year 2002 to 2003

Amount of Change	Number of Respondents	Total Dollar Amount	Average Dollar Amount
Decreased more than $1,000,000	2	($12,000,000)	($6,000,000)
Decreased $500,001 - $1,000,000	3	($2,500,000)	($833,333)
Decreased $100,001 - $500,000	3	($1,150,000)	($383,333)
Decreased $50,001 - $100,000	0	$0	$0
Decreased $1 - $50,000	0	$0	$0
Increased $0 - $50,000	69	$0	$0
Increased $50,001 - $100,000	0	$0	$0
Increased $100,001 - $500,000	2	$750,000	$375,000
Increased $500,001 - $1,000,000	2	$2,000,000	$1,000,000
Increased more than $1,000,000	1	$4,000,000	$4,000,000
Total	82	($8,900,000)	($108,537)

Similar to per occurrence reductions, annual aggregate limits of liability on average declined, but to a much lesser extent than prior years. However, the decreases continued to outnumber the increases this year (14 to 8) and the cumulative effect of restrictions on aggregate limits between 2000 and 2004 is an average restriction in capacity of approximately $3,000,000.

Change in Annual Aggregate Limits - Policy Years 2002 to 2003

Amount of Change	Number of Respondents	Total Dollar Amount	Average Dollar Amount
Decreased more than $1,000,000	8	($30,500,000)	($3,812,500)
Decreased $500,001 - $1,000,000	6	($6,000,000)	($1,000,000)
Decreased $100,001 - $500,000	0	$0	$0
Decreased $50,001 - $100,000	0	$0	$0
Decreased $1 - $50,000	0	$0	$0
Increased $0 - $50,000	62	$0	$0
Increased $50,001 - $100,000	0	$0	$0
Increased $100,001 - $500,000	0	$0	$0
Increased $500,001 - $1,000,000	3	$3,000,000	$1,000,000
Increased more than $1,000,000	5	$27,750,000	$5,550,000
Total	84	($5,750,000)	($68,452)

Deductible Changes

Contrary to findings in prior years, the majority of respondents (65 of 70 who provided deductible comparisons) reported deductible increases between 2002 and 2003 policy years. These increases represent a restriction in coverage, as deductibles (or retentions) are amounts insureds are required to pay out of pocket prior to accessing policy limits of liability. On average, deductibles increased $180,150, although this is skewed by one respondent that reported an $8 million increase in their deductible. This compares to prior studies' findings that, on average, deductibles increased $97,748 between 2001 and 2002, mostly due to three respondents reporting deductible increases ranging from $175,000 to $4 million. Only one respondent reported a material increase in deductibles between 2000 and 2001 in Aon's February 2002 Long Term Care study.

Change in Per Claim Deductible - Policy Year 2002 to 2003

Amount of Change	Number of Respondents	Total Dollar Amount	Average Dollar Amount
Less than $0	5	($355,000)	($71,000)
$0 - $50,000	53	$140,500	$2,651
$50,001 - $100,000	1	$100,000	$100,000
$100,001 - $500,000	6	$1,025,000	$170,833
$500,001 - $1,000,000	4	$3,700,000	$925,000
Greater than $1,000,000	1	$8,000,000	$8,000,000
Total	70	$12,610,500	$180,150

Of the 29 respondents who reported annual aggregate deductible information, the majority reported very little change in their deductibles between policy year 2002 and 2003. Similar results were found in prior Aon Long Term Care Studies. Four respondents reported an increase in their aggregate deductible since last year; three reported a decrease. On average, aggregate deductibles decreased $379,828.

Change in Annual Aggregate Deductible – Policy Year 2002 to 2003

Amount of Change	Number of Respondents	Total Dollar Amount	Average Dollar Amount
Less than $0	3	($15,515,000)	($5,171,667)
$0 - $50,000	22	$50,000	$2,273
$50,001 - $100,000	0	$0	$0
$100,001 - $500,000	0	$0	$0
$500,001 - $1,000,000	3	$2,450,000	$816,667
Greater than $1,000,000	1	$2,000,000	$2,000,000
Total	29	($11,015,000)	($379,828)

Policy Form Changes

Restrictions in coverage are also evident this year by the increase in the number of respondents who reported converting from occurrence form coverage to the more restrictive claims-made coverage*.

Change in Policy Form – Policy Year 2002 to 2003

Policy Form	2002	2003
Occurrence	40	33
Claims-Made	42	49

*Occurrence form coverage provides insurance coverage for any incident occurring during a policy period, regardless of when it is reported. Claims-made coverage provides reimbursement only for claims reported during the policy period and occurring after a specified retroactive date. While retroactive dates may vary, a first year claims-made policy, where the retroactive date is the beginning of the policy period, only provides a fraction (less than 50% for professional liability coverages) of the coverage of an occurrence policy. A fully mature claims-made policy, where the retroactive date is at least five years prior to the inception of the policy year, typically only provides 90% to 95% of the coverage of an occurrence policy.

Conditions and Limitations

The projections contained in our analysis rely on methods and assumptions that are in accordance with standard actuarial practice. Except where specifically noted, the results of this analysis are based entirely on the loss, exposure and insurance coverage data provided to us by the long term care facilities that responded to the AHCA data call. Readers of this report should keep the following observations in mind:

1. We have relied on this loss, exposure and insurance coverage information without detailed verification or audit other than checks for reasonableness. We do not assume any responsibility for errors or omissions in the data or material provided to us.

2. We have assumed that losses reported to us in the aggregate will develop to higher ultimate amounts by the time all claims arising from incidents that have occurred in the historical period under study are reported and eventually closed. This assumption is based on the historical reporting patterns of the long term care industry and is in accordance with standard actuarial practice. Individual claims will likely develop more or less than the percentage of aggregate development. The adjustments we have made to past experience reflect the average effects of changes in the cost of claims.

3. We have assumed that the losses reported to us represent the unlimited amount of indemnity, ALAE and punitive damages paid and reserved as of the report date. To the extent losses have been limited and/or punitive damages not reported our loss projections might be understated.

4. The losses presented in this report are on a nominal, undiscounted basis. They represent the actual dollars paid on an ultimate basis by the time all claims are closed. No recognition of the time value of money or the cost of capital has been included in our projections.

EXHIBIT 1D

EXHIBIT 3D

5. Except where specifically noted, the loss projections presented in this report are based strictly on the claim detail provided to us and, therefore, are a function of the exposure characteristics of the 108 long term care providers who responded to the data call. Seventeen of these long term care providers, representing a significant portion of exposure, are predominantly multi-facility, for-profit operations providing primarily skilled nursing care. The remaining operators are comprised of regional, state or independent long term care providers, both for-profit and not-for-profit. The large majority of the providers who responded are primarily skilled nursing care operators, although there is some representation by operators of exclusively assisted living facilities. The analyses contained in this report represent a blend of the experience of this varied group of participants. Individual nursing home operators around the country or in the states or state groupings presented in this report may have different loss costs depending on their level of nursing care, profit status, and independence.

6. The report is strictly for the use of the American Health Care Association and its members. In addition, this report is being made available to all long term care providers who participated in the data request. This report may also be released to regulatory authorities. If this report is distributed, the report should be distributed in its entirety. All recipients of this report should be aware that the Aon actuaries who signed the report are available to answer questions about it.

The above notwithstanding, we believe that the projections in this report are reasonable, and are based on sound actuarial methods and assumptions. Our conclusions are subject to the ordinary limitations involved in any actuarial analysis, and must not be viewed as absolute or guaranteed results.

Data Sources

The analyses contained in this report are entirely based on an industry wide call to long term care operators for data on GL/PL claims incurred during the last five to twelve years.

In an effort to present a comprehensive analysis from the perspective of all long term care providers, the American Health Care Association, through its various constituencies disseminated a request for data to independent providers, regional multi-facility providers, non-for-profit providers, national multi-facility providers, and the National Center for Assisted Living. In addition, AHCA contacted state executives of long term care associations and other stake holders and encouraged them to share the data request with their membership in order to encourage greater participation by independently owned facilities.

Using a web-based data survey instrument, long term care providers were given a list of data requirements and instructed to submit their data directly to Aon Risk Consultants, Inc. Among the data elements requested were detailed individual general and professional liability claim information for all claims occurring over the past five to ten years, corresponding historical exposure estimates in the form of occupied beds, and specifics regarding insurance coverage terms during the latest two policy years. Data was collected and compiled between the end of September 2003 and early December 2003. In order to ensure the quality of each data submission, there was extensive correspondence with providers via email, telephone, fax, and written correspondence during this period.

108 long term care providers responded to our call in whole or in part. The respondents range in size from independent single facility operators to large national multi-facility companies. Operators responded from forty-nine states (all except Alaska) and the District of Columbia. Seventeen of the respondents are for-profit, multi-facility long term care providers with facilities in numerous states. Twenty of the respondents are regional operators with facilities in at least two but no more than five states. The remaining seventy-one respondents are small independent operators concentrated in one state with one or more facilities. Most of the respondents provide primarily skilled nursing care, although twelve of the respondents are strictly assisted or independent living facility operators.

In developing the benchmarks presented in this report we have relied on the following data.

- **Individual claim detail** – This database is a compilation of 28,441 non-zero long term care general/professional liability claims occurring over the past twelve years. The information included by individual claim is status, accident date, report date, close date, accident state, indemnity paid, allocated loss adjustment expense paid, total paid, indemnity incurred, allocated loss adjustment expense incurred, and total incurred.

- **Historical Loss Development Triangles** – Incurred and paid loss development factors and claim count development factors are derived from a consolidation of the reporting patterns of eight of the largest long term care providers. These eight providers represent approximately 77% of the loss data reported to us. Historical reporting patterns are not available from the other long term care providers. However, the similarity of the patterns for the eight reporting providers and the credibility of the consolidated development pattern justify the use of these patterns to estimate ultimate development for the group of providers as a whole.

- **Occupied Beds** – Annual occupied bed counts corresponding to the years for which loss experience is provided are utilized in this analysis to develop the relative loss cost per bed. Annual licensed bed counts are multiplied by average occupancy rates to derive annual occupied beds. For long term care providers who could not provide average occupancy rates an occupancy rate of 89% is assumed. For all states combined, there are approximately 470,000 licensed beds of which approximately 420,000 are occupied.

- **Industry Bed Counts** – For purposes of determining the percentage of nursing home beds in a particular state, our study utilized the Centers for Medicare & Medicaid Services OSCAR Data Current Surveys, June 2003. Actual percentages shown are calculated by dividing our skilled equivalent beds to this industry source. However, the number of licensed beds stated in any individual state section reflect the total number of beds (including independent living, assisted living and other levels of care) obtained for the purpose of this study.

- **Medicaid Reimbursement Rates** – Average Medicaid per diem reimbursement rates by state are based on rates provided in the testimony of Thomas A. Scully, Administrator, Centers for Medicare & Medicaid Services on nursing home quality before the Senate Finance Committee on Thursday, July 17, 2003. This is a different and more current source than that used in prior Aon studies. This change may contribute to slightly different average Medicaid reimbursement rates. The 2003 year is projected by Aon based on prior year trends. Countrywide average rates are derived by weighting state rates by the occupied beds by state from the study participants.

Definitions

The following definitions are provided to help the users of this report fully understand the analyses presented and the resulting conclusions.

ALAE

ALAE is an abbreviation for allocated loss adjustment expense. ALAE refers to costs, in addition to indemnity payments and reserves, which are incurred in handling claims. Typically, these costs are comprised of legal fees paid by the insured entity in investigating and defending claims. In the context of this study ALAE represents defense costs. The majority of claim data used in this study contained a separate field to identify ALAE costs separately from indemnity costs. Whether separately identified or not, allocated loss adjustment expenses are included in the reported loss information, loss reserving methodologies and loss projections contained in this report. All references to losses throughout our report and exhibits include ALAE except where noted otherwise.

Claim

A claim is a demand by an individual or other entity to recover for a loss. It may involve a formal lawsuit but not necessarily, especially in the case of a general liability claim.

Deductible

A deductible is a layer of loss retained by an insured entity. The insured pays amounts below the deductible and the insurance company pays amounts above the deductible. The higher the deductible the lower the commercial insurance premium. However, this is largely offset by the cost of the portion of claims below the deductible.

Retention is another word commonly used to refer to a deductible. Companies with high deductibles, or retentions, are commonly referred to as self-insured.

A deductible can apply on a per occurrence basis, that is for each individual loss, and/or on an aggregate basis for a given period of time. A typical GL/PL deductible for the health care industry may be expressed as $1,000,000/$3,000,000, meaning $1 million per occurrence and $3 million in the aggregate for the year. With this deductible the insured is responsible for paying

the first $1 million of each claim, subject to a maximum total of $3 million for the year.

Deductibles can apply to the indemnity portion of losses only or the combined cost of indemnity and ALAE.

The losses included in this report are prior to the application of any deductible or retention. That is, they represent the total amount of loss from first dollar to the unlimited reported amount.

Defense Costs

In the context of this report, defense costs include attorneys' fees and other directly allocable costs associated with defending a company against GL/PL claims.

Exposure

Actuaries select an exposure base such that the incidence of claims will tend to vary directly with the exposure of the entity at risk. The actuary must consider both the historical loss level and the corresponding exposures in evaluating historical claim liabilities and expected future costs. It is important to choose an exposure measure that is relevant to the unique situation of each risk group.

In this study we use an exposure base of occupied beds. Occupied beds are calculated by multiplying the number of licensed beds by the average annual occupancy rate. There is a strong correlation between the number of occupied beds and the total amount of losses incurred by a long term care facility. Not all beds are equal in terms of their risk exposure, however. An assisted living bed generates fewer dollars of GL/PL claim activity than a skilled care bed. We have adjusted all beds in this study to the equivalent of a skilled nursing care bed.

By dividing losses by exposures we develop comparative estimates of the long term care industry GL/PL loss costs between states, types of facilities (multi-chain vs. independent) and years of operation.

Frequency

Frequency is the ratio of the number of claims divided by exposures. In this report we measure frequency on an annual basis as the number of claims projected for the given time period divided by the number of occupied beds during that same period. In our summary exhibits we present frequency as the number of claims a year for every 1,000 beds.

General Liability (GL)

General liability exposure generally relates to those sums an entity becomes legally obligated to pay as damages because of a bodily injury (typically including personal and advertising injury) or property damage.

Indemnity

Indemnity refers to the component of claim costs actually paid or reserved to be paid to the plaintiff. Indemnity costs include both the amount provided for the plaintiff, either as a jury award or a settlement, and the amount retained by the plaintiff's attorney. However, in most claim files, including those used to do this study, the split between plaintiff award and plaintiff attorney is not provided. Indemnity may also include punitive damages, although this is not consistently treated among companies.

Limit of Liability

A limit of liability is a maximum amount of coverage provided by an insurance transaction. Above the limit of liability, the insured is responsible for all losses. Limits of liability may be expressed on a per occurrence basis or an aggregate basis, similar to deductibles. The losses included in this study are not limited.

Loss Cost

Loss cost is the cost per exposure of settling and defending claims. Loss cost is calculated as the ratio of total dollars of losses (indemnity and ALAE) to total exposures for a given period of time. In this report exposures are selected to be occupied beds and the time period is one year. Consequently, a loss cost represents the annual amount per occupied bed expected to be paid to defend, settle and/or litigate GL/PL claims arising from incidents occurring during the respective year.

Loss Development

Loss development refers to the change in the estimated value of losses attributable to a body of claims or to a time period until all the claims are closed.

Generally, the reported losses will increase over time for several reasons. First, it is impossible to estimate precisely the ultimate losses and legal expenses for claims when they are initially reported. The estimated unpaid loss for a claim, called a case reserve, is adjusted up or down as more information is obtained. In the aggregate, the upward adjustments tend to be greater than the downward ones. Second, it takes a period of time for some claims to be discovered, reported, and recorded. Claims that have been incurred but have not been reported are called "pure" IBNR claims. Third, closed claims are sometimes reopened. This may be due to legislation, which applies retroactively to claims that have closed. In this report, except where specifically noted, projected loss costs, frequencies and severities by state and by year are all inclusive of actuarially indicated expected loss development.

Loss development also refers to the increase in paid losses as claims are reported, paid to their ultimate values, and closed.

Loss Trend

Loss trend is the change in claim frequency and/or severity from one time period to the next. Factors that affect the frequency and severity of claims are constantly changing over time. Examples of causes include inflation, societal attitudes toward legal action, and changes in laws. Actuaries use trend factors to adjust historical loss experience to comparable levels.

Premium

Premium is the amount paid to an insurance entity to cover costs associated with claims arising from a specifically defined risk. In the context of this report, premium refers to the premium paid for GL/PL insurance. Premium generally is developed as the expected loss cost for the period of coverage plus other underwriting expenses including commission, premium taxes, and general expenses incurred operating an insurance company.

Professional Liability (PL)

Professional liability exposure relates to those sums an entity becomes legally obligated to pay as damages and associated claims and defense expenses because of a negligent act, error or omission in the rendering or failure to render professional services.

Severity

Severity refers to the total dollar amount of a claim including indemnity and ALAE. In this report we measure the average severity for a given year by dividing the total dollars of losses for all claims incurred in the year by the total number of claims.

Underwriting Expenses

Underwriting expenses are expenses incurred in writing commercial insurance in addition to claim (indemnity and ALAE) expenses. Underwriting expenses generally include commission paid to agents and brokers, premium taxes and other general expenses incurred operating an insurance company. Underwriting expenses, when added to claim expenses, represent the total cost underlying commercial insurance premium. In this study we present only the loss costs associated with GL/PL claims. Underwriting expenses are in addition to these costs where GL/PL exposure is commercially insured.

[redacted]

[redacted]

AB 2791

SUPPORT
5 Organizations
1 Individual

OPPOSE
[redacted]
459 Individuals
169 = 628
[redacted]

Excerpted re Form Letter We have included the 1st 3

HELIOS
HEALTHCARE, LLC

April 20, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RECEIVED APR 28 2004

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

- AB 2791 would create yet another avenue for frivolous litigation and impose even greater financial burdens on an already financially strapped system - forcing more and more long-term care providers out of business and putting an entire system of care at risk.

- California utilizes a broad definition to capture resident rights in very general ways. Under AB 2791, this broad definition is stretched ever further becoming a "catch-all" violation, inviting more frivolous litigation. AB 2791 does nothing to enhance or promote resident care and dignity – all it does is put more money into attorneys' pockets while putting long-term care facilities out of business.

- There doesn't appear to be a need for increased penalties since six of the 10 best U.S. cities for nursing-facility care are right here in California, according to a new study by Health Grades, a leading independent health-care rating company. Nationwide, Health Grades ranks Los Angeles as the best major city for nursing-facility care. Long Beach, San Diego, San Francisco and Fresno are fourth through seventh, respectively, and San Jose ranks 10th. None of the 10 worst cities are in California.

California nursing homes are among the most heavily regulated professions, subject to comprehensive annual surprise inspections. Nearly 300 state survey staff from the Department of Health Services spend an average of 200 hours in each facility, each year.

HAMPTON CARE CENTER
442 Hampton Street
Stockton, CA 95204
(209) 466-0456
(209) 466-8140

If you have any questions, please give me a call at 209-466-0456.

Sincerely,

Esther Sokodolo CNA

HELIOS
HEALTHCARE, LLC

April 20, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

- AB 2791 would create yet another avenue for frivolous litigation and impose even greater financial burdens on an already financially strapped system - forcing more and more long-term care providers out of business and putting an entire system of care at risk.

- California utilizes a broad definition to capture resident rights in very general ways. Under AB 2791, this broad definition is stretched ever further becoming a "catch-all" violation, inviting more frivolous litigation. AB 2791 does nothing to enhance or promote resident care and dignity – all it does is put more money into attorneys' pockets while putting long-term care facilities out of business.

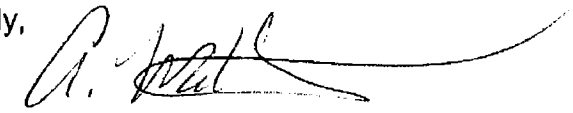
- There doesn't appear to be a need for increased penalties since six of the 10 best U.S. cities for nursing-facility care are right here in California, according to a new study by Health Grades, a leading independent health-care rating company. Nationwide, Health Grades ranks Los Angeles as the best major city for nursing-facility care. Long Beach, San Diego, San Francisco and Fresno are fourth through seventh, respectively, and San Jose ranks 10th. None of the 10 worst cities are in California.

California nursing homes are among the most heavily regulated professions, subject to comprehensive annual surprise inspections. Nearly 300 state survey staff from the Department of Health Services spend an average of 200 hours in each facility, each year.

HAMPTON CARE CENTER
442 Hampton Street
Stockton, CA 95204
(209) 466-0456
(209) 466-8140

If you have any questions, please give me a call at 209-466-0456.

Sincerely,



HELIOS
HEALTHCARE, LLC

April 20, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

- AB 2791 would create yet another avenue for frivolous litigation and impose even greater financial burdens on an already financially strapped system - forcing more and more long-term care providers out of business and putting an entire system of care at risk.

- California utilizes a broad definition to capture resident rights in very general ways. Under AB 2791, this broad definition is stretched ever further becoming a "catch-all" violation, inviting more frivolous litigation. AB 2791 does nothing to enhance or promote resident care and dignity – all it does is put more money into attorneys' pockets while putting long-term care facilities out of business.

- There doesn't appear to be a need for increased penalties since six of the 10 best U.S. cities for nursing-facility care are right here in California, according to a new study by Health Grades, a leading independent health-care rating company. Nationwide, Health Grades ranks Los Angeles as the best major city for nursing-facility care. Long Beach, San Diego, San Francisco and Fresno are fourth through seventh, respectively, and San Jose ranks 10th. None of the 10 worst cities are in California.

California nursing homes are among the most heavily regulated professions, subject to comprehensive annual surprise inspections. Nearly 300 state survey staff from the Department of Health Services spend an average of 200 hours in each facility, each year.

HAMPTON CARE CENTER
442 Hampton Street
Stockton, CA 95204
(209) 466-0456
(209) 466-8140

If you have any questions, please give me a call at 209-466-0456.

Sincerely, Valerie Rucker

Excerpted re form Letter, we have included the 1st 3

La Veta Healthcare Center

A Kindred Community

April 22, 2004

RECEIVED APR 27 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, Ca 95814

Re: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 which would raise the penalty for a resident rights violation from $500 up to $5,000 per violation.

AB 2791 would create yet another avenue for frivolous litigation and impose even greater financial burdens on an already financially strapped system, forcing more and more long-term care facilities out of business and put the entire system of resident care at risk.

Being that California utilizes a broad definition to capture resident rights in very general ways, AB 2791 will only stretch this definition even further becoming a "catch-all" violation. Therefore, AB 2791 does nothing to enhance or promote the care and dignity of residents. All it does is put more and more money in to attorneys' pockets while putting more long-term care facilities out of business.

Furthermore, resident rights violations have nothing to do with the quality of care provided to residents. Rather, they include situations such as using the privacy curtain, caregivers speaking a language other then that of the resident or failure to provide alternate food options on the menu. These are situations that may be frustrating to residents, but they do not put residents in jeopardy of harm and do not affect the care they are given.

In conclusion, I also ask that you take into consideration the fact that California already has six of the ten best cities for nursing-facility care, according to a recent study by Health Grades, and none of the worst.

Sincerely,

Rafael Madrigal
Resident
La Veta

920 West La Veta Avenue Orange, California 92868
714.633.3568 714.633.3746 Fax

La Veta Healthcare Center

A Kindred Community

April 22, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, Ca 95814

Re: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 which would raise the penalty for a resident rights violation from $500 up to $5,000 per violation.

AB 2791 would create yet another avenue for frivolous litigation and impose even greater financial burdens on an already financially strapped system, forcing more and more long-term care facilities out of business and put the entire system of resident care at risk.

Being that California utilizes a broad definition to capture resident rights in very general ways, AB 2791 will only stretch this definition even further becoming a "catch-all" violation. Therefore, AB 2791 does nothing to enhance or promote the care and dignity of residents. All it does is put more and more money in to attorneys' pockets while putting more long-term care facilities out of business.

Furthermore, resident rights violations have nothing to do with the quality of care provided to residents. Rather, they include situations such as using the privacy curtain, caregivers speaking a language other then that of the resident or failure to provide alternate food options on the menu. These are situations that may be frustrating to residents, but they do not put residents in jeopardy of harm and do not affect the care they are given.

In conclusion, I also ask that you take into consideration the fact that California already has six of the ten best cities for nursing-facility care, according to a recent study by Health Grades, and none of the worst.

Sincerely,

920 West La Veta Avenue Orange, California 92868
714.633.3568 714.633.3746 Fax

La Veta Healthcare Center

A Kindred Community

April 22, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, Ca 95814

RECEIVED APR 2...

Re: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 which would raise the penalty for a resident rights violation from $500 up to $5,000 per violation.

AB 2791 would create yet another avenue for frivolous litigation and impose even greater financial burdens on an already financially strapped system, forcing more and more long-term care facilities out of business and put the entire system of resident care at risk.

Being that California utilizes a broad definition to capture resident rights in very general ways, AB 2791 will only stretch this definition even further becoming a "catch-all" violation. Therefore, AB 2791 does nothing to enhance or promote the care and dignity of residents. All it does is put more and more money in to attorneys' pockets while putting more long-term care facilities out of business.

Furthermore, resident rights violations have nothing to do with the quality of care provided to residents. Rather, they include situations such as using the privacy curtain, caregivers speaking a language other then that of the resident or failure to provide alternate food options on the menu. These are situations that may be frustrating to residents, but they do not put residents in jeopardy of harm and do not affect the care they are given.

In conclusion, I also ask that you take into consideration the fact that California already has six of the ten best cities for nursing-facility care, according to a recent study by Health Grades, and none of the worst.

Sincerely,

Rosalia Villarreal
work in la veta

920 West La Veta Avenue Orange, California 92868
714.633.3568 714.633.3746 Fax

Victorian Healthcare Center

A Kindred Community

April 21, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

AB 2791 would create yet another avenue for frivolous litigation and impose even greater financial burdens on an already financially strapped system – forcing more and more long-term care providers out of business and putting an entire system of care at risk.

Patient rights violations have nothing to do with quality of care issues. Rather, they include such situations as a privacy curtain left open, a caregiver speaking in a different language than the patient or the failure to provide an alternative food option on the menu. While perhaps frustrating to the patient, these actual incidents rarely place a patient in any jeopardy.

If you have any questions, please give a call at 415-922-5085.

Sincerely,

Galla Pikovsky
Business Office Manager

2121 Pine Street San Francisco, California 94115
415.922.5085 415.563.2170 Fax

FOO AKS
C TER

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

3400 Bell Road • Auburn, California 95603 • (530) 888-6257 • FAX (530) 888-7298

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Sylvia Zaininger
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

Ex re Form Letter. We have included the 1st 3 2004

Marina Care Center

5240 Sepulveda Blvd • Culver City, CA 90230 • Phone (310) 391-7266 • Fax (310) 397-4998

FAX (916) 319-2197

April 20, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn;

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

California utilizes a broad definition to capture resident rights in very general ways. Under AB 2791, this broad definition is stretched even further becoming a "catch-all" violation, inviting more frivolous litigation. AB 2791 does nothing to enhance or promote resident care and dignity – all it does is put more money into attorney's pockets while putting long-term care facilities out of business.

Furthermore, there does not appear to be a need for increased penalties since six of the 10 best U.S. cities for nursing-facility care are right here in California, according to a new study by Health Grades, a leading independent health-care rating company. Nationwide, Health Grades ranks Los Angeles as the best major city for nursing-facility care. Long Beach, San Diego, San Francisco and Fresno are fourth through seventh, respectively, and San Jose ranks 10th. None of the 10 worst cities are in California.

Finally, California nursing homes are among the most heavily regulated professions, subject to comprehensive annual surprise inspections. Nearly, 300 state survey staff from the Department of Health Services spend an average of 200 hours in each facility, each year.

Sincerely,

Marina Care Center

5240 Sepulveda Blvd • Culver City, CA 90230 • Phone (310) 391-7266 • Fax (310) 397-4998

FAX (916) 319-2197

April 20, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn;

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

California utilizes a broad definition to capture resident rights in very general ways. Under AB 2791, this broad definition is stretched even further becoming a "catch-all" violation, inviting more frivolous litigation. AB 2791 does nothing to enhance or promote resident care and dignity – all it does is put more money into attorney's pockets while putting long-term care facilities out of business.

Furthermore, there does not appear to be a need for increased penalties since six of the 10 best U.S. cities for nursing-facility care are right here in California, according to a new study by Health Grades, a leading independent health-care rating company. Nationwide, Health Grades ranks Los Angeles as the best major city for nursing-facility care. Long Beach, San Diego, San Francisco and Fresno are fourth through seventh, respectively, and San Jose ranks 10th. None of the 10 worst cities are in California.

Finally, California nursing homes are among the most heavily regulated professions, subject to comprehensive annual surprise inspections. Nearly, 300 state survey staff from the Department of Health Services spend an average of 200 hours in each facility, each year.

Sincerely,

Gwendolyn Howard

APR 2004

Marina Care Center

5240 Sepulveda Blvd • Culver City, CA 90230 • Phone (310) 391-7266 • Fax (310) 397-4998

FAX (916) 319-2197

April 20, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn;

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

California utilizes a broad definition to capture resident rights in very general ways. Under AB 2791, this broad definition is stretched even further becoming a "catch-all" violation, inviting more frivolous litigation. AB 2791 does nothing to enhance or promote resident care and dignity – all it does is put more money into attorney's pockets while putting long-term care facilities out of business.

Furthermore, there does not appear to be a need for increased penalties since six of the 10 best U.S. cities for nursing-facility care are right here in California, according to a new study by Health Grades, a leading independent health-care rating company. Nationwide, Health Grades ranks Los Angeles as the best major city for nursing-facility care. Long Beach, San Diego, San Francisco and Fresno are fourth through seventh, respectively, and San Jose ranks 10th. None of the 10 worst cities are in California.

Finally, California nursing homes are among the most heavily regulated professions, subject to comprehensive annual surprise inspections. Nearly, 300 state survey staff from the Department of Health Services spend an average of 200 hours in each facility, each year.

Sincerely,

Ex re Form Letter. We have included the 1st 3

Mission Carmichael
HealthCare Center

APR 20 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95815

April 20, 2004

Dear Assembly Member Cohn,

RE: AB 2791 OPPOSE

I am writing to express my opposition to AB 2791 (Smitian), which would raise the penalty for a resident's rights violation from $500 up to $5000 per violation.

California nursing homes are among the most heavily regulated professions, subject to comprehensive annual surprise inspections. Nearly 300 state survey staff from the Department of Health Services spends an average of 200 hours in each facility, each year.

AB 2791 would create yet another avenue for frivolous litigation and impose even greater financial burdens on an already financially strapped system- forcing more and more long term care providers out of business and putting an entire system of care at risk.

I am a proud caring health care giver to the elderly, no more new regulations, there are enough now.

Sincerely,

Marie Cava
(UNIT SECRETARY)

7620 Mission Avenue ▲ Carmichael, CA 95608-2933 ▲ Tel: 916-488-1580 ▲ Fax: 916-488-7634

Apr-20-04 14:12 From-Mission Carmichael 9164887634 T-618 P.026/026 F-424

Mission Carmichael
HealthCare Center

APR 2 0 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95815

April 20, 2004

Dear Assembly Member Cohn, RE: AB 2791 OPPOSE

I am writing to express my opposition to AB 2791 (Smitian), which would raise the penalty for a resident's rights violation from $500 up to $5000 per violation.

California nursing homes are among the most heavily regulated professions, subject to comprehensive annual surprise inspections. Nearly 300 state survey staff from the Department of Health Services spends an average of 200 hours in each facility, each year.

AB 2791 would create yet another avenue for frivolous litigation and impose even greater financial burdens on an already financially strapped system- forcing more and more long term care providers out of business and putting an entire system of care at risk.

I am a proud caring health care giver to the elderly, no more new regulations, there are enough now.

Sincerely,

Joyce Dremonero

▲ Tel: 916-488-1580 ▲ Fax: 916-488-7634

Mission Carmichael
HealthCare Center

APR 2 0 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95815

April 20, 2004

Dear Assembly Member Cohn, RE: AB 2791 OPPOSE

I am writing to express my opposition to AB 2791 (Smitian), which would raise the penalty for a resident's rights violation from $500 up to $5000 per violation.

California nursing homes are among the most heavily regulated professions, subject to comprehensive annual surprise inspections. Nearly 300 state survey staff from the Department of Health Services spends an average of 200 hours in each facility, each year.

AB 2791 would create yet another avenue for frivolous litigation and impose even greater financial burdens on an already financially strapped system- forcing more and more long term care providers out of business and putting an entire system of care at risk.

I am a proud caring health care giver to the elderly, no more new regulations, there are enough now.

Sincerely,

Monica Moreno
CNA

3630 Mission Avenue ▲ Carmichael, CA 95608-2933 ▲ Tel: 916-488-1580 ▲ Fax: 916-488-7634

Ex re. Form letter we have included the 1st 3

Bayside Care Center

April 22, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn,

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

AB 2791 would create yet another avenue for frivolous litigation and impose even greater financial burdens on an already financially strapped system -- forcing more and more long-term care providers out of business.

Patient rights are certainly important, but these violations have nothing to do with quality care issues. Rather they include such situations as a privacy curtain open, a resident being inadequately covered while being moved to shower room, or failing to provide alternative menu selections. While these are frustrating to residents, such incidents rarely put a resident in jeopardy.

Please vote to oppose AB 2791 (Simitian).

If you have any questions regarding this piece of legislation or any other issues related to our business of "…people, caring for people, caring for people…," please feel free to contact me at (805) 772-2237.

Sincerely,

Linda D Essegian, SL

1405 Teresa Drive Morro Bay, CA 93442 Telephone: (805) 772-2237

Bayside Care Center

April 22, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn,

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

AB 2791 would create yet another avenue for frivolous litigation and impose even greater financial burdens on an already financially strapped system – forcing more and more long-term care providers out of business.

Patient rights are certainly important, but these violations have nothing to do with quality care issues. Rather they include such situations as a privacy curtain open, a resident being inadequately covered while being moved to shower room, or failing to provide alternative menu selections. While these are frustrating to residents, such incidents rarely put a resident in jeopardy.

Please vote to oppose AB 2791 (Simitian).

If you have any questions regarding this piece of legislation or any other issues related to our business of "...people, caring for people, caring for people...," please feel free to contact me at (805) 772-2237.

Sincerely,

Marianne Standen

1405 Teresa Drive Morro Bay, CA 93442 Telephone: (805) 772-2237

Bayside Care Center

April 22, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn,

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

AB 2791 would create yet another avenue for frivolous litigation and impose even greater financial burdens on an already financially strapped system – forcing more and more long-term care providers out of business.

Patient rights are certainly important, but these violations have nothing to do with quality care issues. Rather they include such situations as a privacy curtain open, a resident being inadequately covered while being moved to shower room, or failing to provide alternative menu selections. While these are frustrating to residents, such incidents rarely put a resident in jeopardy.

Please vote to oppose AB 2791 (Simitian).

If you have any questions regarding this piece of legislation or any other issues related to our business of "...people, caring for people, caring for people..." please feel free to contact me at (805) 772-2237.

Sincerely,

Lorraine Adelberg, LNHA

April 22, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn,

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

A basic premise in this country is that "the penalty should fit the crime." Patient rights are certainly important, but these violations have nothing to do with quality care issues. Rather they include such situations as a privacy curtain open, a resident being inadequately covered while being moved to shower room, or failing to provide alternative menu selections. While these are frustrating to residents, such incidents rarely put a resident in jeopardy.

MediCal reimbursement allows nurse aides to be paid from $8-$12 an hour. In our facilities we constantly in-service all staff on resident rights and the sanctity of the freedoms for which our forefathers fought. Taking money from our system lessens the money available for payroll and training and has greater potential to hurt quality care. Higher fines create greater interest by the civil bar, leading to more lawsuits and more distractions for our already over-burdened caregivers.

Please vote to oppose AB 2791 (Simitian).

If you have any questions regarding this piece of legislation or any other issues related to our business of "...people, caring for people, caring for people...," please feel free to contact me at (805) 474-7010 ext. 112.

Sincerely,

Amy Carpenter-Smith

Amy Carpenter-Smith

April 22, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn,

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

A basic premise in this country is that "the penalty should fit the crime." Patient rights are certainly important, but these violations have nothing to do with quality care issues. Rather they include such situations as a privacy curtain open, a resident being inadequately covered while being moved to shower room, or failing to provide alternative menu selections. While these are frustrating to residents, such incidents rarely put a resident in jeopardy.

MediCal reimbursement allows nurse aides to be paid from $8-$12 an hour. In our facilities we constantly in-service all staff on resident rights and the sanctity of the freedoms for which our forefathers fought. Taking money from our system lessens the money available for payroll and training and has greater potential to hurt quality care. Higher fines create greater interest by the civil bar, leading to more lawsuits and more distractions for our already over-burdened caregivers.

Please vote to oppose AB 2791 (Simitian).

If you have any questions regarding this piece of legislation or any other issues related to our business of "...people, caring for people, caring for people...," please feel free to contact me at (805) 474-7010 ext. 112.

Sincerely,

PAUL WILKES

APR 23 2004

April 22, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn,

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

A basic premise in this country is that "the penalty should fit the crime." Patient rights are certainly important, but these violations have nothing to do with quality care issues. Rather they include such situations as a privacy curtain open, a resident being inadequately covered while being moved to shower room, or failing to provide alternative menu selections. While these are frustrating to residents, such incidents rarely put a resident in jeopardy.

MediCal reimbursement allows nurse aides to be paid from $8-$12 an hour. In our facilities we constantly in-service all staff on resident rights and the sanctity of the freedoms for which our forefathers fought. Taking money from our system lessens the money available for payroll and training and has greater potential to hurt quality care. Higher fines create greater interest by the civil bar, leading to more lawsuits and more distractions for our already over-burdened caregivers.

Please vote to oppose AB 2791 (Simitian).

If you have any questions regarding this piece of legislation or any other issues related to our business of "...people, caring for people, caring for people...," please feel free to contact me at (805) 474-7010 ext. 112.

Sincerely,

Suzie Craig

Suzie Craig

Victorian Healthcare Center

A Kindred Company

April 21, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

AB 2791 would create yet another avenue for frivolous litigation and impose even greater financial burdens on an already financially strapped system – forcing more and more long-term care providers out of business and putting an entire system of care at risk.

Patient rights violations have nothing to do with quality of care issues. Rather, they include such situations as a privacy curtain left open, a caregiver speaking in a different language than the patient or the failure to provide an alternative food option on the menu. While perhaps frustrating to the patient, these actual incidents rarely place a patient in any jeopardy.

If you have any questions, please give a call at 415-922-5085.

2121 Pine Street San Francisco, California 94115
415.922.5085 415.563.2170 Fax

Linwood Gardens
Convalescent Hospital

4444 W. Meadow Lane • Visalia, CA 93277 • (559) 627-1241 • Fax (559) 627-2809

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Robert Barker
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

Vineyard Hills Health Center
290 Heather Court • Templeton, CA 93465 • (805) 434-3035 • Fax: (805) 434-3065

April 23, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn,

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

A basic premise in this country is that "the penalty should fit the crime." Patient rights are certainly important, but these violations have nothing to do with quality care issues. Rather they include such situations as a privacy curtain open, a resident being inadequately covered while being moved to shower room, or failing to provide alternative menu selections. While these are frustrating to residents, such incidents rarely put a resident in jeopardy.

MediCal reimbursement allows nurse aides to be paid from $8-$12 an hour. In our facilities we constantly in-service all staff on resident rights and the sanctity of the freedoms for which our forefathers fought. Taking money from our system lessens the money available for payroll and training and has greater potential to hurt quality care. Higher fines create greater interest by the civil bar, leading to more lawsuits and more distractions for our already over-burdened caregivers.

Please vote to oppose AB 2791 (Simitian).

If you have any questions regarding this piece of legislation or any other issues related to our business of "...people, caring for people, caring for people...," please feel free to contact me at (805) 474-7010 ext. 112.

Sincerely,
Katherine Valdez

Vineyard Hills Health Center
290 Heather Court • Templeton,CA 93465 • (805) 434-3035 • Fax: (805) 434-3065

April 23, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn,

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

A basic premise in this country is that "the penalty should fit the crime." Patient rights are certainly important, but these violations have nothing to do with quality care issues. Rather they include such situations as a privacy curtain open, a resident being inadequately covered while being moved to shower room, or failing to provide alternative menu selections. While these are frustrating to residents, such incidents rarely put a resident in jeopardy.

MediCal reimbursement allows nurse aides to be paid from $8-$12 an hour. In our facilities we constantly in-service all staff on resident rights and the sanctity of the freedoms for which our forefathers fought. Taking money from our system lessens the money available for payroll and training and has greater potential to hurt quality care. Higher fines create greater interest by the civil bar, leading to more lawsuits and more distractions for our already over-burdened caregivers.

Please vote to oppose AB 2791 (Simitian).

If you have any questions regarding this piece of legislation or any other issues related to our business of "...people, caring for people, caring for people...," please feel free to contact me at (805) 474-7010 ext. 112.

Sincerely,

María Sullivan

Vineyard Hills Health Center
290 Heather Court • Templeton,CA 93465 • (805) 434-3035 • Fax: (805) 434-3065

April 23, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn,

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

A basic premise in this country is that "the penalty should fit the crime." Patient rights are certainly important, but these violations have nothing to do with quality care issues. Rather they include such situations as a privacy curtain open, a resident being inadequately covered while being moved to shower room, or failing to provide alternative menu selections. While these are frustrating to residents, such incidents rarely put a resident in jeopardy.

MediCal reimbursement allows nurse aides to be paid from $8-$12 an hour. In our facilities we constantly in-service all staff on resident rights and the sanctity of the freedoms for which our forefathers fought. Taking money from our system lessens the money available for payroll and training and has greater potential to hurt quality care. Higher fines create greater interest by the civil bar, leading to more lawsuits and more distractions for our already over-burdened caregivers.

Please vote to oppose AB 2791 (Simitian).

If you have any questions regarding this piece of legislation or any other issues related to our business of "...people, caring for people, caring for people...," please feel free to contact me at (805) 474-7010 ext. 112.

Sincerely,

Dina González

HELIOS
HEALTHCARE, LLC

April 20, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

APR 2 0 2004

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian) which would raise the penalty for a resident's rights violation from $500.00 up to $5000.00 per violation.

Resident rights in a facility are not related to quality of care. It usually is related to a curtain not being pulle closed, a staff member calling the resident by an endearing name rather then Mr. or Mrs. or by the resident's first name. The facilities promote resident rights as if it were the bible for long term care.

We are continually working towards enhancing the quality of life of each of our residents, and maintaining quality care through quality improvement committees. We are already one of the highest regulated industries, and we are subject to annual surprise inspections, with Department of Health staff spending many hours in eacl facility annually.

If you have any questions, please do not hesitate to call me at (530) 246- 0600.

Sincerely,

Pamela K. Eiszele
Administrator

REDDING CARE CENTER
2490 COURT STREET
REDDING, CA 96001
OFFICE: 530.246.0600
FAX: 530.246.0558

Western Care
Construction Company, Inc.
4020 Sierra College Blvd. #200
Rocklin, California 95677
(916) 624-6200

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

April 19, 2004

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation. We do not want to offend anyone in the legislature by stating our opposition. We understand the concern for a resident's well-being.

However, the reality is that the nursing home industry is in crisis. Long Term Care providers have faced a wave of litigation due to the enhanced remedies and the broad definition of neglect under the Elder Abuse Act (EADACPA). This in turn has caused our liability premiums to skyrocket. (From $300 per bed per year in 1999 to more than $2,500 in 2003). All publicly traded companies except two, Manor Care and Beverly, went into bankruptcy during the last few years, along with 20% of privately held companies - due in large part to under-funding by the sponsor programs. California significantly under-funds Medi-Cal. It costs $150-$160 per day to care for one Medi-Cal patient, but reimbursement is $118. If the Medi-Cal reimbursement rate were appropriately set at $150-$200 per day, the provider would not quarrel over a fine when in the wrong; *but first they must have adequate funding to care for the patients properly.* Adding higher fines into the equation is not logical nor responsible. To under-fund a program while adding increasing fines seems hypocritical.

Adequate remedies do exist to protect residents against violations of resident's rights through existing measures, and are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, etc.), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000, and for any civil damages awarded under the EADACPA.

In my view, AB 2791 will make the overall situation worse without adding anything to improve resident care. I urge you to vote "No" on AB 2791.

Sincerely,

Martin A. Harmon
Chairman of the Board
Western Care Construction Company

MAH/pag0404.16

cc: California Association of Health Facilities (CAHF)
Assemblyman Joe Simitian

April 19, 2004

Napa Nursing Center

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees, and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

3275 Villa Lane • Napa, California 94558 • Phone: 707-257-0931 • Fax: 707-257-0936

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Georgia Otterson
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

Placerville Pines
Convalescent Hospital, Inc.
1040 Marshall Way • Placerville, CA 95667
(530) 622-3400 *phone* • (530) 622-1560 *fax*

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of

another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Bradley J. Wilcox
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

Linwood Gardens
Convalescent Hospital

4444 W. Meadow Lane • Visalia, CA 93277 • (559) 627-1241 • Fax (559) 627-2809

April 19, 2004

APR 19 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim – for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Robert Barker
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

Westgate Gardens Convalescent Center
4525 West Tulare Avenue
Visalia, California 93277
Phone (559) 733-0901 Fax (559) 733-8757

April 19, 2004

APR 19 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Ralph Agnello
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

MONTEREY PINES
SKILLED NURSING FACILITY

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

~~APR 19 2004~~

APR 20 2004

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Gene Sajcich
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

HILLTOP MANOR
CONVALESCENT HOSPITAL

April 19, 2004

APR 19 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on

12225 Shale Ridge Lane • Auburn, CA 95602 • (530) 885-7511 • Fax: (530) 885-1845

HELIOS
HEALTHCARE, LLC

4-20-04

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB2791 (Simitian), it would raise the penalty for a resident's rights violation from $500 to $5,000 per violation. There doesn't appear to be a need for increased penalties since six of the 10 best U.S. cities for nursing-facility care are right here in California, according to a new study by Health Grades, a leading independent health-care rating company. Nationwide, Health Grades ranks Los Angeles as the best major city for nursing-facility care. Long Beach, San Diego, San Francisco and Fresno are fourth through seventh, respectively, and San Jose ranks 10th. None of the 10 worst cities are in California. Our focus is on training, ongoing education, and supervision to assure the rights of our residents are protected. Every staff member receives ongoing education focusing on resident's rights and their roll in protecting them.

California nursing homes are among the most heavily regulated professions, subject to comprehensive annual surprise inspections. Nearly 300 state survey staff from the Department of Health Services spends an average of 200 hours in each facility, each year.

If you have any questions, please give me a call at 831-449-5496 ext. 222 or 831-449-8847.

Sincerely,

Laurie Behrend
Administrator

SKYLINE CARE CENTER
348 IRIS DRIVE
SALINAS, CA 93906
OFFICE: 831.449.5496
FAX: 831.757.5049

Lawton Healthcare Center

A Kindred Community

20 April 2004

The Honorable Rececca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

Dear Assembly Member Cohn,

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

My main concern with this bill is that it would invite more law suites under the catch all of residents rights, as defined in California. California has six of the ten best cities for nursing home care, as determined by the independent healthcare rating company Health Grades. After many years of devising a system of penalties ("sticks") for nursing homes I strongly believe that as a society we should be moving towards "carrots" that reward positive behavior.

As a Nursing Home Administrator I learned a long time ago that although there need to be consequences for any employee's improper behavior, if I want to enhance quality of life in my nursing facility I have to begin rewarding the positive behavior of the caregivers.

It's time that the nursing home profession and the state regulators work together to continually improve the care for our dependent frail elders.

Sincerely,

Kevin Ward
Executive Director

1575 7th Avenue San Francisco, California 94122
415.566.1200 415.664.4316 Fax

HELIOS HEALTHCARE, LLC

April 20, 2004

COUNTRY DRIVE CARE

2500 Country Dr
Fremont, CA 94536
(510) 792-4242
(510) 792-4646 fax

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

APR 2 0 2004

OPPOSE AB 2791 (SIMITIAN)

Dear Assembly Member Cohn:

I am writing to express my **opposition to AB2791** (Simitian), which would raise the penalty for a resident's right violation from $500 up to $5,000 per violation.

California nursing homes are among the most heavily regulated professions, subject to comprehensive annual surprise inspections. Nearly 300 state survey staff from the Department of Health Services spends an average of 200 hours in each facility, each year. During these surveys, we often find surveyors putting resident complaints/concerns under a Residents' Right violation even when (1) the complaint is small (ie: too much chicken, they give me spinach and I hate spinch); (2) we have tried to resolve it previously; (3) they had not expressed the concern to the staff for resolution; (4) or the concern is unsubstantiated. Nevertheless, if it is a concern for the surveyor, or they cannot find something more substantial to cite as a deficiency, they will put this concern under a "resident rights" violation. While perhaps frustrating to the residents, these actual incidents rarely place a patient in any jeopardy; nor can we satisfied all individual preferences all the time.

Doesn't it seem counterproductive to fine a facility $5000 for forgetting to close a privacy curtain, or failing to provide an acceptable substitute to a menu item. Why would we want to take money away from facilities that are already struggling to provide the best in quality care, for incidents that do not place a resident in jeopardy?

I have been administering long term care facilities for twenty years. We spend countless hours trying to help our staff what is meant by resident rights, when in fact resident rights is often in the eye of the beholder. Not only do we face educational barriers with our staff in explaining resident rights, we also face cultural and socio-economic barriers that make it very difficult to train to all the nuances of resident rights.

Additionally, I have found resident rights violations are often cited, during complaint investigations (or surveys), just to appease a persistent family member/resident who feels we should provide a level of care that is not reasonable or possible in large cohabitation setting with numerous preferences. When you add that to the fact that we are already underfunded in California, I think you will see that trying to fine a facility into compliance, for a expectation that is open to interpretation, is unfair and will not benefit the California seniors we serve.

Ms. Cohn it is imperative we focus the care dollars available in California to improving and maintaining a reasonable level of care. If you increase the fines for these type of violations, it will only serve to take money away from, what I have spent twenty years trying to do, improving the level of quality despite less and less dollars. The only people who will benefit are the attorneys, who are hired to sue and then defend facilities from these types of allegations and fines. Believe me, facilities will have to try to litigate $5000 fines – we cannot afford not to.

Thank you for carefully considering my request to **OPPOSE AB 2791.** Please think about all the California caregivers who have dedicated their lives to our seniors why should their human judgements/frailty's be judged so harshly, to the detriment of all involved?

Sincerely,

Sandra J. Haskins
Administrator

FOOTHILLS CENTER

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

3400 Bell Road • Auburn, California 95603 • (530) 888-6257 • FAX (530) 888-7298

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Sylvia Zaininger
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

3400 Bell Road • Auburn, California 95603 • (530) 888-6257 • FAX (530) 888-7298

HELIOS
HEALTHCARE, LLC

April 20, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, Ca. 95814

RE: AB 2791 (Simitian) : Oppose

Dear Assembly Member Cohn :

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5000 per violation.

AB 2791 would create yet another avenue for frivolous litigation and impose even greater burdens on an already financially strapped system – forcing more and more long term care providers out of business and putting an entire system of care at risk.

California nursing homes are among the most heavily regulated professions, subject to comprehensive annual surprise inspections. Nearly 300 state survey staff from the Department of Health Services spend an average of 200 hours in each facility each year.

I urge you to oppose this legislation, if you have and questions or would wish to discuss this further please feel free to contact me.

Sincerely,

John Crowley
Administrator
Chico Care Center

CHICO CARE CENTER
188 COHASSET LANE
CHICO, CA 95926
OFFICE: 530.343.6084
FAX: 530.343.6090

Mission Carmichael
HealthCare Center

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95815

April 20, 2004

Dear Assembly Member Cohn, RE: AB 2791 OPPOSE

Mission Carmichael
HealthCare Center

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95815

April 20, 2004

Dear Assembly Member Cohn, RE: AB 2791 OPPOSE

I am writing to express my opposition to AB 2791 (Smitian), which would raise the penalty for a resident's rights violation from $500 up to $5000 per violation.

California nursing homes are among the most heavily regulated professions, subject to comprehensive annual surprise inspections. Nearly 300 state survey staff from the Department of Health Services spends an average of 200 hours in each facility, each year.

AB 2791 would create yet another avenue for frivolous litigation and impose even greater financial burdens on an already financially strapped system- forcing more and more long term care providers out of business and putting an entire system of care at risk.

I am a proud caring health care giver to the elderly, no more new regulations, there are enough now.

Sincerely,

Madge Wells R.N.

Lawton Healthcare Center

A Kindred Community

20 April 2004

The Honorable Rececca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

Dear Assembly Member Cohn,

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

My main concern with this bill is that it would invite more law suites under the catch all of residents rights, as defined in California. California has six of the ten best cities for nursing home care, as determined by the independent healthcare rating company Health Grades. After many years of devising a system of penalties ("sticks") for nursing homes I strongly believe that as a society we should be moving towards "carrots" that reward positive behavior.

As a Nursing Home Administrator I learned a long time ago that although there need to be consequences for any employee's improper behavior, if I want to enhance quality of life in my nursing facility I have to begin rewarding the positive behavior of the caregivers.

It's time that the nursing home profession and the state regulators work together to continually improve the care for our dependent frail elders.

Sincerely,

Kevin Ward
Executive Director

1575 7th Avenue San Francisco, California 94122
415.566.1200 415.664.4316 Fax

Western Care
Construction Company, Inc.
4020 Sierra College Blvd. #200
Rocklin, California 95677
(916) 624-6200

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

April 19, 2004

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation. We do not want to offend anyone in the legislature by stating our opposition. We understand the concern for a resident's well-being.

However, the reality is that the nursing home industry is in crisis. Long Term Care providers have faced a wave of litigation due to the enhanced remedies and the broad definition of neglect under the Elder Abuse Act (EADACPA). This in turn has caused our liability premiums to skyrocket. (From $300 per bed per year in 1999 to more than $2,500 in 2003). All publicly traded companies except two, Manor Care and Beverly, went into bankruptcy during the last few years, along with 20% of privately held companies - due in large part to under-funding by the sponsor programs. California significantly under-funds Medi-Cal. It costs $150-$160 per day to care for one Medi-Cal patient, but reimbursement is $118. If the Medi-Cal reimbursement rate were appropriately set at $150-$200 per day, the provider would not quarrel over a fine when in the wrong; *but first they must have adequate funding to care for the patients properly.* Adding higher fines into the equation is not logical nor responsible. To under-fund a program while adding increasing fines seems hypocritical.

Adequate remedies do exist to protect residents against violations of resident's rights through existing measures, and are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, etc.), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000, and for any civil damages awarded under the EADACPA.

In my view, AB 2791 will make the overall situation worse without adding anything to improve resident care. I urge you to vote "No" on AB 2791.

Sincerely,

Martin A. Harmon
Chairman of the Board
Western Care Construction Company

MAH/pag0404.16

cc: California Association of Health Facilities (CAHF)
Assemblyman Joe Simitian

HELIOS
HEALTHCARE, LLC

April 20, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, Ca. 95814

RE: AB 2791 (Simitian) : Oppose

Dear Assembly Member Cohn :

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5000 per violation.

AB 2791 would create yet another avenue for frivolous litigation and impose even greater burdens on an already financially strapped system – forcing more and more long term care providers out of business and putting an entire system of care at risk.

California nursing homes are among the most heavily regulated professions, subject to comprehensive annual surprise inspections. Nearly 300 state survey staff from the Department of Health Services spend an average of 200 hours in each facility each year.

I urge you to oppose this legislation, if you have and questions or would wish to discuss this further please feel free to contact me.

Sincerely,

John Crowley
Administrator
Chico Care Center

CHICO CARE CENTER
188 COHASSET LANE
CHICO, CA 95926
OFFICE: 530.343.6084
FAX: 530.343.6090

HELIOS HEALTHCARE, LLC

April 20, 2004

COUNTRY DRIVE CARE

2500 Country Dr
Fremont, CA 94536
(510) 792-4242
(510) 792-4646 fax

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

OPPOSE AB 2791 (SIMITIAN)

Dear Assembly Member Cohn:

I am writing to express my **opposition to AB2791** (Simitian), which would raise the penalty for a resident's right violation from $500 up to $5,000 per violation.

California nursing homes are among the most heavily regulated professions, subject to comprehensive annual surprise inspections. Nearly 300 state survey staff from the Department of Health Services spends an average of 200 hours in each facility, each year. During these surveys, we often find surveyors putting resident complaints/concerns under a Residents' Right violation even when (1) the complaint is small (ie: too much chicken, they give me spinach and I hate spinch); (2) we have tried to resolve it previously; (3) they had not expressed the concern to the staff for resolution; (4) or the concern is unsubstantiated. Nevertheless, if it is a concern for the surveyor, or they cannot find something more substantial to cite as a deficiency, they will put this concern under a "resident rights" violation. While perhaps frustrating to the residents, these actual incidents rarely place a patient in any jeopardy; nor can we satisfied all individual preferences all the time.

Doesn't it seem counterproductive to fine a facility $5000 for forgetting to close a privacy curtain, or failing to provide an acceptable substitute to a menu item. Why would we want to take money away from facilities that are already struggling to provide the best in quality care, for incidents that do not place a resident in jeopardy?

I have been administering long term care facilities for twenty years. We spend countless hours trying to help our staff what is meant by resident rights, when in fact resident rights is often in the eye of the beholder. Not only do we face educational barriers with our staff in explaining resident rights, we also face cultural and socio-economic barriers that make it very difficult to train to all the nuances of resident rights.

Additionally, I have found resident rights violations are often cited, during complaint investigations (or surveys), just to appease a persistent family member/resident who feels we should provide a level of care that is not reasonable or possible in large cohabitation setting with numerous preferences. When you add that to the fact that we are already under-funded in California, I think you will see that trying to fine a facility into compliance, for a expectation that is open to interpretation, is unfair and will not benefit the California seniors we serve.

Ms. Cohn it is imperative we focus the care dollars available in California to improving and maintaining a reasonable level of care. If you increase the fines for these type of violations, it will only serve to take money away from, what I have spent twenty years trying to do, improving the level of quality despite less and less dollars. The only people who will benefit are the attorneys, who are hired to sue and then defend facilities from these types of allegations and fines. Believe me, facilities will have to try to litigate $5000 fines – we cannot afford not to.

Thank you for carefully considering my request to **OPPOSE AB 2791.** Please think about all the California caregivers who have dedicated their lives to our seniors why should their human judgements/frailty's be judged so harshly, to the detriment of all involved?

Sincerely,

Sandra J. Haskins
Administrator

Valley View
Skilled Nursing Center, Inc.

1162 South Dora Street
Ukiah, CA 95482
Telephone (707) 462-1436

Corporate Office:
4020 Sierra College Blvd. Suite #180
Rocklin, California 95677
Telephone (916) 624-6230

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation and actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim--for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for a law suit. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Rosemary M. Brown

Rosemary Brown
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

625 Seventh Street · Lakeport CA 95453 · Telephone (707) 263-6101

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in

the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

David Yarbrough
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

MONTEREY PINES
SKILLED NURSING FACILITY

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Gene Sajcich
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

APR 23 2004

FOO[illegible]KS
C[illegible]TER

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

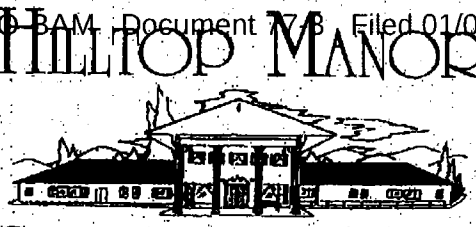
AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Sylvia Zaininger
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

3400 Bell Road • Auburn, California 95603 • (530) 888-6257 • FAX (530) 888-7298



April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim – for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on

12225 Shale Ridge Lane • Auburn, CA 95602 • (530) 885-7511 • Fax: (530) 885-1845

HILLTOP MANOR

CONVALESCENT HOSPITAL

behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Sheila Waddell

Sheila Waddell
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

12225 Shale Ridge Lane • Auburn, CA 95602 • (530) 885-7511 • Fax: (530) 885-1845

HELIOS
HEALTHCARE, LLC

April 20, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation. My concerns are as follows:

- AB 2791 would create yet another avenue for frivolous litigation and impose even greater financial burdens on an already financially strapped system - forcing more and more long-term care providers out of business and putting an entire system of care at risk.

- California utilizes a broad definition to capture resident rights in very general ways. Under AB 2791, this broad definition is stretched ever further becoming a "catch-all" violation, inviting more frivolous litigation. AB 2791 does nothing to enhance or promote resident care and dignity – all it does is put more money into attorneys' pockets while putting long-term care facilities out of business.

- Patient rights violations have nothing to do with quality of care issues. Rather, they include such situations as a privacy curtain left open, a caregiver speaking in a different language than the patient or the failure to provide an alternative food option on the menu. While perhaps frustrating to the patients, these actual incidents rarely place a patient in any jeopardy.

Assembly Member Cohn, I encourage you to really take the above into consideration and stop this bill AB 2791 (Simitian).

Very truly yours,

Stacey Surrett
Administrator

EL CAMINO CARE CENTER
2540 CARMICHAEL WAY
CARMICHAEL, CA 95608
OFFICE: 916.482.0465
FAX: 916.482.7813

DANISH CARE CENTER

April 23, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn,

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

As a dietary manager at Danish Care Center, I have worked in long term care for 20 years. During this time I have seen many changes but not many in favor of the long term facilities. Now again there is to be another change, which will not benefit long term facilities. This new change will not provide better care for the residents, which should be the main concern of the legislators. Instead of worring about more penalties against long term facilities there should be more focus on how to provide more money for improved wages and continued education.

MediCal reimbursement allows nurse aides to be paid from $8-$12 an hour. In our facilities we constantly in-service all staff on resident rights and the sanctity of the freedoms for which our forefathers fought. Taking money from our system lessens the money available for payroll and training and has greater potential to hurt quality care. Higher fines create greater interest by the civil bar, leading to more lawsuits and more distractions for our already over-burdened caregivers.

Please vote to oppose AB 2791 (Simitian).

Sincerely,

Naomi A. Ott

10805 EL CAMINO REAL ★ ATASCADERO, CA 93422 ★ (805) 466-9254 FAX (805) 466-6007

COMPASS HEALTH INC.

DANISH CARE CENTER

April 23, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn,

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

A basic premise in this country is that "the penalty should fit the crime." Patient rights are certainly important, but these violations have nothing to do with quality care issues. Rather they include such situations as a privacy curtain open, a resident being inadequately covered while being moved to shower room, or failing to provide alternative menu selections. While these are frustrating to residents, such incidents rarely put a resident in jeopardy.

MediCal reimbursement allows nurse aides to be paid from $8-$12 an hour. In our facilities we constantly in-service all staff on resident rights and the sanctity of the freedoms for which our forefathers fought. Taking money from our system lessens the money available for payroll and training and has greater potential to hurt quality care. Higher fines create greater interest by the civil bar, leading to more lawsuits and more distractions for our already over-burdened caregivers.

Please vote to oppose AB 2791 (Simitian).

Sincerely,

Benjamin Hughes
Associate Administrator

10805 EL CAMINO REAL ★ ATASCADERO, CA 93422 ★ (805) 466-9254 FAX (805) 466-6007
COMPASS HEALTH INC.

APR 26 2004

DANISH CARE CENTER

April 23, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB2791 (Simitian): Oppose

Dear Assembly Member Cohn,

The purpose of this letter is to express my opposition to AB2791 (Simitian) which will raise the penalty for a resident's rights violation form $500. up to $5000.per violation. The patient's rights are extremely important, neverless these violations do not present a threat to quality care.

I have been a member of the medical profession for over 35 years. Currently I am a licensed nurse, employed as the Director of Staff Development in a 66 bed long term care facility. After years of experience working in almost every field of the profession I am convinced that the long-term care workers are the most challenged employees. Their wages are too low. They need and deserve quality continuing education. Taking money from form our system lessens the money available for payroll and continuing education and the training of new C N As. This presents more potential to affect the quality of care. Higher fines only place a heightened interest by the civil bar, which leads to more lawsuits and unhealthy pressures on the over-burdened caregivers.

I would greatly appreciate your attention and support in the matter.

Please vote to oppose AB2791 (Simitian)

Sincerely,

Eileen L. Thurman

Eileen L. Thurman LVN, DSD

10805 EL CAMINO REAL ★ ATASCADERO, CA 93422 ★ (805) 466-9254 FAX (805) 466-6007

Vineyard Hills Health Center

290 Heather Court • Templeton, CA 93465 • (805) 434-3035 • Fax: (805) 434-3065

APR 23 2004

April 23, 2004

We do our very best to honor all residents rights & a failure to do so is usually accidental - not deliberate. At that point we EDUCATE our staff so it doesn't happen again. Raising the penalty amount can only lead to people wanting

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn,

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

A basic premise in this country is that "the penalty should fit the crime." Patient rights are certainly important, but these violations have nothing to do with quality care issues. Rather they include such situations as a privacy curtain open, a resident being inadequately covered while being moved to shower room, or failing to provide alternative menu selections. While these are frustrating to residents, such incidents rarely put a resident in jeopardy.

MediCal reimbursement allows nurse aides to be paid from $8-$12 an hour. In our facilities we constantly in-service all staff on resident rights and the sanctity of the freedoms for which our forefathers fought. Taking money from our system lessens the money available for payroll and training and has greater potential to hurt quality care. Higher fines create greater interest by the civil bar, leading to more lawsuits and more distractions for our already over-burdened caregivers.

Please vote to oppose AB 2791 (Simitian).

If you have any questions regarding this piece of legislation or any other issues related to our business of "...people, caring for people, caring for people...," please feel free to contact me at (805) 434-3035.

Sincerely,

to hide incidents instead of help clear them up. The death penalty didn't stop serious crime - Encouragement & education works & more severe punishment doesn't.

[illegible signature]

APR 19 2004

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of

ROSEVILLE
CONVALESCENT HOSPITAL

1161 Cirby Way • Roseville, CA 95661
(916) 782-1238 • FAX (916) 786-3597

APR 19 2004

another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

James Paul
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

APR 19 2004

April 19, 2004

Napa Nursing Center

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys' fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys' fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Residents' Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

3275 Villa Lane • Napa, California 94558 • Phone: 707-257-0931 • Fax: 707-257-0936

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Georgia Otterson
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

Western Care
Construction Company, Inc.
4020 Sierra College Blvd. #200
Rocklin, California 95677
(916) 624-6200

APR 19 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814

April 19, 2004

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation. We do not want to offend anyone in the legislature by stating our opposition. We understand the concern for a resident's well-being.

However, the reality is that the nursing home industry is in crisis. Long Term Care providers have faced a wave of litigation due to the enhanced remedies and the broad definition of neglect under the Elder Abuse Act (EADACPA). This in turn has caused our liability premiums to skyrocket. (From $300 per bed per year in 1999 to more than $2,500 in 2003). All publicly traded companies except two, Manor Care and Beverly, went into bankruptcy during the last few years, along with 20% of privately held companies - due in large part to under-funding by the sponsor programs. California significantly under-funds Medi-Cal. It costs $150-$160 per day to care for one Medi-Cal patient, but reimbursement is $118. If the Medi-Cal reimbursement rate were appropriately set at $150-$200 per day, the provider would not quarrel over a fine when in the wrong; *but first they must have adequate funding to care for the patients properly.* Adding higher fines into the equation is not logical nor responsible. To under-fund a program while adding increasing fines seems hypocritical.

Adequate remedies do exist to protect residents against violations of resident's rights through existing measures, and are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, etc.), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000, and for any civil damages awarded under the EADACPA.

In my view, AB 2791 will make the overall situation worse without adding anything to improve resident care. I urge you to vote "No" on AB 2791.

Sincerely,

Martin A. Harmon
Chairman of the Board
Western Care Construction Company

MAH/pag0404.16

cc: California Association of Health Facilities (CAHF)
Assemblyman Joe Simitian

APR 19 2004

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Jesus Barrios
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

APR 19 2004

Placerville Pines
Convalescent Hospital, Inc.

1040 Marshall Way • Placerville, CA 95667

(530) 622-3400 *phone* • (530) 622-1560 *fax*

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of

another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Bradley J. Wilcox
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

LIVE OAK MANOR

APR 19 2004

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

LIVE OAK MANOR

APR 19 2004

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Mindy Beaulieu
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

APR 19 2004

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

El Dorado
Convalescent Hospital

3280 Washington Street • Placerville, California 95667 • Phone: 530/622-6842

An Affiliate of Horizon West Headquarters, Inc.

APR 19 2004

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Karen Freeman
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

Linwood Gardens
Convalescent Hospital
4444 W. Meadow Lane • Visalia, CA 93277 • (559) 627-1241 • Fax (559) 627-2809

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim – for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

Ample opportunity and incentives exist for private right of action. In 1991, the Legislature enacted the Elder and Dependent Adult Civil Protection Act (EADACPA), which allows another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. In addition, EADACPA gave long-term care residents significant enhanced remedies (i.e., attorneys fees and costs, and a $250,000 pain and suffering award), which act as a catalyst for law suits. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Long term care (LTC) facilities and the state budget would be negatively impacted. Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. AB 2791 will make the overall situation worse without adding anything to improve resident care.

AB 2791 does nothing to improve the quality of resident care in a facility. For these reasons, you are urged to vote "No" on AB 2791.

Sincerely,

Robett Barker
Administrator

cc: California Association of Health Facilities (CAHF)
FAX: 1-916-441-6441

Westgate Gardens Convalescent Center
4525 West Tulare Avenue
Visalia, California 93277
Phone (559) 733-0901 Fax (559) 733-8757

April 19, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol Building
Sacramento, CA 95814
FAX: 1-916-319-2197

RE: AB 2791 (Simitian): Oppose

Dear Assembly Member Cohn:

I am writing to express my opposition to AB 2791 (Simitian), which would raise the penalty for a resident's rights violation from $500 up to $5,000 per violation.

Available remedies are not limited to $500. In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief), a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder Abuse Act (EADACPA).

Administrative penalties are based on a direct relationship between the severity of the violation, actual or potential harm suffered by a resident. A violation that does not actually cause harm to the resident, but rather might cause a dignity violation or embarrassment, is appropriately assigned a civil penalty of $500, plus litigation costs and attorneys fees.

The Elder Abuse Act was developed to confer enhanced remedies upon any resident who has suffered harm. By increasing the value of a Resident's Rights violation from $500 to $5,000 per violation, AB 2791 encourages another cause of action to be added to an EADACPA claim in order to increase the value of the entire claim -- for a violation which arguably has produced no actual harm.

Adequate remedies exist for behavior sponsors allege is not being addressed. The sponsors of this bill complain that §1430 does not protect against violations of certain resident's rights, such as "the right of the legal representative to have access to the resident's medical records," "bed hold rights in the event of hospitalization," and "advance notice of a room or roommate change," among other issues. In fact, if the behavior is a violation of a resident's right, then by definition it is covered by §1430 for purposes of bringing a private right of action and for purposes of seeking an injunction on behalf of all residents of the facility. Moreover, if the behavior is determined to be a violation of another statute or regulation and that violation results in harm or potential harm to the resident, then the facility would be liable for administrative remedies, and any civil remedies awarded to the resident under EADACPA.

Date of Hearing: May 19, 2004

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Judy Chu, Chair

AB 2791 (Simitian) – As Amended: May 11, 2004

Policy Committee: Health Vote: 16-0

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY

This bill requires the approved training program of a skilled nursing facility (SNF) and an intermediate care facility (ICF) to include the following:

1) A minimum of one hour of instruction on preventing, recognizing and reporting residents' rights violations, within the 60 hours of classroom training required under current law.

2) Instruction on preventing, recognizing and reporting resident's rights violations, as part of the current requirement of four hours instruction on preventing, recognizing and reporting instances of resident abuse within the total minimum hours of continuing education or inservice training required for certified nursing assistants.

FISCAL EFFECT

Minor absorbable costs to the Department of Health Services (DHS).

COMMENTS

Existing law requires a skilled nursing facility (SNF) or intermediate care facility (ICF) to adopt an approved training program that meets standards established by DHS. The approved training program must consist of certain requirements, including at least a precertification training program that has at least 60 classroom hours of training on basic nursing skills, patient safety and rights, the social and psychological problems of patients, and resident abuse prevention, recognition, and reporting. Within the 60 hours of classroom training, a minimum of six hours of instruction is required on preventing, recognizing, and reporting instances of resident abuse.

This bill would include, within the 60 hours, one hour of instruction on preventing, recognizing and reporting resident's rights violations. Additionally, as part of the current requirement of four hours instruction on resident abuse, this bill would require instruction on preventing, recognizing and reporting residents' rights violations.

It is the author's intent to curtail abuse of nursing home residents and violations of residents' rights through the training requirements in this bill.

Analysis Prepared by: Scott Bain / APPR. / (916) 319-2081

LIS - 5

California Association of Homes and Services for the Aging
1315 I Street, Ste. 100 • Sacramento, CA 95814
916-392-5111 • Fax 916-428-4250 • www.aging.org

May 20, 2004

The Honorable Joseph Simitian
Assemblymember, Twenty-First District
State Capitol, Room 5119
Sacramento, CA 95814

RE: AB 2791 (Simitian) Withdrawal of Opposition and Change to Support

Dear Assemblyman Simitian:

The California Association of Homes & Services for the Aging (CAHSA) represents the full continuum of aging services. CAHSA members are community-based, not-for-profit providers of affordable housing, residential assisted living (RCFEs), continuing care retirement communities (CCRCs) and skilled nursing care. CAHSA members serve over 80,000 older Californians.

I am writing to thank you for your work on AB 2791 and for working with us to address the issues of concern. Based on the amendments included in the May 11, 2004 version of the bill, I am delighted to remove CAHSA's opposition to AB 2791 and to take a support position on the bill.

Sincerely,

Jack E. Christy
Director of Public Policy

cc: Mary Bellamy, Consultant, Assembly Republican Caucus

LEGISLATIVE INTENT SERVICE (800) 666-1917

LIS - 6

ARC - 1

CALIFORNIA HEALTHCARE ASSOCIATION

Providing Leadership in Health Policy and Advocacy

May 18, 2004

The Honorable Joseph Simitian
California State Assembly
State Capitol Building, Room 5119
Sacramento, CA 95814

RE: AB 2791 (Simitian): Neutral As Amended

Dear Assembly Member Simitian:

The California Healthcare Association (CHA) represents California's 500 hospitals and health systems, many of which operate skilled nursing facilities. We appreciate the amendments that have been made to AB 2791. We are happy to remove our opposition and are now neutral on the bill.

The purpose of this bill is to decrease the number of residents' rights violations that occur in SNFs. As amended, this bill aims to achieve this goal via two mechanisms: (1) additional training for nurse assistants regarding residents' rights, including the prevention, recognition, and reporting of violations; and (2) expansion of the residents' rights that a resident may enforce via a penalty on the facility.

CHA supports residents' rights, which recognize and honor the personal integrity and dignity of residents. We believe that this bill, as amended, provides a proactive and common sense approach to strengthening the rights of SNF residents.

Again, thank you for responding to our concerns.

Sincerely,

Judy Citko
Vice President, Continuing Care Services

JJC:vmw

cc: Peter Anderson, consultant, Assembly Republican Caucus

1215 K Street, Suite 800, Sacramento, CA 95814 *Telephone:* 916-443-7401 *Facsimile:* 916-552-7596 *Website:* www.calhealth.org
Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Healthcare Association of San Diego and Imperial Counties

CALIFORNIA
ASSOCIATION OF
HEALTH FACILITIES

CAHF

Supporting People, Health and Quality of Life

2201 K Street
P.O. Box 537004
Sacramento, CA
(95816) 95853-7004
fax (916) 441-6441
(916) 441-6400

1125 West Sixth Street
Suite 304
Los Angeles, CA
90017
fax (213) 627-6106
(213) 627-3000

P.O. Box 370
La Jolla, CA
92038
fax (760) 944-1049
(760) 944-1666

Paul Tunnell
Chairman of the Board

Floyd Rhoades
Vice Chairman of the Board

Frances Foy
Secretary/Treasurer

Richard Mendlen
Immediate Past Chairman

James H. Gomez
CEO/President

May 13, 2004

The Honorable Judy Chu
Chair, Assembly Appropriations Committee
State Capitol Building
Sacramento, CA 95814

RE: AB 2791 (Simitian): Support

Dear Assembly Member Chu:

The California Association of Health Facilities (CAHF), a non-profit professional organization representing a majority of the state's licensed long-term health care facilities, has been working with the author's office to resolve issues of concern over the provisions of AB 2791 (Simitian), which is intended to decrease the number of resident's rights violations that occur in skilled nursing facilities.

We are pleased to inform you that CAHF is removing our opposition and is taking a "support" position to the new amendments included in the May 11, 2004 version of AB 2791. The bill now does two things to help deter resident's rights violations: (1) the bill provides for additional training for direct care workers on how to prevent, recognize, and report resident's rights violations; and (2) the bill expands the liability for facilities who violate any of the federal resident's rights provisions.

In the last round of nursing home "reform" (AB 1731\Shelley\Statutes of 2000), the legislature recognized the importance of having well-trained direct care staff. California currently requires certified nurse assistants to complete 140 hours of training in order to obtain their certification. This is higher than the national requirement, and more than any other state. However, it has been demonstrated that highly trained staff provide better quality care. Therefore, CAHF is in strong support of the recent amendments which require training and instruction to these direct care staff on preventing, identifying, and reporting resident's rights violations. The bill also provides for this training to be included in the total minimum hours of continuing education or in-service training required for certified nurse assistants to renew their certification.

As with many industries, long-term care providers are heavily regulated by both the state and federal governments. Because facilities are already subject to administrative penalties and civil remedies for any violation – whether it be federal or state – of a resident's right, CAHF is not opposed to AB 2791's expansion of the $500 civil penalty to the federal list of resident's rights.

Although CAHF does not believe that additional penalties and enforcement activities will improve nursing home care, we do support AB 2791's approach to providing instruction on preventing resident's rights violations and, if a serious violation should occur, we do not oppose a consumer's right to seek additional remedies.

Sincerely,

Nancy C. Armentrout
Director of Legislative Affairs

cc: Members of the Assembly Appropriations Committee
Assembly Member Joseph Simitian
Scott Bain, Consultant, Assembly Appropriations Committee
Peter Anderson, Consultant, Assembly Republican Caucus

Bet Tzedek Legal Services
THE HOUSE OF JUSTICE
12821 Victory Boulevard • North Hollywood • California 91606
Telephone (818) 769-0136 • Facsimile (818) 769-3290 • www.bettzedek.org

MAY 3 2004

BET TZEDEK THE HOUSE OF JUSTICE

Writer's Direct Line: (818) 487-5226
Writer's E-mail: jspiegel@bettzedek.org

April 30, 2004

VIA FACSIMILE (916)319-2121

The Honorable Joseph Simitian
California State Assembly
State Capitol, Room 5119
Sacramento, California 95814

Re: **Support for AB 2791 (Simitian),**

Dear Assemblymember Simitian:

I am writing on behalf of Bet Tzedek Legal Services to express our strong support for AB 2791, which would modestly increase the liability limit against nursing homes who violate fundamental residents' rights from $500 to $5,000.

Bet Tzedek is a non-profit public interest law center providing free legal representation to over 10,000 low-income, elderly, and disabled people each year throughout Los Angeles County. As Director of the Nursing Home Advocacy Project at Bet Tzedek, I receive numerous telephone calls every week from distraught seniors and their families regarding violations of residents' rights by nursing facilities, including: illegal transfers and discharges; mental and physical abuse; medically unnecessary use of restraints; failure to communicate and coordinate health care; lack of quality care; and denial of access to visitors, telephones, and mail.

AB 2791 is an important and necessary step in helping the elderly and disabled. No California citizen should have to surrender basic rights and civil protections because he or she has been admitted to a nursing home. Although federal and state laws establish the rights of nursing home residents, these rights are frequently infringed upon by nursing facilities because of the lack of oversight and enforcement. By raising the cap on damages for a violation of resident's rights from $500 to $5,000, AB 2791 will help to safeguard fundamental freedoms which no person should have to do without.

Thank you for your stewardship in helping our seniors in their homes away from home, and for making enforcement of their rights a top priority.

Sincerely,

Jody L. Spiegel
Director, Nursing Home Advocacy Project

G:\Jody\Legislation\AB 2791 Ltr2Simitian 4.30.04.wpd

April 26, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol
Sacramento, CA 95814

RE: Opposition to AB 2791 (Simitian)

Dear Assembly Member Cohn:

I am writing to express our opposition to AB 2791 (Simitian), which raises the penalty for a resident's rights violation from $500 to $5,000 per violation.

Crestwood Behavioral Health, Inc. is a mental healthcare provider offering a continuum of services for people with psychiatric disabilities. Crestwood provides institutional and residential services to residents of 48 of California's 58 counties, operating programs in 18 facilities (including skilled nursing facilities) throughout the state.

AB 2791 would create yet another avenue for frivolous litigation by increasing the civil liability of a long-term care provider for resident's rights violations. A ten-fold increase in the amount of liability will only serve to increase lawsuits and does nothing to enhance or promote resident care and dignity.

Patient rights violations have nothing to do with quality of care issues and rarely place a patient in any jeopardy. AB 2791 will put more money in attorney's pockets and impose a greater financial burden on an already financially strapped long-term care system.

There doesn't appear to be a need for increased penalties other than to create greater incentive for attorney's to file lawsuits. The Department of Health Services conducts annual inspections of long-term care facilities and imposes fines for violation of regulations.

For these reasons, we strongly oppose AB 2791.

Sincerely,

Bob Macaluso
Director, Public Affairs

National Senior Citizens Law Center

3435 Wilshire Boulevard, Suite 2860 • Los Angeles, CA 90010 • Tel: (213) 639-0930 • Fax: (213) 639-0934
www.nsclc.org
Writer's email: ecarlson@nsclc.org
Writer's extension: 313

Edward C. King
Executive Director

Gerald A. McIntyre
Directing Attorney

April 21, 2004

Hon. Joseph Simitian
State Capitol
Sacramento, California 95814

Re: Support for AB 2791 (Simitian);
Protection of Rights of Nursing Home Residents

Dear Assemblymember Simitian:

We are pleased to support your Assembly Bill 2791, which takes an important step in protecting the rights of nursing home residents.

For almost 30 years, the National Senior Citizens Law Center has worked to protect the rights of elder Americans in relation to Social Security, Medicare, Medicaid, nursing homes, and other areas. I have worked full-time in protecting the rights of nursing facility residents (and residential care facility residents) since 1989, first in a Los Angeles legal services program and then, since 2001, with the National Senior Citizens Law Center. I am well aware of the difficulties faced by residents and their family members

Although federal and state law is reasonably good in establishing rights, too often enforcement of those rights is negligible or nonexistent. There are good and bad nursing homes, and the bad nursing homes will violate the law based on a cynical calculus that poor care is cheaper (and thus more profitable) than compliance with law.

By raising the cap on actual damages from $500 to $5,000, for a violation of a resident's rights, AB 2791 will help to compel compliance with law. There is no good reason why under current law a nursing facility can cause damages of $4,000 (for example), and have its liability for a proven resident's rights violation capped at $500.

Sincerely,

Eric M. Carlson, Esq.

Assembly Republican Bill Analysis **AB 2791 (Simitian)**

Health Committee **Oppose**

AB 2791 (SIMITIAN)
SKILLED NURSING AND INTERMEDIATE CARE FACILITIES: LIABILITY.

Version: 4/1/04 Last Amended
Vote: Majority
Oppose

Vice-Chair: Todd Spitzer
Tax or Fee Increase: No

Increases the limit from $500 to $5,000 for violating any right of a resident or patient in a skilled nursing or intermediate care facility.

Skilled nursing and intermediate care facilities provide a valuable service for the frail elderly and disabled. Patients, their families or the industry wants the provision of quality care. If a facility is providing poor care, their practices should be corrected or they should not be permitted to stay in business. However, to increase the financial penalty **FOR EACH VIOLATION OF A PATIENT'S RIGHT BY 1,000 PERCENT (THAT'S ONE THOUSAND PERCENT)** is unreasonable and will only encourage lawsuits by attorneys, put nursing homes out of business, and discourage companies from establishing facilities in California.

Why doesn't the Legislature just shut down all of the facilities, then elderly patients rehabilitating after surgery can just remain in the hospital for an additional two months and we can just let the Alzheimers patients wander the streets.

Policy Question

Should the Legislature increase the limit by 1,000 percent for violating any right of a resident or patient in a skilled nursing or intermediate care facility in California?

Summary

AB 2791 increases the limit from $500 to $5,000 for violating any of the Patients Bill of Rights of a resident or patient in a skilled nursing or intermediate care facility.

Support

California Senior Legislature (sponsor)
AARP California
American Federation of State, County and Municipal Employees
California Advocates for Nursing Home Reform
Consumer Attorneys of California
National Senior Citizens Law Center

Assembly Republican Health Votes (0-0) 4/20/04
Ayes: None
Noes: None
Abs. / NV: None

Assembly Republican **Votes** (0-0) 1/1/03
Ayes: None
Noes: None
Abs. / NV: None

Assembly Republican **Votes** (0-0) 1/1/03
Ayes: None
Noes: None
Abs. / NV: None

Assembly Republican **Votes** (0-0) 1/1/03
Ayes: None
Noes: None
Abs. / NV: None

Opposition

California Association of Health Facilities
California Association of Homes and Services for the Aging
California Healthcare Association
Crestwood Behavioral Health, Inc.
658 individuals including facility administrators

Arguments In Support of the Bill

1. The California Advocates for Nursing Home Reform contends that current law "provides for the only remedy available for violation of residents' rights in California. Unfortunately, since this law was first enacted in 1982, fewer than five such actions have been filed. Although remedies available under this section include injunctive relief - an important remedy for violation of residents' rights the $500 limit on damages so reduces the likelihood of legal representation, any opportunity for relief is moot.
2. The National Senior Citizens Law Center argues that "[a]lthough federal and state law is reasonably good in establishing rights, too often enforcement of those rights is negligible or nonexistent. There are good and bad nursing homes, and the bad nursing homes will violate the law based on a cynical calculus that poor care is cheaper (and thus more profitable) than compliance with law. . .By raising the cap on actual damages from $500 to $5,000, for a violation of a resident's rights, AB 2791 will help to compel compliance with law."
3. The Consumer Attorneys of California note that "elder abuse in California is a serious problem. In California, a recent report found that more

than 40% of the state's 1,352 nursing homes were cited for abuse. In Los Angeles County, 37% of the homes were cited."

Arguments In Opposition to the Bill

1. The California Association of Health Facilities (CAHF) makes the following points in opposing the bill:

"Resident's Rights" Are All Inclusive In Nursing Facilities

Resident's Rights have been substantially expanded by both state and federal law over the years. This is evident in current regulations, which have been broadly drafted in very general terms to cover every aspect of care. The "resident rights" category was designed to catch violations of a personal nature, which do not involve any resident harm, or even the potential thereof Typical violations include not offering a preferred food alternative as a substitute for a specific menu item, resident privacy curtains left open, and caregivers not speaking in the resident's language while providing services. The Legislature never intended this section to be abused in the way it has under current practice by attorneys who dress up a complaint with alleged behavior that has artfully been plead to meet the technical definitions of a resident's right violation. AB 2791 would absolutely encourage more of this behavior given the increased penalty amount.

Available Remedies Against Facilities Are Not Limited To $500

In addition to being liable for civil damages of $500 per violation (plus litigation costs, attorneys fees and injunctive relief) for a resident's rights violation, a facility is also liable for administrative penalties that range anywhere from $100 to $100,000 (if the violation meets the definition of a class "B", "A" or "AA" citation), and for any civil damages awarded under the Elder and Dependent Adult Civil Protection Act (EADACPA), which gives long-term care residents an additional private right of action and the ability to collect significant enhanced remedies (i.e., attorney's fees and costs, and a $250,000 pain and suffering award) for any harm suffered.

Administrative penalties are based on a direct relationship between the severity of the violation and actual or potential harm suffered by a resident. A lesser violation that does not actually cause (nor poses even a potential for) harm to the resident, but rather might cause disrespect or embarrassment is appropriately categorized as a resident's rights violation and is assigned a civil penalty of $500, plus litigation costs and attorneys fees. If the resident's rights violation leads to actual harm, the EADACPA statute confers enhanced remedies upon any resident who has suffered harm and is a strong catalyst for litigation. By increasing the value of a resident's rights violation from $500 to $5,000 per violation, AB 2791 only serves to encourage plaintiffs to add another cause of action to an EADACPA claim.

Ample Opportunity And Incentives Exist For Private Right of Action

The proponents of AB 2791 argue that this bill is necessary because it has been over twenty years since Health & Safety Code § 143 0 was enacted to allow a private right of action and it has allegedly been "completely ineffective because of the $500 limit on civil damages." When the Legislature enacted EADACPA in 1991, it encouraged another private right of action for residents who have experienced harm due to "neglect or abuse" in a facility. Virtually every complaint that is filed by a resident for harm suffered in a facility to include a claim under EADACPA. The vast majority of these complaints also include a claim for damages based on a resident's rights violation. The last thing the system needs is additional incentives for litigation.

Increased Penalties Are Inappropriate and Unwarranted

The last round of nursing home "reform" in 2000 (AB 1731) enacted huge new fine levels against facilities for violations of statute that result in a class "AA' or "A" citation. The increased penalty included in AB 2791 was discussed and rejected as part of this reform. Under existing criteria, penalties are awarded for acts or omissions by the facility that range from causing death to having a loose relationship to the health, safety, or security of residents at the facility. Citations are issued without any differentiation between incidents involving an isolated, unintentional mistake on the part of a single employee and incidents involving an actual failure on the part of facility management. There is no reason, and especially no data, to suggest that additional fines will reduce the incidence of violations or increase quality. In fact, these fines and penalties reduce facility finds available for staffing and other critical resident care activities.

LTC Facilities And The State Budget Would Be Negatively Impacted

Providers have seen a tidal wave of litigation created by the enhanced remedies and the broad definition of neglect under EADACPA, which in turn has caused LTC provider's liability premiums to skyrocket from $300 per bed per year in 1999 to more than $2,500 in 2003. In fact, the high cost of coverage triggered a $36 million Medi-Cal rate increase to cover the liability component of the rate in 2002; if this

trend continues, the additional cost to Medi-Cal for liability coverage will soon be more than $100 million per year. With annual premiums approaching $200,000, many facilities have been forced to go without coverage altogether, others are declaring bankruptcy and some are closing. One million deductibles are common place and many facilities are one claim away from financial ruin. AB 2791 will make the overall situation worse without adding anything to improve resident care.

2. The California Healthcare Association notes that "the residents' rights penalty was enacted to provide residents with a remedy when they have suffered an intangible harm of nominal value. In enacting the statute, the legislature recognized a balance between acknowledging these intangible harms and creating an incentive to sue. Increasing the penalty to $5,000, however, creates a substantial financial incentive to sue facilities and dramatically changes the purpose of this statutory provision." They add that "{I}t does not logically follow, however, that people should be able to obtain a monetary windfall by stringing together a series of alleged rights violations into a lawsuit. It is not difficult for a resident to claim that their rights have been violated; relatively minor behavior can be framed as a resident's rights violation."

Fiscal Effect

Unknown.

Comments

Resident Rights in Skilled Nursing Facilities
Title 22, Division 5, California Code of Regulations Section 72527

1. To be fully informed of these rights and of all rules and regulations governing resident conduct.
2. To be fully informed of services available in the facility and of related charges, including any charges for services not covered by the facility.
3. To be fully informed by a physician of his or her total health status and to be afforded the chance to participation an immediate and ongoing basis in the total plan of care including the identification of medical, nursing and psychosocial needs and the planning of related services.
4. To consent or to refuse any treatment or procedure or participation in experimental research.
5. To receive all information that is material to an individuals resident's decision concerning whether to accept or refuse to accept any proposed treatment or procedure.
6. To be transferred or discharged only for medical reasons, or the residents welfare or that of other residents or for nonpayment for his or her stay and to be given reasonable advance notice to ensure orderly transfer or discharge.
7. To be encouraged and assisted throughout the period of stay to exercise rights as a resident and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of resident's choice, free from restraint, interference, coercion, discrimination or reprisal.
8. To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the residents behalf should be facility accept written delegation of this responsibility.
9. To be free from mental and physical abuse.
10. To be assured confidential treatment of financial and health records and to approve or refuse their release, except as authorized by law.
11. To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.
12. Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.
13. To associate and communicate privately with persons of the resident's choice and to send and receive mail unopened.
14. To meet with others and participate in activities of social, religious and community groups.
15. To retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the health, safety or rights of the residents or other residents.
16. If married, to be assured privacy for visits by the resident's spouse and if both are residents in the facility, to be permitted to share a room.
17. To have daily visiting hours established.
18. To have visits from members of the clergy at any time at the request of the resident or the resident's representative.
19. To have visits from persons of the resident's choosing at any time if the resident is critically ill, unless medically contraindicated.
20. To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.
21. To have reasonable access to telephones and to make and receive confidential calls.
22. To be free from any requirement to purchase drugs or rent or purchase medical supplies or equipment from any particular source.
23. To be free from psychotherapeutic drugs and physical restraints used for the purposes of resident discipline or staff convenience and to be free from psychotherapeutic drugs used as a chemical restraint, except in an emergency which threatens to bring immediate injury to the resident or others.

Elder Abuse and Dependent Adult Protection Act

In 1991, the Legislature enacted the Elder Abuse and Dependent Adult Protection Act (EADACPA), which provided incentives for bringing elder abuse claims against nursing home and long-term care (LTC) providers. In California, this law has severely eroded the original MICRA protections for long-term care providers. In response, the plaintiff's bar has stopped filing most garden-variety medical negligence cases against long term care providers under California's professional negligence law in favor of the "alternative" elder abuse or neglect cause of action, where there are no caps on non-economic damages and attorney's fees.

Over the years, information produced by the regulatory system, combined with loopholes in the civil system, has triggered a remarkable erosion for LTC providers from the protections that other health care providers enjoy. The focal point for this erosion was the decision by the California Supreme Court in Delaney v. Baker (1999) 20 Cal.4th 23, which held health care providers liable for punitive damages under EADACPA. Following the Delaney decision, virtually every lawsuit against a LTC provider contains an allegation of elder abuse or neglect because there is no practical way to distinguish between a claim for 'professional negligence' under MICRA and a claim for 'neglect' under the EADACPA.

A recent line of cases decided post-Delaney has focused on the extent to which the trier of fact in an EADACPA case would be allowed to consider the underlying regulatory provisions governing patient care in deciding whether the defendant had committed actionable abuse or neglect. Recently, the Fourth District Court of Appeals determined in Norman v. Life Care Centers of America, Inc. (2003) 107 Cal. App.4th 1233, 1244, that EADACPA liability could be directly premised on a finding of a regulatory violation.

The prevalence of litigation resulting from Delaney has pushed up liability insurance premiums for all facilities serving the elderly. California liability premium trends have escalated more than 350% from 1999 to 2002. Given this trend, the additional cost to the State through the Medi-Cal program cause by the erosion of MICRA protections could reach $236 million annually by 2006. More than two-thirds of nursing home residents rely on the Medicaid (i.e., Medi-Cal) and/or Medicare programs to fund part or all of their health care. However, the skyrocketing costs of civil liability are a real threat to the viability of the entire long-term care system.

Expanded Liability

Over the past seven years, there have been no less than 11 bills that have raised penalties or added enforcement remedies, or have expanded the requirements for reporting/investigating abuse/neglect (in addition to AB 2791). They have all increased the level of scrutiny and the liability for any negligent act or "ommission" that happens in a facility, and have led to the liability crisis facilities face today:

AB 1133 (Gallegos) - Ch. 650, Statutes of 1998

- Increased civil penalties for violations affecting the health of patients in skilled nursing facilities.

AB 1731 (Shelley) - Ch. 451, Statutes of 2000

- Significantly increased civil penalties for skilled nursing facilities up to $100,000.
- Established a state remedy to allow for a temporary manager to be appointed by DHS to run a facility; made it easier for DHS to appoint a court-appointed receiver; and, allows DHS the authority to grant provisional licenses.
- Requires allegations of suspected abuse and neglect to be investigated by DHS within 24-hours.

AB 828 (Cohn) - Ch. 680, Statutes of 2001

- Requires DHS to establish a centralized consumer response unit to respond to complaints about resident care in long-term care facilities.

AB 1212 (Shelley) - Ch. 685, Statutes of 2001

- Clean-up bill to AB 1731 (Shelley) and, subject to penalties, the bill requires skilled nursing facilities to post a "Notice of Violation Remedies" form on all doors of the facility if specified remedies are imposed.

SB 333 (Escutia) - Ch. 301, Statutes of 2002

- Authorizes each county to establish an interagency elder death review team to assist local agencies in identifying and reviewing suspicious elder deaths.

AB 255 (Zettel) - Ch. 54, Statutes of 2003

- Makes changes to the individual mandated reporting requirements for reporting suspected or alleged elder abuse.

AB 1946 (Corbett) - Ch. 550, Statutes of 2003

- Requires each facility, upon admission of a resident, to ask the resident if s/he would like the facility to provide the resident's responsible party with materials regarding resident's rights and responsibilities.

SB 339 (Ortiz) - Ch. 242, Statutes of 2004

- Subject to penalties, the bill imposes new requirements upon long-term care facilities to carrying out a lengthy process of assessment and notification prior to transferring residents from the facility.

AB 634 (Steinberg) - Ch. 242, Statutes of 2004

- Creates a statewide policy prohibiting confidential settlement agreements or agreements to keep information obtained during discovery confidential if the case includes a cause of action for elder abuse or neglect.

SB 577 (Kuehl) - Ch. 878, Statutes of 2004

- Expands the authority of Protection and Advocacy Inc to enter long-term care facilities

to investigate any incident of abuse or neglect of any person with a disability.

SB 130 (Chesbro) - Ch. 750, Statutes of 2004

- Prohibits facilities from using any type of seclusion or restraint unless there is a behavioral emergency.

Policy Consultant: Peter Anderson 5/1/04
Fiscal Consultant:

STATE OF CALIFORNIA
CALIFORNIA SENIOR LEGISLATURE
1600 K Street, 4th Floor, Sacramento, CA 95814
Phone (916) 322-5630 Fax (916) 327-1859

April 20, 2004

The Honorable S. Joseph Simitian
California State Assembly
State Capitol, Room 5119
Sacramento, California 95814

Dear Assembly Member Simitian:

Sponsor for AB 2791 (Simitian), as amended April 1, 2004

On behalf of the 120 members of the California Senior Legislature (CSL), representing 4 million seniors through effective legislative advocacy, I want to thank you for introducing AB 2791. This bill will expand the liability limit for nursing homes for violation of residents' rights from $ 500 to $ 5,000 and it will clarify that it applies to both current and former residents.

It has been two decades since the Health and Safety Code was amended to allow a private right of action for residents of nursing homes whose rights have been violated. Despite many cases of documented violations of residents' rights, the code has been ineffective due to the $ 500 award limit on these cases. The appropriateness of the penalty for a violation of a resident's rights should depend on the severity of the harm to the resident. AB 2791 seeks to make the awards reflect the severity of harm to the resident.

AB 2791 is a positive step in our efforts to protect California's senior population and to reduce the number of violations of residents' rights . We are committed to working with you to ensure the passage and signing of AB 2791. If you would like to discuss this bill with us, please contact Senior Assembly Members Donna Ambrogi at (909) 625-2558 or Helen Karr at (650) 992-5793 or by email: hehkarr@aol.com, or June P. Hamilton, Legislative Liaison, at (916) 322-5630 or by email: jhamil@ccoa.ca.gov.

Sincerely,

Edward Woods

Ed Woods, Chair
Joint Rules Committee (CSL)

jph.ab2791sponsor.ltr4.04

Sponsored by the California Commission on Aging and funded by the California Fund for Senior Citizens

Anderson, Peter

From: Nancy Armentrout [narmentrout@cahf.org]
Sent: Thursday, April 22, 2004 4:55 PM
To: peter.anderson@asm.ca.gov
Subject: AB 2791 - Background on EADACPA

Peter- Here is the background on EADACPA

Background
In 1991, the Legislature enacted the Elder Abuse and Dependent Adult Protection Act (EADACPA), which provided incentives for bringing elder abuse claims against nursing home and long-term care (LTC) providers. In California, this law has severely eroded the original MICRA protections for long-term care providers. In response, the plaintiff's bar has stopped filing most garden-variety medical negligence cases against long term care providers under California's professional negligence law in favor of the "alternative" elder abuse or neglect cause of action, where there are no caps on non-economic damages and attorney's fees.

Over the years, information produced by the regulatory system, combined with loopholes in the civil system, has triggered a remarkable erosion for LTC providers from the protections that other health care providers enjoy. The focal point for this erosion was the decision by the California Supreme Court in Delaney v. Baker (1999) 20 Cal.4th 23, which held health care providers liable for punitive damages under EADACPA. Following the Delaney decision, virtually every lawsuit against a LTC provider contains an allegation of elder abuse or neglect because there is no practical way to distinguish between a claim for 'professional negligence' under MICRA and a claim for 'neglect' under the EADACPA.

A recent line of cases decided post-Delaney has focused on the extent to which the trier of fact in an EADACPA case would be allowed to consider the underlying regulatory provisions governing patient care in deciding whether the defendant had committed actionable abuse or neglect. Recently, the Fourth District Court of Appeals determined in Norman v. Life Care Centers of America, Inc. (2003) 107 Cal. App.4th 1233, 1244, that EADACPA liability could be directly premised on a finding of a regulatory violation.

The prevalence of litigation resulting from Delaney has pushed up liability insurance premiums for all facilities serving the elderly. California liability premium trends have escalated more than 350% from 1999 to 2002. Given this trend, the additional cost to the State through the Medi-Cal program cause by the erosion of MICRA protections could reach $236 million annually by 2006. More than two-thirds of nursing home residents rely on the Medicaid (i.e., Medi-Cal) and/or Medicare programs to fund part or all of their health care. However, the skyrocketing costs of civil liability are a real threat to the viability of the entire long-term care system.

Nancy C. Armentrout
Director of Legislative Affairs
California Association of Health Facilities
ph. (916) 441-6400 ext. 213
fax: (916) 441-6441
e-mail: narmentrout@cahf.org

(A) A current nursing procedure manual.

(B) Provision for the inventory and identification of patients' personal possessions, equipment and valuables.

(C) Screening of all patients for tuberculosis upon admission. These procedures shall be determined by the patient care policy committee. A tuberculosis screening procedure may not be required if there is satisfactory written evidence available that a tuberculosis screening procedure has been completed within 90 days of the date of admission to the facility. Subsequent tuberculosis screening procedures shall be determined by the attending physician.

(D) Notification of physician regarding sudden or marked adverse change in a patient's condition.

(E) Conditions under which restraints are used, the application of restraints, and the mechanism used for monitoring and controlling their use.

(3) Infection control policies and procedures.

(4) Dietary services policies and procedures which include:

(A) Provision for safe, nutritious food preparation and service.

(B) A provision for maintaining a current dietetic service procedure manual.

(5) Pharmaceutical services policies and procedures.

(6) Activity program policies and procedures.

(7) Housekeeping services policies and procedures which include provision for maintenance of a safe, clean environment for patients, employees and the public.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72525. Required Committees.

(a) Each facility shall have at least the following committees: patient care policy, infection control and pharmaceutical service.

(b) Minutes of every committee meeting shall be maintained in the facility and indicate names of members present, date, length of meeting, subject matter discussed and action taken.

(c) Committee composition and function shall be as follows:

(1) Patient care policy committee.

(A) A patient care policy committee shall establish policies governing the following services: Physician, dental, nursing, dietetic, pharmaceutical, health records, housekeeping, activity programs and such additional services as are provided by the facility.

(B) The committee shall be composed of: at least one physician, the administrator, the director of nursing service, a pharmacist, the activity leader and representatives of each required service as appropriate.

(C) The committee shall meet at least annually.

(D) The patient care policy committee shall have the responsibility for reviewing and approving all policies relating to patient care. Based on reports received from the facility administrator, the committee shall review the effectiveness of policy implementation and shall make recommendations for the improvement of patient care.

(E) The committee shall review patient care policies annually and revise as necessary. Minutes shall list policies reviewed.

(F) The Patient Care Policy Committee shall implement the provisions of the Health and Safety Code, Sections 1315 and 1316.5, by means of written policies and procedures.

1. Facilities which choose to allow clinical psychologists to refer patients for admission shall do so only if there are physicians who will provide the necessary medical care for the referred patients.

2. Only physicians shall assume overall care of patients, including performing admitting history and physical examinations and issuing orders for medical care.

(G) The Patient Care Policy Committee shall implement the provisions of the Health and Safety Code, Section 1316, by means of written policies and procedures.

1. Facilities which choose to allow podiatrists to refer patients for admission shall do so only if there are physicians who will provide the necessary medical care for the referred patients.

2. Only physicians shall assume overall care of patients, including performing admitting history and physical examinations.

(2) Infection control committee.

(A) An infection control committee shall be responsible for infection control in the facility.

(B) The committee shall be composed of representatives from the following services; physician, nursing, administration, dietetic, pharmaceutical, activities, housekeeping, laundry and maintenance.

(C) The committee shall meet at least quarterly.

(D) The functions of the infection control committee shall include, but not be limited to:

1. Establishing, reviewing, monitoring and approving policies and procedures for investigating, controlling and preventing infections in the facility.

2. Maintaining, reviewing and reporting statistics of the number, types, sources and locations of infections within the facility.

(3) Pharmaceutical service committee.

(A) A pharmaceutical service committee shall direct the pharmaceutical services in the facility.

(B) The committee shall be composed of the following: a pharmacist, the director of nursing service, the administrator and at least one physician.

(C) The committee shall meet at least quarterly.

(D) The functions of the pharmaceutical service committee shall include, but not be limited to:

1. Establishing, reviewing, monitoring and approving policies and procedures for safe procurement, storage, distribution and use of drugs and biologicals.

2. Reviewing and taking appropriate action on the pharmacist's quarterly report.

3. Recommending measures for improvement of services and the selection of pharmaceutical reference materials.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code.

HISTORY

1. Amendment filed 2–8–83; designated effective 3–2–83 (Register 83, No. 7).

§ 72527. Patients' Rights.

(a) Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated. The facility shall establish and implement written policies and procedures which include these rights and shall make a copy of these policies available to the patient and to any representative of the patient. The policies shall be accessible to the public upon request. Patients shall have the right:

(1) To be fully informed, as evidenced by the patient's written acknowledgement prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(2) To be fully informed, prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or not covered under Titles XVIII or XIX of the Social Security Act.

(3) To be fully informed by a physician of his or her total health status and to be afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care including the identification of medical, nursing and psychosocial needs and the planning of related services.

(4) To consent to or to refuse any treatment or procedure or participation in experimental research.

(5) To receive all information that is material to an individual patient's decision concerning whether to accept or refuse any proposed treatment or procedure. The disclosure of material information for administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function shall include the disclosure of information listed in Section 72528(b).

(6) To be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment for his or her

stay and to be given reasonable advance notice to ensure orderly transfer or discharge. Such actions shall be documented in the patient's health record.

(7) To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

(8) To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept written delegation of this responsibility subject to the provisions of Section 72529.

(9) To be free from mental and physical abuse.

(10) To be assured confidential treatment of financial and health records and to approve or refuse their release, except as authorized by law.

(11) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.

(12) Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.

(13) To associate and communicate privately with persons of the patient's choice, and to send and receive personal mail unopened.

(14) To meet with others and participate in activities of social, religious and community groups.

(15) To retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the health, safety or rights of the patient or other patients.

(16) If married, to be assured privacy for visits by the patient's spouse and if both are patients in the facility, to be permitted to share a room.

(17) To have daily visiting hours established.

(18) To have visits from members of the clergy at any time at the request of the patient or the patient's representative.

(19) To have visits from persons of the patient's choosing at any time if the patient is critically ill, unless medically contraindicated.

(20) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

(21) To have reasonable access to telephones and to make and receive confidential calls.

(22) To be free from any requirement to purchase drugs or rent or purchase medical supplies or equipment from any particular source in accordance with the provisions of Section 1320 of the Health and Safety Code.

(23) To be free from psychotherapeutic drugs and physical restraints used for the purpose of patient discipline or staff convenience and to be free from psychotherapeutic drugs used as a chemical restraint as defined in Section 72018, except in an emergency which threatens to bring immediate injury to the patient or others. If a chemical restraint is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient and used only for a specified and limited period of time.

(24) Other rights as specified in Health and Safety Code, Section 1599.1.

(25) Other rights as specified in Welfare and Institutions Code, Sections 5325 and 5325.1, for persons admitted for psychiatric evaluations or treatment.

(26) Other rights as specified in Welfare and Institutions Code Sections 4502, 4503 and 4505 for patients who are developmentally disabled as defined in Section 4512 of the Welfare and Institutions Code.

(b) A patient's rights, as set forth above, may only be denied or limited if such denial or limitation is otherwise authorized by law. Reasons for denial or limitation of such rights shall be documented in the patient's health record.

(c) If a patient lacks the ability to understand these rights and the nature and consequences of proposed treatment, the patient's representative shall have the rights specified in this section to the extent the right may devolve to another, unless the representative's authority is otherwise limited. The patient's incapacity shall be determined by a court in accordance with state law or by the patient's physician unless the physician's determination is disputed by the patient or patient's representative.

(d) Persons who may act as the patient's representative include a conservator, as authorized by Parts 3 and 4 of Division 4 of the Probate Code (commencing with Section 1800), a person designated as attorney in fact in the patient's valid durable power of attorney for health care, patient's next of kin, other appropriate surrogate decisionmaker designated consistent with statutory and case law, a person appointed by a court authorizing treatment pursuant to Part 7 (commencing with Section 3200) of Division 4 of the Probate Code, or, if the patient is a minor, a person lawfully authorized to represent the minor.

(e) Patients' rights policies and procedures established under this section concerning consent, informed consent and refusal of treatments or procedures shall include, but not be limited to the following:

(1) How the facility will verify that informed consent was obtained or a treatment or procedure was refused pertaining to the administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability of the patient to regain the use of a normal bodily function.

(2) How the facility, in consultation with the patient's physician, will identify consistent with current statutory case law, who may serve as a patient's representative when an incapacitated patient has no conservator or attorney in fact under a valid Durable Power of Attorney for Health Care.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1320, 1599, 1599.1, 1599.2 and 1599.3, Health and Safety Code; and *Cobbs* v. *Grant* (1972) 8 Cal.3d 229.

HISTORY

1. Amendment of subsections (a) and (b), repealer of subsection (c), and new subsections (c), (d), and (e) filed 5-27-92; operative 5-27-92 (Register 92, No. 22).

§ 72528. Informed Consent Requirements.

(a) It is the responsibility of the attending physician to determine what information a reasonable person in the patient's condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure. Information that is commonly appreciated need not be disclosed. The disclosure of the material information and obtaining informed consent shall be the responsibility of the physician.

(b) The information material to a decision concerning the administration of a psychotherapeutic drug or physical restraint, or the prolonged use of a device that may lead to the inability of the patient to regain use of a normal bodily function shall include at least the following:

(1) The reason for the treatment and the nature and seriousness of the patient's illness.

(2) The nature of the procedures to be used in the proposed treatment including their probable frequency and duration.

(3) The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment.

(4) The nature, degree, duration and probability of the side effects and significant risks, commonly known by the health professions.

(5) The reasonable alternative treatments and risks, and why the health professional is recommending this particular treatment.

(6) That the patient has the right to accept or refuse the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time.

(c) Before initiating the administration of psychotherapeutic drugs, or physical restraints, or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function, facility staff shall verify that the patient's health record contains documentation that the patient has given informed consent to the proposed treatment or procedure. The facility shall also ensure that all decisions concerning the withdrawal or withholding of life sustaining treatment are documented in the patient's health record.

Subpart I—Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded

AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A [Reserved]

Subpart B—Requirements for Long Term Care Facilities

SOURCE: 54 FR 5359, Feb. 2, 1989, unless otherwise noted.

§ 483.1 Basis and scope.

(a) *Statutory basis.* (1) Sections 1819 (a), (b), (c), and (d) of the Act provide that—

(i) Skilled nursing facilities participating in Medicare must meet certain specified requirements; and

(ii) The Secretary may impose additional requirements (see section 1819(d)(4)(B)) if they are necessary for the health and safety of individuals to whom services are furnished in the facilities.

(2) Section 1861(l) of the Act requires the facility to have in effect a transfer agreement with a hospital.

(3) Sections 1919 (a), (b), (c), and (d) of the Act provide that nursing facilities participating in Medicaid must meet certain specific requirements.

(b) *Scope.* The provisions of this part contain the requirements that an institution must meet in order to qualify to participate as a SNF in the Medicare program, and as a nursing facility in the Medicaid program. They serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid.

[56 FR 48867, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992; 60 FR 50443, Sept. 29, 1995]

§ 483.5 Definitions.

For purposes of this subpart—

Facility means, a skilled nursing facility (SNF) or a nursing facility (NF) which meets the requirements of sections 1819 or 1919 (a), (b), (c), and (d) of the Act. "Facility" may include a distinct part of an institution specified in § 440.40 of this chapter, but does not include an institution for the mentally retarded or persons with related conditions described in § 440.150 of this chapter. For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the "facility" is always the entity which participates in the program, whether that entity is comprised of all of, or a distinct part of a larger institution. For Medicare, a SNF (see section 1819(a)(1)), and for Medicaid, a NF (see section 1919(a)(1)) may not be an institution for mental diseases as defined in § 435.1009.

[56 FR 48867, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992]

§ 483.10 Resident rights.

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:

(a) *Exercise of rights.* (1) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

(3) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.

(4) In the case of a resident who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.

(b) *Notice of rights and services.* (1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing;

(2) The resident or his or her legal representative has the right—

(i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and

(ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.

(3) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition;

(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and

(5) The facility must—

(i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of—

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

(6) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

(7) The facility must furnish a written description of legal rights which includes—

(i) A description of the manner of protecting personal funds, under paragraph (c) of this section;

(ii) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels;

(iii) A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and

(iv) A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

(8) The facility must comply with the requirements specified in subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or

surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. If an adult individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

(9) The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

(10) The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(11) *Notification of changes.* (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal respresentative or an interested family member when there is—

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions o clinical complications);

(C) A need to alter treatment signifi cantly (i.e., a need to discontinue a existing form of treatment due to ad verse consequences, or to commence new form of treatment); or

(D) A decision to transfer or dis charge the resident from the facility a specified in § 483.12(a).

(ii) The facility must also promptly notify the resident and, if known, th resident's legal representative or inter ested family member when there is—

(A) A change in room or roommat assignment as specified in § 483.15(e)(2) or

(B) A change in resident rights unde Federal or State law or regulations a specified in paragraph (b)(1) of this sec tion.

(iii) The facility must record and pe riodically update the address an phone number of the resident's lega representative or interested famil member.

(c) *Protection of resident funds.* (1) Th resident has the right to manage his o her financial affairs, and the facilit may not require residents to depos their personal funds with the facility.

(2) *Management of personal funds.* Upon written authorization of a res dent, the facility must hold, safeguard manage, and account for the persona funds of the resident deposited with th facility, as specified in paragraph (c)(3)–(8) of this section.

(3) *Deposit of funds.* (i) *Funds in excess of $50.* The facility must deposit a residents' personal funds in excess $50 in an interest bearing account (o accounts) that is separate from any o the facility's operating accounts, an that credits all interest earned on res dent's funds to that account. (In poole accounts, there must be a separate ac counting for each resident's share.)

(ii) *Funds less than $50.* The facili must maintain a resident's persona funds that do not exceed $50 in a non interest bearing account, interest-bea ing account, or petty cash fund.

(4) *Accounting and records.* The facil ity must establish and maintain a sys tem that assures a full and comp and separate accounting, according generally accepted accounting p ciples, of each resident's personal fu

entrusted to the facility on the resident's behalf.

(i) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(ii) The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

(5) *Notice of certain balances.* The facility must notify each resident that receives Medicaid benefits—

(i) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and

(ii) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(6) *Conveyance upon death.* Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(7) *Assurance of financial security.* The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(8) *Limitation on charges to personal funds.* The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)

(i) *Services included in Medicare or Medicaid payment.* During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services:

(A) Nursing services as required at §483.30 of this subpart.

(B) Dietary services as required at §483.35 of this subpart.

(C) An activities program as required at §483.15(f) of this subpart.

(D) Room/bed maintenance services.

(E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry.

(F) Medically-related social services as required at §483.15(g) of this subpart.

(ii) *Items and services that may be charged to residents' funds.* Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:

(A) Telephone.

(B) Television/radio for personal use.

(C) Personal comfort items, including smoking materials, notions and novelties, and confections.

(D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.

(E) Personal clothing.

(F) Personal reading matter.

(G) Gifts purchased on behalf of a resident.

(H) Flowers and plants.

(I) Social events and entertainment offered outside the scope of the activities program, provided under §483.15(f) of this subpart.

(J) Noncovered special care services such as privately hired nurses or aides.

(K) Private room, except when therapeutically required (for example, isolation for infection control).

(L) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by §483.35 of this subpart.

(iii) *Requests for items and services.* (A) The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident.

(B) The facility must not require a resident (or his or her representative) to request any item or service as a condition of admission or continued stay.

(C) The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.

(d) *Free choice.* The resident has the right to—

(1) Choose a personal attending physician;

(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and

(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.

(e) *Privacy and confidentiality.* The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident;

(2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;

(3) The resident's right to refuse release of personal and clinical records does not apply when—

(i) The resident is transferred to another health care institution; or

(ii) Record release is required by law.

(f) *Grievances.* A resident has the right to—

(1) Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and

(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(g) *Examination of survey results.* A resident has the right to—

(1) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability; and

(2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

(h) *Work.* The resident has the right to—

(1) Refuse to perform services for the facility;

(2) Perform services for the facility, if he or she chooses, when—

(i) The facility has documented the need or desire for work in the plan of care;

(ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid;

(iii) Compensation for paid services is at or above prevailing rates; and

(iv) The resident agrees to the work arrangement described in the plan of care.

(i) *Mail.* The resident has the right to privacy in written communications, including the right to—

(1) Send and promptly receive mail that is unopened; and

(2) Have access to stationery, postage, and writing implements at the resident's own expense.

(j) *Access and visitation rights.* (1) The resident has the right and the facility must provide immediate access to any resident by the following:

(i) Any representative of the Secretary;

(ii) Any representative of the State;

(iii) The resident's individual physician;

(iv) The State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965);

(v) The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);

(vi) The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);

(vii) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and

(viii) Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.

(2) The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(3) The facility must allow representatives of the State Ombudsman, described in paragraph (j)(1)(iv) of this section, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with State law.

(k) *Telephone.* The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

(l) *Personal property.* The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

(m) *Married couples.* The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

(n) *Self-Administration of Drugs.* An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.

(o) *Refusal of certain transfers.* (1) An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate—

(i) A resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or

(ii) A resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.

(2) A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.

[56 FR 48867, Sept. 26, 1991, as amended at 57 FR 5302, Mar. 6, 1992; 57 FR 43924, Sept. 23, 1992; 57 FR 53587, Nov. 12, 1992; 60 FR 33293, June 27, 1995]

§ 483.12 Admission, transfer and discharge rights.

(a) Transfer and discharge—

(1) *Definition:* Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) *Transfer and discharge requirements.* The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) The safety of individuals in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate.

(3) *Documentation.* When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by—

(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

(4) *Notice before transfer.* Before a facility transfers or discharges a resident, the facility must—

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(5) *Timing of the notice.* (i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when—

(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or

(E) A resident has not resided in the facility for 30 days.

(6) *Contents of the notice.* The written notice specified in paragraph (a)(4) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement that the resident has the right to appeal the action to the State;

(v) The name, address and telephone number of the State long term care ombudsman;

(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

(7) *Orientation for transfer or discharge.* A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(b) *Notice of bed-hold policy and readmission*—(1) *Notice before transfer.* Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies—

(i) The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility; and

(ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

(2) *Bed-hold notice upon transfer.* At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

(3) *Permitting resident to return to facility.* A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident—

(i) Requires the services provided by the facility; and

(ii) Is eligible for Medicaid nursing facility services.

(c) *Equal access to quality care.*

(1) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment;

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in §483.10(b)(5)(i) and (b)(6) describing the charges; and

(3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.

(d) *Admissions policy.*

(1) The facility must—

(i) Not require residents or potential residents to waive their rights to Medicare or Medicaid; and

(ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

(2) The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,—

(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and

(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

(4) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

[56 FR 48869, Sept. 26, 1991, as amended at 57 FR 43024, Sept. 23, 1992]

§483.13 Resident behavior and facility practices.

(a) *Restraints.* The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

(b) *Abuse.* The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

(c) *Staff treatment of residents.* The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

(1) The facility must—

(i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

(ii) Not employ individuals who have been—

(A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or

(B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and

(iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

[56 FR 48870, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992]

§ 483.15 Quality of life.

A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

(a) *Dignity.* The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

(b) *Self-determination and participation.* The resident has the right to—

(1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;

(2) Interact with members of the community both inside and outside the facility; and

(3) Make choices about aspects of his or her life in the facility that are significant to the resident.

(c) *Participation in resident and family groups.* (1) A resident has the right to organize and participate in resident groups in the facility;

(2) A resident's family has the right to meet in the facility with the families of other residents in the facility;

(3) The facility must provide a resident or family group, if one exists, with private space;

(4) Staff or visitors may attend meetings at the group's invitation;

(5) The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings;

(6) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

(d) *Participation in other activities.* A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(e) *Accommodation of needs.* A resident has the right to—

(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

(2) Receive notice before the resident's room or roommate in the facility is changed.

(f) *Activities.* (1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

(2) The activities program must be directed by a qualified professional who—

(i) Is a qualified therapeutic recreation specialist or an activities professional who—

(A) Is licensed or registered, if applicable, by the State in which practicing; and

(B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or

(ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or

(iii) Is a qualified occupational therapist or occupational therapy assistant; or

(iv) Has completed a training course approved by the State.

(g) *Social Services.* (1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

(2) A facility with more than 120 beds must employ a qualified social worker on a full-time basis.

(3) *Qualifications of social worker.* A qualified social worker is an individual with—

(i) A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and

(ii) One year of supervised social work experience in a health care setting working directly with individuals.

(h) *Environment.* The facility must provide—

(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

(3) Clean bed and bath linens that are in good condition;

(4) Private closet space in each resident room, as specified in § 483.70(d)(2)(iv) of this part;

(5) Adequate and comfortable lighting levels in all areas;

(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71–81°F; and

(7) For the maintenance of comfortable sound levels.

[56 FR 48871, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992]

§ 483.20 Resident assessment.

The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

(a) *Admission orders.* At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

(b) *Comprehensive assessments.*

(1) *Resident assessment instrument.* A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:

(i) Identification and demographic information.

(ii) Customary routine.

(iii) Cognitive patterns.

(iv) Communication.

(v) Vision.

(vi) Mood and behavior patterns.

(vii) Psychosocial well-being.

(viii) Physical functioning and structural problems.

(ix) Continence.

(x) Disease diagnoses and health conditions.

(xi) Dental and nutritional status.

(xii) Skin condition.

(xiii) Activity pursuit.

(xiv) Medications.

(xv) Special treatments and procedures.

(xvi) Discharge potential.

4/22/2004

To: Peter Anderson

From: Simrin Takhar, Legislative Assistant
California Association of Health Facilities
(916)441-6400 X 117

Re: AB 2791

Pages incl. cover: 11

SENATE HEALTH AND HUMAN SERVICES COMMITTEE ANALYSIS

Senator Deborah V. Ortiz, Chair

BILL NO:	**AB 2791**	**A**
AUTHOR:	**Simitian**	**B**
AMENDED:	**May 11, 2004**	
HEARING DATE:	**June 30, 2004**	**2**
FISCAL:	**Appropriations**	**7**
		9
CONSULTANT:		**1**
Bohannon / Vazquez / ak		

SUBJECT

Skilled nursing and intermediate care facilities: training

SUMMARY

This bill requires the approved training program of a skilled nursing facility (SNF) and an intermediate care facility (ICF) to include instruction on preventing, recognizing, and reporting residents' rights violations as part of the current training and instruction required under existing law.

ABSTRACT

Existing law:

1. Requires a SNF or ICF to adopt an approved training program that meets standards established by the State Department of Health Services (DHS).

2. Requires the approved training program to consist of at least the following:
   a. An orientation program to be given to newly employed nurse assistants prior to providing direct patient care in a SNF or ICF;
   b. A precertification training program consisting of:
      - At least 60 classroom hours of training on basic nursing skills, patient safety and rights, the social and psychological problems of patients, and resident abuse prevention, recognition, and reporting;
      - At least 100 hours of supervised and on-the-job training clinical practice;
      - At least two hours of the 60 hours of the classroom training and at least four hours of the 100 hours of the supervised clinical training shall address the special needs of persons with developmental and mental disorders;
   c. Continuing in-service training to assure continuing competency in existing and new nursing skills; and,
   d. Each facility shall consider including training regarding the characteristics and method of assessment and treatment of AIDS.

Continued---

3. Permits a resident or patient of a SCF or ICF to bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights.

4. Requires the licensee to be liable for the acts of the licensee's employees.

5. Makes the licensee liable for up to $500 and for costs and attorney fees, and authorizes the licensee to be enjoined from permitting the violation to continue.

6. Makes an agreement by a resident or patient to waive his or her rights to sue pursuant to this bill void as contrary to public policy.

Existing SNF regulation:

1. Establishes a Patients Bill of Rights, which enumerates 26 rights, including the right to be fully informed, to be transferred or discharged only for specified reasons, to be free from mental and physical abuse, and to be treated with consideration and respect.

This bill:

1. Requires the approved training program to include a minimum of one hour of instruction on preventing, recognizing, and reporting residents' rights violations, within the 60 hours of classroom training required under current law.

2. Requires instruction on preventing, recognizing, and reporting residents' rights violations be included, as part of existing instruction, within the total minimum hours of continuing education or in-service training required for certified nursing assistants.

3. Permits a current or former resident of a SNF or ICF to bring civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights.

4. Makes several clarifying technical changes to existing law.

FISCAL IMPACT

According to the Assembly Committee on Appropriations, there will be minor absorbable costs to DHS.

BACKGROUND AND DISCUSSION

According to the author, the intent of this bill is to ensure that nursing home residents' rights are not violated. He believes that in addition to residents knowing their rights, more importantly, the people who care for them must know how to uphold them.

Existing training requirements

Existing law requires a SNF or ICF to adopt an approved training program that meets standards established by DHS. The approved training program must consist of certain requirements, including at the minimum a precertification training program that has at least 60 classroom hours of training on basic nursing skills, patient safety and rights, the

Continued---

social and psychological problems of patients, and resident abuse prevention, recognition, and reporting. Within the 60 hours of classroom training, a minimum of six hours of instruction is required on preventing, recognizing, and reporting instances of resident abuse. The bill would include, within the 60 hours of classroom training, one hour of instruction on preventing, recognizing, and reporting residents' rights violations.

Existing law provides that a continuing in-service training requirement must be a component of a SNF or INF's training program to assure continuing competency in existing and new nursing skills. Within this training requirement, current law requires a minimum of four hours of instruction on preventing, recognizing, and reporting instances of resident abuse be included within the total minimum hours of training. This bill would require inclusion of instruction on preventing, recognizing, and reporting residents' rights violations within the existing four-hour minimum requirement.

Existing Training Requirements	AB 2791 Training Requirements
Orientation Program	
Precertification Training Program including: 60 hours of classroom training, including - Mandatory minimum of six hours of instruction on preventing, recognizing and reporting instances of resident abuse - Mandatory two hours of training addressing the special needs of persons with developmental and mental disorders	Precertification Training Program including: 60 hours of classroom training, including - Mandatory minimum of six hours of instruction on preventing, recognizing and reporting instances of resident abuse - Mandatory two hours of training addressing the special needs of persons with developmental and mental disorders - *Mandatory one hour of instruction on preventing, recognizing and reporting instances of residents' rights violations*
At least 100 hours of supervised and on-the-job training clinical practice including: - Mandatory four hours of training addressing the special needs of persons with developmental and mental disorders	At least 100 hours of supervised and on-the-job training clinical practice including: - Mandatory four hours of training addressing the special needs of persons with developmental and mental disorders
Continuing, in service training	
- Mandatory minimum four hours of instruction on preventing, recognizing and reporting instances of resident abuse	- Mandatory minimum four hours of instruction on preventing, recognizing and reporting instances of resident abuse, *including instruction on preventing, recognizing and reporting residents' rights violations*

Continued—

Arguments in support

Supporters of the bill believe that no California citizen should have to surrender their basic rights and civil protections because he or she has been admitted to a nursing home. They argue that although federal and state laws have established the rights of nursing home residents, these rights are frequently infringed upon by nursing home facilities. Additionally, supporters argue that residents are illegally evicted, denied phone calls or visitors, and are subjected to humiliation by being paraded naked through a facility – all actions that are violations of their rights.

PRIOR ACTIONS

Assembly Floor:	77 – 0 Pass
Assembly Appropriations:	21 – 0 Do Pass, to Consent Calendar
Assembly Health:	16 – 0 Do Pass as Amended

POSITIONS

Support:

AARP California
Bet Tzedek Legal Services
California Advocates for Nursing Home Reform
California Senior Legislature
California State Employees Association
Consumer Attorneys of California
Council on Aging
County of Santa Cruz
Jewish Family Services
Los Angeles Metro Muli-Disciplinary Team
National Senior Citizens Law Center
Older Women's League of California
Ombudsman/ Advocate, Inc.
Protect Our Parents

Oppose: None received.

-- END --

HAND DELIVER

BACKGROUND INFORMATION REQUEST

TO: ASSEMBLY MEMBER Simitian ROOM 5119

SUBJECT: AB 2791 CONSULTANT:

The above bill has been referred to this Committee for consideration. Please complete the following questions WITH ANY SUPPORTING DOCUMENTATION and HAND DELIVER *TWO COMPLETE SETS* **to Room 2191** AS SOON AS POSSIBLE. **The second set will be forwarded to designated staff in the Republican Caucus.**

➔ Attach copies of ALL ASSEMBLY ANALYSES (policy, fiscal, floor analyses)
➔ Do you plan on amending this bill prior to the hearing?

( ) *YES, will amend* (Please provide brief summary explaining what amendments will accomplish. Indicate if subject of amendments has been addressed by any previous committee.)

(x) NO, will not amend

Amendments - **PLEASE SUBMIT** ONE SIGNED ORIGINAL PLUS NINE UNSIGNED COPIES- **must be submitted in** *Legislative Counsel form* **to the Committee Assistant in Room 2191 NO LATER THAN** 2:00 PM WEDNESDAY OF THE WEEK PRIOR TO THE BILL'S HEARING DATE. **MAJOR LAST MINUTE AMENDMENTS MAY NECESSITATE PUTTING THE BILL OVER TO A LATER DATE.**

1. What is the intent of the bill and reasons prompting its introduction?

The intent of the bill is to ensure that nursing home residents' rights are not violated. Residents' rights, authorized by the Patients Bill of Rights and other state and federal law and regulation, offer several important protections, including:

- the right to be fully informed about services and charges
- the right to refuse treatment
- the right to be free from mental and physical abuse
- the right to have visitors
- the right to have access to the telephone
- the right to not be transferred or evicted illegally

Many residents do not have real choice in selecting a nursing home. Residents are also a vulnerable, captive population. It is not enough that residents know what their rights. The people who care for them must know how to uphold these rights. With an aging population, as well as growing complaints about nursing homes made to the Department of Health Services and the Ombudsman, greater education about preventing, recognizing and reporting residents' rights violations is needed.

2. Sponsor (include phone number).

   California Senior Legislature – June Hamilton, 916-322-5630

3. Staff contact (include phone number and please provide an off-hours phone number).

   Lark Park, 319-2021, pager: 916-857-8877, home: 916-739-0419

4. What is the fiscal impact?

   Minor absorbable costs to DHS.

5. Give summary of arguments in support or opposition--*Attach copies of support/oppose letters*.

   The bill was substantially amended from its original form. There is no opposition.

   Arguments in support: Growing number of complaints filed to Ombudsman and DHS about nursing home residents' rights violations, and changing requirements in staffing of skilled nursing facilities prompt greater education and awareness about preventing, recognizing and reporting residents' rights violations.

6. If any related PRIOR legislation, attach analyses and veto message (if applicable).

7. Other comments.

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referra
Chapter 3. Skilled Nursing Facilities
Article 5. Administration
§72527. Patients' Rights.

§72527. Patients' Rights.

• Note • History

(a) Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated. The facility shall establish and implement written policies and procedures which include these rights and shall make a copy of these policies available to the patient and to any representative of the patient. The policies shall be accessible to the public upon request. Patients shall have the right:

(1) To be fully informed, as evidenced by the patient's written acknowledgement prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(2) To be fully informed, prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or not covered under Titles XVIII or XIX of the Social Security Act.

(3) To be fully informed by a physician of his or her total health status and to be afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care including the identification of medical, nursing and psychosocial needs and the planning of related services.

(4) To consent to or to refuse any treatment or procedure or participation in experimental research.

(5) To receive all information that is material to an individual patient's decision concerning whether to accept or refuse any proposed treatment or procedure. The disclosure of material information for administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function shall include the disclosure of information listed in Section 72528(b).

(6) To be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment for his or her stay and to be given reasonable advance notice to ensure orderly transfer or discharge. Such actions shall be documented in the patient's health record.

(7) To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

(8) To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept written delegation of this responsibility subject to the provisions of Section 72529.

(9) To be free from mental and physical abuse.

(10) To be assured confidential treatment of financial and health records and to approve or refuse

their release, except as authorized by law.

(11) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.

(12) Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.

(13) To associate and communicate privately with persons of the patient's choice, and to send and receive personal mail unopened.

(14) To meet with others and participate in activities of social, religious and community groups.

(15) To retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the health, safety or rights of the patient or other patients.

(16) If married, to be assured privacy for visits by the patient's spouse and if both are patients in the facility, to be permitted to share a room.

(17) To have daily visiting hours established.

(18) To have visits from members of the clergy at any time at the request of the patient or the patient's representative.

(19) To have visits from persons of the patient's choosing at any time if the patient is critically ill, unless medically contraindicated.

(20) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

(21) To have reasonable access to telephones and to make and receive confidential calls.

(22) To be free from any requirement to purchase drugs or rent or purchase medical supplies or equipment from any particular source in accordance with the provisions of Section 1320 of the Health and Safety Code.

(23) To be free from psychotherapeutic drugs and physical restraints used for the purpose of patient discipline or staff convenience and to be free from psychotherapeutic drugs used as a chemical restraint as defined in Section 72018, except in an emergency which threatens to bring immediate injury to the patient or others. If a chemical restraint is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient and used only for a specified and limited period of time.

(24) Other rights as specified in Health and Safety Code, Section 1599.1.

(25) Other rights as specified in Welfare and Institutions Code, Sections 5325 and 5325.1, for persons admitted for psychiatric evaluations or treatment.

(26) Other rights as specified in Welfare and Institutions Code Sections 4502, 4503 and 4505 for patients who are developmentally disabled as defined in Section 4512 of the Welfare and Institutions Code.

(b) A patient's rights, as set forth above, may only be denied or limited if such denial or limitation is otherwise authorized by law. Reasons for denial or limitation of such rights shall be documented in the patient's health record.

(c) If a patient lacks the ability to understand these rights and the nature and consequences of proposed treatment, the patient's representative shall have the rights specified in this section to the extent the right may devolve to another, unless the representative's authority is otherwise limited. The patient's incapacity shall be determined by a court in accordance with state law or by the patient's physician unless the physician's determination is disputed by the patient or patient's representative.

(d) Persons who may act as the patient's representative include a conservator, as authorized by Parts 3 and 4 of Division 4 of the Probate Code (commencing with Section 1800), a person

designated as attorney in fact in the patient's valid durable power of attorney for health care, patient's next of kin, other appropriate surrogate decisionmaker designated consistent with statutory and case law, a person appointed by a court authorizing treatment pursuant to Part 7 (commencing with Section 3200) of Division 4 of the Probate Code, or, if the patient is a minor, a person lawfully authorized to represent the minor.

(e) Patients' rights policies and procedures established under this section concerning consent, informed consent and refusal of treatments or procedures shall include, but not be limited to the following:

(1) How the facility will verify that informed consent was obtained or a treatment or procedure was refused pertaining to the administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability of the patient to regain the use of a normal bodily function.

(2) How the facility, in consultation with the patient's physician, will identify consistent with current statutory case law, who may serve as a patient's representative when an incapacitated patient has no conservator or attorney in fact under a valid Durable Power of Attorney for Health Care.

NOTE

Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1320, 1599, 1599.1, 1599.2 and 1599.3, Health and Safety Code; and *Cobbs* v. *Grant* (1972) 8 Cal.3d 229.

HISTORY

1. Amendment of subsections (a) and (b), repealer of subsection (c), and new subsections (c), (d), and (e) filed 5-27-92; operative 5-27-92 (Register 92, No. 22).

§72528. Informed Consent Requirements.

 • Note • History

(a) It is the responsibility of the attending physician to determine what information a reasonable person in the patient's condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure. Information that is commonly appreciated need not be disclosed. The disclosure of the material information and obtaining informed consent shall be the responsibility of the physician.

(b) The information material to a decision concerning the administration of a psychotherapeutic drug or physical restraint, or the prolonged use of a device that may lead to the inability of the patient to regain use of a normal bodily function shall include at least the following:

(1) The reason for the treatment and the nature and seriousness of the patient's illness.

(2) The nature of the procedures to be used in the proposed treatment including their probable frequency and duration.

(3) The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment.

(4) The nature, degree, duration and probability of the side effects and significant risks, commonly known by the health professions.

(5) The reasonable alternative treatments and risks, and why the health professional is recommending this particular treatment.

(6) That the patient has the right to accept or refuse the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time.

(c) Before initiating the administration of psychotherapeutic drugs, or physical restraints, or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function, facility staff shall verify that the patient's health record contains documentation that the patient has given informed consent to the proposed treatment or procedure. The facility shall also ensure that all decisions concerning the withdrawal or withholding of life sustaining treatment are documented in the patient's health record.

(d) This section shall not be construed to require obtaining informed consent each time a treatment or procedure is administered unless material circumstances or risks change.

(e) There shall be no violation for initiating treatment without informed consent if there is documentation within the patient's health record that an emergency exists where there is an unanticipated condition in which immediate action is necessary for preservation of life or the prevention of serious bodily harm to the patient or others or to alleviate severe physical pain, and it is impracticable to obtain the required consent, and provided that the action taken is within the customary practice of physicians of good standing in similar circumstances.

(f) Notwithstanding Sections 72527(a)(5) and 72528(b)(4), disclosure of the risks of a proposed treatment or procedure may be withheld if there is documentation of one of the following in the patient's health record:

(1) That the patient or patient's representative specifically requested that he or she not be informed of the risk of the recommended treatment or procedure. This request does not waive the requirement for providing the other material information concerning the treatment or procedure.

(2) That the physician relied upon objective facts, as documented in the health record, that would demonstrate to a reasonable person that the disclosure would have so seriously upset the patient that the patient would not have been able to rationally weigh the risks of refusing to undergo the recommended treatment and that, unless inappropriate, a patient's representative gave informed consent as set forth herein.

HEALTH AND SAFETY CODE
Section 1430

1430. (a) Except where the state department has taken action and the violations have been corrected to its satisfaction, any licensee who commits a class "A" or "B" violation may be enjoined from permitting the violation to continue or may be sued for civil damages within a court of competent jurisdiction. Such actions for injunction or civil damages, or both, may be prosecuted by the Attorney General in the name of the people of the State of California upon his or her own complaint or upon the complaint of any board, officer, person, corporation or association, or by any person acting for the interests of itself, its members or the general public. The amount of civil damages which may be recovered in an action brought pursuant to this section shall not exceed the maximum amount of civil penalties which could be assessed on account of the violation or violations.

(b) A resident or patient of a skilled nursing facility, as defined in subdivision (c) of Section 1250, or intermediate care facilities, as defined in subdivision (d) of Section 1250, may bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights in Section 72527 of Title 22 of the California Administrative Code. The suit shall be brought in a court of competent jurisdiction. The licensee shall be liable for the acts of the licensee's employees. The licensee shall be liable for up to five hundred dollars ($500), and for costs and attorney fees, and may be enjoined from permitting the violation to continue. An agreement by a resident or patient of a skilled nursing facility or intermediate care facility to waive his or her rights to sue pursuant to this subdivision shall be void as contrary to public policy.

(c) The remedies specified in this section shall be in addition to any other remedy provided by law.

(Amended by Stats. 1982, Ch. 1455, Sec. 1.)

existing law

HEALTH AND SAFETY CODE
Section 1337.1

1337.1. A skilled nursing or intermediate care facility shall adopt an approved training program that meets standards established by the state department. The approved training program shall consist of at least the following:

(a) An orientation program to be given to newly employed nurse assistants prior to providing direct patient care in skilled nursing or intermediate care facilities.

(b) (1) A precertification training program consisting of at least 60 classroom hours of training on basic nursing skills, patient safety and rights, the social and psychological problems of patients, and resident abuse prevention, recognition, and reporting pursuant to subdivision (e). The 60 classroom hours of training may be conducted within a skilled nursing or intermediate care facility or in an educational institution.

(2) In addition to the 60 classroom hours of training required under paragraph (1), the precertification training program shall consist of at least 100 hours of supervised and on-the-job training clinical practice. The 100 hours may consist of normal employment as a nurse assistant under the supervision of either the director of nurse training or a licensed nurse qualified to provide nurse assistant training who has no other assigned duties while providing the training.

(3) At least two hours of the 60 hours of classroom training and at least four hours of the 100 hours of the supervised clinical training shall address the special needs of persons with developmental and mental disorders, including mental retardation, Alzheimer's disease, cerebral palsy, epilepsy, dementia, Parkinson's disease, and mental illness.

(4) In a precertification training program subject to this subdivision, credit shall be given for the training received in an approved precertification training program adopted by another skilled nursing or intermediate care facility.

(5) This subdivision shall not apply to a skilled nursing or intermediate care facility that demonstrates to the state department that it employs only nurse assistants with a valid certification.

(c) Continuing in-service training to assure continuing competency in existing and new nursing skills.

(d) Each facility shall consider including training regarding the characteristics and method of assessment and treatment of acquired immune deficiency syndrome (AIDS).

(e) (1) The approved training program shall include, within the 60 hours of classroom training, a minimum of six hours of instruction on preventing, recognizing, and reporting instances of resident abuse utilizing those courses developed pursuant to Section 13823.93 of the Penal Code.

(2) A minimum of four hours of instruction on preventing, recognizing, and reporting instances of resident abuse shall be included within the total minimum hours of continuing education or in-service training required and in effect for certified nursing assistants.

(Amended by Stats. 2001, Ch. 685, Sec. 9. Effective January 1, 2002.)

HEALTH AND SAFETY CODE Section: 1337.1

CONSUMER ATTORNEYS OF CALIFORNIA

SUPPORT

April 20, 2004

The Honorable Joe Simitian
5119 State Capitol
Sacramento, CA 95814

RE: AB 2791 (Simitian) SUPPORT

Dear Assembly Member Simitian:

[redacted] as a member of the Protect Our Parents coalition, support AB 2791 (Simitian), which is scheduled to be heard before the Assembly Health Committee on April 27, 2004.

AB 2791 increases the fines for a licensee's violation of the rights of a resident or patient (as detailed in the Patients Bill of Rights) from $500 to $5,000.

Elder abuse in California is a serious problem. In California, a recent report found that more than 40% of the state's 1,352 nursing homes were cited for abuse. In Los Angeles County, 37% of the homes were cited.

Further, a 2003 GAO report found that "despite federal and state oversight infrastructure currently in place, certain California nursing homes have not been and currently are not sufficiently monitored to guarantee the safety and welfare of their residents."

If you or a member of your staff would like to discuss this further, please contact me or one of our legislative representatives in Sacramento.

Sincerely,

James C. Sturdevant
President

Sharon Arkin
President-Elect

cc: Assembly Health Committee

LEGISLATIVE DEPARTMENT
770 L Street, Suite 1200, Sacramento, CA 95814-2721 • (916) 442-6902 • FAX (916) 442-7734
info@caoc.org • http://www.caoc.com

STATE OF CALIFORNIA
CALIFORNIA SENIOR LEGISLATURE
1600 K Street, 4th Floor, Sacramento, CA 95814
Phone (916) 322-5630 Fax (916) 327-1859

SUPPORT April 20, 2004

The Honorable S. Joseph Simitian
California State Assembly
State Capitol, Room 5119
Sacramento, California 95814

Dear Assembly Member Simitian:

Sponsor for AB 2791 (Simitian), as amended April 1, 2004

On behalf of the 120 members of the [redacted], representing 4 million seniors through effective legislative advocacy, I want to thank you for introducing AB 2791. This bill will expand the liability limit for nursing homes for violation of residents' rights from $ 500 to $ 5,000 and it will clarify that it applies to both current and former residents.

It has been two decades since the Health and Safety Code was amended to allow a private right of action for residents of nursing homes whose rights have been violated. Despite many cases of documented violations of residents' rights, the code has been ineffective due to the $ 500 award limit on these cases. The appropriateness of the penalty for a violation of a resident's rights should depend on the severity of the harm to the resident. AB 2791 seeks to make the awards reflect the severity of harm to the resident.

AB 2791 is a positive step in our efforts to protect California's senior population and to reduce the number of violations of residents' rights . We are committed to working with you to ensure the passage and signing of AB 2791. If you would like to discuss this bill with us, please contact Senior Assembly Members Donna Ambrogi at (909) 625-2558 or Helen Karr at (650) 992-5793 or by email: hehkarr@aol.com, or June P. Hamilton, Legislative Liaison, at (916) 322-5630 or by email: jhamil@ccoa.ca.gov.

Sincerely,

Edward Woods

Ed Woods, Chair
Joint Rules Committee (CSL)

jph.ab2791sponsor.ltr4.04

Sponsored by the California Commission on Aging and funded by the California Fund for Senior Citizens

California Advocates for Nursing Home Reform

415-974-5171 • 800-474-1116 • Fax 415-777-2904 • www.canhr.org • info@canhr.org
650 Harrison Street, 2nd Floor • San Francisco, California 94107

SUPPORT

April 20, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, CA 95814

RE: AB 2791(Simitian) - Support

Dear Assemblymember Cohn:

On behalf of [redacted] I would like to express our support for AB 2791 (Simitian), which would expand the provisions of a private right of action for nursing home residents whose rights have been violated.

Health and Safety Code §1430(b) provides for the only remedy available for violation of residents' rights in California. Unfortunately, since this law was first enacted in 1982, fewer than five such actions have been filed. Although remedies available under this section include injunctive relief - an important remedy for violation of residents' rights - the $500 limit on damages so reduces the likelihood of legal representation, any opportunity for relief is moot.

Thus, residents who are illegally evicted, denied phone calls or visitors or subjected to humiliation by being paraded naked through a facility, are denied any relief.

I strongly urge your support of AB 2791, which would help make enforcement of residents' rights more than just words.

Sincerely,

Patricia L. McGinnis
Executive Director

cc: Assemblyman Joseph Simitian

National Senior Citizens Law Center

3435 Wilshire Boulevard, Suite 2860 • Los Angeles, CA 90010 • Tel: (213) 639-0930 • Fax: (213) 639-0934
www.nsclc.org
Writer's email: ecarlson@nsclc.org
Writer's extension: 313

Edward C. King
Executive Director

Gerald A. McIntyre
Directing Attorney

SUPPORT

April 21, 2004

Hon. Joseph Simitian
State Capitol
Sacramento, California 95814

Re: Support for AB 2791 (Simitian);
Protection of Rights of Nursing Home Residents

Dear Assemblymember Simitian:

We are pleased to support your Assembly Bill 2791, which takes an important step in protecting the rights of nursing home residents.

For almost 30 years, the [redacted] has worked to protect the rights of elder Americans in relation to Social Security, Medicare, Medicaid, nursing homes, and other areas. I have worked full-time in protecting the rights of nursing facility residents (and residential care facility residents) since 1989, first in a Los Angeles legal services program and then, since 2001, with the National Senior Citizens Law Center. I am well aware of the difficulties faced by residents and their family members

Although federal and state law is reasonably good in establishing rights, too often enforcement of those rights is negligible or nonexistent. There are good and bad nursing homes, and the bad nursing homes will violate the law based on a cynical calculus that poor care is cheaper (and thus more profitable) than compliance with law.

By raising the cap on actual damages from $500 to $5,000, for a violation of a resident's rights, AB 2791 will help to compel compliance with law. There is no good reason why under current law a nursing facility can cause damages of $4,000 (for example), and have its liability for a proven resident's rights violation capped at $500.

Sincerely,

:ic M. Carlson, Esq.

Ombudsman/Advocate, Inc.
525 Laurel St. Ste.140
Santa Cruz, CA 95060
Santa Cruz (831) 429-1913 San Benito (831) 636-1638 Fax 429-9102

Protect, through advocacy, education and intervention, the rights of facility-placed seniors and disabled persons, and individuals with mental health needs.

April 24, 2004

Assemblywoman Rebecca Cohn, Chair
Assembly Health Committee
State Capitol, Rm. 6005
Sacramento, CA 95814
Fax #: 916-319-2197

SUPPORT

RE: AB 2791

Dear Assemblywoman Cohn,

[redacted] Inc., I'm writing, on behalf of the Long-Term Care Ombudsman Program and the Patients' Rights Advocate Program serving Santa Cruz and San Benito Counties, in support of AB 2791, introduced by Assemblyman Simitian.

The long-term care facility-placed residents deserve a legal outlet that can realistically assist in rights protection. In the best of cases, facility residents have limited access to legal assistance. With so little value placed on rights violations and abuse occurrences, legal counsel has been virtually nonexistent. Increasing the damages available improves the practicality of legal recourse.

As you may be aware, state oversight agencies do not, or are unable to, adequately address rights and abuse issues to the residents' satisfaction. Since we are a society in which importance is often attached to a dollar value, increasing the amount of damages from $500 to $5,000, not only provides a more viable course of action for residents, but increases the importance of residents' rights to dignity and quality of care, regardless of their residence.

Ombudsman/Advocate, Inc., an independent nonprofit providing advocacy and rights protection to seniors, facility-placed residents and mental health clients, urges your support of AB 2791 in Committee and active support for an Assembly full vote.

Sincerely,

Kathleen Johnson
Executive Director
Ombudsman/Advocate, Inc.
525 Laurel St., Ste. 140
Santa Cruz, CA 95010
831-429-1913

cc: Assemblyman Joe Simitian

AARP California

SUPPORT

SENATE HEALTH & HUMAN SERVICES COMMITEE
SAVE
DO NOT REMOVE FROM FILE

April 26, 2004

Honorable Rebecca Cohn, Chair
Assembly Health Committee
State Capitol, Room 6005
Sacramento, California 95814

via Facsimile & Mail

Re: AB 2791 (Simitian) Support

Dear Assemblymember Cohn:

On behalf of the over 3 million members of [redacted] I am pleased to communicate our support for AB 2791.

We commend this legislation to expand the provisions of a private right of action for nursing home residents whose rights have been violated.

Health and Safety Code 1430(b) provides for the only remedy available for violation of residents' rights in California. Unfortunately, since this law was first enacted in 1982, fewer than five such actions have been filed. Although remedies available under this section include injunctive relief, an important remedy for violation of residents' rights the $500 limit on damages so reduces the likelihood of legal representation, any opportunity for relief is moot.

As a consequence, residents who are illegally evicted, denied phone calls or visitors or subjected to humiliation in any form, are denied any relief.

AARP strongly urges your support for AB 2791, which would help make enforcement of residents' rights more than just a symbolic gesture.

Thank you for your consideration. If you have any questions on our position or need more information, please contact, Lupe De La Cruz, Manager of Advocacy, at 916-556-3036.

Respectfully,

Helen Russ
California State President

cc: Assemblymember Simitian
Assembly Committee on Aging & LTC

980 9th Street, Suite 700 | Sacramento, CA 95814 | 916-446-2277 | 916-556-3000 fax
200 South Los Robles Avenue, Suite 400 | Pasadena, CA 91101 | 626-585-9500 | 626-583-8500 fax
James G. Parkel, President | William D. Novelli, Executive Director and CEO | www.aarp.org/ca

Bet Tzedek Legal Services
THE HOUSE OF JUSTICE
[illegible] Victory Boulevard • North Hollywood • California 91606
[illegible]one (818) 769-0136 • Facsimile (818) 763-3299 • www.bettzedek.org

SUPPORT

Writer's Direct Line: (818) 487-5226
Writer's E-mail: jspiegel@bettzedek.org

April 30, 2004

VIA FACSIMILE (916)319-2121

The Honorable Joseph Simitian
California State Assembly
State Capitol, Room 5119
Sacramento, California 95814

Re: Support for AB 2791 (Simitian),

Dear Assemblymember Simitian:

I am writing on behalf of [redacted] to express our strong support for AB 2791, which would modestly increase the liability limit against nursing homes who violate fundamental residents' rights from $500 to $5,000.

Bet Tzedek is a non-profit public interest law center providing free legal representation to over 10,000 low-income, elderly, and disabled people each year throughout Los Angeles County. As Director of the Nursing Home Advocacy Project at Bet Tzedek, I receive numerous telephone calls every week from distraught seniors and their families regarding violations of residents' rights by nursing facilities, including: illegal transfers and discharges; mental and physical abuse; medically unnecessary use of restraints; failure to communicate and coordinate health care; lack of quality care; and denial of access to visitors, telephones, and mail.

AB 2791 is an important and necessary step in helping the elderly and disabled. No California citizen should have to surrender basic rights and civil protections because he or she has been admitted to a nursing home. Although federal and state laws establish the rights of nursing home residents, these rights are frequently infringed upon by nursing facilities because of the lack of oversight and enforcement. By raising the cap on damages for a violation of resident's rights from $500 to $5,000, AB 2791 will help to safeguard fundamental freedoms which no person should have to do without.

Thank you for your stewardship in helping our seniors in their homes away from home, and for making enforcement of their rights a top priority.

Sincerely,

Jody L. Spiegel
Director, Nursing Home Advocacy Project

G:\Jody\Legislation\AB 2791 ltr2Simitian 4.30.04.wpd

PROTECT OUR PARENTS

A COALITION OF:

The Congress of California Seniors, GRAY Panthers, California Advocates for Nursing Home Reform, Older Women's League, Californians For Quality Care, Consumer Attorneys of California, AARP, and the Consumer Federation of California

SUPPORT

May 3, 2004

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, CA 95814

RE: AB 2791 (SIMITIAN) SUPPORT

On behalf of the [redacted], a coalition of senior advocate organizations, I would like to express our support for AB 2791 (Simitian), which would expand the civil liability limit for a private right of action for nursing home residents whose rights have been violated.

Residents' rights are more than just words. They reflect the quality of daily living in care facilities. Health and Safety Code 1430(b) provides a remedy for violations of residents' rights in California. But since the law was first enacted, few actions have been filed despite the numerous documented violations of residents' rights. By raising the cap on civil damages from $500 to $5,000 for a violation of residents' rights, AB 2791 will help to compel compliance with the law.

AB 2791 is a positive step toward protecting California's growing senior population. We strongly urge your support of AB 2791.

cc: Assemblyman Joe Simitian
Assembly Health Committee

L.A. METRO MULTI-DISCIPLINARY TEAM
For Consultation on Elders at Risk

SUPPORT

"A Community-Government Partnership Working Together to Insure Safety, Respect, Quality of Life and Justice for Seniors"

May 3, 2004

The Honorable S. Joseph Simitian
California State Assembly
State Capitol, Room 5119
Sacramento, California 95814

RE: AB 2791 (Simitian)

Dear Assembly Member Simitian:

As Co-Chair of the L[redacted] (MDT) for Consultation on Elders at Risk and Publisher of *www.LA4seniors.com*, I want to thank you for introducing AB 2791 to protect the rights and dignity of nursing home residents.

By expanding the liability limit when a nursing home violates residents' rights from $ 500 to $ 5,000, AB 2791 will provide a needed remedy and access to justice. AB 2791 will also create an incentive for facilities to provide quality care to elderly residents and be an effective deterrent against abuse and neglect.

Nursing home patients are the most vulnerable, isolated and forgotten members of our community. I am grateful for your work on their behalf and am committee to working with you to ensure the passage and signing of AB 2791.

Sincerely,

Anne Marie Lardeau
Co-chair, L.A. Metro MDT

Organization Address:
3440 Troy Drive
Hollywood, CA 90068-1436

Web Address:
http://www.la4seniors.com

Phone: 323-876-4121
Fax: 323-876-4197
Email: MDT@la4seniors.com

BEFORE THE BOARD OF SUPERVISORS
OF THE COUNTY OF SANTA CRUZ, STATE OF CALIFORNIA

RESOLUTION NO. 130-2004

On the motion of Supervisor Pirie
duly seconded by Supervisor Campos
the following resolution is adopted

RESOLUTION URGING PASSAGE OF ASSEMBLY BILL 2791

WHEREAS, Assembly Member Joe Simitian has introduced Assembly Bill 2791 into the California State Assembly; and

WHEREAS, existing law allows a resident or patient of a skilled nursing facility to bring a civil action against the licensee of a facility for violations of his/her rights, but limits the liability to $500; and

WHEREAS, despite the number of violations of rights that have taken place, virtually no lawsuits have been filed under existing law for 20 years because lawyers will not take on these cases for amounts so small and the maximum does not reflect the severity of many violations; and

WHEREAS, AB 2791 proposes to raise the maximum award to $5,000, which would make it feasible for private attorneys to take on such cases; and

WHEREAS, AB 2791 explicitly states that both current and former residents of nursing homes will be able to sue for violations; and

WHEREAS, AB 2791 gives seniors an effective way to fight abuse and mistreatment.

NOW, THEREFORE, BE IT RESOLVED that the Santa Cruz County Board of Supervisors hereby urges passage of Assembly Bill 2783.

PASSED AND ADOPTED by the Board of Supervisors of the County of Santa Cruz, State of California, this 4th day of May, 2004, by the following vote:

AYES: SUPERVISORS Beautz, Pirie, Campos, Stone and Wormhoudt
NOES: SUPERVISORS None
ABSENT: SUPERVISORS None

MARDI WORMHOUDT

MARDI WORMHOUDT, Chair
Board of Supervisors

GAIL T. BORKOWSKI

ATTEST: _____
Clerk of said Board

RESOLUTION URGING PASSAGE OF ASSEMBLY BILL 2791
Page 2

Approved as to form:

County Counsel

DISTRIBUTION: Assembly Member Joe Simitian
Senator Bruce McPherson
Senator Byron Sher
Assembly Member John Laird
Assembly Member Simon Salinas
Governor Arnold Schwarzenegger
Seniors Commission
Long Term Care Interagency Commission
Human Resources Agency

1690K2

STATE OF CALIFORNIA)
COUNTY OF SANTA CRUZ) ss
I, SUSAN A. MAURIELLO, County Administrative Officer and ex-officio Clerk of the Board of Supervisors of the County of Santa Cruz, State of California do hereby certify that the foregoing is a true and correct copy of the resolution passed and adopted by and entered in the minutes of the said board. In witness whereof I have hereunto set my hand and affixed the seal of the said Board on 3/6, 20 04.
SUSAN A. MAURIELLO, County Administrative Officer
By Deputy

Council on Aging
Silicon Valley
Providing the Best for Seniors
2115 The Alameda, San Jose, California 95126-1141 408-296-8290 fax: 408-249-8918 e-mail: webmaster@scccoa.org

May 4, 3004

SUPPORT

The Honorable Rebecca Cohn
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, CA 95814

On behalf of [redacted] Silicon Valley (COA), I would like to express our support for AB 2791 (Simitian), which would expand the civil liability limit for private right of action for nursing home residents whose rights have been violated.

Residents' rights are more than just words. They reflect the quality of daily living in care facilities. Health and Safety Code 1430(b) provides the only remedy available for violation of residents' rights in California. But since the law was first enacted, few actions have been filed despite the numerous documented violations of residents' rights. Although the remedies available under this section include injunctive relief, the $500 limit on damages reduces the likelihood of legal representation. Therefore, the enforcement of these rights is often negligible or nonexistent. By raising the cap on annual damages from $500 to $5,000 for a violation of residents' rights, AB 2791 will help to compel compliance with the law.

Individuals residing in institutional care settings currently have very few rights. AB 2791 is a positive step toward protecting California's growing senior population. I strongly urge your support of AB 2791.

Sincerely,

Stephen M. Schmoll
Executive Director

cc: Assemblyman Joe Simitian.

May 4, 2004

JFS
ish Family Service
of Los Angeles
www.jfsla.org

The Honorable Joseph Simitian
California State Assembly
State Capitol, Room 5119
Sacramento, CA 95814

SUPPORT

Re: Support for AB 2791 (Simitian)

Dear Assembly Member Simitian:

I am writing on behalf of Friends to the Elderly of [redacted] to express our strong support for AB 2791, which would modestly increase the liability limit from $500 to $5,000 against nursing homes that violate fundamental residents' rights.

The mission of Jewish Family Service is to strengthen and enhance individual, family and community life by providing a wide range of services at every stage of the life cycle, especially to those who are poor and disadvantaged, on a non-sectarian basis. Jewish family Service operates a broad range of programs from 23 locations throughout Los Angeles County and serves over sixty thousand residents each year. Jewish Family Service operates five adult and children's counseling offices, five senior centers and specialized programs in the prevention and treatment of family violence, substance abuse, homelessness and services to people with disabilities and AIDS. We are dedicated to serving traditionally hard-to-reach segments of the population. Our constituency includes the well and frail elderly, victims of domestic violence and their children, younger adults (18-55) with developmental and physical disabilities, immigrant populations, families and individuals who are homeless, at-risk youth, children who are chronically ill and disabled and persons with AIDS, among many others.

Friends to the Elderly was established in 1998 with the goals of alleviating the isolation and loneliness among seniors living in long-term care facilities. Volunteers are screened, trained, matched and supervised to provide friendship and advocacy services for seniors through regular visits.

AB 2791 is an important step in helping nursing home residents. Life in a nursing home is very difficult for our elders. This bill promotes residents' rights and supports a segment of our population that is increasing and is often forgotten.
AB 2791 will help safeguard fundamental rights for these seniors living out the last of their precious lives in long-term care facilities.

Thank you for your leadership in helping our seniors to maintain their fundamental rights.

Sincerely,

Kay Ginsberg

Kay Ginsberg, Director
Friends to the Elderly of Jewish Family Service

6505 Wilshire Boulevard, Suite 500 • Los Angeles, CA 90048
323/761-8800 • FAX 323/761-8801 • Fiscal Office FAX 323/761-8787 • http://www.jfsla.org

OWL/CA

Older Women's League of California
926 J Street #1117, Sacramento CA 95814
• (916) 444-2526 - Fax (916) 441-1881
VOICES OF MIDLIFE AND OLDER WOMEN

June 18, 2004

Support for AB 2791 Simitian

The Honorable Joseph Simitian
State Capitol
Sacramento, CA 95814

SUPPORT

Dear Assembly Member Simitian:

The Older Women's League is pleased to add our name to the list of supporters of SB 2791, a bill which will expand the rights of nursing home residents to bring civil suits against nursing homes that violate their rights. These are rights which are in the Patient Bill of Rights and in other state and federal laws. It also raises the civil liability for such violations from the present $500.00 to $5,000 plus costs and attorneys fees.

In spite of all the laws we have seen enacted regarding nursing homes, we still are seeing numerous complaints from residents. The previous penalty is too low to impress on nursing homes the seriousness of their actions, and it also is too low for the resident to obtain legal representation. In much of life, we have learned that "money talks." The possibility of these higher payments may have the real effect we want: Fewer reasons to bring charges against nursing homes because the care will improve.

The Older Women's League is not interested in punitive actions against nursing homes. We want conditions to be such that care will improve because workers know what is right to do and they have the time to adequately care for patients. We hope that will be the real outcome of AB 2791.

Yours truly,

Betty Perry

Betty Perry,
Public Policy Director, OWL

CC: Senate Health

CALIFORNIA STATE EMPLOYEES ASSOCIATION

REPRESENTING
the people who serve the people

SHERRIE GOLDEN
Governmental Affairs
1108 'O' Street, Suite 350
Sacramento, CA 95814
(916) 442-0250
Fax (916) 552-5540
email: jballin@calcsea.org
cmiller@calcsea.org

June 18, 2004

Roger Dunstan, Consultant
State Capitol, Room 2191
Sacramento, CA 95814

SUPPORT

RE: Assembly Bill 2791 (Simitian)

Dear Roger:

The California State Employees Association (CSEA) is an organization that represents about 135,660 current and retired state employees. The State of California's employees are employed in urban offices, rural offices, state colleges and universities, developmental centers, prisons, Youth Authority Institutions, special schools, state hospitals, hatcheries, border stations and on state bridges.

On behalf of the CSEA, I would like to inform you of our support for AB 2791 which will be heard in the Senate Health and Human Services Committee on June 30, 2004.

If you have any questions regarding this support please feel free to contact me at (916) 442-0250.

Sincerely,

Sherrie Golden

Sherrie Golden
Governmental Affairs Division Administrator

SG:jb
ab2791.frm

SENATE RULES COMMITTEE
Office of Senate Floor Analyses
1020 N Street, Suite 524
(916) 445-6614 Fax: (916) 327-4478

AB 2791

THIRD READING

Bill No: AB 2791
Author: Simitian (D)
Amended: 5/11/04 in Assembly
Vote: 21

SENATE HEALTH & HUMAN SERV. COMMITTEE: 11-0, 6/30/04
AYES: Ortiz, Aanestad, Alarcon, Ashburn, Battin, Chesbro, Escutia, Figueroa, Kuehl, Romero, Vasconcellos
NO VOTE RECORDED: Florez, Vincent

SENATE APPROPRIATIONS COMMITTEE: Senate Rule 28.8

ASSEMBLY FLOOR: 77-0, 5/25/04 (Passed on Consent) - See last page for vote

SUBJECT: Skilled nursing and intermediate care facilities: training

SOURCE: Author

DIGEST: This bill requires the approved training program of a skilled nursing facility (SNF) and an intermediate care facility (ICF) to include instruction on preventing, recognizing, and reporting residents' rights violations as part of the current training and instruction required under existing law.

ANALYSIS: Existing law:

1. Requires a SNF or ICF to adopt an approved training program that meets standards established by the State Department of Health Services (DHS).

CONTINUED

2. Requires the approved training program to consist of at least the following:

   A. An orientation program to be given to newly employed nurse assistants prior to providing direct patient care in a SNF or ICF.

   B. A precertification training program consisting of:

      I. At least 60 classroom hours of training on basic nursing skills, patient safety and rights, the social and psychological problems of patients, and resident abuse prevention, recognition, and reporting.

      II. At least 100 hours of supervised and on-the-job training clinical practice.

      III. At least two hours of the 60 hours of the classroom training and at least four hours of the 100 hours of the supervised clinical training shall address the special needs of persons with developmental and mental disorders.

   C. Continuing in-service training to assure continuing competency in existing and new nursing skills.

   D. Each facility shall consider including training regarding the characteristics and method of assessment and treatment of AIDS.

3. Permits a resident or patient of a SCF or ICF to bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights.

4. Requires the licensee to be liable for the acts of the licensee's employees.

5. Makes the licensee liable for up to $500 and for costs and attorney fees, and authorizes the licensee to be enjoined from permitting the violation to continue.

6. Makes an agreement by a resident or patient to waive his or her rights to sue pursuant to this bill void as contrary to public policy.

CONTINUED

Existing SNF regulation establishes a Patients Bill of Rights, which enumerates 26 rights, including the right to be fully informed, to be transferred or discharged only for specified reasons, to be free from mental and physical abuse, and to be treated with consideration and respect.

This bill:

1. Requires the approved training program to include a minimum of one hour of instruction on preventing, recognizing, and reporting residents' rights violations, within the 60 hours of classroom training required under current law.

2. Requires instruction on preventing, recognizing, and reporting residents' rights violations be included, as part of existing instruction, within the total minimum hours of continuing education or in-service training required for certified nursing assistants.

3. Permits a current or former resident of a SNF or ICF to bring civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights.

4. Makes several clarifying technical changes to existing law.

Comments

According to the author, the intent of this bill is to ensure that nursing home residents' rights are not violated. He believes that in addition to residents knowing their rights, more importantly, the people who care for them must know how to uphold them.

Existing training requirements. Existing law requires a SNF or ICF to adopt an approved training program that meets standards established by DHS. The approved training program must consist of certain requirements, including at the minimum a precertification training program that has at least 60 classroom hours of training on basic nursing skills, patient safety and rights, the social and psychological problems of patients, and resident abuse prevention, recognition, and reporting. Within the 60 hours of classroom training, a minimum of six hours of instruction is required on preventing, recognizing, and reporting instances of resident abuse. The bill would include, within the 60 hours of classroom training, one hour of instruction on preventing, recognizing, and reporting residents' rights violations.

CONTINUED

Existing law provides that a continuing in-service training requirement must be a component of a SNF or INF's training program to assure continuing competency in existing and new nursing skills. Within this training requirement, current law requires a minimum of four hours of instruction on preventing, recognizing, and reporting instances of resident abuse be included within the total minimum hours of training. This bill would require inclusion of instruction on preventing, recognizing, and reporting residents' rights violations within the existing four-hour minimum requirement.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

SUPPORT: (Verified 7/28/04)

AARP California
Bet Tzedek Legal Services
California Advocates for Nursing Home Reform
California Senior Legislature
California State Employees Association
Consumer Attorneys of California
Council on Aging
County of Santa Cruz
Jewish Family Services
Los Angeles Metro Muli-Disciplinary Team
National Senior Citizens Law Center
Older Women's League of California
Ombudsman/Advocate, Inc.
Protect Our Parents

ARGUMENTS IN SUPPORT: Supporters of the bill believe that no California citizen should have to surrender their basic rights and civil protections because he or she has been admitted to a nursing home. They argue that although federal and state laws have established the rights of nursing home residents, these rights are frequently infringed upon by nursing home facilities. Additionally, supporters argue that residents are illegally evicted, denied phone calls or visitors, and are subjected to humiliation by being paraded naked through a facility – all actions that are violations of their rights.

CONTINUED

ASSEMBLY FLOOR:

AYES: Aghazarian, Bates, Berg, Bermudez, Bogh, Calderon, Campbell, Canciamilla, Chan, Chavez, Chu, Cogdill, Cohn, Corbett, Correa, Cox, Daucher, Diaz, Dutra, Dutton, Dymally, Firebaugh, Frommer, Garcia, Goldberg, Hancock, Harman, Haynes, Jerome Horton, Shirley Horton, Houston, Jackson, Keene, Koretz, La Malfa, La Suer, Laird, Leno, Levine, Lieber, Liu, Longville, Lowenthal, Maddox, Maldonado, Matthews, Maze, McCarthy, Montanez, Mountjoy, Mullin, Nakanishi, Nakano, Nation, Negrete McLeod, Oropeza, Pacheco, Parra, Pavley, Plescia, Reyes, Richman, Ridley-Thomas, Runner, Salinas, Samuelian, Simitian, Spitzer, Steinberg, Strickland, Vargas, Wesson, Wiggins, Wolk, Wyland, Yee, Nunez

NO VOTE RECORDED: Benoit, Kehoe, Leslie

CP:sl 8/4/04 Senate Floor Analyses

SUPPORT/OPPOSITION: SEE ABOVE

****** END ******

AMENDMENT DATE: May 11, 2004 **BILL NUMBER:** AB 2791
POSITION: Neutral **AUTHOR:** J. Simitian
SPONSOR: California Senior Legislature

BILL SUMMARY

This bill would require skilled nursing facility staff training programs to include at least one hour of instruction on preventing, recognizing, and reporting residents' rights violations. This bill would also clarify that former facility residents may bring civil actions against facilities for violations of any state or federal law or regulation.

FISCAL SUMMARY

This bill would not result in significant costs to the Department of Health Services (DHS), which licenses skilled nursing facilities, as DHS facility reviews for compliance with these provisions would be conducted during the normal licensing review. Additionally, this bill should not increase the cost of skilled nursing facility staff training programs because the overall training requirement would remain at 60 hours of classroom training. To the extent current training programs do not include instruction on preventing, recognizing, and reporting residents' rights violations, this bill would supplant other training currently being taught.

COMMENTS

The Department of Finance is neutral on this bill.

The intent of this bill is to curtail abuse of facility residents and violations of residents' rights by providing more specific training on those rights for nurse assistant staff.

Code/Department Agency or Revenue Type	SO LA CO RV	(Fiscal Impact by Fiscal Year) (Dollars in Thousands) PROP 98	FC	2003-2004	FC	2004-2005	FC	2005-2006	Fund Code
4260/Hlth Svcs	SO	No	---------- No/Minor Fiscal Impact ----------						0001

Analyst/Principal (0543) B. Sands — Date 7/20/04
Program Budget Manager Terrie Tatosian — Date 7/20/04
Department Deputy Director — Original Signed by: Stephen W. Kessler — Date JUL 21 2004

Governor's Office: By: JF Date: 7/27/04 Position Approved ✓ Position Disapproved

BILL ANALYSIS 465 Form DF-43 (Rev 03/95 Buff)
HLTH :AB2791-3973 7/20/2004 9:48 AM

SENATE RULES COMMITTEE
Office of Senate Floor Analyses
1020 N Street, Suite 524
(916) 445-6614 Fax: (916) 327-4478

AB 2791

THIRD READING

Bill No: AB 2791
Author: Simitian (D)
Amended: 5/11/04 in Assembly
Vote: 21

SENATE HEALTH & HUMAN SERV. COMMITTEE: 11-0, 6/30/04
AYES: Ortiz, Aanestad, Alarcon, Ashburn, Battin, Chesbro, Escutia, Figueroa, Kuehl, Romero, Vasconcellos
NO VOTE RECORDED: Florez, Vincent

SENATE APPROPRIATIONS COMMITTEE: Senate Rule 28.8

ASSEMBLY FLOOR: 77-0, 5/25/04 (Passed on Consent) - See last page for vote

SUBJECT: Skilled nursing and intermediate care facilities: training

SOURCE: Author

DIGEST: This bill requires the approved training program of a skilled nursing facility (SNF) and an intermediate care facility (ICF) to include instruction on preventing, recognizing, and reporting residents' rights violations as part of the current training and instruction required under existing law.

ANALYSIS: Existing law:

1. Requires a SNF or ICF to adopt an approved training program that meets standards established by the State Department of Health Services (DHS).

CONTINUED

2. Requires the approved training program to consist of at least the following:

   A. An orientation program to be given to newly employed nurse assistants prior to providing direct patient care in a SNF or ICF.

   B. A precertification training program consisting of:

      I. At least 60 classroom hours of training on basic nursing skills, patient safety and rights, the social and psychological problems of patients, and resident abuse prevention, recognition, and reporting.

      II. At least 100 hours of supervised and on-the-job training clinical practice.

      III. At least two hours of the 60 hours of the classroom training and at least four hours of the 100 hours of the supervised clinical training shall address the special needs of persons with developmental and mental disorders.

   C. Continuing in-service training to assure continuing competency in existing and new nursing skills.

   D. Each facility shall consider including training regarding the characteristics and method of assessment and treatment of AIDS.

3. Permits a resident or patient of a SCF or ICF to bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights.

4. Requires the licensee to be liable for the acts of the licensee's employees.

5. Makes the licensee liable for up to $500 and for costs and attorney fees, and authorizes the licensee to be enjoined from permitting the violation to continue.

6. Makes an agreement by a resident or patient to waive his or her rights to sue pursuant to this bill void as contrary to public policy.

CONTINUED

Existing SNF regulation establishes a Patients Bill of Rights, which enumerates 26 rights, including the right to be fully informed, to be transferred or discharged only for specified reasons, to be free from mental and physical abuse, and to be treated with consideration and respect.

This bill:

1. Requires the approved training program to include a minimum of one hour of instruction on preventing, recognizing, and reporting residents' rights violations, within the 60 hours of classroom training required under current law.

2. Requires instruction on preventing, recognizing, and reporting residents' rights violations be included, as part of existing instruction, within the total minimum hours of continuing education or in-service training required for certified nursing assistants.

3. Permits a current or former resident of a SNF or ICF to bring civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights.

4. Makes several clarifying technical changes to existing law.

Comments

According to the author, the intent of this bill is to ensure that nursing home residents' rights are not violated. He believes that in addition to residents knowing their rights, more importantly, the people who care for them must know how to uphold them.

Existing training requirements. Existing law requires a SNF or ICF to adopt an approved training program that meets standards established by DHS. The approved training program must consist of certain requirements, including at the minimum a precertification training program that has at least 60 classroom hours of training on basic nursing skills, patient safety and rights, the social and psychological problems of patients, and resident abuse prevention, recognition, and reporting. Within the 60 hours of classroom training, a minimum of six hours of instruction is required on preventing, recognizing, and reporting instances of resident abuse. The bill would include, within the 60 hours of classroom training, one hour of instruction on preventing, recognizing, and reporting residents' rights violations.

CONTINUED

Existing law provides that a continuing in-service training requirement must be a component of a SNF or INF's training program to assure continuing competency in existing and new nursing skills. Within this training requirement, current law requires a minimum of four hours of instruction on preventing, recognizing, and reporting instances of resident abuse be included within the total minimum hours of training. This bill would require inclusion of instruction on preventing, recognizing, and reporting residents' rights violations within the existing four-hour minimum requirement.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

SUPPORT: (Verified 7/28/04)

AARP California
Bet Tzedek Legal Services
California Advocates for Nursing Home Reform
California Senior Legislature
California State Employees Association
Consumer Attorneys of California
Council on Aging
County of Santa Cruz
Jewish Family Services
Los Angeles Metro Muli-Disciplinary Team
National Senior Citizens Law Center
Older Women's League of California
Ombudsman/Advocate, Inc.
Protect Our Parents

ARGUMENTS IN SUPPORT: Supporters of the bill believe that no California citizen should have to surrender their basic rights and civil protections because he or she has been admitted to a nursing home. They argue that although federal and state laws have established the rights of nursing home residents, these rights are frequently infringed upon by nursing home facilities. Additionally, supporters argue that residents are illegally evicted, denied phone calls or visitors, and are subjected to humiliation by being paraded naked through a facility – all actions that are violations of their rights.

ASSEMBLY FLOOR:

AYES: Aghazarian, Bates, Berg, Bermudez, Bogh, Calderon, Campbell, Canciamilla, Chan, Chavez, Chu, Cogdill, Cohn, Corbett, Correa, Cox, Daucher, Diaz, Dutra, Dutton, Dymally, Firebaugh, Frommer, Garcia, Goldberg, Hancock, Harman, Haynes, Jerome Horton, Shirley Horton, Houston, Jackson, Keene, Koretz, La Malfa, La Suer, Laird, Leno, Levine, Lieber, Liu, Longville, Lowenthal, Maddox, Maldonado, Matthews, Maze, McCarthy, Montanez, Mountjoy, Mullin, Nakanishi, Nakano, Nation, Negrete McLeod, Oropeza, Pacheco, Parra, Pavley, Plescia, Reyes, Richman, Ridley-Thomas, Runner, Salinas, Samuelian, Simitian, Spitzer, Steinberg, Strickland, Vargas, Wesson, Wiggins, Wolk, Wyland, Yee, Nunez

NO VOTE RECORDED: Benoit, Kehoe, Leslie

CP:sl 8/4/04 Senate Floor Analyses

SUPPORT/OPPOSITION: SEE ABOVE

****** END ******

[redacted]

AB 2791

THIRD READING

[redacted]: AB 2791
[redacted]: Simitian (D)
[redacted]: 5/11/04 in Assembly
[redacted]: 21

SENATE HEALTH & HUMAN SERV. COMMITTEE: 11-0, 6/30/04
AYES: Ortiz, Aanestad, Alarcon, Ashburn, Battin, Chesbro, Escutia, Figueroa, Kuehl, Romero, Vasconcellos
NO VOTE RECORDED: Florez, Vincent

38-8

ASSEMBLY FLOOR: 77-0, 5/25/04 (Passed on Consent) - See last page for vote

[redacted]: Skilled nursing and intermediate care facilities: training

[redacted]: Author

[redacted]: This bill requires the approved training program of a skilled nursing facility (SNF) and an intermediate care facility (ICF) to include instruction on preventing, recognizing, and reporting residents' rights violations as part of the current training and instruction required under existing law.

[redacted]: Existing law:

1. Requires a SNF or ICF to adopt an approved training program that meets standards established by the State Department of Health Services (DHS).

2. Requires the approved training program to consist of at least the following:

CONTINUED

A. An orientation program to be given to newly employed nurse assistants prior to providing direct patient care in a SNF or ICF.

B. A precertification training program consisting of:

I. At least 60 classroom hours of training on basic nursing skills, patient safety and rights, the social and psychological problems of patients, and resident abuse prevention, recognition, and reporting.

II. At least 100 hours of supervised and on-the-job training clinical practice.

III. At least two hours of the 60 hours of the classroom training and at least four hours of the 100 hours of the supervised clinical training shall address the special needs of persons with developmental and mental disorders.

C. Continuing in-service training to assure continuing competency in existing and new nursing skills.

D. Each facility shall consider including training regarding the characteristics and method of assessment and treatment of AIDS.

3. Permits a resident or patient of a SCF or ICF to bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights.

4. Requires the licensee to be liable for the acts of the licensee's employees.

5. Makes the licensee liable for up to $500 and for costs and attorney fees, and authorizes the licensee to be enjoined from permitting the violation to continue.

6. Makes an agreement by a resident or patient to waive his or her rights to sue pursuant to this bill void as contrary to public policy.

Existing SNF regulation establishes a Patients Bill of Rights, which enumerates 26 rights, including the right to be fully informed, to be

transferred or discharged only for specified reasons, to be free from mental and physical abuse, and to be treated with consideration and respect.

This bill:

1. Requires the approved training program to include a minimum of one hour of instruction on preventing, recognizing, and reporting residents' rights violations, within the 60 hours of classroom training required under current law.

2. Requires instruction on preventing, recognizing, and reporting residents' rights violations be included, as part of existing instruction, within the total minimum hours of continuing education or in-service training required for certified nursing assistants.

3. Permits a current or former resident of a SNF or ICF to bring civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights.

4. Makes several clarifying technical changes to existing law.

Comments

According to the author, the intent of this bill is to ensure that nursing home residents' rights are not violated. He believes that in addition to residents knowing their rights, more importantly, the people who care for them must know how to uphold them.

Existing training requirements. Existing law requires a SNF or ICF to adopt an approved training program that meets standards established by DHS. The approved training program must consist of certain requirements, including at the minimum a precertification training program that has at least 60 classroom hours of training on basic nursing skills, patient safety and rights, the social and psychological problems of patients, and resident abuse prevention, recognition, and reporting. Within the 60 hours of classroom training, a minimum of six hours of instruction is required on preventing, recognizing, and reporting instances of resident abuse. The bill would include, within the 60 hours of classroom training, one hour of instruction on preventing, recognizing, and reporting residents' rights violations.

Existing law provides that a continuing in-service training requirement must be a component of a SNF or INF's training program to assure continuing competency in existing and new nursing skills. Within this training requirement, current law requires a minimum of four hours of instruction on preventing, recognizing, and reporting instances of resident abuse be included within the total minimum hours of training. This bill would require inclusion of instruction on preventing, recognizing, and reporting residents' rights violations within the existing four-hour minimum requirement.

[redacted]: Appropriation: No Fiscal Com.: Yes Local: Yes

[redacted]: (Verified >) 7/28/04

AARP California
Bet Tzedek Legal Services
California Advocates for Nursing Home Reform
California Senior Legislature
California State Employees Association
Consumer Attorneys of California
Council on Aging
County of Santa Cruz
Jewish Family Services
Los Angeles Metro Muli-Disciplinary Team
National Senior Citizens Law Center
Older Women's League of California
Ombudsman/Advocate, Inc.
Protect Our Parents

[redacted]: (Verified >)

>

ARGUMENTS IN SUPPORT: Supporters of the bill believe that no California citizen should have to surrender their basic rights and civil protections because he or she has been admitted to a nursing home. They argue that although federal and state laws have established the rights of nursing home residents, these rights are frequently infringed upon by nursing home facilities. Additionally, supporters argue that residents are illegally evicted, denied phone calls or visitors, and are subjected to humiliation by being paraded naked through a facility – all actions that are violations of their rights.

CONTINUED

[redacted]: >

ASSEMBLY FLOOR:

AYES: Aghazarian, Bates, Berg, Bermudez, Bogh, Calderon, Campbell, Canciamilla, Chan, Chavez, Chu, Cogdill, Cohn, Corbett, Correa, Cox, Daucher, Diaz, Dutra, Dutton, Dymally, Firebaugh, Frommer, Garcia, Goldberg, Hancock, Harman, Haynes, Jerome Horton, Shirley Horton, Houston, Jackson, Keene, Koretz, La Malfa, La Suer, Laird, Leno, Levine, Lieber, Liu, Longville, Lowenthal, Maddox, Maldonado, Matthews, Maze, McCarthy, Montanez, Mountjoy, Mullin, Nakanishi, Nakano, Nation, Negrete McLeod, Oropeza, Pacheco, Parra, Pavley, Plescia, Reyes, Richman, Ridley-Thomas, Runner, Salinas, Samuelian, Simitian, Spitzer, Steinberg, Strickland, Vargas, Wesson, Wiggins, Wolk, Wyland, Yee, Nunez

NO VOTE RECORDED: Benoit, Kehoe, Leslie

[redacted]

[redacted]

[redacted]

[redacted]

Peterson, Claudia

From: Park, Lark
Sent: Wednesday, July 28, 2004 1:11 PM
To: Peterson, Claudia
Subject: RE: AB 2791

Hi, Claudia - no changes. - Lark

-----Original Message-----
From: Peterson, Claudia
Sent: Wednesday, July 28, 2004 1:06 PM
To: Park, Lark
Subject: AB 2791

Hi Lark:

Do you have any changes to the list of support/opposition to AB 2791 as it appears on the Senate Health and Human Services Committee analysis? Please let me know ASAP. Thanks.

Claudia Peterson
Senate Floor Analyses
445-6614
Fax No. 327-4478

SFA - 12

CALIFORNIA STATE EMPLOYEES ASSOCIATION

REPRESENTING
the people who serve the people

SHERRIE GOLDEN
Governmental Affairs
1108 'O' Street, Suite 350
Sacramento, CA 95814
(916) 442-0250
Fax (916) 552-5540
email: jballin@calcsea.org
cmiller@calcsea.org

July 8, 2004

Office of the Senate Floor Analysis
1020 N Street
Sacramento, CA 95814

RE: Assembly Bill 2791 (Simitian)

Dear Ladies and Gentlemen:

The California State Employees Association (CSEA) is an organization that represents about 135,660 current and retired state employees. The State of California's employees are employed in urban offices, rural offices, state colleges and universities, developmental centers, prisons, Youth Authority Institutions, special schools, state hospitals, hatcheries, border stations and on state bridges.

On behalf of the CSEA, I would like to inform you of our support for AB 2791 which will be heard in the Senate Appropriations Committee on August 2, 2004.

If you have any questions regarding this support please feel free to contact me at (916) 442-0250.

Sincerely,

Sherrie Golden
Governmental Affairs Division Administrator

SG:jb
ab2791a.frm

SENATE FLOOR ANALYSES WORKSHEET **CONSULTANT:** _____

THIRD READING / CONSENT / (DO AHEAD)

Bill No.: AB 2791
Author: Dutton (R)
Amended: 5-11-04 in Assem
Vote Required:: 2/1

SEN. H&S COM.: Vote 11-0, Date 6-30
SEN. APPROP. COM.: Vote _____, Date _____ / 28.8 / NONFISCAL
SEN. FLOOR: Vote _____, Date _____ / **ASSY FLOOR:** Vote 77-0, Date 5-27

SUBJECT: A

SOURCE:

DIGEST:
AB

ANALYSIS: C, LO

FISCAL EFFECT: Appropriation: No Fiscal Committee: Yes Local: Yes

SUPPORT: Verification Date _____

F

OPPOSITION: Verification Date _____

ARGUMENTS IN SUPPORT:

F

ARGUMENTS IN OPPOSITION:

SENATE HEALTH AND HUMAN SERVICES COMMITTEE ANALYSIS

Senator Deborah V. Ortiz, Chair

BILL NO:	**AB 2791**	**A**
AUTHOR:	**Simitian**	**B**
AMENDED:	**May 11, 2004**	
HEARING DATE:	**June 30, 2004**	**2**
FISCAL:	**Appropriations**	**7**
		9
CONSULTANT:		**1**
Bohannon / Vazquez / ak		

SUBJECT

Skilled nursing and intermediate care facilities: training

SUMMARY

This bill requires the approved training program of a skilled nursing facility (SNF) and an intermediate care facility (ICF) to include instruction on preventing, recognizing, and reporting residents' rights violations as part of the current training and instruction required under existing law.

ABSTRACT

Existing law:

1. Requires a SNF or ICF to adopt an approved training program that meets standards established by the State Department of Health Services (DHS).

2. Requires the approved training program to consist of at least the following:
   a. An orientation program to be given to newly employed nurse assistants prior to providing direct patient care in a SNF or ICF;
   b. A precertification training program consisting of:
      - At least 60 classroom hours of training on basic nursing skills, patient safety and rights, the social and psychological problems of patients, and resident abuse prevention, recognition, and reporting;
      - At least 100 hours of supervised and on-the-job training clinical practice;
      - At least two hours of the 60 hours of the classroom training and at least four hours of the 100 hours of the supervised clinical training shall address the special needs of persons with developmental and mental disorders;
   c. Continuing in-service training to assure continuing competency in existing and new nursing skills; and,
   d. Each facility shall consider including training regarding the characteristics and method of assessment and treatment of AIDS.

Continued---

3. Permits a resident or patient of a SCF or ICF to bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights.

4. Requires the licensee to be liable for the acts of the licensee's employees.

5. Makes the licensee liable for up to $500 and for costs and attorney fees, and authorizes the licensee to be enjoined from permitting the violation to continue.

6. Makes an agreement by a resident or patient to waive his or her rights to sue pursuant to this bill void as contrary to public policy.

Existing SNF regulation:

1. Establishes a Patients Bill of Rights, which enumerates 26 rights, including the right to be fully informed, to be transferred or discharged only for specified reasons, to be free from mental and physical abuse, and to be treated with consideration and respect.

This bill:

1. Requires the approved training program to include a minimum of one hour of instruction on preventing, recognizing, and reporting residents' rights violations, within the 60 hours of classroom training required under current law.

2. Requires instruction on preventing, recognizing, and reporting residents' rights violations be included, as part of existing instruction, within the total minimum hours of continuing education or in-service training required for certified nursing assistants.

3. Permits a current or former resident of a SNF or ICF to bring civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights.

4. Makes several clarifying technical changes to existing law.

FISCAL IMPACT

According to the Assembly Committee on Appropriations, there will be minor absorbable costs to DHS.

BACKGROUND AND DISCUSSION

According to the author, the intent of this bill is to ensure that nursing home residents' rights are not violated. He believes that in addition to residents knowing their rights, more importantly, the people who care for them must know how to uphold them.

Existing training requirements

Existing law requires a SNF or ICF to adopt an approved training program that meets standards established by DHS. The approved training program must consist of certain requirements, including at the minimum a precertification training program that has at least 60 classroom hours of training on basic nursing skills, patient safety and rights, the

Continued—

social and psychological problems of patients, and resident abuse prevention, recognition, and reporting. Within the 60 hours of classroom training, a minimum of six hours of instruction is required on preventing, recognizing, and reporting instances of resident abuse. The bill would include, within the 60 hours of classroom training, one hour of instruction on preventing, recognizing, and reporting residents' rights violations.

Existing law provides that a continuing in-service training requirement must be a component of a SNF or INF's training program to assure continuing competency in existing and new nursing skills. Within this training requirement, current law requires a minimum of four hours of instruction on preventing, recognizing, and reporting instances of resident abuse be included within the total minimum hours of training. This bill would require inclusion of instruction on preventing, recognizing, and reporting residents' rights violations within the existing four-hour minimum requirement.

Existing Training Requirements	AB 2791 Training Requirements
Orientation Program	
Precertification Training Program including: 60 hours of classroom training, including - Mandatory minimum of six hours of instruction on preventing, recognizing and reporting instances of resident abuse - Mandatory two hours of training addressing the special needs of persons with developmental and mental disorders	Precertification Training Program including: 60 hours of classroom training, including - Mandatory minimum of six hours of instruction on preventing, recognizing and reporting instances of resident abuse - Mandatory two hours of training addressing the special needs of persons with developmental and mental disorders - *Mandatory one hour of instruction on preventing, recognizing and reporting instances of residents' rights violations*
At least 100 hours of supervised and on-the-job training clinical practice including: - Mandatory four hours of training addressing the special needs of persons with developmental and mental disorders	At least 100 hours of supervised and on-the-job training clinical practice including: - Mandatory four hours of training addressing the special needs of persons with developmental and mental disorders
Continuing, in service training	
- Mandatory minimum four hours of instruction on preventing, recognizing and reporting instances of resident abuse	- Mandatory minimum four hours of instruction on preventing, recognizing and reporting instances of resident abuse, *including instruction on preventing, recognizing and reporting residents' rights violations*

Continued---

Arguments in support

Supporters of the bill believe that no California citizen should have to surrender their basic rights and civil protections because he or she has been admitted to a nursing home. They argue that although federal and state laws have established the rights of nursing home residents, these rights are frequently infringed upon by nursing home facilities. Additionally, supporters argue that residents are illegally evicted, denied phone calls or visitors, and are subjected to humiliation by being paraded naked through a facility – all actions that are violations of their rights.

PRIOR ACTIONS

Assembly Floor:	77 – 0 Pass
Assembly Appropriations:	21 – 0 Do Pass, to Consent Calendar
Assembly Health:	16 – 0 Do Pass as Amended

POSITIONS

Support:

AARP California
Bet Tzedek Legal Services
California Advocates for Nursing Home Reform
California Senior Legislature
California State Employees Association
Consumer Attorneys of California
Council on Aging
County of Santa Cruz
Jewish Family Services
Los Angeles Metro Muli-Disciplinary Team
National Senior Citizens Law Center
Older Women's League of California
Ombudsman/ Advocate, Inc.
Protect Our Parents

Oppose: None received.

-- END --

EXHIBIT 2

Matthew Borden, Esq. (SBN: 214323)
borden@braunhagey.com
J. Noah Hagey, Esq. (SBN: 262331)
hagey@braunhagey.com
BRAUNHAGEY & BORDEN LLP
220 Sansome Street, Second Floor
San Francisco, CA 94104
Telephone: (415) 599-0210
Facsimile: (415) 276-1808

Kelly Bagby (admitted *pro hac vice*)
AARP FOUNDATION LITIGATION
kbagby@aarp.org
601 E Street, NW
Washington, D.C. 20049
Telephone: (202) 434-2103

Attorneys for Plaintiffs

BY FAX

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SACRAMENTO

GLORIA SINGLE, CALIFORNIA LONG TERM CARE OMBUDSMAN ASSOCIATION,

Plaintiffs,

v.

CATHEDRAL PIONEER CHURCH HOMES II, CONGREGATIONAL CHURCH RETIREMENT COMMUNITY, BIXBY KNOLLS TOWERS, INC., GOLD COUNTRY HEALTH CENTER, MAYFLOWER GARDENS HEALTH FACILITIES, INC., STOCKTON CONGREGATIONAL HOMES, INC., FOUNDATION PROPERTY MANAGEMENT, INC., RHF MANAGEMENT, INC., RETIREMENT HOUSING FOUNDATION, AND DOES 1-10,

Defendants.

Case No. 34-2017-00220058-CU-NP-GDS

THIRD AMENDED COMPLAINT FOR VIOLATIONS OF PATIENT'S RIGHTS, CALIFORNIA HEALTH AND SAFETY CODE § 1430(b); UNLAWFUL BUSINESS PRACTICES, CALIFORNIA BUSINESS & PROFESSIONS CODE §§ 17200, *et seq.*; DECLARATORY RELIEF

Compl. Filed:	October 2, 2017
First Am. Compl. Filed:	January 22, 2018
Second Am. Compl. Filed:	March 23, 2018
Trial Date:	None

Plaintiffs Gloria Single, by and through her Power of Attorney, Aubrey Jones and California Long Term Care Ombudsman Association allege as follows:

INTRODUCTION

1. Plaintiffs bring this action to enjoin Defendants' illegal practice of dumping vulnerable nursing facility residents into hospitals.

2. To maximize profit through decreased staffing, unscrupulous nursing facilities try to illegally evict the residents who are the neediest of staff time and require the greatest levels of care. One such method is hospital dumping, in which the facility gives away the resident's bed when the resident is temporarily hospitalized and refuses to readmit the resident after she is medically cleared to return home.

3. Hospital dumping violates state and federal law, which requires facilities to hold open the beds of residents who have been temporarily hospitalized.

4. Plaintiff Gloria Single is 82 years old. She suffers from pulmonary disease, chronic pain, fainting and dementia and requires long-term skilled nursing care. She lives at a skilled nursing facility called Pioneer House.

5. Pioneer House is run by a national entity called Retirement Housing Foundation. According to its website, Retirement Housing Foundation is a "faith-based" organization, rooted in the ideals of the United Church of Christ. The website also claims that part of Retirement Housing Foundation's "concern is for the whole person includes residents, their families and staff and Retirement Housing Foundation strives to be fair in all relationships." http://www.rhf.org/mission-vision-philosophy/. In actuality, Retirement Housing Foundation is a business enterprise that systemically understaffs its facilities and deliberately ignores the mandatory statutory procedures for discharging residents to increase the profits of its owners and/or operators Laverne R. Joseph, Darryl M. Sexton, Frank G. Jahrling, John E. Trinka, S.M. Simington, Christina E. Potter, Deborah Stouff, John Bauman, and Raymond East.

6. Defendants dumped Ms. Single into a hospital on March 23, 2017, and refused to readmit her once the hospital cleared her to return home. After a hearing before the California

Department of Health Care Services ("DHCS"), the State issued a seven-page Order requiring that "Pioneer House must immediately readmit Gloria Single to the first available bed."

7. Defendants continue to flout the State's Order and still refuse to readmit Ms. Single. As a result, Ms. Single is spending what may be the last days of her life separated from her husband, who continues to live at Pioneer House. Each day this occurs, Defendants are imposing irreparable and cruel injury on Ms. Single and her family.

8. Plaintiff California Long Term Care Ombudsman Association is a public interest organization dedicated to protecting the rights of nursing home residents, including their rights to readmission. It has taken the extreme measure of bringing this case because nursing facilities, such as Pioneer House, routinely ignore State Readmission Orders because the State refuses to enforce them itself. As a result, the only remedy for dumping victims, such as Ms. Single, is to seek redress from the Court.

9. Accordingly, Plaintiffs respectfully seek an injunction requiring Defendants to readmit Ms. Single, to stop dumping vulnerable residents, to comply with the readmission and discharge laws and to obey DHCS Readmission Orders. Plaintiffs also seek statutory damages for each day Defendants have violated and continue to violate the law.

PARTIES

A. Plaintiffs

10. Plaintiff Gloria Single was, at all relevant times, a resident of Pioneer House, located at 415 P Street, Sacramento, CA 95814 in Sacramento County, and thus a "resident" under Health and Safety Code § 1430.

11. Plaintiff California Long Term Care Ombudsman Association ("CLTCOA") is a membership organization made up of 35 local Long-Term Care ("LTC") Ombudsman Programs, their staff, certified volunteers and program supporters. As explained in its mission statement, a true and correct copy of which is attached as **Exhibit 1**, CLTCOA's mission is "to provide a unified voice in advocacy and assistance to Local LTC Ombudsman Programs in California to enable the local programs to provide Ombudsman services to the residents of long term care facilities." One of the purposes of the Association is to "act as an effective statewide professional

association" for the Local Ombudsman Programs. *Id.* CLTCOA's members are established pursuant to 42 U.S.C. § 3058g, which requires States to create an Ombudsman program to, *inter alia*, "identify, investigate, and resolve complaints" by residents which "relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the residents," to "provide services to assist the residents in protecting the health, safety, welfare, and rights of the residents" and to "analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other governmental policies and actions, that pertain to the health, safety, welfare, and rights of the residents, with respect to the adequacy of long-term care facilities and services in the State." Representatives of State Ombudsman have the right to "[i]dentify, investigate, and resolve complaints that are made by, or on behalf of, residents of long term care facilities . . . ." Cal. Welf. & Inst. Code § 9712.5.

12. An association like CLTCOA has standing to sue when: (1) its members have standing to sue in their own right; (2) the interests at stake are germane to the organization's purpose; (3) and neither the claim asserted nor the relief requires individual members' participation in the lawsuit. *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs., Inc.,* 528 U.S. 167 (2000). CLTCOA's members have standing to sue in their own right. CLTCOA and its members have a longstanding interest at stake in stopping Defendants from illegally dumping patients. None of the claims asserted require participation by any of the local Ombudsman.

13. CLTCOA has suffered economic injury as a direct consequence of its work fighting against the practice of illegally evicting nursing facility residents. *Animal Legal Defense Fund v. LT Napa Partners LLC*, 234 Cal. App. 4th 1270, 1279 (2015). CLTCOA and its member Ombudsman Programs have worked regularly to combat unfair and illegal practices related to illegal evictions. CLTCOA members in recent years report that illegal and unsafe nursing facility evictions is the fastest growing complaint for Ombudsman Programs, and these complaints have increased sixty-three percent since FY 2012. Over the last four years, CLTCOA has dedicated ten percent of its time to counseling and advising local LTC Ombudsman about investigations and resolutions of patient complaints, many of which relate to illegal evictions. Therefore, CLTCOA's resources have been diverted to advise its members on eviction related inquiries. In order to meet

this need, CLTCOA expends resources for its staff and board members to regularly attend conferences for receiving training and discussing these issues. These expenditures cause CLTCOA to divert a significant percentage of resources to addressing the issue of patient dumping. In 2017, due to the growing number of complaints, CLTCOA's board decided to heavily invest the association's resources (more than 100 hours of staff and board time) to sponsor AB 940 (Weber), a bill to amend Section 1439.6 of the Health and Safety Code to require nursing facilities to notify the Local LTC Ombudsman Program of any facility-initiated transfers or discharges (*see* Letter to Governor Brown, a true and correct copy of which is attached hereto as **Exhibit 2**). In August 2017, the Governor signed AB 940 into law.

14. CLTCOA and its members also must address inadequate staffing in nursing facilities that can lead to illegal discharges when a resident demonstrates behavior that the facility lacks sufficient trained staff to handle (for example, when a facility employs an insufficient number of registered nurses). CLTCOA expends its resources providing support and education to Local Ombudsman programs for all these services. CLTCOA also sponsors and/or supports legislation that impacts quality of life and quality of care for long-term care residents. It often comments on, supports or opposes legislation that affects the health, welfare and safety of facility residents. Further, CLTCOA also expends resources lobbying for funding for local Ombudsman Programs about substantive and procedural due process rights in the event of a discharge or eviction as this issue is a top concern to such programs in California and throughout the country. As a result of Defendants dumping Ms. Single, CLTCOA has been forced to divert resources from its numerous other organizational missions discussed above.

15. Further, CLTCOA's member organizations expend precious time actively helping residents, including Ms. Single, to obtain administrative orders securing readmission to their homes after temporary hospitalization. The individual Ombudsman programs do not have the resources to act as a Plaintiff in a lawsuit like this one because their budgets are stretched to capacity. The Ombudsman Programs collectively fund CLTCOA to address the growing workload caused by problems, like resident dumping, that negatively affect their ability to do their work. The Ombudsman programs are directly harmed when nursing facilities flagrantly disregard federal and

state laws designed to protect vulnerable residents. CLTCOA is acting as a Plaintiff in this matter in furtherance of its mission to provide a unified voice to California's Long-Term Care Ombudsman programs so that they can fulfill their statutory mission to provide Ombudsman services.

B. Defendants

16. Defendants are all part of the same commonly owned and operated chain of assisted living and skilled nursing facilities that is held in an impenetrable labyrinth of legal entities designed to hide money and evade legal and tax obligations.

17. Defendants are a unified enterprise under the umbrella of Defendant Retirement Housing Foundation, which they have elected to structure like an abusive tax shelter. Each facility is an ostensibly separate LLC, all of which are managed by Retirement Housing Foundation. At least some of the real estate on which the Defendant facilities sit is held by separate entities. The facility Defendants make various payments to Defendant Foundation Property Management and Retirement Housing Foundation. But these are just payments to themselves because the companies are owned and controlled by the same people, who operate the various companies as a single business for the unified purpose of lining their pockets with money that should go to resident care.

18. Laverne R. Joseph, Darryl M. Sexton, Frank G. Jahrling, John E. Trinka, S.M. Simington, Christina E. Potter, Deborah Stouff, John Bauman, and Raymond East serve as Officers and Directors of Pioneer House and/or each of the other skilled nursing facilities named below. According to the website, these same individuals are also Officers and Directors of Defendant Retirement Housing Foundation.

RHF
Board of Directors

(Back Row L to R) Ray East, (Chairperson), David Ethington, Rev. David Moyer, Frank Jahrling (Treasurer) and Dr. Laverne R. Joseph, (Front Row L to R) Dr. Darryl M. Sexton, (Vice Chairperson), Christina E. Potter (Vice Chairperson), Rev. Dr. Norma Nomura DeSaegher, and Dr. John Bauman, (Absent - Stewart Simington)

19. Defendant Cathedral Pioneer Church Homes II, d/b/a Pioneer House ("Pioneer House") is a skilled nursing facility as defined in Health & Safety Code § 1250(c), and is therefore subject to Health & Safety Code § 1430(b). Pioneer House is located at 415 P Street, Sacramento, California 95814. In a filing made under penalty of perjury, Pioneer House identified its officers and directors as follows:

I) Governing Board Officers and Members		
Line No.	(1) Name	(2) Occupation
160	LAVERNE R. JOSEPH	PRESIDENT
161	DARRYL M. SEXTON	VICE PRESIDENT
162	FRANK G. JAHRLING	TREASURER
163	DEBORAH J. S	SECRETARY
164	F JAHRLING	DIRECTOR
165	6 OTHERS	DIRECTOR

20. The above individuals are also officers and directors (and/or relatives/spouses of officers and directors) of Defendant Retirement Housing Foundation.

21. In addition to having interlocking directors, the website for Pioneer House states: "Pioneer House is part of Retirement Housing Foundation." Pioneer House has admitted in public filings under penalty of perjury that Defendant Retirement Housing Foundation is its "parent organization," that it has paid Retirement Housing Foundation hundreds of thousands of dollars (roughly 10% of gross revenues) in "related-party fees" every year, that it has paid Defendant Retirement Property Management over a hundred thousand dollars a year in "related party transactions," and that the other facilities named as Defendants herein are "commonly owned and controlled." In papers filed under penalty of perjury with the government, Pioneer House lists its mailing address as 911 N. Studebaker Road, Long Beach, CA 90815, which is also the address for Defendants Retirement Housing Foundation, RHF Management, Inc., and Retirement Housing Foundation Property.

22. At the same time Pioneer House was making all these payments to other entities owned and controlled by the same individuals that run Pioneer House and "borrowing" money "payable to related parties," Pioneer House reported that its health care operations generated a loss exceeding $748,000 (with Pioneer House showing a net loss of $110,676) in 2016, an operating

loss for health care operations exceeding $702,000 in 2015, and an operating loss for health care operations exceeding $741,000 in 2014. These sworn statements by Pioneer House also represent that Pioneer House operated at a negative 0.18 margin in 2016, and similarly low margins in other years.

23. Without being part of a larger business enterprise, a facility operating under the financial conditions reported by Pioneer House would be insolvent, would not be able to secure investment and would not be able to pay its stakeholders. However, such business structures are common in the skilled nursing facility industry, where at least part of the true profits of the facility are paid to related entities as rent, management fees, debt service, and other fees to evade tax, avoid oversight, and to help secretly distribute money earmarked for resident care to the individuals who own the business.

24. Defendant Bixby Knolls Towers, Inc. ("Bixby Knolls Towers") is a skilled nursing facility as defined in Health & Safety Code § 1250(c), and is therefore subject to Health & Safety Code § 1430(b). Bixby Knolls Towers is located at 3737 Atlantic Avenue, Long Beach, California 90807 and is part of the same commonly owned and managed chain as the other Defendant facilities named herein. Bixby Knolls Towers has admitted in public filings under penalty of perjury that Retirement Housing Foundation is its "parent organization."

25. The officers and directors of Bixby Knolls Towers are also officers and directors (and/or relatives/spouses of officers and directors) of Defendants Retirement Housing Foundation and Pioneer House.

I) Governing Board Officers and Members			
Line No.	(1) Name	(2) Occupation	(3) Compensation *
160	LAVERNE R. JOSEPH	PRESIDENT	$
161	DARRYL M. SEXTON	VICE PRESIDENT / DIRECTOR	
162	DEBORA STOUFF	SECRETARY	
163	FRANK G. JAHRLING	TREASURER / DIRECTOR	
164	S SIMINGTON, J TRNKA, J BAUMAN	DIRECTORS	
165	R EAST, C POTTER	DIRECTORS	

26. According to documents that Bixby Knolls Towers filed under penalty of perjury, in 2016, Bixby Knolls Towers reported a loss of $1,284,903 from health care operations following a

similar loss of over $1 million in 2015. In 2016, it reported a margin of negative .021 with a return on equity of negative 0.18.

27. In 2016, Bixby Knolls reported long-term debt to a related party that it described as "CORP ADV." It also reported related party transactions to Retirement Housing Foundation for a "management fee," lists Defendant RFH Property as its Management Company, reported a total home office cost allocation exceeding $837,000 (over 13% of its gross revenue) and represented that the other facility Defendants in this action are "under common ownership or control."

28. On information and belief, the numbers reported above are further skewed by the fact that Bixby Knolls Towers provides assisted living services along with skilled nursing services and it is unclear from publicly available information exactly how or why expenses are allocated to the skilled nursing business. The same is true for other facility Defendants named herein, including Pioneer House.

29. For similar reasons as given with Pioneer House, without being part of a larger business enterprise where the facility's profits are withdrawn through other entities in the business structure, a facility operating under the financial conditions reported by Bixby Knolls Towers, *e.g.*, a consistently negative return on equity and operating margin, would not be desirable.

30. Defendant Congregational Church Retirement Community, d/b/a Auburn Ravine Terrace ("Auburn Ravine Terrace") is a skilled nursing facility as defined in Health & Safety Code § 1250(c), and is therefore subject to Health & Safety Code § 1430(b). Auburn Ravine Terrace is located at 750 Auburn Ravine Road, Auburn, California 95603-3820 and is part of the same commonly owned and managed chain as Pioneer House and the other facilities named herein. Auburn Ravine Terrace has admitted in public filings under penalty of perjury that Retirement Housing Foundation is its "parent organization," that it pays Retirement Housing Foundation hundreds of thousands of dollars in related-party fees every year, that it has paid Defendant Retirement Foundation Housing Property over a hundred thousand dollars a year in related party transactions, and that the other facilities named as Defendants herein are "commonly owned and controlled." At the same time, Auburn Ravine Terrace reported that its health care operations

generated a loss exceeding $467,000 in 2016, a loss exceeding $684,000 in 2015, and a loss exceeding $540,000 in 2014. Its reported operating margin for 2016 was negative 0.09.

31. Auburn Ravine Terrace lists its mailing address as 911 N. Studebaker Road, Long Beach, CA 90815, which is also the address for Defendant Retirement Housing Foundation, and identifies the other facility Defendants as "facilities under common ownership or control."

32. Defendant Gold Country Health Center ("Gold Country") is a skilled nursing facility as defined in Health & Safety Code § 1250(c), and is therefore subject to Health & Safety Code § 1430(b). Gold Country is located at 6041 Golden Center Court, Placerville, California 95667 and is part of the same commonly owned and managed chain as the other Defendant facilities named herein. Gold Country has admitted in public filings under penalty of perjury that Retirement Housing Foundation is its "parent organization," that it pays Retirement Housing Foundation hundreds of thousands of dollars in related-party management fees every year, that it has paid Defendant Retirement Foundation Housing Property over a hundred thousand dollars a year in related party transactions, and that the other facilities named as Defendants herein are "commonly owned and controlled." Gold Country reported that its health care operations generated a loss exceeding $4,900 in 2016, $27,000 in 2015, and $450 in 2014, while at the same time reporting almost $1.5 million in non-healthcare income in 2016. It reported a return on equity of negative 0.86 in 2016. Gold Country lists its mailing address as 911 N. Studebaker Road, Long Beach, CA 90815, which is also the address for Defendant Retirement Housing Foundation.

33. Gold Country identified substantial long-term debt to a "related party," which it described as "ADVANCED FROM CORP WITH FLOATING DETAILS." The officers and directors of the entity are the same as those for Pioneer House and Retirement Housing Foundation:

l) Governing Board Officers and Members			
Line No.	(1) Name	(2) Occupation	(3) Compensation *
160	JOHN BAUMAN	DIRECTOR	$
161	RAYMOND EAST	DIRECTOR	
162	FRANK G. JAHRLING	CORP TREASURER / DIRECTOR	
163	CHRISTINA E. POTTER	DIRECTOR	
164	DARRYL M. SEXTON	DIRECTOR	
165	JOHN E TRINKA, S. M. SIMINGTON	DIRECTORS	

34. Defendant Mayflower Gardens Health Facilities, Inc. d/b/a Mayflower Gardens Convalescent Hospital ("Mayflower") is a skilled nursing facility as defined in Health & Safety Code § 1250(c), and is therefore subject to Health & Safety Code § 1430(b). Mayflower is located at 6570 West Avenue L-12, Lancaster, California 93536 and is part of the same commonly owned and managed chain as the other Defendant facilities named herein. Mayflower has admitted in public filings under penalty of perjury that Retirement Housing Foundation is its "parent organization." It identifies a "related party payment" of $1,990,767 to Retirement Housing Foundation and reports a home office cost allocation exceeding $450,000 (more than 10% of its gross revenue). It further notes long-term debt to related parties of almost $2,000,000, which it describes as "ADVANCES FROM CORPORATE." At the same time, Mayflower reported that its health care operations generated a loss exceeding $103,000 in 2016, $410,000 in 2015 and $436,000 in 2014. As with Gold Country, Mayflower reported substantial non-healthcare revenues. In 2016, its operating margin was negative 0.03, and its return on equity was negative 0.18.

35. Mayflower reports that the other facilities named as Defendants herein are "commonly owned and controlled." Its officers and directors are also officers and directors (and/or relatives/spouses of officers and directors) of Defendant Retirement Housing Foundation. Mayflower lists its mailing address as 911 N. Studebaker Road, Long Beach, CA 90815, which is also the address for Defendant Retirement Housing Foundation.

36. Defendant Stockton Congregational Homes, Inc. d/b/a Plymouth Square ("Plymouth Square") is a skilled nursing facility as defined in Health & Safety Code § 1250(c), and is therefore subject to Health & Safety Code § 1430(b). Plymouth Square is located at 1319 N. Madison Street, Stockton, California 95202 and is part of the same commonly owned and managed chain as the other Defendant facilities named herein. Plymouth Square has admitted in public filings under penalty of perjury that Retirement Housing Foundation is its "parent organization," that it had home office cost allocations exceeding $321,000, and that the other facilities named as Defendants herein are "commonly owned and controlled." It listed as "payable to a related party" almost

$1,700,000 to Defendant RFH Property, and another $1,194,925 to Retirement Housing Foundation.

37. At the same time, Plymouth Square reported a net operating loss of $434,828 in 2016, $507,892 in 2015, and $322,459 in 2014 and $118,362 in 2013. In 2016, its operating margin was negative 0.21.

38. Plymouth Square lists its mailing address as 911 N. Studebaker Road, Long Beach, CA 90815, which is also the address for Defendant Retirement Housing Foundation, and identifies as officers and directors the same individuals who are officers and directors of Pioneer House, Retirement Housing Foundation and the various other Defendants herein, and/or their spouses or relatives.

39. No rational business owner would continue to operate a business that is losing substantial amounts year after year, generating miserable returns and/or operating on razor thin margins in the manner reported by the individual facility Defendants; nor would any rational investor put money into any such business. On information and belief, the individual facilities are transferring profits through payments of rent, debt service, management fees, other fees and/or cost allocations that wash through the labyrinth of entities in the Retirement Housing Foundation empire, and eventually into the pockets of the owners, all the while concealing Defendants' actual profits and evading tax.

40. Defendant RHF Management, Inc. ("RHF Management") is a California corporation located at 911 Studebaker Road in Long Beach, California. Its CEO is Laverne R. Joseph, who is also the CEO of Retirement Housing Foundation, and also serves as an officer and director for some of the facility Defendants. The other Officers and Directors also serve as Officers and Directors for Retirement Housing Foundation and the facility Defendants. On information and belief, RHF Management is the management company that manages Pioneer House and all the other nursing facilities in Defendants' chain. According to its website, the services RHF Management provides include "management supervision & financial management" and "corporate-compliance maintenance."

41. Defendant Foundation Property Management, Inc. ("RHF Property") is a California Corporation located at 911 Studebaker Road in Long Beach, California. Its CEO is Laverne R. Joseph, who is the CEO of Retirement Housing Foundation, and also serves as an officer and director for some of the facility Defendants. The other Officers and Directors also serve as Officers and Directors for Retirement Housing Foundation and the facility Defendants. On information and belief, RHF Property owns the real property on which Pioneer House sits and all the other real property used by Defendants' chain of nursing facilities.

42. Defendant Retirement Housing Foundation purports to be a non-profit corporation. Its Officers and Directors include the same individuals that serve as Officers and Directors of the Defendant facilities, including, without limitation Laverne R. Joseph, Raymond East, Christina E. Potter, Darryl M. Sexton, Frank G. Jahrling, John Bauman, Deborah Stouff, and Stewart M. Simington. On information and belief, Defendants are all part of the same nursing facility chain, which is under the ownership and/or control of at least the above-named individuals.

43. On information and belief, Retirement Housing Foundation provides shared, centralized services, processes and resources for each of the facility Defendants, which may include without limitation: creating common, standardized policies for each of the facility Defendants, tracking and responding to deficiencies found by the California Department of Public Health ("DPH") for each of the facility Defendants, managing and controlling compliance for each of the facility Defendants, providing centralized management and common personnel to instruct and/or advise the facility Defendants on patient care and operations, providing training for staff and/or management at the facility Defendants, keeping centralized information for all the facility Defendants, performing payroll and HR functions for each of the facility Defendants, providing marketing strategies and public relations strategies for each of the facility Defendants, dealing with state licensing for each of the facility Defendants, providing centralized accounting for each of the facility Defendants, preparing budgets for each of the facility Defendants, performing risk management for each of the facility Defendants, providing common training and resources for each Facility, performing centralized purchasing for the Facilities (and creating economies of scale), and providing common information technology for each of the facility Defendants.

44. In addition to the above, Retirement Housing Foundation aided and abetted the facility Defendants' flagrant disregard for federal and state laws meant to protect vulnerable nursing home residents.

45. The true names and/or capacities, whether corporate, individual, associate, or otherwise of DOES 1 through 10, inclusive, are unknown to Plaintiffs, who have therefore sued them by their fictitious names. When their true names and/or capacities are ascertained, Plaintiffs will seek leave to amend this Complaint by inserting their true names and/or capacities.

46. Each of the Defendants, including DOES 1 to 10, was the agent, servant and employee of all of the remaining Defendants and in doing the things herein alleged was acting within the course and scope of such agency or employment and with the consent and permission of the remaining Defendants; and were operating together for a single, unified purpose.

47. Plaintiffs are informed and believe and thereon allege that DOES 1 to 10 were responsible in some manner for the events and happenings set forth herein. It shall be deemed that whenever and wherever in this Complaint any Defendant, whether specifically named or not, is the subject of any charging allegation, that DOES 1 to 10 are likewise the subject of that charging allegation.

JURISDICTION AND VENUE

48. The Court has jurisdiction over this action pursuant to Health and Safety Code § 1430 which allows enforcement in any court of competent jurisdiction. The California Superior Court has jurisdiction over this action pursuant to California Constitution Article VI § 10, which grants the Superior Court "original jurisdiction in all cases except those given by statute to other trial courts." The statutes under which this action is brought do not grant jurisdiction to any other trial court.

49. Venue is proper herein pursuant to Code of Civil Procedure §§ 395 and 395.5 because one or more of the violations alleged in this Complaint arose in the County of Sacramento.

FACTS

A. Defendants Dump Ms. Single

50. Ms. Single was admitted as a resident at Pioneer House in November 2016. Her husband also resides there.

51. On March 23, 2017, Defendants involuntarily hospitalized Ms. Single at Sutter Medical Center, a general acute care hospital. The same day, the hospital cleared Ms. Single to return home. Thereafter, Defendants refused to readmit her.

52. The hospital invited Defendants to assess Ms. Single to see if she could return home. Defendants, however, refused to do so.

53. By discharging Ms. Single in this manner, Defendants circumvented the legal process for evicting nursing home residents, which would have accorded Ms. Single numerous substantive and procedural rights, including the right to remain at home while she challenged any decision to discharge her, and the right to have an ombudsman from CLTCOA advocate for her and help explain her rights and choices.

54. Left with no other choice, on May 17, 2017, Ms. Single invoked her right to a hearing before the California DHCS on whether Defendants were required to readmit her.

55. On May 24, 2017, a hearing was held before the California DHCS. The hearing was attended by Ms. Single and Pioneer House. At the hearing, Pioneer House was represented by counsel and presented sworn testimony and evidence. Ms. Single was not represented by counsel.

56. After the hearing, the State ruled in Ms. Single's favor and issued a seven-page Order holding: "Pioneer House must immediately readmit Gloria Single to the first available bed." A true and correct copy of the State's Order is attached hereto as **Exhibit 3**.

57. Despite the State's Order requiring readmission, Defendants continue to refuse to readmit Ms. Single.

58. As a result, Ms. Single is separated from her husband. Each day she is separated from her husband, she suffers brutal and irreparable harm, especially given the deteriorating condition of their respective health conditions.

59. Following Defendants' refusal to readmit her, Ms. Single was imprisoned in a hospital for approximately three months. During that time, she received no activities or stimulation other than television, and stopped talking as a result. In addition to injuring Ms. Single, Defendants' conduct needlessly squandered valuable tax dollars on confining Ms. Single to a hospital bed.

60. Because she was unable to endure living in a hospital, Ms. Single eventually agreed to placement at a different nursing facility – until such time she can return home. She still wants to return to living at Pioneer House so she can be with her husband, and so that her son can visit her more easily.

61. Because she was confined to a hospital bed for so long instead of walking around at her home, Ms. Single may have permanently lost her ability to walk.

B. Defendants' Systemic Violations of Resident Rights

62. Defendants' illegal conduct toward Ms. Single was not an accident. According to its own discovery responses, Pioneer House has not issued a discharge notice in the last two years, rendering every discharge within this period unlawful *per se*. On information and belief, the other facility Defendants have failed to provide discharge notices to their residents.

63. Defendants' facilities are also chronically and intentionally understaffed. On the day Ms. Single was sent to the hospital, Pioneer House had a registered nursing hour per patient day ("RN NHPPD") ratio of 0.208, when it should have had at least four times that many registered nurses.[1] This virtually guaranteed that nobody with sufficient training was available to address Ms. Single's needs, including her agitation on the day that Defendants dumped her. This was no accident; for at least the last four years, Pioneer House has not employed a sufficient number of RNs (the most expensive employees) to provide adequate care to its residents.

64. On many days, Pioneer House had no RNs at all, which is a per se violation of the residents' rights. 42 C.F.R. § 483.35. Attached hereto as **Exhibit 4** is a copy of the staffing data

[1] RN NHPPD is the only meaningful measurement of whether a facility has enough staffing to ensure the health and safety of its residents. *See, e.g.*, Castle, N.G., Anderson, R.A., *Caregiver Staffing in Nursing Homes and Their Influence on Quality of Care: Using Dynamic Panel Estimation Methods*, MED. CARE 49(6) 545-52 (June 2011).

that Pioneer House submitted electronically to the government based on its own time records for the first quarter of 2017. As seen therein, the facility never had adequate RN staffing on any of the days that quarter and had no RNs at all on multiple occasions.

65. Defendants' other facilities are similarly understaffed. Attached hereto as **Exhibit 5** is the staffing data that Auburn Ravine Terrace submitted electronically to the government based on its own time records for the first quarter of 2017. As seen therein, the facility never had adequate RN staffing on any of the days that period and had no RNs there on 26 of the 90 days. In the remaining days, the facility was most often understaffed by more than 500%.

66. Attached hereto as **Exhibit 6** is the staffing data for Plymouth Square submitted electronically to the government based on its own time records for the first quarter of 2017. As seen therein, the facility never had adequate RN staffing on any of the days that period and on 57 out of 90 days, had no RNs whatsoever.

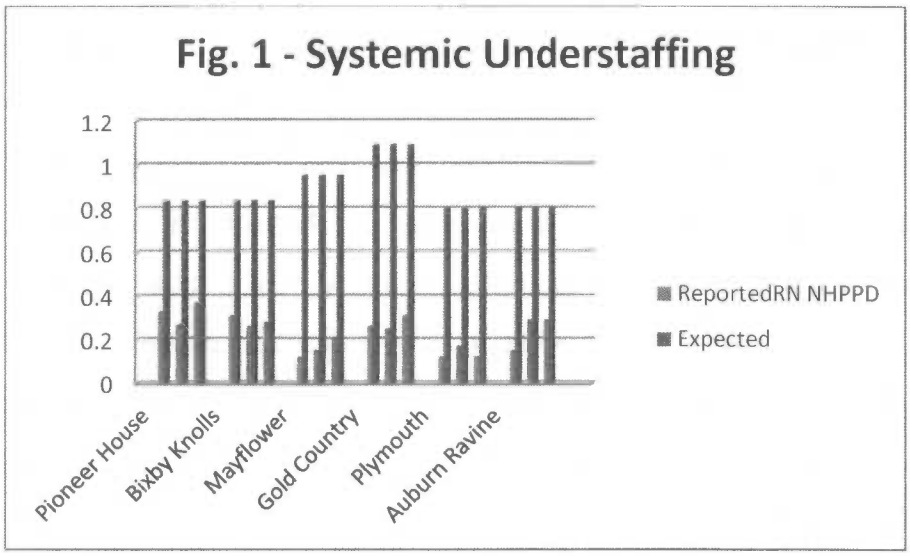
67. Likewise, Bixby Knolls' daily and yearly staffing data shows profound understaffing on every single day for which daily data is available.

68. Finally, for the entirety of 2016 (the last year for which data is publicly available), Defendant Mayflower Gardens reported an average RN NHPPD of 0.21, when it should have had an RN NHPPD of .95. In other words, it was over 450% understaffed.

69. Yearly reports Defendants submitted under penalty of perjury to the Office of Statewide Health Planning and Development ("OSHPD"), reveal chronic and systemic understaffing for the each of the Facility Defendants for the last four years. Interestingly, the actual staffing data based on Defendants' time records appears to be even less than the staffing numbers Defendants reported to OSHPD under penalty of perjury.

70. As seen in Figure 1 below, which represents a three-year study of Defendants' self-reported staffing data, each of their facilities falls drastically below the level of qualified staff necessary to carry out the functions of the facility.[2]

[2] Figure 1 was generated based on staffing and salary data Defendants submitted under penalty of perjury to the government and the CMS standard for expected staffing.



71. It has long been known that insufficient staffing causes profound harm to nursing home residents. *See, e.g.*, C. Harrington, Nursing Home Reform: Addressing Critical Staffing Issues, NURSING OUTLOOK 35 (5), 208-209 (1987); C. Kovner, M. Mezey, and C. Harrington, *Research Priorities for Staffing, Case Mix, and Quality of Care in U.S. Nursing Homes*, JOURNAL OF NURSING SCHOLARSHIP 32 (1):77-80 (2000); C. Harrington, *CMS Study: Correlation Between Staffing and Quality, Nursing Counts*, AM. J. OF NURSING 102 (9): 65-66 (2002). Government studies have likewise shown that understaffing is directly related to the quality of care that nursing home residents receive. *See, e.g.*, U.S. Centers for Medicare and Medicaid Services, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes* (2001).

72. Understaffing, like dumping, is an unlawful, profit-maximizing behavior. Over the last four years, Defendants have received over $10,000,000 in ill-gotten gains through deliberate and systemic understaffing.

CAUSES OF ACTION

First Cause of Action
Violation of California Health and Safety Code § 1430(b)

73. Plaintiffs incorporate the previous paragraphs as though fully set forth herein.

74. Health & Safety Code § 1430(b) states that "[a] current or former resident or patient of a skilled nursing facility, as defined in subdivision (c) of Section 1250 . . . may bring a civil action against the licensee of a facility who violates any of the rights of the resident or patient as set

forth in the Patient Bill of Rights in Section 72527 of Title 22 of the California Code of Regulations ("C.C.R."), or any other right provided for by federal or state law or regulation. The suit shall be brought in a court of competent jurisdiction. The licensee shall be liable for the acts of the licensee's employees. The licensee shall be liable for up to five hundred dollars ($500), and for costs and attorney fees, and may be enjoined from permitting the violation to continue …."

75. By failing to provide a timely bed-hold notice, Defendants violated Ms. Single's right to such notice under 42 U.S.C. § 1396r(c)(2)(D)(ii), which requires skilled nursing facilities to issue a bed-hold notice to any resident who is hospitalized prior to or contemporaneously with the hospitalization.

76. Defendants violated Ms. Single's statutory rights by refusing to readmit her after she informed Defendants of her desire to return and was medically cleared to do so. 22 C.C.R. § 72520(a); Health & Safety Code § 1599.79; 42 U.S.C. § 1396r(c)(2)(D)(iii).

77. Defendants effected a transfer or discharge of Ms. Single without following any of the legal requirements for doing so, *e.g.*, providing 30-days' notice, helping find her a new place to live, and making sure that she is properly prepared and oriented.

78. Defendants are refusing to comply with a lawful order by the California Department of Health Care Services.

79. Defendants' refusal to readmit Ms. Single resulted in her being deprived of the rights as a nursing facility resident to "be fully informed by a physician of […] her total health status" and was not afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care," in violation of Ms. Single's federal and state rights. 22 C.C.R. § 72527(a)(3); 42 C.F.R. § 483.10(c)(iv), (c)(v) and (c)(3).

80. Defendants' refusal to readmit Ms. Single resulted in her being deprived of the rights as a nursing facility resident to "receive all information that is material to an individual patient's decision concerning whether to accept or refuse any proposed treatment or procedure." 22 C.C.R. § 72527(a)(4).

81. Defendants' discharge of Ms. Single and their refusal to readmit her resulted in her being deprived of the rights as a nursing facility resident to "be transferred or discharged only for

medical reasons, or the patient's welfare or that of other patients or for nonpayment for her stay." 22 C.C.R. § 72527(a)(6).

82. Defendants' discharge of Ms. Single and their refusal to readmit her resulted in her being deprived of the rights as a nursing facility resident to "be encouraged and assisted throughout the period of her stay to exercise rights as a patient and a citizen, and to this end voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, discrimination or reprisal." 22 C.C.R. § 72527(a)(7); 42 C.F.R. § 483.10(b)(1).

83. Defendants' discharge of Ms. Single and their refusal to readmit her resulted in her being deprived of the rights as a nursing facility resident to "be free from mental and physical abuse." 22 C.C.R. § 72527(a)(10).

84. Defendants' discharge of Ms. Single and their refusal to readmit and reunite her with her husband resulted in her being deprived of the rights as a nursing facility resident to "meet with others and participate in activities of social, religious and community groups." 22 C.C.R. § 72527(a)(15).

85. Defendants' illegal treatment of Ms. Single violates 22 C.C.R. § 72527(a)(12), which requires all nursing home residents "to be treated with consideration, respect and full recognition of dignity and individuality …." 42 C.F.R. § 483.10(a)(3).

86. Defendants' discharge of Ms. Single and their refusal to readmit and reunite her with her husband resulted in her being deprived of the rights as a nursing facility resident to "be assured privacy for visits by the patient's spouse." 22 C.C.R. § 72527(a)(17).

87. Defendants' conduct violated Ms. Single's rights under Health & Safety Code § 1599.1.

88. Defendants' conduct violated Ms. Single's rights under 42 C.F.R. § 483.35.

Second Cause of Action
Violation of California Business & Professions Code §§ 17200 *et seq.*

89. Plaintiffs incorporate the previous paragraphs as though fully set forth herein.

90. Defendants' conduct alleged herein is unlawful, fraudulent and/or unfair.

91. Ms. Single has lost money or property as a result of Defendants' unlawful, fraudulent and/or unfair conduct.

Third Cause of Action
Declaratory Relief

92. Plaintiffs incorporate the previous paragraphs as though fully set forth herein.

93. Through the facts alleged above, an actual and justiciable controversy exists between the parties. Defendants contend that they were allowed to discharge Ms. Single without following the statutory procedures for effecting a discharge, that they did not have to honor Ms. Single's bedhold right because they asserted that she was dangerous and that they were not required to follow the lawful order issued by DHCS requiring them to readmit Ms. Single. Ms. Single contends that a facility may never discharge a resident without following all of the statutorily required discharge procedures, that a facility never has any ground for refusing to honor a resident's bedhold right, and that failure to follow a lawful readmission order by DHCS violates a resident's rights. An actual controversy exists as to at least each of these issues and as to whether Defendants violated Ms. Single's other rights as identified above.

94. A declaration by this Court will be useful in resolving the rights and obligations of the parties.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for judgment against Defendants as follows:

A. A permanent injunction enjoining Defendants Pioneer House and Retirement Housing Foundation from refusing to re-admit Ms. Single and from taking any action in retaliation against Ms. Single, including, but not limited to, discharge or transfer from Pioneer House;

B. A permanent injunction enjoining Defendants, and each of them, and their contractors, agents, servants and employees and all persons acting under in concert with or for them from:

(1) Violating the bed-hold requirement;

(2) Refusing to comply with readmission Orders issued by the California Department of Healthcare Services;

(3) Discharging any residents without a legally valid reason and without following all of the procedures required by law.

C. A permanent injunction, enjoining Defendants, and each of them, and their contractors, agents, servants and employees and all persons acting under in concert with or for them to adopt procedures to prevent recurring violations of the laws governing the readmission and discharge of residents;

D. Appointment of a monitor to ensure compliance with all injunctive relief issued by the Court;

E. Statutory damages as allowed by law;

F. Declaratory relief;

G. Costs of suit herein incurred;

H. Attorney's fees; and

I. All such other and further relief as the Court may deem just, proper, and equitable.

Dated: July 11, 2018

BRAUNHAGEY & BORDEN LLP

By: _____
Matthew Borden

By: _____
Kelly Bagby

Attorneys for Plaintiffs Gloria Single and California Long Term Care Ombudsman Association

DEMAND FOR JURY TRIAL

Plaintiffs hereby demand a jury trial of all claims and causes of action triable before a jury.

Dated: July 11, 2018

Respectfully submitted,

BRAUNHAGEY & BORDEN LLP

By: _____
Matthew Borden

Attorneys for Plaintiffs Gloria Single and California Long Term Care Ombudsman Association

EXHIBIT 1

CLTCOA
California Long-Term Care Ombudsman Association

1230 N St., Ste. 201
Sacramento, CA 95814
office: 916-426-3697
LColeman@CLTCOA.org
www.CLTCOA.org

By-Laws of
California Long-Term Care Ombudsman Association

ARTICLE I. NAME

The name of the organization will be:

California Long-Term Care Ombudsman Association
(Referred to as CLTCOA)

ARTICLE II. MISSION

The mission of CLTCOA is to provide a unified voice in advocacy and assistance to the Local Long Term Care Ombudsman Programs in California to enable the local programs to provide Ombudsman services to the residents of long term care facilities.

ARTICLE III. PURPOSE

The purposes for this Association are to:

- Advocate for long term care residents by documenting and representing concerns to appropriate legislative bodies, agencies and organizations.
- Promote the importance of local Long-Term Care Ombudsman Programs to appropriate legislative bodies, agencies and organizations
- Provide local Ombudsman Programs supportive services and quality ongoing educational programs; and
- Act as an effective statewide professional association.

EXHIBIT 2

1230 N St., Ste. 201
Sacramento, CA 95814
office: 916-426-3697
LColeman@CLTCOA.org
www.CLTCOA.org

September 14, 17

The Honorable Governor Jerry Brown
State Capitol
Sacramento, CA 95814

Fax 916-558-3160

RE: AB 940 (Weber)– Support- Long-term health care facilities: notice

Dear Governor Brown:

On behalf of The California Long-Term Care Ombudsman Association (CLTCOA) a membership association comprised of the local Long-Term Care (LTC) Ombudsman Programs, their staff, volunteers and supporters, we write to request your support to sign into law AB 940 (Weber) Long-term health care facilities: notice.

In November 2016, the federal rules regarding Skilled Nursing Facility discharge notification for residents receiving care in skilled nursing facilities was amended. The intent behind the update was to ensure that when a resident received a discharge or eviction notice they would be afforded a more timely opportunity for support from the Long-Term Care (LTC) Ombudsman, in that, a copy of the notice would be sent to the LTC Ombudsman Program. But the federal rule did not make it clear on the details for when, how and to which Ombudsman office the notices should be sent. Even with the most recent attempt by CMS in May 2017 to clarify the details, confusion still exists.

AB 940 seeks to codify California Health & Safety Codes to reflect the recent amendment to the Federal rules and provide much needed clarity of the federal rule by specifying that whenever a skilled nursing facility initiates a resident's discharge or eviction from the facility:

- the resident must receive a written notice of discharge,
- a copy of the discharge notice will be sent, as soon as practically possible,
- electronically,
- to the local LTC Ombudsman Program and
- if a facility intentionally does not send the notice, the Department of Public Health may issue a class B violation citation.

On May 4, 2017, Centers for Medicare and Medicaid Services (CMS) issued Survey & Certification Letter 17-27-NH, to provide clarity on the intent behind several of the October 2016 amendments, including the discharge notice amendment. CMS wrote that sending these discharge notices affirms CMS's stated commitment to person-centered care by:

- improving residents' access to the services of the State LTC Ombudsman Program during the discharge process,
- providing added protection to residents and
- ensuring the Office of the State LTC Ombudsman and the representative of the Office (local LTC Ombudsman Programs) are aware of facility practices and activities related to transfer and discharges.

In the June 22, 2017 letter from the National Association of State Ombudsman Programs (NASOP), authored by the chair of the NASOP Advocacy Committee, the California State LTC Ombudsman Joseph Rodrigues wrote, "NASOP wholeheartedly agrees with CMS's statement" and "believe that facilities should continue to send these notices". NASOP went on to say that making these notices to the LTC Ombudsman mandatory assures that residents have the fastest and easiest possible access to their services when facing possible eviction.

The State and Federally mandated purpose of the LTC Ombudsman Program is to ensure the highest possible quality of life and quality of care for residents of long-term care facilities. They serve as eyes, ears and advocates for residents, particularly the 60% of residents without family members visiting to observe care, report problems or to provide assistance.

Complaint investigations conducted by local LTC Ombudsman Programs for improper, unsafe and illegal discharges are a recently growing problem all across the state. In 2016 local programs investigated 1,504 complaints regarding discharge and evictions a 68% increase from 2012.

In other states that have had the discharge notification to the local LTC Ombudsman Program already in place, these programs report a reduction in inappropriate discharges.

LTC Ombudsman programs will use the information they receive in these notices to help individual residents, track trends, and work with health care facilities on systems changes to reduce inappropriate discharges.

Many residents when faced with discharge are not aware of their options. This bill ensures California residents of skilled nursing facilities will be afforded a greater opportunity for timely intervention from their local LTC Ombudsman Program.

CLTCOA is pleased to be sponsoring AB 940. The bill was amended to remove all objections and received unanimous support in both houses. We seek your support, signing this bill, to provide additional advocacy protections for skilled nursing facility residents into California law.

Sincerely,

Leza Coleman

Leza Coleman
Executive Director

EXHIBIT 3

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
Director

EDMUND G. BROWN JR.
Governor

May 24, 2017

Gloria Single - Patient
c/o Aubrey Jones – Appellant
2944 Loyola Drive
Davis, CA 95618

IN THE MATTER OF THE REFUSAL TO READMIT OF
GLORIA SINGLE
APPEAL NUMBER 17-1251

Dear Ms. Single,

Enclosed is a copy of the refusal to readmit appeal decision in this matter, which was executed on behalf of the Department of Health Care Services. This decision constitutes the Final Decision and Order of the Department.

Sincerely,

Gary Diffenderffer, Chief
Sacramento Section II
Administrative Appeals

Enclosure

cc: Robert Godfrey – Administrator
Pioneer House
415 P Street
Sacramento, CA 95814

See Next Page

cc: Continued from Previous Page

Department of Public Health
Center for Health Care Quality
165 Capitol Avenue
Sacramento, CA 95814

CDPH_CHCQ_TDA_RTR@CDPH.CA.GOV

Department of Public Health
Office of Legal Services
1415 L Street, Suite 500
Sacramento, CA 95814

CDPHLegalRTR@cdph.ca.gov

BEFORE THE STATE OF CALIFORNIA

DEPARTMENT OF HEALTH CARE SERVICES

OFFICE OF ADMINISTRATIVE HEARINGS AND APPEALS

In the Matter of the Refusal to Readmit: Gloria Single - Patient c/o Aubrey Jones – Appellant 2944 Loyola Drive Davis, CA 95618	REFUSAL TO READMIT APPEAL NO. 17-1251 **DECISION AND ORDER**

SUMMARY

On March 23, 2017, Pioneer House (a long-term care skilled nursing facility, hereinafter referred to as Facility) advised Sutter Medical Center (a general acute care hospital, hereinafter referred to as GACH) that it could not readmit Gloria Single (hereinafter referred to as Resident) following her treatment at the GACH.

On April 26, 2017, Aubrey Jones (Resident's son, hereinafter referred to as Appellant) filed an appeal with this office, on Resident's behalf, to assert Resident's right to readmission pursuant to California Health and Safety Code (CHSC), §1599.1(h)(1).

PRESENTATION AT HEARING

The hearing convened at 12:00 p.m. on Wednesday, May 17, 2017, at the GACH. Participants of the hearing are a matter of record.

All testimony was taken under oath and the proceedings were digitally recorded.

///

///

I

Documentation and evidence, presented at the hearing, established the following:

Resident is a female Medi-Cal beneficiary, 82 years of age, initially admitted to Facility on November 17, 2016. Resident's diagnosis includes chronic obstruction pulmonary disease; Alzheimer's disease; dementia; and a history of concussion and syncope. She suffers from chronic pain and depressive disorders.

Resident has recent history of increased agitation and anxiety.

II

The following summarizes Facility's arguments, related to its decision to refuse Resident's readmission:

Facility recounted details, leading up to Resident's transfer to the GACH. Facility stated that, on March 23, 2017, Resident became extremely agitated in the small dining room, where staff and other residents were present, including Resident's spouse. Resident began yelling and throwing plastic utensils. This behavior incited fear in other residents and staff and 9-1-1 was called. Resident exhibited physically aggressive behavior toward the responding police officers. Resident was transferred to the GACH, with police oversight under Welfare and Institutions Code, § 5150; involuntary detention.[1]

Facility acknowledged that the GACH requested readmission from Facility, later the same day. Facility informed the GACH that it could not readmit Resident. Facility added that Appellant concurred with Facility's determination that Resident needs a different setting. Facility provided Appellant with the names of other SNFs, which are better equipped to address residents with behavioral symptoms.

Facility presented testimony and documentation associated with its contention that Resident's behavioral needs cannot be met in that her primary need is a mental

---

[1] Detention of mentally disordered person for evaluation and treatment.

health issue; she has no skilled nursing needs; she poses a risk to others; and is independent with her ADLs.

Facility cited two conditions, unique to its facility, which hinder its ability to meet Resident's needs. One, Facility is very small, with a population of only 49 residents, limiting areas in which Resident can be redirected to. Second, Resident's spouse resides at Facility and is a trigger for Resident's agitation. Resident is engrossed in her spouse and his activities, in a controlling manner, as well as in interactions that others have with her spouse. Resident interferes with her spouse's meals. Since Resident's transfer, her spouse has had a positive weight gain. He is more relaxed and verbalized appreciation that Resident was no longer at Facility.

Facility testified that it received clinical documentation from the GACH, on or about April 17, 2017, which indicated that Resident has had episodes of agitation while hospitalized. Facility again notified the GACH that it cannot readmit Resident.

Prior to this hearing, Facility attempted to assess Resident at the GACH and observed Resident in a private room; curled in a fetal position and somnolent. In Facility's opinion, Resident appeared overmedicated, which is not allowed in a skilled nursing facility (SNF). The GACH declined to allow Facility to review Resident's clinical record; hence, it was unable to perform a thorough assessment.

Facility presented an order from Resident's attending physician (MD), dated March 17, 2017, wherein he prescribed Depakote sprinkles for her mood disorder after Resident became verbally aggressive toward her spouse. MD documented, on May 16, 2017, that Resident has no psychiatric condition, which would provide a basis for administering antipsychotic medications to Resident; as such, psychotropic medications are not recommended. MD wrote that the presence of Resident's spouse triggers the majority of her behavior problems. Based upon these reasons, MD opined, Facility cannot meet Resident's needs.

///

III

Appellant pointed out that Resident has been at the GACH for eight weeks, without activities or stimuli, except to watch television. She has stopped talking. Appellant characterized Facility's refusal to readmit as "patient dumping," which is both unfair and cruel treatment against a resident with dementia.

Appellant agreed to search for alternate placement; however, none of the locations that Facility referred him to accepted Resident. Other SNFs either have no beds or have a lengthy waiting list. Appellant provided a list of one-dozen SNFs in Sacramento and Yolo counties, which he has contacted.

Appellant presented a photo of Resident and her spouse interacting, and stated his belief that keeping the two together is the right thing to do.

IV

The GACH testified that they assessed Resident and she does not have acute care needs for hospitalization; however, Resident was admitted due to Facility's refusal to allow her back.

The GACH sent Facility clinical notes, on April 17, 2017, and invited Facility to assess Resident; however, Facility did not accept this offer. The GACH acknowledged that it later denied Facility access to Resident's chart, as Facility had made no arrangements to review her records and Facility's request was not associated with an actual intent to readmit Resident. The GACH pointed out that hospitals typically share information with a receiving facility for the purpose of continuity of care. Such sharing of information is exempted from privacy requirements; however, no such exemption applied at that point and access to Resident's chart would have first required authorization from Appellant.

The GACH described two incidences where Resident exhibited increased agitation, as well as her current medication regimen, which includes Zyprexa, Seroquel, Risperdal, and Aricept. The GACH also pursued other SNFs known for accepting

residents with behavioral issues; however, there were no admission offers.

ANALYSIS AND CONCLUSIONS

I have reviewed the testimony and documents presented at the hearing.

I

Title 22, California Code of Regulations (22, CCR.) § 72520, et seq. provides that upon transferring a patient to a hospital, a SNF must inform the resident or their responsible party, in writing, of their right to exercise a bed-hold of seven days. This notice is required each time a resident is hospitalized. A facility that fails to issue this notice, must offer the resident readmission to the first available bed. Equivalent notification and policy requirements are also contained in Title 42 Code of Federal Regulations (42 CFR) § 483.15(d)(1) and (d)(2).

I considered Appellant's testimony that Facility did not provide him with a written notice, outlining Facility's bed-hold and readmission policies, at the time of Resident transfer. A bed-hold offer was made verbally. Facility failed to rebut this testimony with evidence of a written bed-hold and readmission policy notice.

Resident was evaluated by the GACH and determined to have no acute care need. Accordingly, the GACH requested that Facility readmit Resident, during her bed-hold period; however, Facility refused to accept Resident due to the behavioral problems that precipitated her transfer and are further discussed in Section II below.

I noted that the purpose for Resident's hospitalization was to be evaluated. This evaluation was completed in the GACH's emergency department and Resident was determined not to have a need for acute care hospitalization, nor did she qualify for acute psychiatric hospitalization (diagnoses is not a mental illness).

Therefore, I find that Facility failed to meet these bed-hold and notification requirements and the remedy to offer readmission to the first available bed applies.

II

According to 42 CFR § 483.15(e)(1), a facility must establish and follow a written

policy permitting residents to return to their previous bed, if available, after the bed-hold period, or to the first available bed if the resident's bed is no longer available. When a facility determines that a resident cannot return, it must comply with the provisions outlined under 42 CFR § 483.15(c). Facility presented no exception to this federal requirement.

Due to Facility's refusal to readmit Resident, her hospitalization has now exceeded the bed-hold period. I considered Facility's arguments and the challenges that her behavioral problems present, in view of her hypersensitivity surrounding interactions with her spouse. The key principles that SNFs must employ are to use an individual approach to the problem, including staffing; caregiver training; modification to the physical environment; and other factors that may lessen a resident's distress. In response to Facility's argument concerning Resident's current medication regimen, I agree that Facility will need to follow recommended guidelines in place concerning the necessary documentation, monitoring, and assessment of residents who are admitted from a hospital to a SNF on psychotropic medications, including, the potential for gradual dose reduction.

When interventions have failed and a SNF determines that a resident's needs cannot be met, the regulations provide a remedy for SNFs to perform person-centered discharge planning in order to identify an alternate location, which can meet the resident's needs. In such cases, a SNF must also identify the services at the receiving facility that can meet the specific need(s).[2]

In this case, Facility failed to provide Resident with the due process that is required at the time Facility determined that she could not be readmitted, as outlined under 42 CFR § 483.15(c), which include but are not limited to, issuing a written notice indicating the reason for the refusal. Refusing to readmit a resident after hospitalization is an inappropriate means to transact the permanent discharge of a resident.

---

[2] 42 CFR §§ 483.21 et seq. and 483.15(c)(2)(i)(B)

This tribunal finds Facility's refusal is clearly a transfer/discharge within the meaning of this federal law and it is not exempt from the next bed requirement *(St. John of God Retirement Care Center v. Department, supra, 2 Cal. App 5th at P. 653).*

Therefore, I find that Facility failed to meet these readmission requirements.

SUMMARY OF FINDINGS

Facility failed to comply with 42 CFR § 483.15 pertaining to the transfer and readmission of Resident as follows:

- Failed to issue a written bed-hold notice, upon transfer;
- Failed to readmit Resident during her bed-hold period; and
- Failed to readmit Resident to the first available bed.

DECISION AND ORDER

The appeal is GRANTED. Pioneer House must immediately readmit Gloria Single to the first available bed, upon receipt of the clinical records that Sutter Medical Center routinely provides to the receiving facility.

This is the FINAL DECISION AND ORDER of the Department. No further administrative remedies are available. [3]

Lynn M. Heisler

LYNN M. HEISLER
Hearing Officer

5/24/2017
Date

[3] If, upon readmission, Facility can support that any of the six reasons for the involuntary transfer of Resident, it may issue a transfer notice. However, this notice and Facility documentation must contain all the required elements to support that the transfer or discharge is appropriate in accordance with Title 42 CFR §§ 483.15 and 483.21.

EXHIBIT 4

PROVNUM	PROVNAME	STATE	CY_Qtr	WorkDate	hrs_RN_DONadmin	hrs_RN	hrs_LPN_admin	hrs_LPN	hrs_CNA	hrs_NA_trn	hrs_MedAide	MDScensus	RN NHPPD	Expected	Deficit	%deficit
555542	PIONEER HOUSE	CA	2017Q1	20170119	8	8.5	15	41.5	119	0	0	44	0.193181818	0.835042763	0.641860944	432.2574301
555542	PIONEER HOUSE	CA	2017Q1	20170120	8	17	15	40.5	110.75	0	0	43	0.395348837	0.835042763	0.439693925	211.2166988
555542	PIONEER HOUSE	CA	2017Q1	20170121	0	16.5	0	32.75	117.5	0	0	43	0.38372093	0.835042763	0.451321832	217.6172048
555542	PIONEER HOUSE	CA	2017Q1	20170122	0	16	0	32.25	109.25	0	0	43	0.372093023	0.835042763	0.462949739	224.4177425
555542	PIONEER HOUSE	CA	2017Q1	20170101	0	24	0	24.75	94.25	0	0	45	0.533333333	0.835042763	0.301709429	156.570518
555542	PIONEER HOUSE	CA	2017Q1	20170102	0	16.25	0	32.75	104.25	0	0	45	0.361111111	0.835042763	0.473931652	231.2426112
555542	PIONEER HOUSE	CA	2017Q1	20170103	8	8	8	50	115.75	0	0	45	0.177777778	0.835042763	0.657264985	469.711554
555542	PIONEER HOUSE	CA	2017Q1	20170104	8	9	15.25	46.25	110.5	0	0	45	0.2	0.835042763	0.635042763	417.5213813
555542	PIONEER HOUSE	CA	2017Q1	20170105	8	8.75	16	47.75	106.25	0	0	45	0.194444444	0.835042763	0.640598318	429.4505637
555542	PIONEER HOUSE	CA	2017Q1	20170106	8	16.75	15.75	41	103.75	0	0	46	0.364130435	0.835042763	0.470912328	229.3251766
555542	PIONEER HOUSE	CA	2017Q1	20170107	0	16	0	33.25	112	0	0	45	0.355555556	0.835042763	0.479487207	234.855777
555542	PIONEER HOUSE	CA	2017Q1	20170108	0	16.5	0	33	123.5	0	0	43	0.38372093	0.835042763	0.451321832	217.6172048
555542	PIONEER HOUSE	CA	2017Q1	20170109	8	17.25	17.5	42	120.25	0	0	42	0.410714286	0.835042763	0.424328477	203.3147596
555542	PIONEER HOUSE	CA	2017Q1	20170110	8	8	15.5	50.75	111.5	0	0	42	0.19047619	0.835042763	0.644566572	438.3974504
555542	PIONEER HOUSE	CA	2017Q1	20170111	8	0	14	49.75	110.75	0	0	42	0	0.835042763	0.835042763	
555542	PIONEER HOUSE	CA	2017Q1	20170112	8	0	13.75	51	111	0	0	41	0	0.835042763	0.835042763	
555542	PIONEER HOUSE	CA	2017Q1	20170113	8	8.25	15.25	52.75	122.25	0	0	42	0.196428571	0.835042763	0.638614191	425.1126792
555542	PIONEER HOUSE	CA	2017Q1	20170114	0	24	0	29	123.75	0	0	43	0.558139535	0.835042763	0.276903228	149.6118283
555542	PIONEER HOUSE	CA	2017Q1	20170115	0	16.25	0	38.5	118	0	0	44	0.369318182	0.835042763	0.465724581	226.1038865
555542	PIONEER HOUSE	CA	2017Q1	20170116	8	16	16	40.75	117.25	0	0	44	0.363636364	0.835042763	0.471406399	229.6367597
555542	PIONEER HOUSE	CA	2017Q1	20170117	8	8.25	15.5	41.5	119.25	0	0	44	0.1875	0.835042763	0.647542763	445.3561401
555542	PIONEER HOUSE	CA	2017Q1	20170118	8	17.25	16.75	32.75	116.75	0	0	44	0.392045455	0.835042763	0.442997308	212.9964148
555542	PIONEER HOUSE	CA	2017Q1	20170123	8	16.5	15.75	35.5	122	0	0	43	0.38372093	0.835042763	0.451321832	217.6172048
555542	PIONEER HOUSE	CA	2017Q1	20170124	8	8	16	49.25	114	0	0	43	0.186046512	0.835042763	0.648996251	448.8354849
555542	PIONEER HOUSE	CA	2017Q1	20170125	8	12	8	36.75	113	0	0	43	0.279069767	0.835042763	0.555972995	299.2236566
555542	PIONEER HOUSE	CA	2017Q1	20170126	8	12	8	33.5	115	0	0	43	0.279069767	0.835042763	0.555972995	299.2236566
555542	PIONEER HOUSE	CA	2017Q1	20170127	8	16.75	12.25	40	115.25	0	0	43	0.389534884	0.835042763	0.445507879	214.3691868
555542	PIONEER HOUSE	CA	2017Q1	20170128	0	16.25	0	32.75	116	0	0	42	0.386904762	0.835042763	0.448138001	215.8264371
555542	PIONEER HOUSE	CA	2017Q1	20170129	0	16	0	32	103.75	0	0	42	0.380952381	0.835042763	0.454090382	219.1987252
555542	PIONEER HOUSE	CA	2017Q1	20170130	8	16.25	14.25	40.75	110.75	0	0	41	0.396341463	0.835042763	0.438701299	210.6877124
555542	PIONEER HOUSE	CA	2017Q1	20170131	8	13.75	17.25	39.5	103.25	0	0	41	0.335365854	0.835042763	0.499676909	248.9945692
555542	PIONEER HOUSE	CA	2017Q1	20170201	8	10	7.5	31.75	93.5	0	0	41	0.243902439	0.835042763	0.591140324	342.3675327
555542	PIONEER HOUSE	CA	2017Q1	20170202	8	8.5	7.75	31.75	104.75	0	0	42	0.202380952	0.835042763	0.63266181	412.6093651
555542	PIONEER HOUSE	CA	2017Q1	20170203	8	17.25	0	31.25	99.5	0	0	42	0.410714286	0.835042763	0.424328477	203.3147596
555542	PIONEER HOUSE	CA	2017Q1	20170204	0	24	0	24.5	97.5	0	0	42	0.571428571	0.835042763	0.263614191	146.1324835
555542	PIONEER HOUSE	CA	2017Q1	20170205	0	18.75	0	39.75	107.5	0	0	42	0.446428571	0.835042763	0.388614191	187.0495788
555542	PIONEER HOUSE	CA	2017Q1	20170206	8	16.25	15.25	40.75	100.5	0	0	41	0.396341463	0.835042763	0.438701299	210.6877124
555542	PIONEER HOUSE	CA	2017Q1	20170207	8	16	16	40.75	128	0	0	42	0.380952381	0.835042763	0.454090382	219.1987252
555542	PIONEER HOUSE	CA	2017Q1	20170208	8	2	15.5	42	124	0	0	41	0.048780488	0.835042763	0.786262275	1711.837663
555542	PIONEER HOUSE	CA	2017Q1	20170209	8	10	15.75	48.25	96.75	0	0	42	0.238095238	0.835042763	0.596947525	350.7179603
555542	PIONEER HOUSE	CA	2017Q1	20170210	8	20.25	15.5	25.75	107.5	0	0	42	0.482142857	0.835042763	0.352899906	173.1940545
555542	PIONEER HOUSE	CA	2017Q1	20170211	0	15.75	0	41.5	103.5	0	0	41	0.384146341	0.835042763	0.450896421	217.3762112
555542	PIONEER HOUSE	CA	2017Q1	20170212	0	16.25	0	32.75	106.5	0	0	41	0.396341463	0.835042763	0.438701299	210.6877124
555542	PIONEER HOUSE	CA	2017Q1	20170213	8	16.25	19.25	41	114.75	0	0	41	0.396341463	0.835042763	0.438701299	210.6877124
555542	PIONEER HOUSE	CA	2017Q1	20170214	8	8	20	52.75	119.25	0	0	41	0.195121951	0.835042763	0.639920811	427.9594159
555542	PIONEER HOUSE	CA	2017Q1	20170215	8	2	18.5	47.25	109.25	0	0	41	0.048780488	0.835042763	0.786262275	1711.837663
555542	PIONEER HOUSE	CA	2017Q1	20170216	8	8.75	18.75	45.75	107.5	0	0	41	0.213414634	0.835042763	0.621628129	391.2771802
555542	PIONEER HOUSE	CA	2017Q1	20170217	8	18.75	13.75	32.75	125.75	0	0	45	0.416666667	0.835042763	0.418376096	200.410263
555542	PIONEER HOUSE	CA	2017Q1	20170218	0	15.25	0	42	116.5	0	0	45	0.338888889	0.835042763	0.496153874	246.4060611
555542	PIONEER HOUSE	CA	2017Q1	20170219	0	8	0	49	103.25	0	0	45	0.177777778	0.835042763	0.657264985	469.711554
555542	PIONEER HOUSE	CA	2017Q1	20170220	8	16.25	8	32.25	109.25	0	0	44	0.369318182	0.835042763	0.465724581	226.1038865
555542	PIONEER HOUSE	CA	2017Q1	20170221	8	8	16	40.5	109.75	0	0	44	0.181818182	0.835042763	0.653224581	459.2735195
555542	PIONEER HOUSE	CA	2017Q1	20170222	8	2	15.75	39.25	101	0	0	44	0.045454545	0.835042763	0.789588217	1837.094078
555542	PIONEER HOUSE	CA	2017Q1	20170223	8	8.75	14.75	41.75	108.5	0	0	44	0.198863636	0.835042763	0.636179126	419.9072178
555542	PIONEER HOUSE	CA	2017Q1	20170224	8	16.75	14.5	32.5	111	0	0	43	0.389534884	0.835042763	0.445507879	214.3691868
555542	PIONEER HOUSE	CA	2017Q1	20170225	0	22.25	0	39	109.75	0	0	43	0.51744186	0.835042763	0.317600902	161.3790508
555542	PIONEER HOUSE	CA	2017Q1	20170226	0	8.25	0	47.5	109	0	0	43	0.191860465	0.835042763	0.643182298	435.2344096
555542	PIONEER HOUSE	CA	2017Q1	20170227	8	16	16.25	41.75	111.5	0	0	43	0.372093023	0.835042763	0.462949739	224.4177425
555542	PIONEER HOUSE	CA	2017Q1	20170228	8	8	15.25	47	99	0	0	43	0.186046512	0.835042763	0.648996251	448.8354849
555542	PIONEER HOUSE	CA	2017Q1	20170301	8	8.5	15.5	42.25	120.25	0	0	43	0.197674419	0.835042763	0.637368344	422.4333976
555542	PIONEER HOUSE	CA	2017Q1	20170302	8	8.5	16.5	47.5	122	0	0	43	0.197674419	0.835042763	0.637368344	422.4333976
555542	PIONEER HOUSE	CA	2017Q1	20170303	0	16.5	8	32.25	109.75	0	0	43	0.38372093	0.835042763	0.451321832	217.6172048
555542	PIONEER HOUSE	CA	2017Q1	20170304	0	15.25	0	38.5	103.75	0	0	42	0.363095238	0.835042763	0.471947525	229.9789904
555542	PIONEER HOUSE	CA	2017Q1	20170305	0	16.5	0	32.25	92	0	0	41	0.402439024	0.835042763	0.432603738	207.4954744
555542	PIONEER HOUSE	CA	2017Q1	20170306	8	16.25	15.75	32	119.75	0	0	42	0.386904762	0.835042763	0.448138001	215.8264371
555542	PIONEER HOUSE	CA	2017Q1	20170307	8	8.25	7.75	48.5	111	0	0	42	0.196428571	0.835042763	0.638614191	425.1126792
555542	PIONEER HOUSE	CA	2017Q1	20170308	8	8.5	3.75	40.25	103.75	0	0	42	0.202380952	0.835042763	0.63266181	412.6093651
555542	PIONEER HOUSE	CA	2017Q1	20170309	8	8.5	12.25	40.25	112	0	0	42	0.202380952	0.835042763	0.63266181	412.6093651
555542	PIONEER HOUSE	CA	2017Q1	20170310	8	16.75	15.5	38.5	103.75	0	0	42	0.398809524	0.835042763	0.436233239	209.3838569
555542	PIONEER HOUSE	CA	2017Q1	20170311	0	22.75	0	31.75	98	0	0	42	0.541666667	0.835042763	0.293376096	154.1617408
555542	PIONEER HOUSE	CA	2017Q1	20170312	0	8.25	0	38.75	100.75	0	0	42	0.196428571	0.835042763	0.638614191	425.1126792

555542 PIONEER HOUSE	CA	2017Q1	20170313	8	16	8	40.25	111.75	0	0	42	0.380952381	0.835042763	0.454090382	219.1987252
555542 PIONEER HOUSE	CA	2017Q1	20170314	8	6	15.75	47	107.25	0	0	42	0.142857143	0.835042763	0.69218562	584.5299339
555542 PIONEER HOUSE	CA	2017Q1	20170315	8	8.75	15.5	42.25	123.5	0	0	42	0.208333333	0.835042763	0.626709429	400.8205261
555542 PIONEER HOUSE	CA	2017Q1	20170316	8	9	15.5	46	113.25	0	0	42	0.214285714	0.835042763	0.620757048	389.6866226
555542 PIONEER HOUSE	CA	2017Q1	20170317	8	8	15.5	41.25	100	0	0	42	0.19047619	0.835042763	0.644566572	438.3974504
555542 PIONEER HOUSE	CA	2017Q1	20170318	0	15.5	0	32.25	87.5	0	0	42	0.369047619	0.835042763	0.465995144	226.2696518
555542 PIONEER HOUSE	CA	2017Q1	20170319	0	13.25	0	38.25	96	0	0	42	0.31547619	0.835042763	0.519566572	264.6928002
555542 PIONEER HOUSE	CA	2017Q1	20170320	0	16.5	15.75	33.75	126	0	0	42	0.392857143	0.835042763	0.44218562	212.5563396
555542 PIONEER HOUSE	CA	2017Q1	20170321	8	8	16.25	49	108.25	0	0	43	0.186046512	0.835042763	0.648996251	448.8354849
555542 PIONEER HOUSE	CA	2017Q1	20170322	8	8.75	15.75	48	130.5	0	0	43	0.203488372	0.835042763	0.631554391	410.3638719
[redacted]															
555542 PIONEER HOUSE	CA	2017Q1	20170324	8	17	16	24.25	104.75	0	0	43				354.966689
555542 PIONEER HOUSE	CA	2017Q1	20170325	0	16	0	33.75	124	0	0	43				
555542 PIONEER HOUSE	CA	2017Q1	20170326	8.25	4	0	39	104	0	0	43				
555542 PIONEER HOUSE	CA	2017Q1	20170327	8	14	8	34	115.25	0	0	43				
555542 PIONEER HOUSE	CA	2017Q1	20170328	8	0	8	50.25	110.75	0	0	44				
555542 PIONEER HOUSE	CA	2017Q1	20170329	8	5.5	8	55	100.75	0	0	44				
555542 PIONEER HOUSE	CA	2017Q1	20170330	8	16.5	8	41	97.25	0	0	44				
555542 PIONEER HOUSE	CA	2017Q1	20170331	8	16.5	8	24.5	109.5	0	0	43				

EXHIBIT 5

PROVNUM	PROVNAM	STATE	CY_Qtr	WorkDate	hrs_RN_DONadmin	hrs_RN	hrs_LPN_admin	hrs_LPN	hrs_CNA	hrs_NA_trn	hrs_MedAide	MDScensus	RN NHPPD	Expected	Deficit	%deficit
555645	AUBURN R CA		2017Q1	20170101	0	16.25	0	32.75	82.25	0	0	54	0.300925926	0.805074632	0.504148706	**267.5324929**
555645	AUBURN R CA		2017Q1	20170102	0	9.5	0	47.5	105.25	0	0	55	0.172727273	0.805074632	0.632347359	**466.0958393**
555645	AUBURN R CA		2017Q1	20170103	8	7.75	16	41.75	97	0	0	55	0.140909091	0.805074632	0.664165541	**571.3432869**
555645	AUBURN R CA		2017Q1	20170104	8	8	16	40.75	112.25	0	0	56	0.142857143	0.805074632	0.662217489	**563.5522421**
555645	AUBURN R CA		2017Q1	20170105	8	8	16	40.25	112.5	0	0	57	0.140350877	0.805074632	0.664723754	**573.615675**
555645	AUBURN R CA		2017Q1	20170106	0	8	16	38.75	109.75	0	0	56	0.142857143	0.805074632	0.662217489	**563.5522421**
555645	AUBURN R CA		2017Q1	20170107	0	8	0	35.25	98.5	0	0	57	0.140350877	0.805074632	0.664723754	**573.615675**
555645	AUBURN R CA		2017Q1	20170108	0	8	0	40.25	108.5	0	0	57	0.140350877	0.805074632	0.664723754	**573.615675**
555645	AUBURN R CA		2017Q1	20170109	8	14.75	16	39.5	104	0	0	57	0.25877193	0.805074632	0.546302702	**311.1135864**
555645	AUBURN R CA		2017Q1	20170110	8	15.5	16	32.75	103	0	0	57	0.271929825	0.805074632	0.533144807	**296.0597032**
555645	AUBURN R CA		2017Q1	20170111	8	12.75	16	32.75	117	0	0	57	0.223684211	0.805074632	0.581390421	**359.9157176**
[illegible]													0	0.805074632	0.805074632	
555645	AUBURN R CA		2017Q1	20170113	8	8	16	40.5	105.5	0	0	56	0.142857143	0.805074632	0.662217489	**563.5522421**
555645	AUBURN R CA		2017Q1	20170114	0	15.5	0	25.5	103.5	0	0	56	0.276785714	0.805074632	0.528288917	**290.8656733**
555645	AUBURN R CA		2017Q1	20170115	0	16	0	32.5	103.5	0	0	56	0.285714286	0.805074632	0.519360346	**281.776121**
555645	AUBURN R CA		2017Q1	20170116	8	8	16	40	85.5	0	0	56	0.142857143	0.805074632	0.662217489	**563.5522421**
[illegible]													0	0.805074632	0.805074632	
[illegible]													0	0.805074632	0.805074632	
555645	AUBURN R CA		2017Q1	20170119	8	12.25	16	32.5	101.75	0	0	55	0.222727273	0.805074632	0.582347359	**361.4620795**
555645	AUBURN R CA		2017Q1	20170120	8	12.75	16	32.75	96.5	0	0	55	0.231818182	0.805074632	0.57325645	**347.2870959**
555645	AUBURN R CA		2017Q1	20170121	0	23.75	0	24.5	96.5	0	0	55	0.431818182	0.805074632	0.37325645	**186.4383357**
555645	AUBURN R CA		2017Q1	20170122	0	8	0	40.5	90.75	0	0	55	0.145454545	0.805074632	0.659620086	**553.4888092**
555645	AUBURN R CA		2017Q1	20170123	8	8	16	40.5	119.75	0	0	56	0.142857143	0.805074632	0.662217489	**563.5522421**
555645	AUBURN R CA		2017Q1	20170124	8	7.75	16	41.75	103.25	0	0	56	0.138392857	0.805074632	0.666681774	**581.7313466**
555645	AUBURN R CA		2017Q1	20170125	8	8	16	33	91.5	0	0	56	0.142857143	0.805074632	0.662217489	**563.5522421**
555645	AUBURN R CA		2017Q1	20170126	8	8.25	16	33.5	92	0	0	56	0.147321429	0.805074632	0.657753203	**546.4749014**
[illegible]													0	0.805074632	0.805074632	
555645	AUBURN R CA		2017Q1	20170128	0	8	0	41	121.75	0	0	56	0.142857143	0.805074632	0.662217489	**563.5522421**
555645	AUBURN R CA		2017Q1	20170129	0	8	0	47	116	0	0	56	0.142857143	0.805074632	0.662217489	**563.5522421**
555645	AUBURN R CA		2017Q1	20170130	8	8	16	32.75	106	0	0	57	0.140350877	0.805074632	0.664723754	**573.615675**
555645	AUBURN R CA		2017Q1	20170131	8	8	16	39.5	102.75	0	0	57	0.140350877	0.805074632	0.664723754	**573.615675**
555645	AUBURN R CA		2017Q1	20170201	8	8.5	16	32.75	103.25	0	0	57	0.149122807	0.805074632	0.655951825	**539.8735764**
[illegible]													0	0.805074632	0.805074632	
555645	AUBURN R CA		2017Q1	20170203	8	8.5	8	40.5	106	0	0	57	0.149122807	0.805074632	0.655951825	**539.8735764**
555645	AUBURN R CA		2017Q1	20170204	0	16	0	32.5	95.75	0	0	57	0.280701754	0.805074632	0.524372877	**286.8078375**
555645	AUBURN R CA		2017Q1	20170205	0	16	0	32.5	85.5	0	0	56	0.285714286	0.805074632	0.519360346	**281.776121**
555645	AUBURN R CA		2017Q1	20170206	8	8	16	32.5	87.75	0	0	56	0.142857143	0.805074632	0.662217489	**563.5522421**
[illegible]													0	0.805074632	0.805074632	
[illegible]													0	0.805074632	0.805074632	
555645	AUBURN R CA		2017Q1	20170209	8	7.75	16	40.75	93.5	0	0	56	0.138392857	0.805074632	0.666681774	**581.7313466**
555645	AUBURN R CA		2017Q1	20170210	8	8	16	40.75	91.75	0	0	56	0.142857143	0.805074632	0.662217489	**563.5522421**
555645	AUBURN R CA		2017Q1	20170211	0	16	0	32.25	90	0	0	56	0.285714286	0.805074632	0.519360346	**281.776121**
555645	AUBURN R CA		2017Q1	20170212	0	16.25	0	33	87.25	0	0	56	0.290178571	0.805074632	0.51489606	**277.4411038**
[illegible]													0	0.805074632	0.805074632	
555645	AUBURN R CA		2017Q1	20170214	8	8	8	41	95.25	0	0	55	0.145454545	0.805074632	0.659620086	**553.4888092**
555645	AUBURN R CA		2017Q1	20170215	8	8	8	40	94.75	0	0	54	0.148148148	0.805074632	0.656926483	**543.4253763**
555645	AUBURN R CA		2017Q1	20170216	8	7.75	8	40.25	79	0	0	54	0.143518519	0.805074632	0.661556113	**560.9552271**
[illegible]													0	0.805074632	0.805074632	
555645	AUBURN R CA		2017Q1	20170218	0	8	0	40.25	99.25	0	0	54	0.148148148	0.805074632	0.656926483	**543.4253763**
555645	AUBURN R CA		2017Q1	20170219	0	8	0	40.75	90	0	0	54	0.148148148	0.805074632	0.656926483	**543.4253763**
555645	AUBURN R CA		2017Q1	20170220	0	8	8	40.5	78	0	0	54	0.148148148	0.805074632	0.656926483	**543.4253763**
555645	AUBURN R CA		2017Q1	20170221	8	8	16	40.75	104.75	0	0	55	0.145454545	0.805074632	0.659620086	**553.4888092**
555645	AUBURN R CA		2017Q1	20170222	8	8	8	32.75	109.5	0	0	55	0.145454545	0.805074632	0.659620086	**553.4888092**
[illegible]													0	0.805074632	0.805074632	

555645 AUBURN R CA	2017Q1	20170224	8	8	16	40.75	109.75	0	0	55	0.145454545	0.805074632	0.659620086	553.4888092
555645 AUBURN R CA	2017Q1	20170225	0	15.75	0	32.5	105.5	0	0	55	0.286363636	0.805074632	0.518710995	281.1371729
555645 AUBURN R CA	2017Q1	20170226	0	16.25	0	32.5	104	0	0	55	0.295454545	0.805074632	0.509620086	272.4867984
555645 AUBURN R CA	2017Q1	20170227	8	7.75	16	40.25	95.5	0	0	55	0.140909091	0.805074632	0.664165541	571.3432869
[redacted]											0	0.805074632	0.805074632	
											0	0.805074632	0.805074632	
555645 AUBURN R CA	2017Q1	20170302	0	8	16	41	114.5	0	0	55	0.145454545	0.805074632	0.659620086	553.4888092
555645 AUBURN R CA	2017Q1	20170303	8	7.75	16	33.75	96.75	0	0	56	0.138392857	0.805074632	0.666681774	581.7313466
555645 AUBURN R CA	2017Q1	20170304	0	16	0	32.5	95.25	0	0	56	0.285714286	0.805074632	0.519360346	281.776121
555645 AUBURN R CA	2017Q1	20170305	0	16.5	0	32	103	0	0	56	0.294642857	0.805074632	0.510431774	273.2374507
555645 AUBURN R CA	2017Q1	20170306	0	9	8	40.5	81.5	0	0	56	0.160714286	0.805074632	0.644360346	500.9353263
[redacted]											0	0.805074632	0.805074632	
											0	0.805074632	0.805074632	
											0	0.805074632	0.805074632	
											0	0.805074632	0.805074632	
555645 AUBURN R CA	2017Q1	20170311	0	8	0	40.5	95.5	0	0	58	0.137931034	0.805074632	0.667143597	583.6791079
555645 AUBURN R CA	2017Q1	20170312	0	8	0	39.75	94	0	0	58	0.137931034	0.805074632	0.667143597	583.6791079
[redacted]											0	0.805074632	0.805074632	
											0	0.805074632	0.805074632	
											0	0.805074632	0.805074632	
											0	0.805074632	0.805074632	
											0	0.805074632	0.805074632	
555645 AUBURN R CA	2017Q1	20170318	0	8	0	43.5	101.75	0	0	57	0.140350877	0.805074632	0.664723754	573.615675
555645 AUBURN R CA	2017Q1	20170319	0	8	0	40	95.75	0	0	57	0.140350877	0.805074632	0.664723754	573.615675
[redacted]											0	0.805074632	0.805074632	
											0	0.805074632	0.805074632	
											0	0.805074632	0.805074632	
555645 AUBURN R CA	2017Q1	20170323	0	8	16	48	110.75	0	0	57	0.140350877	0.805074632	0.664723754	573.615675
555645 AUBURN R CA	2017Q1	20170324	8	8	16	56.25	96.75	0	0	57	0.140350877	0.805074632	0.664723754	573.615675
555645 AUBURN R CA	2017Q1	20170325	0	16	0	47.25	95.25	0	0	57	0.280701754	0.805074632	0.524372877	286.8078375
555645 AUBURN R CA	2017Q1	20170326	0	14.75	0	33.5	75.75	0	0	57	0.25877193	0.805074632	0.546302702	311.1135864
[redacted]											0	0.805074632	0.805074632	
555645 AUBURN R CA	2017Q1	20170328	8	8	16	48.5	94.5	0	0	58	0.137931034	0.805074632	0.667143597	583.6791079
555645 AUBURN R CA	2017Q1	20170329	8	8	16	49.25	103.75	0	0	57	0.140350877	0.805074632	0.664723754	573.615675
555645 AUBURN R CA	2017Q1	20170330	8	8	16	56.5	93.75	0	0	57	0.140350877	0.805074632	0.664723754	573.615675
[redacted]											0	0.805074632	0.805074632	
														480.7791648

EXHIBIT 6

PROVNUM	PROVNAM	STATE	CY_Qtr	WorkDate	hrs_RN_DONadmin	hrs_RN	hrs_LPN_admin	hrs_LPN	hrs_CNA	hrs_NA_trn	hrs_MedAide	MDScensus	RN NHPPD	Expected	Deficit	%Deficit
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
555692	PLYMOUTH	CA	2017Q1	20170114	0	7.5	0	22.75	64	0	0	28	0.267857143	0.801071702	0.533214559	299.0667688
555692	PLYMOUTH	CA	2017Q1	20170115	0	8	0	25	59.75	0	0	27	0.296296296	0.801071702	0.504775406	270.3616995
555692	PLYMOUTH	CA	2017Q1	20170101	0	6	0	24.5	67.5	0	0	28	0.214285714	0.801071702	0.586785988	373.833461
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
555692	PLYMOUTH	CA	2017Q1	20170105	0	8	15	25.25	80	0	0	26	0.307692308	0.801071702	0.493379395	260.3483032
[illegible]														0.801071702	0.801071702	
555692	PLYMOUTH	CA	2017Q1	20170107	0	8	0	25	52.5	0	0	26	0.307692308	0.801071702	0.493379395	260.3483032
555692	PLYMOUTH	CA	2017Q1	20170108	0	7.25	0	30	55.5	0	0	27	0.268518519	0.801071702	0.532553184	298.3301512
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
555692	PLYMOUTH	CA	2017Q1	20170117	8	8	14	25.5	68.75	0	0	27	0.296296296	0.801071702	0.504775406	270.3616995
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
555692	PLYMOUTH	CA	2017Q1	20170121	0	8	0	25.5	70.75	0	0	27	0.296296296	0.801071702	0.504775406	270.3616995
555692	PLYMOUTH	CA	2017Q1	20170122	0	8	0	26.75	68.25	0	0	29	0.275862069	0.801071702	0.525209633	290.3884921
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
555692	PLYMOUTH	CA	2017Q1	20170128	0	8	0	24.75	75	0	0	31	0.258064516	0.801071702	0.543007186	310.4152846
555692	PLYMOUTH	CA	2017Q1	20170129	0	8	0	25	67.5	0	0	31	0.258064516	0.801071702	0.543007186	310.4152846
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
555692	PLYMOUTH	CA	2017Q1	20170204	0	8	0	24.5	61	0	0	33	0.242424242	0.801071702	0.55864746	330.4420772
555692	PLYMOUTH	CA	2017Q1	20170205	0	8	0	24.75	53.5	0	0	33	0.242424242	0.801071702	0.55864746	330.4420772
555692	PLYMOUTH	CA	2017Q1	20170206	0	8	15	25.25	53.5	0	0	33	0.242424242	0.801071702	0.55864746	330.4420772
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
555692	PLYMOUTH	CA	2017Q1	20170211	0	7	0	24.75	53.5	0	0	35	0.2	0.801071702	0.601071702	400.5358511
555692	PLYMOUTH	CA	2017Q1	20170212	0	8	0	25.5	55.5	0	0	34	0.235294118	0.801071702	0.565777585	340.4554735
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
555692	PLYMOUTH	CA	2017Q1	20170215	8	10	16	26.75	61.5	0	0	37	0.27027027	0.801071702	0.530801432	296.3965298
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
555692	PLYMOUTH	CA	2017Q1	20170218	0	7.75	0	25	63.75	0	0	35	0.221428571	0.801071702	0.579643131	361.7743171
555692	PLYMOUTH	CA	2017Q1	20170219	0	8.25	0	25.5	71	0	0	35	0.235714286	0.801071702	0.565357417	339.848601
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
[illegible]														0.801071702	0.801071702	
555692	PLYMOUTH	CA	2017Q1	20170223	0	8.25	17	34	68.75	0	0	37	0.222972973	0.801071702	0.578098729	359.268521

[redacted]													0.801071702	0.801071702	[redacted]
555692	PLYMOUTI CA	2017Q1	20170225	0	8.75	0	25.5	72.75	0	0	37	0.236486486	0.801071702	0.564585216	338.7388912
555692	PLYMOUTI CA	2017Q1	20170226	0	9.25	0	34	79.75	0	0	36	0.256944444	0.801071702	0.544127258	311.7684463
[redacted]													0.801071702	0.801071702	[redacted]
[redacted]													0.801071702	0.801071702	[redacted]
[redacted]													0.801071702	0.801071702	[redacted]
555692	PLYMOUTI CA	2017Q1	20170302	8	8	16.5	28.25	80.25	0	0	37	0.216216216	0.801071702	0.584855486	370.4956623
555692	PLYMOUTI CA	2017Q1	20170303	8	7.5	15.75	18	74	0	0	37	0.202702703	0.801071702	0.598369	395.1953731
555692	PLYMOUTI CA	2017Q1	20170304	0	7.75	0	25	77.75	0	0	36	0.215277778	0.801071702	0.585793924	372.1107262
555692	PLYMOUTI CA	2017Q1	20170305	0	7.75	8	31.75	67.25	0	0	37	0.209459459	0.801071702	0.591612243	382.4471353
555692	PLYMOUTI CA	2017Q1	20170306	8	8.5	8	25	56.75	0	0	37	0.22972973	0.801071702	0.571341973	348.7017998
[redacted]													0.801071702	0.801071702	[redacted]
[redacted]													0.801071702	0.801071702	[redacted]
555692	PLYMOUTI CA	2017Q1	20170309	8	8.75	8.25	24	71.5	0	0	36	0.243055556	0.801071702	0.558016147	329.5837861
[redacted]													0.801071702	0.801071702	[redacted]
555692	PLYMOUTI CA	2017Q1	20170311	0	8.5	0	25.5	52.75	0	0	37	0.22972973	0.801071702	0.571341973	348.7017998
555692	PLYMOUTI CA	2017Q1	20170312	0	16	0	15.75	61	0	0	37	0.432432432	0.801071702	0.36863927	185.2478311
555692	PLYMOUTI CA	2017Q1	20170313	8	8	7.75	32	64	0	0	37	0.216216216	0.801071702	0.584855486	370.4956623
[redacted]													0.801071702	0.801071702	[redacted]
[redacted]													0.801071702	0.801071702	[redacted]
555692	PLYMOUTI CA	2017Q1	20170316	8	8	16.25	32.5	76.25	0	0	38	0.210526316	0.801071702	0.590545386	380.5090586
[redacted]													0.801071702	0.801071702	[redacted]
555692	PLYMOUTI CA	2017Q1	20170318	0	8.25	0	30.75	53.25	0	0	38	0.217105263	0.801071702	0.583966439	368.978481
555692	PLYMOUTI CA	2017Q1	20170319	0	8.25	0	24.75	56	0	0	38	0.217105263	0.801071702	0.583966439	368.978481
[redacted]													0.801071702	0.801071702	[redacted]
[redacted]													0.801071702	0.801071702	[redacted]
[redacted]													0.801071702	0.801071702	[redacted]
555692	PLYMOUTI CA	2017Q1	20170323	0	7.75	16.75	25.25	62.5	0	0	36	0.215277778	0.801071702	0.585793924	372.1107262
[redacted]													0.801071702	0.801071702	[redacted]
555692	PLYMOUTI CA	2017Q1	20170325	0	8	0	24.25	71.5	0	0	35	0.228571429	0.801071702	0.572500274	350.4688697
[redacted]													0.801071702	0.801071702	[redacted]
555692	PLYMOUTI CA	2017Q1	20170327	8	4.25	16.5	36.25	65.25	0	0	38	0.111842105	0.801071702	0.689229597	716.2523455
[redacted]													0.801071702	0.801071702	[redacted]
[redacted]													0.801071702	0.801071702	[redacted]
[redacted]													0.801071702	0.801071702	[redacted]
[redacted]													0.801071702	0.801071702	[redacted]

EXHIBIT 3

Gregory L. Johnson, 177889
Jody C. Moore, 192601
Katherine A. Bowles, 287426
JOHNSON MOORE
1429 E. Thousand Oaks Blvd. Suite 202
Thousand Oaks, California 91362
Telephone: (805) 988-3661
Facsimile: (805) 494-4777

Kelly Bagby, Pro Hac Vice
AARP FOUNDATION LITIGATION
601 E. Street NW
Washington CA 20049
Telephone: (202) 434-2103
Facsimile: (202) 434-6424

Attorneys for Plaintiffs KATHI LEVINE, as Successor-in-Interest to PATRICIA THOMAS, and on behalf of others similarly situated

SUPERIOR COURT OF CALIFORNIA

COUNTY OF VENTURA

KATHI LEVINE as Successor-in-Interest to PATRICIA THOMAS, and on behalf of others similarly situated,

Plaintiffs,

vs.

VENTURA CONVALESCENT HOSPITAL; and DOES 1-100, inclusive,

Defendants.

CASE NO.: 56-2011-00406713-CU-AT-VTA

~~*AMENDED* [PROPOSED]~~ **ORDER RE MOTION FOR PRELIMINARY APPROVAL OF CLASS ACTION SETTLEMENT**

Date: January 31, 2014
Time: 8:30 a.m.
Dept.: 43

[PROPOSED] ORDER

Having read and considered the parties' Settlement Agreement and Motion for Preliminary Approval, and the exhibits thereto, IT IS HEREBY ORDERED:

1. This Order hereby incorporates by reference the definitions in the Settlement Agreement, and all terms used herein shall have the same meaning as set forth in the Settlement Agreement. In the event of inconsistency, however, the terms of this Order shall control.

2. For purposes of settlement only, and in accordance with the standards set forth in *Dunk v. Ford Motor Company*, 48 Cal. App. 4th (1996), the Court preliminarily certifies this litigation as a class action and preliminarily certifies the Settlement Class as follows:

3. The Court finds that the requirements of California Code of Civil Procedure § 382 have been satisfied and the Court has made a preliminary determination that the above-captioned plaintiff ("Named Plaintiff") is an adequate class representative for the Settlement Class.

4. The following firms and attorneys are approved as Class Counsel to represent the Settlement Class: Jody C. Moore and Gregory L. Johnson of JOHNSON MOORE, and Kelly Bagby of AARP Foundation Litigation. Any Settlement Class Member may enter an appearance in this lawsuit, at his or her own expense, either individually or through counsel of their own choice. However, if they do not enter an appearance, they will be represented by Class Counsel.

5. The Court hereby preliminarily approves the settlement as set forth in the Settlement Agreement as falling within the range of a settlement that may be granted final approval.

6. The Settlement Administrator shall be Gilardi & Co., LLC.

7. A Fairness Hearing for Final Approval shall be held on APRIL 17, 2014 at 8:30 AM, before the Honorable _____ in Department 43 of the Ventura County Superior Court located at 800 South Victoria Avenue, Ventura, CA 93009. The purpose of the Fairness Hearing for Final Approval will be to determine whether: (a) the proposed Settlement Agreement should be finally approved by the Court as fair, reasonable, and adequate; (b) any objections to the settlement should be granted or overruled; (c) the Fees and Expense Payment that Class Counsel seeks should be approved in the amounts requested; (d) the Service Payments

to Named Plaintiffs should be approved in the amount requested; and (e) the Final Approval Order and Judgment dismissing the Action with prejudice should be entered.

8. The Court hereby approves the form and content of the Class Notice, attached as Exhibit B.

9. On or before 10 calendar days after this Order is signed, Settling Defendant shall provide to the Settlement Administrator the name, last known contact information and social security number of all Settlement Class Members, and/or their legal representatives, to the extent such information is within the possession, custody or control of Settling Defendant. All information provided by Settling Defendant under this paragraph shall be maintained as confidential and used solely for the purpose of providing Class Notice and discharging its obligations under the Settlement Agreement and this Order.

10. Within 30 days of the filing date of this Order, the Settlement Administrator shall mail the Class Notice with the Claim Form and Probate Form attached to all Settlement Class Members for whom addresses can be reasonably located in accordance with the procedures set forth in this Order.

11. Both prior to Class Notice mailing and in re-mailing for notices returned as undeliverable, the Settlement Administrator shall update addresses for Settlement Class Members using appropriate procedures, including without limitation, utilizing the National Change of Address database and skip traces.

12. The Court finds that dissemination of the Class Notice in the manner set forth in this Order meets the requirements of California code of Civil Procedure §382, California Rule of court 3.769(f), and due process, and further constitutes the best notice practicable under the circumstances and shall constitute due and sufficient notice to all persons entitled thereto.

13. Any Settlement Class Member may request exclusion from the Settlement Class by mailing a written Request for Exclusion to the Settlement Administrator that is postmarked within 30 calendar days after the Class Notice Date, or, if that day is a Sunday or Holiday, the first business day thereafter. Any Settlement Class Member who submits a valid and timely Request for Exclusion shall have no rights under the Agreement, will not be entitled to any

benefits pursuant to the Agreement, and will not be bound by the Agreement, this Order, or the Final Approval Order and Judgment.

14. Absent relief from the Court, members of the Settlement Class who do not exclude themselves by the timely completion and mailing of a Request for Exclusion shall be deemed to be Settlement Class Members and be bound by the terms and conditions of the Settlement Agreement and the Final Approval Order and Judgment. Any Settlement Class Member who wishes to object to all or any part of the proposed settlement, including the request by Class Counsel for approval of the Fees and Expense Payment, must do so in writing. Settlement Class Members may also appear at the Fairness Hearing for Final Approval, either in person or through an attorney at their own expense, provided that they notify the Court of their intent to do so. The Settlement Class Member shall include any legal support he or she wishes to bring to the Court's attention and any evidence the Settlement Class Member wishes to introduce in support of the objection. All written objections, supporting papers and/or notices of intent to appear at the Fairness Hearing for Final Approval must:

(a) clearly identify the case name and number (*Kathi Levine v. Ventura Convalescent, et al., case number 56-2011-00406713-CU-AT-VTA*); **and**

(b) Either:

(i) ~~be submitted to the Court either by mailing to the Superior Court of California, County of Ventura, at 800 South Victoria Avenue, Ventura, CA 93009,~~ or by filing in person at any location of the Superior Court, County of Ventura that includes a facility for civil filings with a copy mailed to JOHNSON MOORE c/o Jody C. Moore, Class Counsel, at 1429 E. Thousand Oaks Blvd. Suite 202, Thousand Oaks, CA 91362 and WILSON GETTY c/o William C. Wilson, Defendant's counsel, at 12555 High Bluff Drive, Suite 270, San Diego CA, 92130; **or**

(ii) be mailed to the JOHNSON MOORE at 1429 E. Thousand Oaks Blvd. Suite 202, Thousand Oaks, CA 91362 with a request that it be filed with the court; and

(c) **be post-marked** OR FILED **on or before** 4-1-14

All written objections, supporting papers and/or notices of intent to appear mailed exclusively to JOHNSON MOORE will be submitted to the court for filing by JOHNSON MOORE with a declaration regarding the manner of service and post mark date, with proof of service on Defendant's Counsel.

15. The clerk of the Superior Court, County of Ventura is hereby ordered to waive any first appearance fee or filing fee for any Settlement Class Member who wishes to file an objection or notice of intent to appear at the Final Approval Hearing. The clerk of the Superior Court, County of Ventura is further directed to accept any written objection, supporting papers, and/or notice of intent to appear, irrespective of its form.

16. Only Settlement Class Members who have timely submitted or filed properly completed written notices of their intent to appear will be entitled to be heard at the Final Approval Hearing, unless the Court orders otherwise. Any Settlement Class member who does not make his or her objection in the manner provided for herein shall be deemed to have waived such objection and shall forever be foreclosed from making any objection to the fairness, reasonableness, or adequacy of the proposed settlement or to the award of the Fees and Expense Payment, unless the Court orders otherwise.

17. All papers in support of the motion for final approval of the Settlement Agreement and any request by Class Counsel for approval of the Fees and Expense Payment shall be filed not later than twenty one days before the Fairness Hearing for Final Approval. Any opposition papers shall be filed not later than fourteen days before the Fairness Hearing for Final Approval, and any reply papers shall be filed not later than five days before the Fairness Hearing for Final Approval.

18. The Court reserves the right to adjourn the date of the Fairness Hearing for Final Approval without further notice to Settlement Class Members, and retains jurisdiction to consider all further applications arising out of our connected with the proposed Settlement Agreement.

19. Pending the Court's ruling at the Fairness Hearing for Final Approval, neither the Named Plaintiffs, Settlement Class Members, nor any other person or entity shall institute or prosecute any of the matters referenced as Released Claims in the Settlement Agreement.

20. Neither the Settlement Agreement, nor any of its terms or provisions, nor any of the negotiations or proceedings connected with it shall be construed in any other lawsuit as an admission or concession by Settling Defendant of the truth of any of the allegations in the Action, or of any liability, fault or wrongdoing of any kind.

IT IS SO ORDERED.

Date: 1.31.14

HON. MARK S. BORRELL

EXHIBIT B

NOTICE OF PROPOSED CLASS ACTION SETTLEMENT

You are receiving this Notice because you or a loved one was a patient of Dr. Gary Proffett while residing at Ventura Convalescent Center (VCH) and he or she received a certain type of prescription medication.

This notice pertains to the settlement of a class action lawsuit entitled *Kathi Levine v. Ventura Convalescent Hospital, et al., case number 56-2011-00406713-CU-AT-VTA, in the Superior Court for the State of California, County of Ventura* (the "Lawsuit"). The Settlement Class includes: (1) Resident Class Members, which are all persons who resided in Ventura Convalescent Hospital at any time between November 14, 2008 and November 14, 2011 (the "Settlement Class Period") and received a psychotherapeutic medication prescribed by Dr. Gary Proffett, and 2) Successor Class Members, who are all persons named as a beneficiary in a will or living trust of a deceased Resident Class Member, or if there was no will or living trust and depending on the circumstances, may be the surviving spouse, domestic partner, child, parent, sibling, grandchild, grandparent or other relative of a deceased Resident Class Member.

To confirm whether you are a Settlement Class Member, call 1-877-295-8827.

WHAT IS THE LAWSUIT ABOUT?

Plaintiffs (*Kathi Levine and others similarly situated*) allege that employees of Ventura Convalescent Hospital gave psychotherapeutic medications to residents without verifying that a conversation had taken place between the resident (or his/her legal representative) and the doctor who prescribed the medication (Dr. Gary Proffett) to communicate the information required by California Code of Regulations, Title 22, Section 72528. In short, the lawsuit is about meeting the legal requirements for obtaining "informed consent." Ventura Convalescent Hospital denies all allegations of wrongdoing, fault or liability alleged in the Complaint. The Parties intend to resolve the Action and settle all claims asserted by the Plaintiffs and the Class in according to the terms and conditions in the Agreement.

WHAT ARE THE KEY SETTLEMENT TERMS?

1. **Settlement Fund.** Settling Defendant (*Ventura Convalescent Hospital et al.*) shall pay the entire amount of indemnity remaining on its insurance policy into the Settlement Fund no later than 10 calendar days after trial court signs the Final Approval Order and Judgment. At present, the amount available for indemnity is approximately $730,000.00, and this is because attorney's fees and costs spent defending the lawsuit diminish the amount available to be paid by the insurance policy. The Settlement Fund shall cover all of Settling Defendant's monetary obligations under the settlement (not including any costs to comply with the Injunction other than monitoring), but including all Cash Payments, Monitoring Costs, Settlement Administration Costs, Service Payments and the Fee and Expense Payments. The Settlement Fund shall be maintained in an interest-bearing, secure account. All interest earned on the Settlement Fund shall become part of the Settlement Fund and shall not revert to Settling Defendant.

2. **Cash Payments.** Cash Payments will be made to Eligible Settlement Class Members that timely submit a claim form. All eligible Settlement Class Members shall receive a Cash Payment of $600. **To obtain a payment, Resident Class Members and Successor Class Members must mail a completed claim form (enclosed) that is post-marked no later than May 31, 2014 to Levine v. Ventura Settlement Administrator, c/o Gilardi & Co. LLC, P.O. Box 8060, San Rafael, CA 94912-8060.**

3. **Ongoing Monitoring.** Plaintiffs and Ventura Convalescent Hospital have also agreed that an independent third party shall monitor compliance with Section 72528 for a period of at least two years. This will involve surprise inspections by an experienced skilled nursing facility consultant (Monitor) who will have access to records and other information to determine whether the Ventura Convalescent Hospital staff are complying with the laws regarding informed consent. The Monitor will then prepare reports to be filed with the court. The monitoring program is part of an Injunction (Court Order), agreed to by the Parties and entered by the court. Ventura Convalescent Hospital has agreed to use a new form to verify informed consent. If the Monitor's reports show that Ventura Convalescent Hospital is substantially complying with its legal obligations regarding informed consent, the Injunction will be in effect only for two years and the cost of the monitoring, approximately $25,000, will come from the Settlement Fund. If one of the Monitor's reports shows that Ventura Convalescent Hospital is not substantially complying with its legal obligations, Ventura Convalescent Hospital must do a number of things to bring the facility into substantial compliance, including providing additional training to staff and providing a corrective action plan. If two of the Monitor's reports show that Ventura Convalescent Hospital is not in substantial compliance, Ventura Convalescent Hospital will have to allow the Monitor to conduct two additional inspections. The cost of these two additional inspections will be paid for by Ventura Convalescent Hospital and not by the Settlement Fund. If the Monitor's reports show at least three instances of noncompliance, Ventura Convalescent Hospital will have violated the Injunction and Plaintiffs may ask the Court to extend the period for the Injunction or for any other appropriate remedy.

4. **Releases.** In exchange for these benefits, Settlement Class Members will be releasing all claims under Health and Safety Code section 1430(b), Title 22 California Code of Regulation Sections 72528 and 72527 as it relates to informed consent. By releasing these claims, you will be giving up important rights and benefits, so you may wish to consult with your own attorney regarding participation in the settlement. This release does not include any action to enforce the Settlement Agreement and does not include any and all individual claims for personal injuries, wrongful death, elder abuse, or Health and Safety Code section 1430(b) claims that are not based on violations of 22 C.C.R. Section 72528, relating to informed consent verification.

5. **Other Terms.** Subject to Court approval, the following payments will be made from the Settlement Fund: Service Payments to the named plaintiff in an amount to be determined by the Court; Settlement Administration Costs estimated at $10,000; attorney's fees not to exceed $450,000.00 and litigation costs not to exceed $50,000.00 (the "Fees and Expenses Payment"). Class Counsel may request additional attorneys' fees and costs for work performed after the Preliminary Approval Date, but only to the extent that monies are available from the Settlement Fund after all obligations and reserves for the Settlement Class have been met. The actual amount of any attorneys' fees and costs paid to Class Counsel will be determined by the Court.

FINAL SETTLEMENT APPROVAL

The Court has set the date for a hearing on the Motion for Final Settlement Approval, the approval of Plaintiffs' fee and cost application, and approval of the service payments to the named class representative for _____ at __ a.m. (the "Final Approval Hearing"). The Final Approval Hearing will occur in Department 43 of the Superior Court of California, County of Ventura, at 800 South Victoria Avenue, Ventura, CA 93009.

WHO REPRESENTS YOU?

The Court has appointed Gregory L. Johnson and Jody C. Moore of JOHNSON MOORE and Kelly Bagby of AARP Foundation Litigation to serve as "Class Counsel." JOHNSON MOORE is located at 1429 East Thousand Oaks Boulevard, Suite 202, Thousand Oaks, CA 91362. They may be contacted by phone at 805-988-3661.

WHAT ARE YOUR OPTIONS?

If you wish to participate in the settlement, here is what you need to do. If you are a Former Resident or Successor Class Member, you must complete and mail a claim form **post-marked on or before May 31, 2014 to Levine v. Ventura Settlement Administrator, c/o Gilardi & Co. LLC, P.O. Box 8060, San Rafael, CA 94912-8060.** Before you submit the claim form, however, you should consider whether the receipt of settlement funds will impact your eligibility for Medi-Cal or other benefits. Information regarding this issue is available by visiting www.canhr.org. If you submit a claim form and receive a settlement check, you will be legally bound by all orders and judgment of the Court, and you will not be able to sue, or continue to sue the Defendant for the claims released.

If you do not want to remain a Class Member, you may choose to exclude yourself from the Lawsuit by mailing an opt-out request post-marked by **April 1, 2014** to **Levine v. Ventura Settlement Administrator, c/o Gilardi & Co. LLC, P.O. Box 6002, Larkspur, CA 94977-6002.** If you opt out, you will not receive any settlement payment and you will not have a right to object to the settlement or be heard at the Final Approval Hearing. However, you will retain your right to sue Defendant for any claims you may have related to verification of informed consent and will not be bound by any Court orders or judgments related to this Action. The money that would have gone to you will instead go to a charitable organization, approved by the Court, that is focused on issues relating to verification of informed consent in nursing facilities.

If you wish to remain a Settlement Class Member but object to the proposed settlement, you must notify the Court and Counsel for the Parties of your intent to do so. Any objections to the proposed settlement must be in writing. You may also appear at the Final Approval Hearing, either in person or through an attorney at your own expense, provided that you notify the Court in writing of your intent to do so. All written objections, supporting papers and/or notices of intent to appear at the Final Approval Hearing must: (a) clearly identify the case name and number (*Kathi Levine v. Ventura Convalescent, et al., case number 56-2011-00406713-CU-AT-VTA*); (b) ~~be submitted to the Court either by mailing to Department 43 of the Superior Court of California, County of Ventura, Administration Building at 800 South Victoria Avenue, Ventura, CA 93009, or~~ by filing in person at any location of the Superior Court, County of Ventura that includes a facility for civil filings; (c) be mailed to the law firms identified below; and (d) **be post-marked on or before April 1, 2014.**

Johnson Moore
c/o Jody C. Moore
1429 E Thousand Oaks Blvd., Suite 202
Thousand Oaks, CA 93160
(805) 988-3661
Class Counsel

WILSON GETTY LLP
c/o William C. Wilson
12555 High Bluff Drive, Suite 270
San Diego, CA 92130
(858) 847-3237
Defendant's Counsel

HOW CAN YOU GET MORE INFORMATION?

This notice summarizes the Settlement Agreement only. To obtain the complete Settlement Agreement, you may request a copy be emailed to you by calling 805-988-3661, or examine the Settlement Agreement, along with the pleadings and other records in this litigation, including the Settlement Agreement, at the Courthouse located at 800 S Victoria Ave, Ventura, CA 93009, between the hours of 8:30 a.m. and 4:00 p.m., Monday through Friday, excluding Court holidays. For any other questions, contact the Settlement Administrator at **Levine v. Ventura Settlement Administrator, c/o Gilardi & Co. LLC, P.O. Box 8060, San Rafael, CA 94912-8060 or by calling toll free to 1-877-295-8827.**

PLEASE DO NOT CONTACT THE COURT.

EXHIBIT 4A

EXHIBIT 2A

Legislative Research & Intent LLC

1107 9th Street, Suite 220, Sacramento, CA 95814
(800) 530.7613 · (916) 442.7660 · fax (916) 442.1529
www.lrihistory.com · intent@lrihistory.com

Legislative History of

CALIFORNIA
HEALTH & SAFETY CODE
§ 1430

As Amended By
Statutes of 1982, Chapter 1455, § 1
Senate Bill 1930 – Petris

Legislative Research & Intent LLC

1107 9th Street, Suite 220, Sacramento, CA 95814
(800) 530.7613 · (916) 442.7660 · fax (916) 442.1529
www.lrihistory.com · intent@lrihistory.com

Authentication of the Records and Table of Contents

Legislative History Research Report Regarding:
CALIFORNIA HEALTH & SAFETY CODE § 1430
As Amended By Statutes of 1982, Chapter 1455, § 1, SB 1930 – Petris

I, Carolina C. Rose, declare that this report includes:

- *Historical documents surrounding the adoption of the above enactment.* These documents were obtained by the staff of Legislative Research & Intent LLC and are true and correct copies of the originals obtained from the designated official, public sources in California unless another source is indicated, with the following exceptions: In some cases, pages may have been reduced in size to fit an 8 ½" x 11" sized paper. Or, for readability purposes, pages may have been enlarged or cleansed of black marks or spots. Lastly, paging and relevant identification have been inserted.

  Since 1983 LRI has specialized in the historical research surrounding the adoption, amendment and/or repeal of California statutes, regulations and constitutional provisions pursuant to California Code of Civil Procedure § 1859 which states in pertinent part: "In the construction of a statute the intention of the Legislature ... is to be pursued, if possible ...." Our research and expert witness services have assisted the courts in understanding and applying the underlying purpose of enactments in countless cases, such as *Redlands Community Hospital v. New England Mutual Life Insurance Co,* 23 Cal. App.4th 899 at 906 (1994). LRI also provides similar research for other states and at the federal level. (Formerly Legislative Research Institute and Legislative Research, Incorporated.)

- *A table of contents itemizing the documents.* This table of contents cites the sources of the documents.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct and that I could and would so testify in a court of law if called to be a witness.

Executed December 12, 2011, in Sacramento, California.

Carolina C. Rose, President

Table of Contents

PRIMARY SOURCE RECORDS (UNPUBLISHED HARDCOPY): At least one official California source is cited for the primary source records provided in this report. Multiple copies may have been obtained from various sources (primarily State Archives, the state library system and/or legislative offices), but the clearest/most legible version was selected for this report.

- NOTE: The Senate reported the bill off the floor and to the Assembly on "Consent," signifying lack of controversy, no debate or discussion, with the roll-call substituting for the vote.

DOCUMENTS GENERATED DURING ASSEMBLY DELIBERATIONS

Bill analysis worksheet (background information) and attachments, if any.....22
Assembly Committee on
(Source: State Archives:

Assembly policy committee analysis.....27
Assembly Committee on Judiciary
(Source: State Archives: Assembly Committee on Judiciary)

NOTE: The Assembly policy committee reported the bill out on "Consent," signifying lack of controversy, no hearing or discussion, with the roll-call substituting for the vote.

Assembly policy committee Republican analysis.....30
(Source: State Archives: Assembly Committee on Judiciary)

NOTE: The Assembly reported the bill off the floor and to the Senate on "Consent," signifying lack of controversy, no debate or discussion, with the roll-call substituting for the vote.

SENATE "CONCURRENCE" DOCUMENTS

NOTE: If the bill was amended "in the other house" (i.e., an Assembly Bill amended in the Senate or vice versa) it must return to the house of origin for "concurrence" on the other house's amendment(s). Concurrence results in immediate passage to the enrolled bill file (to the Governor). Nonconcurrence forces the bill into a joint house "conference committee."

Here there was concurrence.

Senate floor analyses: Concurrence in Assembly Amendments/Unfinished Business.....32

Partisan Caucus

Senate Democratic Caucus
(Source: State Archives: Senate Democratic Caucus)

Senate Republican Caucus (sometimes untitled)
(Source: State Archives: Senate Republican Caucus)

NOTE: The Senate reported the bill off the floor and to the Governor on "Consent," signifying lack of controversy, no debate or discussion, with the roll-call substituting for the vote.

ENROLLED (GOVERNOR) MATERIALS
FROM STATE ARCHIVES

UNITEMIZED CORRESPONDENCE/MATERIALS
BY SOURCE FROM STATE ARCHIVES

Legislative Research & Intent LLC

1107 9th Street, Suite 220, Sacramento, CA 95814
(800) 530.7613 · (916) 442.7660 · fax (916) 442.1529
www.lrihistory.com · intent@lrihistory.com

General Enactment History

Legislative Research & Intent LLC hereby certifies that the accompanying record/s is/are true and correct copies of the original/s obtained from one or more official, public sources in California unless another source is indicated, with the following exceptions : In some cases, pages may have been reduced in size to fit an 8 ½" x 11" sized paper. Or, for readability purposes, pages may have been enlarged or cleansed of black marks or spots. Lastly, for ease of reference, paging and relevant identification have been inserted.

Introduced by Senator Petris

March 17, 1982

An act to amend Section 1430 of the Health and Safety Code, relating to health facilities.

LEGISLATIVE COUNSEL'S DIGEST

SB 1930, as introduced, Petris. Health facilities.

Under existing law, a licensee of certain health facilities who violates licensing provisions may be enjoined from permitting the violation to continue or sued for civil damages, as specified, in addition to any other remedy provided by law. Existing licensing provisions contain a skilled nursing and intermediate care facility patient's bill of rights.

This bill would permit a patient or resident of a skilled nursing facility or intermediate care facility to bring a civil action against the facility if his or her rights under this patient's bill of rights are violated, as specified.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 1430 of the Health and Safety Code is amended to read:

1430. *(a)* Except where the state department has taken action and the violations have been corrected to its satisfaction, any licensee who commits a class "A" or "B" violation may be enjoined from permitting the violation to continue or may be sued for civil damages within a court of competent jurisdiction. Such actions for injunction or civil damages, or both, may be prosecuted by the Attorney General in the name of the people of the State of California upon his *or her* own complaint or upon

the complaint of any board, officer, person, corporation or association, or by any person acting for the interests of itself, its members or the general public. The amount of civil damages which may be recovered in an action brought pursuant to this section shall not exceed the maximum amount of civil penalties which could be assessed on account of the violation or violations.

(b) A resident or patient of a skilled nursing facility, as defined in subdivision (c) of Section 1250, or intermediate care facilities, as defined in subdivision (d) of Section 1250, may bring a civil action against the licensee of a facility who violates any rights of the resident or patient under the provisions of Chapter 3.9 (commencing with Section 1599). The suit shall be brought in a court of competent jurisdiction. The licensee shall be liable for up to two thousand five hundred dollars ($2,500) or three times the actual damages, whichever is greater, and for costs and attorney fees, and may be enjoined from permitting the violation to continue. An agreement by a resident or patient of a skilled nursing facility or intermediate care facility to waive his or her rights to sue pursuant to this subdivision shall be void as contrary to public policy.

(c) The remedies specified in this section shall be in addition to any other remedy provided by law.

O

AMENDED IN SENATE APRIL 26, 1982

SENATE BILL No. 1930

Introduced by Senator Petris

March 17, 1982

An act to amend Section 1430 of the Health and Safety Code, relating to health facilities.

LEGISLATIVE COUNSEL'S DIGEST

SB 1930, as amended, Petris. Health facilities.

Under existing law, a licensee of certain health facilities who violates licensing provisions may be enjoined from permitting the violation to continue or sued for civil damages, as specified, in addition to any other remedy provided by law. Existing licensing provisions contain a skilled nursing and intermediate care facility patient's bill of rights.

This bill would permit a patient or resident of a skilled nursing facility or intermediate care facility to bring a civil action against the facility if his or her rights under this patient's bill of rights are violated, as specified. *The bill would provide that the licensee shall be liable for the acts of the licensee's employees.*

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 1430 of the Health and Safety Code is amended to read:

1430. (a) Except where the state department has taken action and the violations have been corrected to its satisfaction, any licensee who commits a class "A" or "B" violation may be enjoined from permitting the violation to continue or may be sued for civil damages within a

court of competent jurisdiction. Such actions for injunction or civil damages, or both, may be prosecuted by the Attorney General in the name of the people of the State of California upon his or her own complaint or upon the complaint of any board, officer, person, corporation or association, or by any person acting for the interests of itself, its members or the general public. The amount of civil damages which may be recovered in an action brought pursuant to this section shall not exceed the maximum amount of civil penalties which could be assessed on account of the violation or violations.

(b) A resident or patient of a skilled nursing facility, as defined in subdivision (c) of Section 1250, or intermediate care facilities, as defined in subdivision (d) of Section 1250, may bring a civil action against the licensee of a facility who violates any rights of the resident or patient *as set forth in the Patients Bill of Rights in Section 72527 of Title 22 of the California Administrative Code or as set forth* under the provisions of Chapter 3.9 (commencing with Section 1599). The suit shall be brought in a court of competent jurisdiction. *The licensee shall be liable for the acts of the licensee's employees.* The licensee shall be liable for up to two thousand five hundred dollars ($2,500) or three times the actual damages, whichever is greater, and for costs and attorney fees, and may be enjoined from permitting the violation to continue. An agreement by a resident or patient of a skilled nursing facility or intermediate care facility to waive his or her rights to sue pursuant to this subdivision shall be void as contrary to public policy.

(c) The remedies specified in this section shall be in addition to any other remedy provided by law.

O

AMENDED IN SENATE MAY 12, 1982

AMENDED IN SENATE APRIL 26, 1982

SENATE BILL No. 1930

Introduced by Senator Petris

March 17, 1982

An act to amend Section 1430 of the Health and Safety Code, relating to health facilities.

LEGISLATIVE COUNSEL'S DIGEST

SB 1930, as amended, Petris. Health facilities.

Under existing law, a licensee of certain health facilities who violates licensing provisions may be enjoined from permitting the violation to continue or sued for civil damages, as specified, in addition to any other remedy provided by law. Existing licensing ~~provisions~~ *regulations* contain a skilled nursing and intermediate care facility patient's bill of rights.

This bill would permit a patient or resident of a skilled nursing facility or intermediate care facility to bring a civil action against the facility if his or her rights under this patient's bill of rights are violated, as specified. The bill would provide that the licensee shall be liable for the acts of the licensee's employees.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 1430 of the Health and Safety Code is amended to read:

1430. (a) Except where the state department has taken action and the violations have been corrected to its satisfaction, any licensee who commits a class "A" or "B"

violation may be enjoined from permitting the violation to continue or may be sued for civil damages within a court of competent jurisdiction. Such actions for injunction or civil damages, or both, may be prosecuted by the Attorney General in the name of the people of the State of California upon his or her own complaint or upon the complaint of any board, officer, person, corporation or association, or by any person acting for the interests of itself, its members or the general public. The amount of civil damages which may be recovered in an action brought pursuant to this section shall not exceed the maximum amount of civil penalties which could be assessed on account of the violation or violations.

(b) A resident or patient of a skilled nursing facility, as defined in subdivision (c) of Section 1250, or intermediate care facilities, as defined in subdivision (d) of Section 1250, may bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights in Section 72527 of Title 22 of the California ~~Administrative Code or as set forth under the provisions of Chapter 3.9 (commencing with Section 1599). The suit~~ *Administrative Code. The suit* shall be brought in a court of competent jurisdiction. The licensee shall be liable for the acts of the licensee's employees. The licensee shall be liable for ~~up to two thousand five hundred dollars ($2,500) or three times the actual damages, whichever is greater, and for costs and~~ *damages according to proof, punitive damages upon proof of repeated or intentional violations, and for costs and* attorney fees, and may be enjoined from permitting the violation to continue. An agreement by a resident or patient of a skilled nursing facility or intermediate care facility to waive his or her rights to sue pursuant to this subdivision shall be void as contrary to public policy.

(c) The remedies specified in this section shall be in addition to any other remedy provided by law.

O

AMENDED IN ASSEMBLY AUGUST 2, 1982

AMENDED IN SENATE MAY 12, 1982

AMENDED IN SENATE APRIL 26, 1982

SENATE BILL No. 1930

Introduced by Senator Petris

March 17, 1982

An act to amend Section 1430 of the Health and Safety Code, relating to health facilities.

LEGISLATIVE COUNSEL'S DIGEST

SB 1930, as amended, Petris. Health facilities.

Under existing law, a licensee of certain health facilities who violates licensing provisions may be enjoined from permitting the violation to continue or sued for civil damages, as specified, in addition to any other remedy provided by law. Existing licensing regulations contain a skilled nursing and intermediate care facility patient's bill of rights.

This bill would permit a patient or resident of a skilled nursing facility or intermediate care facility to bring a civil action against the facility if his or her rights under this patient's bill of rights are violated, as specified. The bill would provide that the licensee shall be liable for the acts of the licensee's employees.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 1430 of the Health and Safety Code is amended to read:

1430. (a) Except where the state department has taken action and the violations have been corrected to its

satisfaction, any licensee who commits a class "A" or "B" violation may be enjoined from permitting the violation to continue or may be sued for civil damages within a court of competent jurisdiction. Such actions for injunction or civil damages, or both, may be prosecuted by the Attorney General in the name of the people of the State of California upon his or her own complaint or upon the complaint of any board, officer, person, corporation or association, or by any person acting for the interests of itself, its members or the general public. The amount of civil damages which may be recovered in an action brought pursuant to this section shall not exceed the maximum amount of civil penalties which could be assessed on account of the violation or violations.

(b) A resident or patient of a skilled nursing facility, as defined in subdivision (c) of Section 1250, or intermediate care facilities, as defined in subdivision (d) of Section 1250, may bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights in Section 72527 of Title 22 of the California Administrative Code. The suit shall be brought in a court of competent jurisdiction. The licensee shall be liable for the acts of the licensee's employees. The licensee shall be liable for ~~damages according to proof, punitive damages upon proof of repeated or intentional violations, and for costs and attorney fees, and may be enjoined from permitting the violation to continue. An~~ *up to five hundred dollars ($500), and for costs and attorney fees, and may be enjoined from permitting the violation to continue. An* agreement by a resident or patient of a skilled nursing facility or intermediate care facility to waive his or her rights to sue pursuant to this subdivision shall be void as contrary to public policy.

(c) The remedies specified in this section shall be in addition to any other remedy provided by law.

O

Senate Bill No. 1930

CHAPTER 1455

An act to amend Section 1430 of the Health and Safety Code, relating to health facilities.

[Approved by Governor September 27, 1982. Filed with Secretary of State September 28, 1982.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1930, Petris. Health facilities.

Under existing law, a licensee of certain health facilities who violates licensing provisions may be enjoined from permitting the violation to continue or sued for civil damages, as specified, in addition to any other remedy provided by law. Existing licensing regulations contain a skilled nursing and intermediate care facility patient's bill of rights.

This bill would permit a patient or resident of a skilled nursing facility or intermediate care facility to bring a civil action against the facility if his or her rights under this patient's bill of rights are violated, as specified. The bill would provide that the licensee shall be liable for the acts of the licensee's employees.

The people of the State of California do enact as follows:

SECTION 1. Section 1430 of the Health and Safety Code is amended to read:

1430. (a) Except where the state department has taken action and the violations have been corrected to its satisfaction, any licensee who commits a class "A" or "B" violation may be enjoined from permitting the violation to continue or may be sued for civil damages within a court of competent jurisdiction. Such actions for injunction or civil damages, or both, may be prosecuted by the Attorney General in the name of the people of the State of California upon his or her own complaint or upon the complaint of any board, officer, person, corporation or association, or by any person acting for the interests of itself, its members or the general public. The amount of civil damages which may be recovered in an action brought pursuant to this section shall not exceed the maximum amount of civil penalties which could be assessed on account of the violation or violations.

(b) A resident or patient of a skilled nursing facility, as defined in subdivision (c) of Section 1250, or intermediate care facilities, as defined in subdivision (d) of Section 1250, may bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients Bill of Rights in Section 72527 of Title 22 of the California Administrative Code. The suit shall be

brought in a court of competent jurisdiction. The licensee shall be liable for the acts of the licensee's employees. The licensee shall be liable for up to five hundred dollars ($500), and for costs and attorney fees, and may be enjoined from permitting the violation to continue. An agreement by a resident or patient of a skilled nursing facility or intermediate care facility to waive his or her rights to sue pursuant to this subdivision shall be void as contrary to public policy.

(c) The remedies specified in this section shall be in addition to any other remedy provided by law.

O

CALIFORNIA LEGISLATURE

AT SACRAMENTO

1981–82 REGULAR SESSION

SENATE FINAL HISTORY

SHOWING ACTION TAKEN IN THIS SESSION ON ALL SENATE BILLS, CONSTITUTIONAL AMENDMENTS, CONCURRENT, JOINT RESOLUTIONS AND SENATE RESOLUTIONS

CONVENED DECEMBER 1, 1980
ADJOURNED SINE DIE NOVEMBER 30, 1982

DAYS IN SESSION 257

CALENDAR DAYS 729

LT. GOVERNOR MIKE CURB
President of the Senate

SENATOR DAVID ROBERTI
President pro Tempore

Compiled Under the Direction of
DARRYL R WHITE
Secretary of the Senate

By
DAVID H. KNEALE
History Clerk

S.B. No. 1929—Ayala.

An act to add Section 7910.5 to the Government Code, relating to state and local government, and declaring the urgency thereof, to take effect immediately.

1982

Mar 16—Introduced. Read first time. To Com on RLS. for assignment. To print.
Mar. 25—To Com. on ED.
April 1—Art. IV, Sec. 8(a), of Constitution suspended. Joint Rule 55 suspended. Set for hearing April 21, 1982.
April 13—From committee with author's amendments. Read second time. Amended. Re-referred to committee.
May 17—From committee: Do pass as amended, but first amend, and re-refer to Com. on FIN. (Ayes 6. Noes 0. Page 8955.)
May 18—Read second time. Amended. Re-referred to Com. on FIN.
May 24—From committee: Be placed on second reading file pursuant to Senate Rule 28.8.
May 25—Read second time. To third reading.
June 1—To Special Consent Calendar.
June 3—Read third time. Urgency clause adopted. Passed. (Ayes 35. Noes 0. Page 10306.) To Assembly.
June 3—In Assembly. Read first time. Held at Desk
June 15—To Com. on ED.
Nov. 30—From committee without further action.
Nov. 30—From Assembly without further action.

S.B. No. 1930—Petris.

An act to amend Section 1430 of the Health and Safety Code, relating to health facilities.

1982

Mar. 17—Introduced. Read first time. To Com. on RLS. for assignment. To print.
Mar. 18—From print. May be acted upon on or after April 17, 1982.
Mar. 25—To Com. on JUD.
April 7—Set for hearing April 20, 1982.
April 14—Set, first hearing. Hearing canceled at the request of author.
April 26—From committee with author's amendments. Read second time. Amended. Re-referred to committee.
April 27—Hearing postponed by committee. Set for hearing May 4, 1982.
May 11—From committee: Do pass as amended. (Ayes 7. Noes 0. Page 9309.)
May 12—Read second time. Amended. To third reading.
May 17—To Special Consent Calendar.
May 20—Read third time. Passed. (Ayes 37. Noes 0. Page 9730.) To Assembly.
May 20—In Assembly. Read first time. Held at Desk.
June 2—To Com. on JUD
Aug. 2—From committee with author's amendments. Read second time. Amended. Re-referred to committee.
Aug. 5—From committee: Do pass. To Consent Calendar.
Aug. 9—Read second time. To Consent Calendar.
Aug 12—Read third time. Passed. (Ayes 78. Noes 0. Page 16914.) To Senate.
Aug. 12—In Senate. To unfinished business
Aug 16—To Special Consent Calendar.
Aug 18—Senate concurs in Assembly amendments (Ayes 39. Noes 0. Page 13448.) To enrollment.
Aug. 23—Enrolled. To Governor at 2 p.m.
Sept 27—Approved by Governor.
Sept. 28—Chaptered by Secretary of State. Chapter 1455, Statutes of 1982.

36—SH—3679

Legislative Research & Intent LLC

1107 9th Street, Suite 220, Sacramento, CA 95814
(800) 530.7613 · (916) 442.7660 · fax (916) 442.1529
www.lrihistory.com · intent@lrihistory.com

Documents Generated During Senate Deliberations

Legislative Research & Intent LLC hereby certifies that the accompanying record/s is/are true and correct copies of the original/s obtained from one or more official, public sources in California unless another source is indicated, with the following exceptions : In some cases, pages may have been reduced in size to fit an 8 ½" x 11" sized paper. Or, for readability purposes, pages may have been enlarged or cleansed of black marks or spots. Lastly, for ease of reference, paging and relevant identification have been inserted.

SB 1930 (Petris)
As amended April 26
Health & Safety Code
MRR

SB 1930

CIVIL ACTIONS
-PATIENT'S BILL OF RIGHTS-

HISTORY

Source: Author

Prior Legislation: None

Support: CRLA; United Neighbors in Action; Grey Panthers; Alameda County Legal Aid Society; Standing Committee on Legal Problems of Aging of the Legal Services Section of the State Bar

Opposition: No Known

KEY ISSUE

SHOULD A RESIDENT OF A SKILLED NURSING OR INTERMEDIATE CARE FACILITY BE AUTHORIZED TO BRING A CIVIL ACTION AGAINST THE FACILITY FOR VIOLATION OF THE PATIENT'S BILL OF RIGHTS?

PURPOSE

AB 1203 (Levine) of 1979 enacted the Patient's Bill of Rights, which sets forth fundamental human rights to which all patients in skilled nursing or intermediate care facilities are entitled. A licensee who violates these rights may be enjoined from permitting the violation to continue or may be sued for civil damages by the Attorney General.

This bill would, in addition, authorize a patient or resident of a skilled nursing or intermediate care

(More)

facility to bring an action for damages or for an injunction under the Patient's Bill of Rights.

The purpose of this bill is to protect and ensure the rights of people residing in nursing homes.

COMMENT

1. Inadequacy of existing law

Existing law authorizes the Attorney General, upon her own complaint or upon the complaint of any board, officer, person, corporation, or association, to bring an action against a licensee who violates specified licensing provisions.

According to the author, this protection is not sufficient to ensure a patient her rights. The author argues that "since the State is making major cuts in services to people, it is more important than ever to allow the institutionalized individual the ability to protect their own constitutional rights in the private sector."

2. Rights protected

The Patient's Bill of Rights grants the following to residents of nursing homes:

(a) An adequate number of qualified personnel to carry out all the functions of the facility;

(b) Good personal hygiene, care to prevent bedsores, measures to prevent and reduce incontinence;

(More)

(c) Food of a quality and quantity in accordance with physician's orders;

(d) An activity program staffed and equipped to meet each patient's orders;

(e) A clean facility in good repair;

(f) A nurses' call system;

(g) Additional rights guaranteed by regulation.

Additional rights that would be protected by this bill include those listed in Title 22, Sec. 72527 of the Administrative Code. These include the opportunity to visit people of the patient's choice, to participate in planning medical treatment, the right to be fully informed of fees and rates, to be free from mental and physical abuse, and to confidential treatment of personal and medical records.

3. Facilities affected

The facilities against which a patient could bring a civil action under this bill would be skilled nursing facilities and intermediate care facilities.

The former are defined as health facilities that provide skilled nursing care and supportive care to patients whose primary need is for skilled nursing care on an extended basis.

The latter are health facilities that provide inpatient care to ambulatory or semiambulatory patients who have a recurring need for skilled

(More)

nursing supervision and supportive care but who do not require continuous skilled nursing care.

4. Damages and injunction allowed

This bill would authorize a patient or resident whose rights under the Patient Bill of Rights had been violated to bring an action for damages and an injunction against the licensee of the facility.

The damages for which a licensee could be liable under this bill would be limited to $2,500 or three times the actual damages, whichever was greater, and for costs and attorney fees. Licensees would be liable for their employee's acts.

The bill would provide also that any attempted waiver of the right to sue on the part of a patient would be void.

****

THIRD READING

SENATE DEMOCRATIC CAUCUS SENATOR PAUL B. CARPENTER Chairman	Bill No.: SB 1930 Amended: 5-12-82* Author: Petris (D) Vote Required: Majority Assembly Floor Vote:

SUBJECT: Health facilities

POLICY COMMITTEE: Judiciary

AYES: (7) Doolittle, Petris, Presley, Robbins, Roberti, Sieroty, Davis

NOES: (0)

SUMMARY OF LEGISLATION:

AB 1203 (Levine) of 1979 enacted the Patient's Bill of Rights, which sets forth fundamental human rights to which all patients in skilled nursing or intermediate care facilities are entitled. A licensee who violates these rights may be enjoined from permitting the violation to continue or may be sued for civil damages by the Attorney General.

This bill would, in addition, authorize a patient or resident of a skilled nursing or intermediate care facility to bring an action for damages or for an injunction under the Patient's Bill of Rights.

FISCAL EFFECT: No state cost.

PROPONENTS: (Verified by author 5-11-82)

California Rural Legal Assistance (CRLA)
United Neighbors in Action
Grey Panthers
Alameda County Legal Aid Society
Family Service Agency, San Francisco
West Contra Costa County Grey Panthers
Western Center on Law and Poverty
Standing Committee on Legal Problems of Aging of the Legal Services Section of the State Bar

OPPOSITION:

~~California Health Care Facilities~~ (opposition removed by 5-12-82 amendments)

ARGUMENTS IN SUPPORT:

Proponents state that, according to the author, existing protection is not sufficient to ensure patient rights. The author argues that "since the State is making major cuts in services to people, it is more important than ever to allow the institutionalized individual the ability to protect their own constitutional rights in the private sector."

CONTINUED

COMMENT:

The Patient's Bill of Rights grants the following to residents of nursing homes:

1. An adequate number of qualified personnel to carry out all the functions of the facility;

2. Good personal hygiene, care to prevent bedsores, measures to prevent and reduce incontinence;

3. Food of a quality and quantity in accordance with physician's orders;

4. An activity program staffed and equipped to meet each patient's orders;

5. A clean facility in good repair;

6. A nurses' call system;

7. Additional rights guaranteed by regulation.

Additional rights that would be protected by this bill include those listed in Title 22, Sec. 72527 of the Administrative Code. These include the opportunity to visit people of the patient's choice, to participate in planning medical treatment, the right to be fully informed of fees and rates, to be free from mental and physical abuse, and to confidential treatment of personal and medical records.

*5-12-82 amendments reflected in Summary of Legislation (above). However, these amendments were not available in print at the time of this writing.

LLE:ft 5-12-82

Legislative Research & Intent LLC

1107 9th Street, Suite 220, Sacramento, CA 95814
(800) 530.7613 · (916) 442.7660 · fax (916) 442.1529
www.lrihistory.com · intent@lrihistory.com

Documents Generated During Assembly Deliberations

Legislative Research & Intent LLC hereby certifies that the accompanying record/s is/are true and correct copies of the original/s obtained from one or more official, public sources in California unless another source is indicated, with the following exceptions : In some cases, pages may have been reduced in size to fit an 8 ½" x 11" sized paper. Or, for readability purposes, pages may have been enlarged or cleansed of black marks or spots. Lastly, for ease of reference, paging and relevant identification have been inserted.

PLEASE RETURN IMMEDIATELY TO

ASSEMBLY COMMITTEE ON JUDICIARY

6031 State Capitol

Bill Analysis

Work Sheet

RE: Bill No. SB 1930 - Petris

Please complete this form and return it to the Assembly Committee on Judiciary as soon as possible.

PLEASE INDICATE THE RECORD OF FINAL VOTE IN EACH SENATE COMMITTEE IN WHICH THIS BILL WAS ANALYZED. IN ADDITION, KINDLY SUPPLY THE SENATE FLOOR VOTE.

1. Origin of the Bill:

(a) What is the source of the bill? (What person, organization or governmental entity, if any, requested introduction?)
Western Center on Law & Pverty
United Neighbors in Action

(b) Has a similar bill been before either this or a previous session of the Legislature? If so, please identify the Session, bill number and disposition of the bill.

No

(c) Has there been an interim committee report on the bill? If so, please identify the report.

No

2. Problem or deficiency in the present law which the bill seeks to remedy: Existing statuet establishes basic rights of dignity and self-respect to persons residing in nursing homes. The Patient Bill of Rights (Title 22, Sect. 72527) establishes these rights in regulation. (OVER)

3. Please attach copies of any background material in explanation of the bill, or state where such material is available for reference by the committee staff and letters of support or opposition.

4. Hearing: 10 Min.

(a) Approximate amount of time necessary for hearing.
10 Min.

(b) Preference for date of hearing.
August 4, 1982

(c) Names of witnesses to testify at the hearing.

Eric Gold, Western Centers

2. SB 1930 establishes a clear mechanism of enforcing these rights. By setting up a private right of action and awarding a fine and attorney fees the personal and private rights of these residents can be protected. The protections are mere wards without meaning if there is no way to guarantee these basic rights.

PATIENT'S BILL OF RIGHTS

1. Each patient shall be fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct and responsibilities;

2. Each patient shall be fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not covered under Titles XVIII or XIV of the Social Security Act, or not covered by the facility's basic per diem rate;

3. Each patient shall be fully informed, by a physician, of his or her medical condition unless medically contraindicated (as documented, by a physician, in his or her medical record), and shall be afforded the opportunity to participate in the planning of his or her medical treatment and to refuse to participate in experimental research;

4. Each patient shall be transferred or discharged only for medical reasons, or for his or her welfare or that of other patients, or for non-payment for his or her stay except as prohibited by titles XVIII or XIX of the Social Security Act), and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in his medical record;

5. Each patient shall be encouraged and assisted throughout his period of stay, to exercise his rights as a patient and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. May manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient from injury to himself or to others;

8. Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care institution, or as required by law or third-party payment contract;

9. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

10. Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

11. May associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician in his medical record);

12. May meet with, and participate in activities of, social, religious, and community groups at his discretion, unless medically contraindicated (as documented by his physician in his medical record);

13. May retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients, and unless medically contraindicated (as documented by his physician in his medical record); and

14. If married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician in the medical record).

All rights and responsibilities specified in paragraphs 1 through 4, as they pertain to (a) a patient adjudicated incompetent in accordance with State law; (b) a patient who is found, by his physician, to be medically incapable of understanding these rights; or (c) a patient who exhibits a communication barrier, devolve to such patient's guardian, next of kin, sponsoring agency(ies), or representative payee (except when the facility itself is representative payee) selected pursuant to Section 205(j) of the Social Security Act.

15. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.

16. To have daily visiting hours established.

17. To have members of the clergy admitted at the request of the patient or person responsible at any time.

18. To allow relatives or persons responsible to visit critically ill patients at any time, unless medically contraindicated.

19. To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

20. To have reasonable access to telephone, both to make and receive confidential calls.

ASSEMBLY COMMITTEE ON JUDICIARY SB 1930
ELIHU M. HARRIS, Chairman

SB 1930 (Petris) As amended 08/02/82

PRIOR ACTION

Sen. Jud. Com. 7-0 Sen. Floor 37-0

SUBJECT

This bill is intended to provide residents of skilled nursing or intermediate care facilities with a private cause of action for violation of regulations promulgated pursuant to the Patient's Bill of Rights.

DIGEST

Under existing law, the Legislature has recognized that residents or patients in skilled nursing and intermediate care facilities are entitled to certain fundamental rights (the Patient's Bill of Rights). Although existing law authorizes the Attorney General to initiate actions for damages or to enjoin violation of regulations related to the health and safety of residents of such facilities, there is no specific authority to initiate actions for violation of all the rights protected in the Patient's Bill of Rights.

This bill would authorize a patient or resident of a skilled nursing or intermediate care facility to bring an action for damages or an injunction against the licensee of such a facility who violates any of the rights protected by regulations promulgated under the Patient's Bill of Rights. A licensee would be liable for damages up to $500 and for costs and attorneys' fees. In addition, the licensee of the facility would be liable for the action of his or her employees. The right to bring such action could not be waived.

STAFF COMMENTS

1. Western Center on Law and Poverty, Inc.,the source of this bill, states that by enacting the Patient's Bill of Rights (H&S Code Sections 1599 et seq.) it was clear that the Legislature intended to ensure that nursing homes and intermediate care facilities respect the fundamental rights of their resident. However, the source points out that the legislation failed to provide for any specific mechanism for either an individual resident to enforce his or her rights or for a regulating agency (e.g., Department of Health) to punish or prevent violation of rights which were not directly related to health or safety within the facilities. This bill, argues the source, will provide the needed enforcement mechanism.

(CONTINUED)

2. In Health and Safety Code Section 1599 et seq. (The Patient's Bill of Rights) the Legislature "expressly set forth fundamental human rights which all patients in skilled nursing homes or intermediate care facilities are entitled to..." The Patient's Bill of Rights grants the following to residents of these facilities:

   (a) An adequate number of qualified personnel to carry out all the functions of the facility;

   (b) Good personal hygiene, care to prevent bedsores, measures to prevent and reduce incontinence;

   (c) Food of a quality and quantity in accordance with physician's orders;

   (d) An activity program staffed and equipped to meet each patient's orders;

   (e) A clean facility in good repair;

   (f) A nurses' call system;

   (g) Additional rights guaranteed by regulation.

   The additional rights that would be protected by this bill include those listed in Title 22, Sec. 72527 of the Administrative Code. These rights include the opportunity to visit people of the patient's choice, to participate in planning medical treatment, the right to be fully informed of fees and rates, to be free from mental and physical abuse, and to confidential treatment of personal and medical records.

3. The facilities against which a patient could bring a civil action under this bill would be skilled nursing facilities and intermediate care facilities. The former are defined as health facilities that provide skilled nursing care and supportive care to patients whose primary need is for skilled nursing care on an extended basis. The latter are health facilities that provide inpatient care to ambulatory or semiambulatory patients who have a recurring need for skilled nursing supervision and supportive care but who do not require continuous skilled nursing care.

SOURCE

Western Center on Law and Poverty

SUPPORT

Gray Panthers
United Neighbors in Action
California Association of Health Facilities

OPPOSITION

Unknown

ASSEMBLY JUDICIARY COMMITTEE - MINORITY
CHARLES R. IMBRECHT, VICE-CHAIRMAN

SB 1950
BILL NUMBER

APPROPRIATION:	No	AMENDED:	8/2/82
LOCAL MANDATE:	No	AUTHOR:	Petris
URGENCY:	No	CONSULTANT:	Prosser

COMMENTS: This bill is intended to provide residents of skilled nursing or intermediate care facilities with a private cause of action for violation of regulations promulgated under the Patients Bill of Rights

For each violation the patient could recover a maximum of $500 plus attorneys fees at cost. The patient could also obtain an injunction against future violations.

The policy question involved is whether or not violation of administrative regulation is and of itself should give to a cause of action for damages. These regulations are established by the Department of Health which reflect conformity with federal requirements.

A copy of the regulation is attached.

SUPPORT/OPPOSITION: S: Western Center on Law & Poverty
Gray Panthers
United Neighbors in Action
California Assoc. of Health Services

O: Unknown

RECOMMENDATION: Policy

Legislative Research & Intent LLC

1107 9th Street, Suite 220, Sacramento, CA 95814
(800) 530.7613 · (916) 442.7660 · fax (916) 442.1529
www.lrihistory.com · intent@lrihistory.com

Senate "Concurrence" Documents

Legislative Research & Intent LLC hereby certifies that the accompanying record/s is/are true and correct copies of the original/s obtained from one or more official, public sources in California unless another source is indicated, with the following exceptions : In some cases, pages may have been reduced in size to fit an 8 ½" x 11" sized paper. Or, for readability purposes, pages may have been enlarged or cleansed of black marks or spots. Lastly, for ease of reference, paging and relevant identification have been inserted.

UNFINISHED BUSINESS

SENATE DEMOCRATIC CAUCUS SENATOR PAUL B. CARPENTER Chairman	Bill No.: SB 1930 Amended: 8-2-82 Author: Petris (D) Vote Required: Majority Assembly Floor Vote:

SUBJECT: Health facilities

POLICY COMMITTEE: Judiciary

AYES: (7) Doolittle, Petris, Presley, Robbins, Roberti, Sieroty, Davis

NOES: (0)

SUMMARY OF LEGISLATION:

AB 1203 (Levine) of 1979 enacted the Patient's Bill of Rights, which sets forth fundamental human rights to which all patients in skilled nursing or intermediate care facilities are entitled. A licensee who violates these rights may be enjoined from permitting the violation to continue or may be sued for civil damages by the Attorney General.

As it passed the Senate:

This bill would, in addition, authorize a patient or resident of a skilled nursing or intermediate care facility to bring an action for damages or for an injunction under the Patient's Bill of Rights.

The bill also specifies that the licensee shall be liable for the acts of the licensee's employees. The licensee shall be liable for damages according to proof, punitive damages upon proof of repeated or intentional violations, and for costs and attorneys fees, and may be enjoined from permitting the violation to continued.

Assembly amendments change the licensee's liability to "up to $500, and for costs and attorney fees, and may be enjoined from permitting the violation to continue."

FISCAL EFFECT: No state cost.

PROPONENTS: (Verified by author 5-11-82)

California Rural Legal Assistance (CRLA)
United Neighbors in Action
Grey Panthers
Alameda County Legal Aid Society
Standing Committee on Legal Problems of Aging of the Legal Services Section of the State Bar
Family Service Agency, San Francisco
West Contra Costa County Grey Panthers
Western Center on Law and Poverty

CONTINUED

OPPOSITION:

~~California Health Care Facilities~~ (opposition removed by 5-12-82 amendments)

ARGUMENTS IN SUPPORT:

Proponents state that, according to the author, existing protection is not sufficient to ensure patient rights. The author argues that "since the State is making major cuts in services to people, it is more important than ever to allow the institutionalized individual the ability to protect their own constitutional rights in the private sector."

COMMENT:

The Patient's Bill of Rights grants the following to residents of nursing homes:

1. An adequate number of qualified personnel to carry out all the functions of the facility;

2. Good personal hygiene, care to prevent bedsores, measures to prevent and reduce incontinence;

3. Food of a quality and quantity in accordance with physician's orders;

4. An activity program staffed and equipped to meet each patient's orders;

5. A clean facility in good repair;

6. A nurses' call system,

7. Additional rights guaranteed by regulation.

Additional rights that would be protected by this bill include those listed in Title 22, Sec. 72527 of the Administrative Code. These include the opportunity to visit people of the patient's choice, to participate in planning medical treatment, the right to be fully informed of fees and rates, to be free from mental and physical abuse, and to confidential treatment of personal and medical records.

Roll Call

The roll was called and the bill was passed by the following vote:
AYES (37)—Senators Alquist, Ayala, Beverly, Boatwright, Campbell, Carpenter, Craven, Davis, Dills, Doolittle, Ellis, Foran, Garamendi, Alex Garcia, Greene, Holmdahl, Johnson, Keene, Maddy, Marks, Mello, Mills, Montoya, Nielsen, O'Keefe, Petris, Presley, Richardson, Robbins, Roberti, Russell, Seymour, Sieroty, Speraw, Stiern, Vuich, and Watson.
NOES (0)—None.
Bill ordered transmitted to the Assembly.

5-20-82 SP.1930

CONTINUED

Roll Call

The roll was called and the Senate concurred in Assembly amendments by the following vote:

AYES (39)—Senators Alquist, Ayala, Beverly, Boatwright, Campbell, Carpenter, Craven, Davis, Dills, Doolittle, Ellis, Foran, Garamendi, Alex Garcia, Marz Garcia, Greene, Holmdahl, Johnson, Keene, Marks, Mello, Mills, Montoya, Nielsen, O'Keefe, Petris, Presley, Rains, Richardson, Robbins, Roberti, Russell, Schmitz, Seymour, Sieroty, Speraw, Stiern, Vuich, and Watson.

NOES (0)—None.

Above bill ordered enrolled.

8-18-82

$. 13448

LLE:ga 8-10-82

SENATE REPUBLICAN CAUCUS

SENATOR KENNETH L. MADDY, Chairman

ASSEMBLY AMENDMENTS

POSITIONS:

SUPPORT: CRLA, United Neighbors for Action, Grey Panthers, Alameda County Legal Aid Society, State Bar Legal Services Section, Standing Committee on Legal Problems of Aging

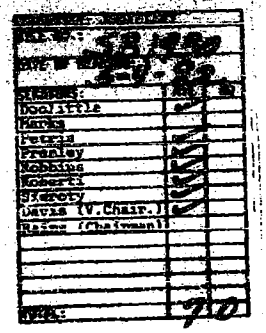
BILL NUMBER: SB 1930

AUTHOR: Petris

AMENDED COPY: 8/12/82

MAJORITY VOTE

Committee Votes:



Senate Floor Vote: 8/20/82 Pg. 9730

The roll was called and the bill was passed by the following vote:
AYES (37)—Senators Alquist, Ayala, Beverly, Boatwright, Campbell, Carpenter, Craven, Davis, Dills, Doolittle, Ellis, Foran, Garamendi, Alex Garcia, Greene, Hart, Johnson, Kapiloff, Maddy, Marks, Mello, Mills, Montoya, Nielsen, O'Connell, Petris, Presley, Richardson, Robbins, Roberti, Russell, Seymour, Sieroty, Sparkman, Stiern, Vuich, and Watson.
NOES (0)—None.
Bill ordered transmitted to the Assembly.

Assembly Floor Vote: 79-0 8/12/82

DIGEST

This bill authorizes a patient or resident of a skilled nursing or intermediate care facility to bring an action for damages or an injunction under the Patient's Bill of Rights.

Assembly amendments make defendant liable for up to $500, plus costs and attorney's fees and allow defendant to be enjoined from permitting the violation to continue.

FISCAL EFFECT: Appropriation, no. Fiscal Committee, no. Local, no.

COMMENTS

AB 1203 (Levine) of 1979 enacted the Patient's Bill of Rights, which sets forth fundamental human rights to which all patients in skilled nursing or intermediate care facilities are entitled. A licensee who violates these rights may be enjoined from permitting the violation to continue or may be sued for civil damages by the Attorney General.

According to the author, this protection is not sufficient to ensure a patient her rights. The author argues that "since the state is making major cuts in services to people, it is more important than ever to allow the institutionalized individual the ability to protect their own constitutional rights in the private sector."

The Patient's Bill of Rights grants the following to residents of nursing homes:

(a) An adequate number of qualified personnel to carry out all the functions of the facility;

(b) Good personal hygiene, care to prevent bedsores, measures to prevent and reduce incontinence;

(c) Food of a quality and quantity in accordance with physician's orders;

(d) An activity program staffed and equipped to meet each patient's orders;

(e) A clean facility in good repair;

(f) A nurses' call system;

(g) Additional rights guaranteed by regulation.

8/10/...

Legislative Research & Intent LLC

1107 9th Street, Suite 220, Sacramento, CA 95814
(800) 530.7613 · (916) 442.7660 · fax (916) 442.1529
www.lrihistory.com · intent@lrihistory.com

Enrolled (Governor) Materials

OWEN K. KUNS
RAY H. WHITAKER
CHIEF DEPUTIES

JERRY L. BASSETT
KENT L. DECHAMBEAU
STANLEY M. LOURIMORE
EDWARD K. PURCELL
JOHN T. STUDEBAKER

JOHN CORZINE
ROBERT CULLEN DUFFY
ROBERT D. GRONKE
SHERWIN C. MACKENZIE, JR.
ANN M. MACKEY
TRACY O. POWELL II
RUSSELL L. SPARLING
JIMMIE WING
PRINCIPAL DEPUTIES

3021 STATE CAPITOL
SACRAMENTO 95814
(916) 445-3057

8011 STATE BUILDING
107 SOUTH BROADWAY
LOS ANGELES 90012
(213) 620-2550

Legislative Counsel of California

BION M. GREGORY

GERALD ROSS ADAMS
DAVID D. ALVES
MARTIN L. ANDERSON
PAUL ANTLER
CHARLES C. ASBILL
JAMES L. ASHFORD
SHARON G. BRENNAN
EILEEN J. BURTON
HENRY J. CONTRERAS
BEN E. DALE
CLINTON J. DEWITT
C. DAVID DICKERSON
KATHRYN E. DONOVAN
FRANCES S. DORBIN
LAWRENCE H. FEIN
SHARON R. FISHER
JOHN FOSSETTE
HARVEY J. FOSTER
CLAY FULLER
ALVIN D. GRESS
JOYCE E. HEE
THOMAS R. HEUER
JACK I. HORTON
SANDRA HUGHES
MICHAEL J. KERSTEN
L. DOUGLAS KINNEY
VICTOR KOZIELSKI
ROMULO I. LOPEZ
JAMES A. MARSALA
ROBERT G. MILLER
JOHN A. MOGER
VERNE L. OLIVER
EUGENE L. PAINE
MARGUERITE ROTH
JERRY J. RUIZ
MICHAEL B. SALERNO
MARY SHAW
WILLIAM K. STARK
MARK FRANKLIN TERRY
JEFF THOM
RICHARD B. WEISBERG
DANIEL A. WEITZMAN
THOMAS D. WHELAN
CHRISTOPHER ZIRKLE
DEPUTIES

Sacramento, California
August 23, 1982

Honorable Edmund G. Brown Jr.
Governor of California
Sacramento, CA

Senate Bill No. 1930

Dear Governor Brown:

Pursuant to your request we have reviewed the above-numbered bill authored by Senator Petris and, in our opinion, the title and form are sufficient and the bill, if chaptered, will be constitutional. The digest on the printed bill as adopted correctly reflects the views of this office.

Very truly yours,

Bion M. Gregory
Legislative Counsel

By Robert D. Gronke
Robert D. Gronke
Principal Deputy

RDG:AB

Two copies to Honorable Nicholas C. Petris, pursuant to Joint Rule 34.

ENROLLED BILL MEMORANDUM TO GOVERNOR	DATE September 20, 1982
BILL NO. SB 1930	AUTHOR Petris

Vote—Senate ___Unanimous

Ayes— 37
Noes— 0

Vote—Assembly ___Unanimous

Ayes— 78
Noes— 0

SB 1930 - Petris — This bill creates a private right of action for violation of the personal rights of nursing home residents.

SPONSOR

Author

SUPPORT

Department of Aging
Governor's Office -- Legal Affairs
Western Center of Law and Poverty
Gray Panthers

OPPOSITION

None known

FISCAL IMPACT

None

Recommendation	APPROVE

588

ENROLLED BILL REPORT

AGENCY	BILL NUMBER
GOVERNOR'S OFFICE	SB 1930
DEPARTMENT, BOARD OR COMMISSION	AUTHOR
LEGAL AFFAIRS	Petris

Under existing law, the Legislature has recognized that residents or patients in skilled nursing and intermediate care facilities are entitled to certain fundamental rights (the Patient's Bill of Rights). Although existing law authorizes the Attorney General to initiate actions for damages or to enjoin violation of regulations related to the health and safety of residents of such facilities, there is no specific authority to initiate actions for violation of all the rights protected in the Patient's Bill of Rights.

This bill would authorize a patient or resident of a skilled nursing or intermediate care facility to bring an action for damages or an injunction against the licensee of such a facility who violates any of the rights protected by regulations under the Patient's Bill of Rights. A licensee would be liable for damages up to $500 and for costs and attorneys' fees. In addition, the licensee of the facility would be liable for the action of his or her employees. The right to bring such action could not be waived.

Proponents: Western Center on Law and Poverty (source)
Gray Panthers
United Neighbors in Action
Board of Supervisors of the County of Santa Cruz
California Association of Health Facilities
Department of Aging
California Rural Legal Assistance
Alameda County Legal Aid Society
Standing Committee on Legal Problems of Aging of the Legal Services Section of the State Bar
Family Service Agency, San Francisco
West Contra Costa Grey Panthers

Opposition: None

The purpose of this bill is to protect and ensure the rights of people residing in skilled nursing or intermediate care facilities. Proponents argue that existing protection is not sufficient to ensure patient rights. The author argues that "since the State is making major cuts in services to people, it is more important than ever to allow the institutionalized individual the ability to protect their own constitutional rights in the private sector."

We recommend the bill be signed.

RECOMMENDATION: SIGN

ANALYST	DATE	LEGAL AFFAIRS SECRETARY	DATE
Stan Cross	8/30/82	Byron S. Georgiou	8/30/82

Health & Welfare | SB 1930

Petris

Creates private right of action for violation of nursing home residents personal rights.

HISTORY, SPONSORSHIP, AND RELATED BILLS

a) Senator Nicholas C. Petris sponsored this bill to strengthen existing law.

b) Previous legislation by Senator Charles Percy (1974) introduced a Patients' Bill of Rights, and the California licensing standards for nursing homes, which included patients' rights provisions, became law in 1975.

c) The changes made by this bill create a specific private right of action for long-term care residents when their personal rights are violated.

d) The Department has had an approved support position.

VOTE

	Ayes	Noes
Assembly	78	0
Senate	37	0

SPECIFIC FINDINGS

a) Health and Safety Code, Section 1430, currently allows that a licensee of certain health facilities who violates licensing provisions may be enjoined from permitting the violation to continue or sued for civil damages. The Health and Safety Code, Section 1599, includes within existing licensing regulations a skilled nursing and intermediate care facility patients' bill of rights.

Current efforts to protect patients' rights are limited to annual inspections by the Facilities Licensing Unit (Department of Health Services),* and the right of Ombudsmen to enter long-term care facilities (AB 1433, Chapter 891, 1979). *There is currently a trend at the federal level to decrease inspections to once every two years.

b) If enacted, this bill will not establish a new program or expand an existing program.

If passed, Section 1430 of the Health and Safety Code, relating to health facilities, will be amended.

This is an improvement of the current method in that a facility licensee is held accountable for their employees actions, liability of licensee is clarified, and it makes it practical for attorneys to pursue a civil action suit on behalf of a resident whose private rights have been violated.

(CONTINUED)

Sign

8/25/82 | 8/25/82

SPECIFIC FINDINGS (Cont.)

The intent of this bill could not be met through regulation. When individual rights are in jeopardy, the force of the law is required.

c) The objective of the bill is consistent with those of the Department, the Agency and the Administration, which is to maintain and protect the rights of the elderly.

d) By creating a more meaningful private right of action for long-term care facility residents, responsibility is more appropriately placed.

FISCAL IMPACT

- None to this Department.

RECOMMENDATION

- Sign.

- This bill should help assure better quality of care and provide recourse for long-term care residents by creating a more meaningful private right of action, by specifying amount of damages, and by not restricting damages to present amounts for "A" or "B" citations. The bill is consistent with the program objectives of the Department, and should be enacted into law.

This page was left intentionally blank.

PLEASE REPLY TO
SACRAMENTO ADDRESS
STATE CAPITOL, ROOM 5080
SACRAMENTO
95814
(916) 445-6577

LEGISLATIVE ADDRESS
1111 JACKSON STREET
SUITE 7016
OAKLAND, CALIFORNIA
94607-4976
(415) 464-1333

NICHOLAS C. PETRIS
NINTH SENATORIAL DISTRICT
ALAMEDA AND CONTRA COSTA COUNTIES

COMMITTEES
FINANCE
JUDICIARY
JOINT LEGISLATIVE BUDGET
JOINT RULES
SELECT COMMITTEE ON HOUSING AND URBAN AFFAIRS
SELECT COMMITTEE ON MARITIME INDUSTRY

CALIFORNIA LEGISLATURE

Senate

September 14, 1982

The Honorable Edmund G. Brown Jr.
Governor of California
State Capitol
Sacramento, California 95814

Dear Governor Brown:

Senate Bill 1930 is presently on your desk. I urge your signature on this measure.

SB 1930 is a bill to protect and insure the private rights of persons living in nursing homes. It is so tragic when basic rights such as privacy in medical treatment, freedom from mental and physical abuse, accessibility to visitors, or ability to make confidential phone calls are violated and there is no where to turn for help. Presently, the government has the responsibility of enforcing an individual's civil rights. This bill would allow a resident or patient of nursing facility to personally bring suit against the facility. Since the State has made major cuts in services to people, it is more important than ever to allow the institutionalized individual the ability to protect their own constitutional rights in the private sector. My bill would provide that greatly needed avenue of relief.

There was no opposition to this bill as I worked closely with all groups concerned to reach a compromise on the controversial sections. Please support this vital bill.

Sincerely,

Nicholas C. Petris

NICHOLAS C. PETRIS

NCP:shf

Legislative Research & Intent LLC

1107 9th Street, Suite 220, Sacramento, CA 95814
(800) 530.7613 · (916) 442.7660 · fax (916) 442.1529
www.lrihistory.com · intent@lrihistory.com

Unitemized Correspondence/Materials By Source

Legislative Research & Intent LLC hereby certifies that the accompanying record/s is/are true and correct copies of the original/s obtained from one or more official, public sources in California unless another source is indicated, with the following exceptions : In some cases, pages may have been reduced in size to fit an 8 ½" x 11" sized paper. Or, for readability purposes, pages may have been enlarged or cleansed of black marks or spots. Lastly, for ease of reference, paging and relevant identification have been inserted.

Legislative Research & Intent LLC

1107 9th Street, Suite 220, Sacramento, CA 95814
(800) 530.7613 · (916) 442.7660 · fax (916) 442.1529
www.lrihistory.com · intent@lrihistory.com

Author's File Materials

Legislative Research & Intent LLC hereby certifies that the accompanying record/s is/are true and correct copies of the original/s obtained from one or more official, public sources in California unless another source is indicated, with the following exceptions : In some cases, pages may have been reduced in size to fit an 8 ½" x 11" sized paper. Or, for readability purposes, pages may have been enlarged or cleansed of black marks or spots. Lastly, for ease of reference, paging and relevant identification have been inserted.

ASSEMBLY COMMITTEE ON JUDICIARY
ELIHU M. HARRIS, Chairman

SB 1930

SB 1930 (Petris) As amended 08/02/82

PRIOR ACTION

Sen. Jud. Com. 7-0 Sen. Floor 37-0

SUBJECT

This bill is intended to provide residents of skilled nursing or intermediate care facilities with a private cause of action for violation of regulations promulgated pursuant to the Patient's Bill of Rights.

DIGEST

Under existing law, the Legislature has recognized that residents or patients in skilled nursing and intermediate care facilities are entitled to certain fundamental rights (the Patient's Bill of Rights). Although existing law authorizes the Attorney General to initiate actions for damages or to enjoin violation of regulations related to the health and safety of residents of such facilities, there is no specific authority to initiate actions for violation of all the rights protected in the Patient's Bill of Rights.

This bill would authorize a patient or resident of a skilled nursing or intermediate care facility to bring an action for damages or an injunction against the licensee of such a facility who violates any of the rights protected by regulations promulgated under the Patient's Bill of Rights. A licensee would be liable for damages up to $500 and for costs and attorneys' fees. In addition, the licensee of the facility would be liable for the action of his or her employees. The right to bring such action could not be waived.

STAFF COMMENTS

1. Western Center on Law and Poverty, Inc.,the source of this bill, states that by enacting the Patient's Bill of Rights (H&S Code Sections 1599 et seq.) it was clear that the Legislature intended to ensure that nursing homes and intermediate care facilities respect the fundamental rights of their resident. However, the source points out that the legislation failed to provide for any specific mechanism for either an individual resident to enforce his or her rights or for a regulating agency (e.g., Department of Health) to punish or prevent violation of rights which were not directly related to health or safety within the facilities. This bill, argues the source, will provide the needed enforcement mechanism.

(CONTINUED)

2. In Health and Safety Code Section 1599 et seq. (The Patient's Bill of Rights) the Legislature "expressly set forth fundamental human rights which all patients in skilled nursing homes or intermediate care facilities are entitled to..." The Patient's Bill of Rights grants the following to residents of these facilities:

   (a) An adequate number of qualified personnel to carry out all the functions of the facility;

   (b) Good personal hygiene, care to prevent bedsores, measures to prevent and reduce incontinence;

   (c) Food of a quality and quantity in accordance with physician's orders;

   (d) An activity program staffed and equipped to meet each patient's orders;

   (e) A clean facility in good repair;

   (f) A nurses' call system;

   (g) Additional rights guaranteed by regulation.

   The additional rights that would be protected by this bill include those listed in Title 22, Sec. 72527 of the Administrative Code. These rights include the opportunity to visit people of the patient's choice, to participate in planning medical treatment, the right to be fully informed of fees and rates, to be free from mental and physical abuse, and to confidential treatment of personal and medical records.

3. The facilities against which a patient could bring a civil action under this bill would be skilled nursing facilities and intermediate care facilities. The former are defined as health facilities that provide skilled nursing care and supportive care to patients whose primary need is for skilled nursing care on an extended basis. The latter are health facilities that provide inpatient care to ambulatory or semiambulatory patients who have a recurring need for skilled nursing supervision and supportive care but who do not require continuous skilled nursing care.

SOURCE

Western Center on Law and Poverty

SUPPORT

Gray Panthers
United Neighbors in Action
California Association of Health Facilities

OPPOSITION

Unknown

ASSEMBLY COMMITTEE ON JUDICIARY
ELIHU M. HARRIS, Chairman

SB 1930

SB 1930 (Petris) As amended 08/02/82

PRIOR ACTION

Sen. Jud. Com. 7-0 Sen. Floor 37-0

SUBJECT

This bill is intended to provide residents of skilled nursing or intermediate care facilities with a private cause of action for violation of the Patient's Bill of Rights.

DIGEST

Under existing law, the Legislature has recognized that residents or patients in skilled nursing and intermediate care facilities are entitled to certain fundamental rights (the Patient's Bill of Rights). Although existing law authorizes the Attorney General to initiate actions for damages or to enjoin violation of regulations related to the health and safety of residents of such facilities, there is no specific authority to initiate actions for violation of all the rights protected in the Patient's Bill of Rights.

This bill would authorize a patient or resident of a skilled nursing or intermediate care facility to bring an action for damages or an injunction against the licensee of such a facility who violates any of the rights protected by the Patient's Bill of Rights. A licensee would be liable for damages up to $500 and for costs and attorneys' fees. In addition, the licensee of the facility would be liable for the action of his or her employees. The right to bring such action could not be waived.

STAFF COMMENTS Bill provides for damages - a $500 fine + attorney costs.

1. Western Center on Law and Poverty, Inc.,the source of this bill, states that by enacting the Patient's Bill of Rights (H&S Code Sections 1599 et seq.) it was clear that the Legislature intended to ensure that nursing homes and intermediate care facilities respect the fundamental rights of their resident. However, the source points out that the legislation failed to provide for any specific mechanism for either an individual resident to enforce his or her rights or for a regulating agency (e.g., Department of Health) to punish or prevent violation of rights which were not directly related to health or safety within the facilities. This bill, argues the source, will provide the needed enforcement mechanism.

(CONTINUED)

2. In Health and Safety Code Section 1599 et seq. (The Patient's Bill of Rights) the Legislature "expressly set forth fundamental human rights which all patients in skilled nursing homes or intermediate care facilities are entitled to..." The Patient's Bill of Rights grants the following to residents of these facilities:

   (a) An adequate number of qualified personnel to carry out all the functions of the facility;

   (b) Good personal hygiene, care to prevent bedsores, measures to prevent and reduce incontinence;

   (c) Food of a quality and quantity in accordance with physician's orders;

   (d) An activity program staffed and equipped to meet each patient's orders;

   (e) A clean facility in good repair;

   (f) A nurses' call system;

   (g) Additional rights guaranteed by regulation.

   Additional rights that would be protected by this bill include those listed in Title 22, Sec. 72527 of the Administrative Code. These rights include the opportunity to visit people of the patient's choice, to participate in planning medical treatment, the right to be fully informed of fees and rates, to be free from mental and physical abuse, and to confidential treatment of personal and medical records.

3. The facilities against which a patient could bring a civil action under this bill would be skilled nursing facilities and intermediate care facilities. The former are defined as health facilities that provide skilled nursing care and supportive care to patients whose primary need is for skilled nursing care on an extended basis. The latter are health facilities that provide inpatient care to ambulatory or semiambulatory patients who have a recurring need for skilled nursing supervision and supportive care but who do not require continuous skilled nursing care.

Wrong

We amended out H+S reg.

We are only enforcing the regulations

SOURCE

Western Center on Law and Poverty

SUPPORT

Gray Panthers
United Neighbors in Action
California Association of Health ~~Services~~ Facilities

OPPOSITION

Unknown

SENATE COMMITTEE ON JUDICIARY 1981-82 Regular Session

SB 1930 (Petris)
As amended April 26
Health & Safety Code
MRR

S
B

1
9
3
0

CIVIL ACTIONS
-PATIENT'S BILL OF RIGHTS-

HISTORY

Source: Author

Prior Legislation: None

Support: CRLA; United Neighbors in Action; Grey Panthers; Alameda County Legal Aid Society; Standing Committee on Legal Problems of Aging of the Legal Services Section of the State Bar

Opposition: No Known

KEY ISSUE

SHOULD A RESIDENT OF A SKILLED NURSING OR INTERMEDIATE CARE FACILITY BE AUTHORIZED TO BRING A CIVIL ACTION AGAINST THE FACILITY FOR VIOLATION OF THE PATIENT'S BILL OF RIGHTS?

PURPOSE

not true as to Pat. Bill of Pts.

AB 1203 (Levine) of 1979 enacted the Patient's Bill of Rights, which sets forth fundamental human rights to which all patients in skilled nursing or intermediate care facilities are entitled. A licensee who violates these rights may be enjoined from permitting the violation to continue or may be sued for civil damages by the Attorney General.

This bill would, in addition, authorize a patient or resident of a skilled nursing or intermediate care

(More)

old

facility to bring an action for damages or for an injunction under the Patient's Bill of Rights.

The purpose of this bill is to protect and ensure the rights of people residing in nursing homes.

COMMENT

1. Inadequacy of existing law

Existing law authorizes the Attorney General, upon her own complaint or upon the complaint of any board, officer, person, corporation, or association, to bring an action against a licensee who violates specified licensing provisions.

According to the author, this protection is not sufficient to ensure a patient her rights. The author argues that "since the State is making major cuts in services to people, it is more important than ever to allow the institutionalized individual the ability to protect their own constitutional rights in the private sector."

2. Rights protected

The Patient's Bill of Rights grants the following to residents of nursing homes:

(a) An adequate number of qualified personnel to carry out all the functions of the facility;

(b) Good personal hygiene, care to prevent bedsores, measures to prevent and reduce incontinence;

(More)

(c) Food of a quality and quantity in accordance with physician's orders;

(d) An activity program staffed and equipped to meet each patient's orders;

(e) A clean facility in good repair;

(f) A nurses' call system;

(g) Additional rights guaranteed by regulation.

Additional rights that would be protected by this bill include those listed in Title 22, Sec. 72527 of the Administrative Code. These include the opportunity to visit people of the patient's choice, to participate in planning medical treatment, the right to be fully informed of fees and rates, to be free from mental and physical abuse, and to confidential treatment of personal and medical records.

3. Facilities affected

The facilities against which a patient could bring a civil action under this bill would be skilled nursing facilities and intermediate care facilities.

The former are defined as health facilities that provide skilled nursing care and supportive care to patients whose primary need is for skilled nursing care on an extended basis.

The latter are health facilities that provide inpatient care to ambulatory or semiambulatory patients who have a recurring need for skilled

(More)

nursing supervision and supportive care but who do not require continuous skilled nursing care.

4. Damages and injunction allowed

This bill would authorize a patient or resident whose rights under the Patient Bill of Rights had been violated to bring an action for damages and an injunction against the licensee of the facility.

The damages for which a licensee could be liable under this bill would be limited to $2,500 or three times the actual damages, whichever was greater, and for costs and attorney fees. Licensees would be liable for their employee's acts.

The bill would provide also that any attempted waiver of the right to sue on the part of a patient would be void.

****

old

SENATE COMMITTEE ON JUDICIARY 1981-82 Regular Session

SB 1930 (Petris)
As amended April 26
Health & Safety Code
MRR

SB 1930

CIVIL ACTIONS
-PATIENT'S BILL OF RIGHTS-

HISTORY

Source: Author

Prior Legislation: None

Support: CRLA

Opposition: No Known

KEY ISSUE

SHOULD A RESIDENT OF A SKILLED NURSING OR INTERMEDIATE CARE FACILITY BE AUTHORIZED TO BRING A CIVIL ACTION AGAINST THE FACILITY FOR VIOLATION OF THE PATIENT'S BILL OF RIGHTS?

PURPOSE

AB 1203 (Levine) of 1979 enacted the Patient's Bill of Rights, which sets forth fundamental human rights to which all patients in skilled nursing or intermediate care facilities are entitled. A licensee who violates these rights may be enjoined from permitting the violation to continue or may be sued for civil damages by the Attorney General.

This bill would, in addition, authorize a patient or resident of a skilled nursing or intermediate care facility to bring an action for damages or for an injunction under the Patient's Bill of Rights.

(More)

The purpose of this bill is to protect and ensure the rights of people residing in nursing homes.

COMMENT

1. Inadequacy of existing law

Existing law authorizes the Attorney General, upon her own complaint or upon the complaint of any board, officer, person, corporation, or association, to bring an action against a licensee who violates specified licensing provisions.

According to the author, this protection is not sufficient to ensure a patient her rights. The author argues that "since the State is making major cuts in services to people, it is more important than ever to allow the institutionalized individual the ability to protect their own constitutional rights in the private sector."

2. Rights protected

The Patient's Bill of Rights grants the following to residents of nursing homes:

(a) An adequate number of qualified personnel to carry out all the functions of the facility;

(b) Good personal hygiene, care to prevent bedsores, measures to prevent and reduce incontinence;

(c) Food of a quality and quantity in accordance with physician's orders;

(More)

(d) An activity program staffed and equipped to meet each patient's orders;

(e) A clean facility in good repair;

(f) A nurses' call system;

(g) Additional rights guaranteed by regulation.

Additional rights that would be protected by this bill include those listed in Title 22, Sec. 72527 of the Administrative Code. These include the opportunity to visit people of the patient's choice, to participate in planning medical treatment, the right to be fully informed of fees and rates, to be free from mental and physical abuse, and to confidential treatment of personal and medical records.

3. Facilities affected

The facilities against which a patient could bring a civil action under this bill would be skilled nursing facilities and intermediate care facilities.

The former are defined as health facilities that provide skilled nursing care and supportive care to patients whose primary need is for skilled nursing care on an extended basis.

The latter are health facilities that provide inpatient care to ambulatory or semiambulatory patients who have a recurring need for skilled nursing supervision and supportive care but who do not require continuous skilled nursing care.

(More)

4. Damages and injunction allowed

This bill would authorize a patient or resident whose rights under the Patient Bill of Rights had been violated to bring an action for damages and an injunction against the licensee of the facility.

The damages for which a licensee could be liable under this bill would be limited to $2,500 or three times the actual damages, whichever was greater, and for costs and attorney fees. Licensees would be liable for their employee's acts.

The bill would provide also that any attempted waiver of the right to sue on the part of a patient would be void.

****

ASSEMBLY COMMITTEE ON JUDICIARY SB 1930
ELIHU M. HARRIS, Chairman

SB 1930 (Petris) As amended 08/02/82

Correction Coming

PRIOR ACTION

Sen. Jud. Com. 7-0 Sen. Floor 37-0

SUBJECT

This bill is intended to provide residents of skilled nursing or intermediate care facilities with a private cause of action for violation of the Patient's Bill of Rights.

DIGEST

Under existing law, the Legislature has recognized that residents or patients in skilled nursing and intermediate care facilities are entitled to certain fundamental rights (the Patient's Bill of Rights). Although existing law authorizes the Attorney General to initiate actions for damages or to enjoin violation of regulations related to the health and safety of residents of such facilities, there is no specific authority to initiate actions for violation of all the rights protected in the Patient's Bill of Rights.

This bill would authorize a patient or resident of a skilled nursing or intermediate care facility to bring an action for damages or an injunction against the licensee of such a facility who violates any of the rights protected by the Patient's Bill of Rights. A licensee would be liable for damages up to $500 and for costs and attorneys' fees. In addition, the licensee of the facility would be liable for the action of his or her employees. The right to bring such action could not be waived.

STAFF COMMENTS

1. Western Center on Law and Poverty, Inc.,the source of this bill, states that by enacting the Patient's Bill of Rights (H&S Code Sections 1599 et seq.) it was clear that the Legislature intended to ensure that nursing homes and intermediate care facilities respect the fundamental rights of their resident. However, the source points out that the legislation failed to provide for any specific mechanism for either an individual resident to enforce his or her rights or for a regulating agency (e.g., Department of Health) to punish or prevent violation of rights which were not directly related to health or safety within the facilities. This bill, argues the source, will provide the needed enforcement mechanism.

(CONTINUED)

2. Patient's Bill of Rights) the Legislature "expressly set forth fundamental human rights which all patients in skilled nursing homes or intermediate care facilities are entitled to..." The Patient's Bill of Rights grants the following to residents of these facilities:

   (a) An adequate number of qualified personnel to carry out all the functions of the facility;

   (b) Good personal hygiene, care to prevent bedsores, measures to prevent and reduce incontinence;

   (c) Food of a quality and quantity in accordance with physician's orders;

   (d) An activity program staffed and equipped to meet each patient's orders;

   (e) A clean facility in good repair;

   (f) A nurses' call system;

   (g) Additional rights guaranteed by regulation.

   Additional rights that would be protected by this bill include those listed in Title 22, Sec. 72527 of the Administrative Code. These rights include the opportunity to visit people of the patient's choice, to participate in planning medical treatment, the right to be fully informed of fees and rates, to be free from mental and physical abuse, and to confidential treatment of personal and medical records.

3. The facilities against which a patient could bring a civil action under this bill would be skilled nursing facilities and intermediate care facilities. The former are defined as health facilities that provide skilled nursing care and supportive care to patients whose primary need is for skilled nursing care on an extended basis. The latter are health facilities that provide inpatient care to ambulatory or semiambulatory patients who have a recurring need for skilled nursing supervision and supportive care but who do not require continuous skilled nursing care.

SOURCE

Western Center on Law and Poverty

SUPPORT

Gray Panthers
United Neighbors in Action
California Association of Health ~~Services~~ Facilities

OPPOSITION

Unknown

Consultant R. R. Lopez
08/04/82

SB 1930

This page was left intentionally blank.

WESTERN CENTER ON LAW AND POVERTY, INC.
Northern California Office
1900 "K" Street, Suite 200, Sacramento, California 95814
Telephone (916) 442-0753

To: Felice Tannenbaum

From: Kate Meiss KEM

Re: Amendment to 1930

Date: April 20, 1982

In response to your request, I have written up an amendment to 1930 that makes clear which rights it covers. The attached copy indicates where it should be inserted. Also another line should be added making it clear the owner is responsible for her employee's acts. Please let me know what other help I can provide.

Amend. #1. Any rights of the patient as set forth under the provisions of Chapter 3.9 commencing with sections 1599. Such actions shall be limited to those rights set forth in The Patients Bill of Rights, Title 22 Section 72527.

Amend. #2 The licensee shall be liable for the acts of her employees.

jj
encls.

April 21, 1982

TO: Legislative Counsel

FROM: Belice Tanenbaum

RE: Amendments to SB 1930

AMENDMENT I

page 2 line 13 strike; under the provisions of Chapter 3.9 (commencing with Section 1599).

Insert: as set forth under the provisions of Chapter 3.9 commencing with Sections 1599. Such actions shall be limited to those rights set forth in the Patients Bill of Rights, Title 22 Section 72527.

AMENDMENT II

page 2 line 15 following "jurisdiction."

Insert: The licensee shall be liable for the acts of the employees.

REQUESTED BY: URGENT April 23, 1982

GRAY PANTHERS

Office
YWCA
1515 Webster Street
Oakland, CA. 94612.
444 - 7126

Answering Service
A Central Place
Oakland, CA. 64612
834 - 7897

file SB1930

April 21, 1982

SENATOR N. PETRIS

Dear Senator Petris:

At our Health Committee meeting on 4/19/82 we endorsed your bill SB1930 that allows a nursing home resident to sue for $2500 if her/his rights are violated. We commend you for sponsoring this bill as it will strengthen patients' rights.

Sincerely,

GENE SHAREE
Convenor

[redacted] REC'D

AGE AND YOUTH IN ACTION

April 21, 1982

TO: Legislative Counsel

FROM: Belice Tanenbaum

RE: Amendments to SB 1930

AMENDMENT I

page 2 line 13 strike; under the provisions of Chapter 3.9 (commencing with Section 1599).

Insert: as set forth under the provisions of Chapter 3.9 commencing with Sections 1599. Such actions shall be limited to those rights set forth in the Patients Bill of Rights, Title 22 Section 72527.

AMENDMENT II

page 2 line 15 following "jurisdiction."

Insert: The licensee shall be liable for the acts of the employees.

REQUESTED BY: URGENT April 23, 1982

California Rural Legal Assistance Foundation

1900 K Street, Suite 200
Sacramento, CA 95814
P.O. Box 161698
Sacramento, CA 95816
(916) 446-7904

April 22, 1982

TO: Senate Judiciary Committee Members

RE: SB 1930 (Petris) - Support

We urge you to vote for SB 1930, which will help residents of nursing homes defend their rights. SB 1930 allows residents to bring civil actions if their basic human rights under the Health & Safety Code are violated. These rights include the opportunity to receive and visit with persons of their choice, being fully informed of possible financial charges, the opportunity to participate in the planning of medical treatment, transfers or discharges only for medical reasons, managing personal financial affairs or, at least, timely accounting, freedom from mental and physical abuse, confidential treatment of personal and medical records.

Without passage of SB 1930, there is generally no practical way for a resident to enforce his/her rights under the Health & Safety section. At present the only recourse for residents when their rights are violated is administrative. It is not only cumbersome, it is virtually unavailable, because of cutbacks caused by the budget crunches, in the number of nursing home inspectors. SB 1930 would allow private attorneys to fill this gap when residents' rights are violated.

We urge an "Aye" vote.

Sincerely,

Emma E. Gunterman

EMMA E. GUNTERMAN
Advocate

EEG/rh

WESTERN CENTER ON LAW AND POVERTY, INC.
Northern California Office
1900 "K" Street, Suite 200, Sacramento, California 95814
Telephone (916) 442-0753

April 22, 1982

Honorable Nicholas C. Petris
Member of the Senate
State Capitol, Room 5080
Sacramento, CA 95814

Re: SB1930 - Support

Dear Senator Petris:

Enclosed you will find our letter in support of SB1930.

We are in full support of this bill and look forward to continuing to work with your staff on this issue and other issues relating to heal care and nursing homes.

Sincerely,

Katherine E. Meiss

KATHERINE E. MEISS
Staff Attorney

jj
Encls.

WESTERN CENTER ON LAW AND POVERTY, INC.
Northern California Office
1900 "K" Street, Suite 200, Sacramento, California 95814
Telephone (916) 442-0753

April 22, 1982

Honorable
Member of the Senate
State Capitol, Room
Sacramento, CA 95814

Re: Support of SB1930, creating a private right of action to enforce S.N.F., I.C.F. Patient's Bill of Rights

Dear Senator

On behalf of our eligible clients and the Western Center on Law and Poverty, I am writing to express our support for SB1930 which will be heard in Senate Judiciary on Tuesday, April 27, 1982.

This bill would create a private right of action under which residents of skilled nursing facilities (S.N.F.) and intermediate care facilities (I.C.F.) would be able to enjoin their collected damages for violation of their basic human rights as set forth in the Patient's Bill of Rights.

The Patient's Bill of Rights was enacted by the Legislature to ensure that residents of SNFs and ICFs would be treated with dignity and respect and would have their basic human and civil right protected. The Bill of Rights would include such things as: the right to participate in religious and social activities; the right to be encouraged and assisted in exercising their rights as a patient and citizen; the right to communicate and associate in private; and the right to refuse to participate in medical research.

The rights protected by the Bill of Rights are fundamental human rights that most citizens take for granted. However, for residents in nursing homes who are frail and dependent by nature, the Legislature recognized the need to specifically enumerate such rights and inform patients of them. Unfortunately, the mechanism that existed to enforce those rights are not effective.

Because most of these violations do not affect the safety or health of residents, abuses of the Bill of Rights are treated as "C" violations. Since they are mere "Cs" under

the citation system, they are not subject to a fine. The Department's inspectors are overworked and, therefore, unable to adequately protect these specific rights from abuse.

Structurally, the most appropriate form to consider violation of human rights is the judicial system, not an administrative agency such as Licensing and Certification. Clearly, a resident cannot bring an independent judicial action to enforce the Bill of Rights. For those rights set out in the Bill of Rights that happen to be judicially protected civil rights, residents would not be able to do so because of the lack of "State action".

Clearly, as the law currently stands, the Legislature has declared the importance of these fundamental human rights, but to ensure the protections in the Bill of Rights are truly meaningful and will be respected, an enforcement mechanism must be created.

SB1930 creates that mechanism, therefore, we urge you to support this bill.

Sincerely,

Katherine E. Meiss

KEM/aa

SB 1930 (Petris)

RUSSELL S. BALISOK
ATTORNEY AT LAW
1888 CENTURY PARK EAST, 6TH FLOOR
LOS ANGELES, CALIFORNIA 90067
TELEPHONE (213) 277-2889

ALDEN F. [illegible]

April 22, 1982

Senator Alan Robbins
State of California
State Capitol
Room 5714
Sacramento, CA 95814

Re: Skilled Nursing Facilities

Dear Senator Robbins:

I am a resident of Van Nuys and a constituent, although my practice is in Century City.

I have devoted a substantial portion of my private practice to the rights of our elderly in Skilled Nursing Facilities (convalescent hospitals) and, for the last several years, have been frustrated for a variety of reasons in my attempt to effect redress for substandard care rendered in nursing homes.

Because of this history, I was delighted to receive today a photocopy of Senate Bill No. 1930, introduced by Senator Petris on March 17, 1982, and I heartily urge your support for the measure.

As Senator Petris must certainly have been aware when he introduced the bill, although federal and state law provide for a variety of "rights" to nursing home and intermediate care facility patients, there is no enforcement mechanism capable of enforcing these rights, and no effective way to obtain redress for such deprivations. By Senator Petris' simple amendment to Health & Safety Code §1430, this changes. Passage of Senate Bill

1930 will undoubtedly be vigorously opposed by the California Association of Health Facilities, but precisely because it portends real adherence to the fundamental human rights which should inure to the patient's benefit.

Very truly yours,

RUSSELL S. BALISOK

RSB:em

cc: Senator Petris

Legal Aid Society of Alameda County

COMPLIANCE PROJECT

2357 SAN PABLO AVENUE
OAKLAND, CALIFORNIA 94612
Telephone 465-4376

file 1930

April 23, 1982

Senator Omer L. Rains
Senate Judiciary Committee
State Capitol
Room 2187
Sacramento, California 95814

Re: SB 1930

Dear Senator Rains:

On April 27, 1982, Senator Petris' bill, SB 1930, will be heard by the Senate Judiciary Committee. We write in support of this bill.

SB 1930 provides elderly citizens, residing in nursing homes, with a private right of action, statutory fine, and attorneys' fees, in the event their fundamental rights, as set forth in the patient bill of rights, are violated by the nursing home. Such a remedy is needed because there exists no meaningful mechanism by which these rights may now be enforced.

The patient bill of rights, set forth in 22 Cal. Adm. Code § 72527, seeks to preserve the dignity and self-respect of those senior citizens living in nursing homes. Among the rights guaranteed to such nursing home residents are the rights to:

(a) participate in religious services and receive visits from clergy;

(b) refuse participation in medical experiments;

(c) receive personal mail unopened;

(d) visit with family and friends;

(e) have private conversations;

(f) be visited at anytime if critically ill;

(g) have reasonable access to telephones.

[all unless medically contraindicated.]

A copy of section 72527 is enclosed.

These rights are so fundamental that any decent, self-respecting nursing home would honor them. Yet, unfortunately, there is a small minority of homes where these rights are persistently violated and residents are deprived of dignity and privacy.

Although any violation of these rights is abhorrent, present law does not provide for a meaningful method of enforcement, and provides that only those regulatory violations which relate to health, safety, or security may result in a monetary penalty. The rights set forth in section 72527 have been determined not to relate to health, safety, or security, thus carry no penalty, and are not enforced.

Senator Petris' bill seeks to remedy this situation. If enacted, a nursing home resident denied his rights, will have the option of a lawsuit which, if successful, will result in a fine or damages plus counsel fees. The vast majority of nursing homes will, of course, never experience such a lawsuit. The small minority, who refuse to respect the dignity of their residents, will now have an incentive to mend their ways, and a penalty if they choose not to do so.

SB 1930 will help protect the dignity and individuality of our elder citizens and we urge its expeditious passage.

Sincerely,

Eric P. Gold
Attorney at Law

EPG:bjm

cc: Senator Petris
Senator Beverly
Senator Presley
Senator Roberti
Senator Sieroty
Senator Marks
Senator Doolittle
Senator Davis
Richard Thomson

Legal Aid Society of Alameda County

COMPLIANCE PROJECT

2357 SAN PABLO AVENUE
OAKLAND, CALIFORNIA 94612
Telephone 465-4376

April 23, 1982

Senator Omer L. Rains
Senate Judiciary Committee
State Capitol
Room 2187
Sacramento, California 95814

Re: SB 1930

Dear Senator Rains:

On April 27, 1982, Senator Petris' bill, SB 1930, will be heard by the Senate Judiciary Committee. We write in support of this bill.

SB 1930 provides elderly citizens, residing in nursing homes, with a private right of action, statutory fine, and attorneys' fees, in the event their fundamental rights, as set forth in the patient bill of rights, are violated by the nursing home. Such a remedy is needed because there exists no meaningful mechanism by which these rights may now be enforced.

The patient bill of rights, set forth in 22 Cal. Adm. Code § 72527, seeks to preserve the dignity and self-respect of those senior citizens living in nursing homes. Among the rights guaranteed to such nursing home residents are the rights to:

(a) participate in religious services and receive visits from clergy;

(b) refuse participation in medical experiments;

(c) receive personal mail unopened;

(d) visit with family and friends;

(e) have private conversations;

(f) be visited at anytime if critically ill;

(g) have reasonable access to telephones.

[all unless medically contraindicated.]

A copy of section 72527 is enclosed.

These rights are so fundamental that any decent, self-respecting nursing home would honor them. Yet, unfortunately, there is a small minority of homes where these rights are persistently violated and residents are deprived of dignity and privacy.

Although any violation of these rights is abhorrent, present law does not provide for a meaningful method of enforcement, and provides that only those regulatory violations which relate to health, safety, or security may result in a monetary penalty. The rights set forth in section 72527 have been determined not to relate to health, safety, or security, thus carry no penalty, and are not enforced.

Senator Petris' bill seeks to remedy this situation. If enacted, a nursing home resident denied his rights, will have the option of a lawsuit which, if successful, will result in a fine or damages plus counsel fees. The vast majority of nursing homes will, of course, never experience such a lawsuit. The small minority, who refuse to respect the dignity of their residents, will now have an incentive to mend their ways, and a penalty if they choose not to do so.

SB 1930 will help protect the dignity and individuality of our elder citizens and we urge its expeditious passage.

Sincerely,

Eric P. Gold
Attorney at Law

EPG:bjm

cc: Senator Petris
Senator Beverly
Senator Presley
Senator Roberti
Senator Sieroty
Senator Marks
Senator Doolittle
Senator Davis
Richard Thomson

72527. Patients' Rights.

(a) Written policies regarding the rights of patients shall be established and shall be available to the patient, to any guardian, next of kin, sponsoring agency or representative payee and to the public. Such policies and procedures shall ensure that each patient admitted to the facility shall have the following rights and be notified of the facility's obligations.

(1) To be fully informed, as evidenced by the patient's written acknowledgement prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(2) To be fully informed, prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or not covered under Titles XVIII or XIX of the Social Security Act.

(3) To be fully informed by a physician of his or her medical condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of medical treatment and to refuse to participate in experimental research.

(4) To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.

(5) To be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment for his or her stay and to be given reasonable advance notice to ensure orderly transfer or discharge. Such actions shall be documented in the patient's health record.

(6) To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

(7) To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept written delegation of this responsibility subject to the provisions of Section 72529.

(8) To be free from mental and physical abuse and to be free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician or other person lawfully authorized to prescribe care for a specified and limited period of time, or when necessary to protect the patient from injury to himself or to others.

(9) To be assured confidential treatment of personal and medical records and to approve or refuse their release to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third party payment contract.

(10) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.

(11) Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.

(12) To associate and communicate privately with persons of the patient's choice, and to send and receive personal mail unopened, unless medically contraindicated.

(13) To meet with others and participate in activities of social, religious and community groups, unless medically contraindicated.

(14) To retain and use personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients and unless medically contraindicated.

(15) If married, to be assured privacy for visits by the patient's spouse and if both are patients in the facility, to be permitted to share a room, unless medically contraindicated.

(16) To have daily visiting hours established.

(17) To have visits from members of the clergy at any time at the request of the patient or the patient's guardian.

(18) To allow relatives, or persons responsible, to visit critically ill patients at any time, unless medically contraindicated.

(19) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

(20) To have reasonable access to telephones and to make and receive confidential calls.

(b) A patient's rights, as set forth above, may be denied or limited only for good cause which shall be evidenced by the written order of the attending physician, and may only be denied or limited if such denial or limitation is otherwise authorized by law. Reasons for denial or limitation of such rights shall be documented by the attending physician in the patient's health record.

(c) All rights specified in Section 72527(a)(1) through (4) as they pertain to a patient adjudicated incompetent in accordance with state law, to a patient who is found by his physician to be medically incapable of understanding these rights, or to a patient who exhibits a communication barrier, shall devolve to such patient's guardian, next of kin, sponsoring agency or representative payee (except when the facility itself is representative payee).

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1599, 1599.1, 1599.2 and 1599.3, Health and Safety Code.

SB 1930

WEST CONTRA COSTA COUNTY GRAY PANTHERS
1751 Eastshore Boulevard
El Cerrito, California 94530
Telephone (415) 232-9606, 232-1122

April 23,1982.

Senator Omer Rains
Chairman,Judiciary Committee

SB

Dear Senator,

We write in support of SB 1930 which we understand would permit the exercise of a long neglected right of legal action by or on behalf of aggrieved patients of nursing homes.

The cover-up of nursing home abuses of helpless patients must be stopped-even if these abuses were occuring only rarely,which we know they are not.

We believe this reform can be an accomplishment at no cost to the state government.

Please help us make this a year of substantial hursing home reform by moving this Bill along without crippling amendments,and accept our thanks for your understanding and support.

On behalf of the West County Chapter,

and with best wishes

Arthur E. Schroeder,Cor. Sec't'y.

C.C. Sen. Petris
United Nabors in Action
WCGP

THE LEGAL SERVICES SECTION

OF THE STATE BAR OF CALIFORNIA

April 24, 1982

555 FRANKLIN STREET
SAN FRANCISCO 94102-4498
TELEPHONE 561-8250
AREA CODE 415

Honorable Nicholas Petris
State Senate
State Capitol
Sacramento, CA 95814

Dear Senator Petris:

The Standing Committee on Legal Problems of Aging of the Legal Services Section of the State Bar of California wishes to express its support for SB 1930, your Nursing Home Residents' Rights Protection Bill.

The Standing Committee on Legal Problems of Aging is comprised of attorneys and lay advocates experienced in extending legal protections to isolated, poor, and disabled old persons living independently and in nursing homes throughout California. A key goal of the Committee is to improve aged and disabled persons' access to legal remedies when their rights and safety are imperiled.

Research suggests that litigation is severely underutilized as a means of redressing incidents of nursing home neglect. There are several reasons for the paucity of private lawsuits in this important area, which we believe SB 1930 will address.

Attorneys are understandable reluctant to undertake expensive and time-consuming litigation because damages are limited under the present private right of action clause in the Health and Safety Code to the amount of a State Licensing citation, generally in the range of $50-$250.

Conventional methods for calculating damages in personal injury suits result in extremely small "actual damages" awards when the typical plaintiff is an eighty year old, severely disabled woman residing in a nursing home. Neither the resident nor the lawyer in such a suit stands to gain much for the amount of anxiety and hard work involved in pursuing the litigation.

Major damages (and even attorneys' fees) can theoretically be won for violations of a person's civil rights under 42 USC section 1983 (and 1985). The large awards granted in such cases are commensurate with the seriousness of the act of depriving a helpless, dependent person of her/his rights. In these actions, however, the plaintiff must be able to prove the licensee acted in the capacity of the state in violating her/his civil rights.

This relatively new and untested area of law is presently being explored by the vanguard of the legal profession. The language of SB 1930 ensures that the civil rights afforded nursing home residents under California law can be enforced in a simple and equitable fashion by any member of the Bar.

Nursing home residents need to be able to sue for violations of their rights by nursing home operators and their agents. SB 1930 clears the principal barriers to the appropriate use of legal remedies by nursing home residents.

The views expressed herein are expressed on behalf of the Executive Committee of the Legal Services Section and its Committee on Legal Problems of Aging, and not on behalf of the State Bar. The Bar's Board of Governors has not reviewed or taken a position on this legislation.

Sincerely,

Susan Mattox
Section Administrator
on Behalf of the Executive Committee
of the Legal Services Section
of the State Bar of California

cc: Peter Jensen,
Legislative Representative
State Bar of California

GRAY PANTHERS
401 REYNOLDS CIRCLE
SAN JOSE CA 95112

western union Mailgram® UNITED STATES POSTAL SERVICE U.S.MAIL

4-044131S116 04/26/82 ICS IPMRNCZ CSP SACB
4082988551 MGM TDRN SAN JOSE CA 32 04-26 0329P EST

file
SB 1930

NICHOLAS PETRIS, MEMBER SENATE JUDICIARY
COMMITTEE
STATE CAPITOL
SACRAMENTO CA 95814

PLEASE PASS SB1930 NURSING HOME RESIDENTS MUST BE ABLE TO SECURE THEIR RIGHTS
RICHARD GREGORY, CHAIRMAN LEGISLATIVE COMMITTEE, CALIFORNIA GRAY PANTHERS

15:30 EST

MGMCOMP MGM

APR 27 RECD

5241 (R1/78)

GRAY PANTHERS of the Berkeley area

AGE AND YOUTH IN ACTION

2101 A Woolsey Street, Berkeley, CA 94705 • 845-5208

April 27, 1982

Senator Nicholas C. Petris
Senate Judiciary Committee
State Capitol
Sacramento, Ca. 95814

Dear Mr. Petris:

I am writing to you on behalf of the Berkeley Gray Panthers and the Coalition of Nursing Home Reform Advocates to express our support of SB1930(Petris), which would allow nursing home residents to sue for violations of the Patients' Bill of Rights. As you know, these rights are elementary to human dignity: the right to voice grievances, to meet with advocates, to maintain at least some degree of privacy in a relatively powerless situation.

I would alert you that Health Department Licensing officials in our district have recently indicated to us that patients' rights are not a priority in this time of cutbacks. This unfortunate stance, together with the prospect of further disabling cutbacks in inspections on both the state and federal levels, make prompt passage of this bill, without weakening amendments, of utmost importance to quality patient care.

Finally, SB1930 carries no cost to state or local governments, and provides the right to obtain costs and attorney's fees from the offending party.

We fully support this bill and your efforts to improve nursing home care in California. Please let me know if we can be of assistance in the future.

Sincerely,

Timothy Orr
Berkeley Gray Panthers
Coalition of Nursing Home
Reform Advocates

THE STATE BAR OF CALIFORNIA

Office of the Legislative Representative

1210 K STREET SACRAMENTO, CALIFORNIA 95814

TELEPHONE (916) 444-2762

April 28, 1982

SB 1930
file

The Honorable Nicholas Petris
Senator, 9th District
State Capitol, Room 5080
Sacramento, California 95814

Dear Senator Petris:

RE: Senate Bill 1930

The State Bar Standing Committee on Legal Problems of Aging has reviewed the above-referenced measure and its comments and position are enclosed herewith.

It is the policy of the State Bar to refer various measures which affect the practice of law to the State Bar Committees or Sections for review and comment. The Standing Committee on Legal Problems of Aging composed of legal experts and attorney practitioners in the area of Legal Problems of Aging has reviewed your measure and expressed the enclosed concerns. The comments are intended to provide input to the legislative process from the expertise and legal resources of the constituency of the State Bar. It should be emphasized that its position and comments are those of the Standing Committee on Legal Problsms of Aging and not the State Bar.

The Legislative Representative of the State Bar may be contacted for further information or assistance in obtaining an expert witness to testify before Legislative Committee.

Sincerely,

Peter Jensen
Legislative Representative

enc.

cc(w/enc): Richard Thomson, Consultant
Senate Judiciary Committee

THE STATE BAR OF CALIFORNIA

Office of the Legislative Representative

1210 K STREET SACRAMENTO, CALIFORNIA 95814

TELEPHONE (916) 444-2762

April 28, 1982

The Honorable Nicholas Petris
Senator, 9th District
State Capitol, Room 5080
Sacramento, California 95814

Dear Senator Petris:

RE: Senate Bill 1930

The State Bar Standing Committee on Legal Problems of Aging has reviewed the above-referenced measure and its comments and position are enclosed herewith.

It is the policy of the State Bar to refer various measures which affect the practice of law to the State Bar Committees or Sections for review and comment. The Standing Committee on Legal Problems of Aging composed of legal experts and attorney practitioners in the area of Legal Problems of Aging has reviewed your measure and expressed the enclosed concerns. The comments are intended to provide input to the legislative process from the expertise and legal resources of the constituency of the State Bar. It should be emphasized that its position and comments are those of the Standing Committee on Legal Problsms of Aging and not the State Bar.

The Legislative Representative of the State Bar may be contacted for further information or assistance in obtaining an expert witness to testify before Legislative Committee.

Sincerely,

Peter Jensen
Legislative Representative

enc.

cc(w/enc): Richard Thomson, Consultant
Senate Judiciary Committee

Major damages (and even attorneys' fees) can theoretically be won for violations of a person's civil rights under 42 USC section 1983 (and 1985). The large awards granted in such cases are commensurate with the seriousness of the act of depriving a helpless, dependent person of her/his rights. In these actions, however, the plaintiff must be able to prove the licensee acted in the capacity of the state in violating her/his civil rights.

This relatively new and untested area of law is presently being explored by the vanguard of the legal profession. The language of SB 1930 ensures that the civil rights afforded nursing home residents under California law can be enforced in a simple and equitable fashion by any member of the Bar.

Nursing home residents need to be able to sue for violations of their rights by nursing home operators and their agents. SB 1930 clears the principal barriers to the appropriate use of legal remedies by nursing home residents.

The views expressed herein are expressed on behalf of the Executive Committee of the Legal Services Section and its Committee on Legal Problems of Aging, and not on behalf of the State Bar. The Bar's Board of Governors has not reviewed or taken a position on this legislation.

Sincerely,

Susan Mattox
Section Administrator
on Behalf of the Executive Committee
of the Legal Services Section
of the State Bar of California

cc: Peter Jensen,
Legislative Representative
State Bar of California

April 23, 1982

file
SB 1930

Dear Senator Petris,

I am writing to you to thank you for introducing SB 1930.

The patients' rights are critical to upgrading the care of nursing home residents. But what good are 'rights' unless there is the ability to enforce them.

I hope that SB 1930 will help residents get the treatment they deserve.

Sincerely,

Elizabeth Finn
P.O. Box 145
Occidental, CA 95465

APR 29 1982

FAMILY SERVICES AGENCY
1010 GOUGH
SAN FRANCISCO CA 94109

western union Mailgram®

UNITED STATES POSTAL SERVICE U.S.MAIL

4-063365S123 05/03/82 ICS IPMRNCZ CSP SACB
4154748757 MGM TDRN SAN FRANCISCO CA 51 05-03 0606P EST

SENATOR NICHOLAS PETRIS
STATE CAPITOL
SACRAMENTO CA 95814

ABUSE OF PATIENT'S RIGHTS IS A DAILY OCCURENCE AND MOST OFTEN GO UNRESOLVED BECAUSE THERE IS NO ACCESS FOR LEGAL REDRESS THE CALIFORNIA LONG TERM CARE OMBUDSMAN PROGRAM AND THE SAN FRANCISCO OMBUDSMAN PROGRAM URGE YOUR SUPPORT OF SB 1930
MARGOT JASIE, OMBUDSMAN

18:09 EST

MGMCOMP MGM

MAY [illegible]

5241 (R1/78)

638

TO REPLY BY MAILGRAM, SEE REVERSE SIDE FOR WESTERN UNION'S TOLL - FREE PHONE NUMBERS

May 6, 1982

Dear Barry Keene,

You may remember me as principal of Lewis Elementary School in Santa Rosa, when you were a member of the Community Action Council. I was a judge's appointee by way of the Probation Department as a Juvenile Justice Commission.

I am writing to ask you to support the effort of devoted people supporting SB1930 thereby providing patients in rest homes ~~to~~ with some reasonable legal way of correcting abuses pertaining to their care.

Best wishes,

Morton Trauf
806 McDonald Ave.
Santa Rosa,
CA 95404

Legal Aid Society of Alameda County

COMPLIANCE PROJECT

2357 SAN PABLO AVENUE
OAKLAND, CALIFORNIA 94612
Telephone 465-4376

May 7, 1982

5/11 Jean — Pls. send from 5/4 amended version Thanks

Felice Tanenbaum
Office of Senator Petris
Room 5080
State Capitol
Sacramento, California

Re: S.B. 1930

Dear Felice:

When you get a copy of the amended version of S.B. 1930, please send me several copies.

Thanks.

Sincerely,

Eric P. Gold
Attorney at Law

EPG:bjm

Sent copies 5/11/82

EXHIBIT 4B

EXHIBIT 2B

ADVISORY COUNCIL ON AGING
2425 Bisso Lane, #110
Concord, California 94520
(415) 671-4233

Contra Costa County

May 19, 1982

Janet J. Levy, Director
California Department of Aging
1020 19th Street
Sacramento, CA 95814

Dear Ms. Levy:

The Contra Costa County Advisory Council on Aging has directed me to write you regarding the Federal Government proposal to hold funds appropriated under the Older Americans Act to enforce health and safety standards in board-and-care homes occupied by elderly and handicapped.

The Advisory Council endorses the recommendation of the Legislative Review Committee that the California Department of Social Services be required to strengthen the licensing regulations and requirements, and monitoring of the board-and-care homes immediately. Since CDA has no authority over licensing, it should not be cut back because of another department's error.

We urge immediate action to correct this potential disaster.

Sincerely,

Thelma D. Dahlin

Thelma D. Dahlin, Chair
Legislative Review Committee

Edna Selley ab

Edna Selley, President
Advisory Council on Aging

ES:TD:ab
cc - U. S. Agency on Aging
Calif. Health & Welfare Agy.
Senator A. Cranston
Senator S. Hayakawa
Congressman G. Miller
Congressman R. Dellums
Senator D. Boatwright
Senator N. Petris
Assemblymen, R. Campbell; W. Baker; T. Bates.
CCC Board of Supervisors

MAY 25 RECD

THE CONTRA COSTA COUNTY ADVISORY COUNCIL ON AGING IS APPOINTED BY THE BOARD OF SUPERVISORS TO ADVISE THE AREA AGENCY ON AGING ON ALL MATTERS RELATED TO THE DEVELOPEMENT AND ADMINISTRATION OF THE ANNUAL AREA AGENCY PLAN AND OPERATIONS CONDUCTED THEREUNDER, IN ACCORDANCE WITH MANDATES FROM THE OLDER AMERICANS ACT. ANY COMMENTS OR RECOMMENDATIONS MADE BY THE COUNCIL OR ITS INDIVIDUAL MEMBERS DO NOT REPRESENT THE OFFICIAL POSITION OF THE COUNTY OR ANY OF ITS OFFICERS.

ADVISORY COUNCIL ON AGING
2425 Bisso Lane, #110
Concord, California 94520
(415) 671-4233

Contra Costa County

File

Dear, please note their support on SB 1930 file.

May 19, 1982

Mr. John W. Riggle, Executive Dir.
California Commission on Aging
1020 9th Street, Room 260
River City Bank Building
Sacramento, CA 95814

Dear Mr. Riggle:

The Contra Costa County Advisory Council on Aging has directed me to write you regarding the Joint Rules Committee report on the four bills supported in your May 4, 1982 meeting. The Legislative Review Committee has been watching these bills and today recommended support of all of them. The Advisory Council approved this support:

AB 3714 Roos/Moorhead
SCR 14 Mello
AB 2997 Felando
SB 1930 Petris

As the home base support group for our Contra Costa Senior Legislator delegation, we are happy to endorse this group of bills.

Sincerely,

Thelma C Dahlin

Thelma C. Dahlin, Chair
Legislative Review Committee

Edna Selley

Edna Selley, President
Advisory Council

ES:TD:ab
cc - Senator Boatwright
Senator Petris
Assemblyman Campbell
" Baker
" Bates

THE CONTRA COSTA COUNTY ADVISORY COUNCIL ON AGING IS APPOINTED BY THE BOARD OF SUPERVISORS TO ADVISE THE AREA AGENCY ON AGING ON ALL MATTERS RELATED TO THE DEVELOPEMENT AND ADMINISTRATION OF THE ANNUAL AREA AGENCY PLAN AND OPERATIONS CONDUCTED THEREUNDER, IN ACCORDANCE WITH MANDATES FROM THE OLDER AMERICANS ACT. ANY COMMENTS OR RECOMMENDATIONS MADE BY THE COUNCIL OR ITS INDIVIDUAL MEMBERS DO NOT REPRESENT THE OFFICIAL POSITION OF THE COUNTY OR ANY OF ITS OFFICERS.

72527. Patients' Rights.

(a) Written policies regarding the rights of patients shall be established and shall be available to the patient, to any guardian, next of kin, sponsoring agency or representative payee and to the public. Such policies and procedures shall ensure that each patient admitted to the facility shall have the following rights and be notified of the facility's obligations.

(1) To be fully informed, as evidenced by the patient's written acknowledgement prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(2) To be fully informed, prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or not covered under Titles XVIII or XIX of the Social Security Act.

(3) To be fully informed by a physician of his or her medical condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of medical treatment and to refuse to participate in experimental research.

(4) To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.

(5) To be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment for his or her stay and to be given reasonable advance notice to ensure orderly transfer or discharge. Such actions shall be documented in the patient's health record.

(6) To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

(7) To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept written delegation of this responsibility subject to the provisions of Section 72529.

(8) To be free from mental and physical abuse and to be free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician or other person lawfully authorized to prescribe care for a specified and limited period of time, or when necessary to protect the patient from injury to himself or to others.

(9) To be assured confidential treatment of personal and medical records and to approve or refuse their release to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third party payment contract.

(10) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.

(11) Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.

(12) To associate and communicate privately with persons of the patient's choice, and to send and receive personal mail unopened, unless medically contraindicated.

(13) To meet with others and participate in activities of social, religious and community groups, unless medically contraindicated.

(14) To retain and use personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients and unless medically contraindicated.

(15) If married, to be assured privacy for visits by the patient's spouse and if both are patients in the facility, to be permitted to share a room, unless medically contraindicated.

(16) To have daily visiting hours established.

(17) To have visits from members of the clergy at any time at the request of the patient or the patient's guardian.

(18) To allow relatives, or persons responsible, to visit critically ill patients at any time, unless medically contraindicated.

(19) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

(20) To have reasonable access to telephones and to make and receive confidential calls.

(b) A patient's rights, as set forth above, may be denied or limited only for good cause which shall be evidenced by the written order of the attending physician, and may only be denied or limited if such denial or limitation is otherwise authorized by law. Reasons for denial or limitation of such rights shall be documented by the attending physician in the patient's health record.

(c) All rights specified in Section 72527(a)(1) through (4) as they pertain to a patient adjudicated incompetent in accordance with state law, to a patient who is found by his physician to be medically incapable of understanding these rights, or to a patient who exhibits a communication barrier, shall devolve to such patient's guardian, next of kin, sponsoring agency or representative payee (except when the facility itself is representative payee).

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1599, 1599.1, 1599.2 and 1599.3, Health and Safety Code.

WEISSBURG AND ASLANIS
ATTORNEYS AT LAW
32ND FLOOR, TWO CENTURY PLAZA
2049 CENTURY PARK EAST
LOS ANGELES, CALIFORNIA 90067
TELEPHONE (213) 277-2223
TELECOPIER (213) 557-8475

SACRAMENTO OFFICE
SACRAMENTO, CALIFORNIA 95814
(916) 443-8005

WASHINGTON OFFICE
1111 NINETEENTH STREET, N.W.
SUITE 406
WASHINGTON, D.C. 20036
(202) 223-6666

SAN FRANCISCO OFFICE
THREE EMBARCADERO CENTER
SUITE 2060
SAN FRANCISCO, CALIFORNIA 94111
(415) 434-4484

ALAN I. EPSTEIN
ROBERT J. GERST
ROBERT A. KLEIN
ALBERT C. MOUR
PETER ARONSON
CARL WEISSBURG
RICHARD A. BLACKER
WM. R. RICHEY
GALEN D. POWERS*
JAY N. HARTZ
PATRIC HOOPER
MARK S. WINDISCH
J. MARK WAXMAN
MICHAEL J. TICHON
ROBERT W. LUNDY, JR.
JAMES C. PYLES*
KENNETH M. STERN
CARL H. HITCHNER
KATHLEEN H. DRUMMY
ROBERT D. SEVELL
GARY S. MOBLEY
ROBERT M. DAWSON

LENARD I. PICK
LAWRENCE W. BERGER
LLOYD A. BOOKMAN
THOMAS H. MABIE
DAVID S. NEIGER
ROBERT B. MCCRAY
RONALD N. SUTTER
PATRICK K. O'HARE
RICHARD A. JONES
GAIL ANDERSON
DONNA E. ERB
RICHARD S. KLEIN
THOMAS G. BROCKINGTON
MARK A. KADZIELSKI
DAN GROSZKRUGER
GUY COLLIER*
DIANE MILLMAN*
JAMES R. KALYVAS
PETER J. DIEDRICH
JENNIFER P. CODY
BRUCE R. GILBERT*

OF COUNSEL
JOANNE B. STERN
ELMER D. MARTIN, III**
ROBERT J. ENDERS

*NOT MEMBER OF CALIFORNIA BAR
**A PROFESSIONAL CORPORATION

June 1, 1982

PLEASE ADDRESS REPLY TO
Los Angeles

Mr. Bruce Yarwood
Executive Vice President
California Association of
Health Facilities
1401 21st Street, Suite 202
Sacramento, California 95814

6/7 Gave me draft response

Re: Senate Bill 1930

Dear Mr. Yarwood:

This letter sets forth our concerns regarding the above mentioned Bill. We do not believe the Bill should be supported and cannot be modified because it serves to substantially expand the nature and extent of recovery for violations of patients' rights far beyond that available under existing law.

Senate Bill 1930 provides for the institution of a civil action against a skilled nursing facility or intermediate care facility by a patient or resident alleging a violation of the "patients' rights" set forth in Section 72527 of Title 22 of the California Administrative Code. Specifically, the Bill authorizes the payment of attorneys' fees to a successful plaintiff, provides for an award of punitive damages "in the case of intentional or repeated violations," and imposes liability on the facility licensee for the acts of his or her employees.

Under current law, Section 72527 violations clearly invoke valid civil actions which are available to an injured patient. The rights delineated therein (e.g., to refuse treatment where legally permissible, to manage personal finances, to be free from mental and physical abuse or physical restraints (unless authorized), to be treated with consideration, to communicate privately with others, to retain and use personal possessions) effectively establish the requisite standard of care. Traditional tort theories can thusly be applied when a facility breaches the duty imposed by this standard which causes a patient injury.

SB1930 is duplicative

see #1 (Eric's response)

To further bolster a patient's cause of action for negligence under existing law, a violation of the regulations as set forth in Section 72527 will constitute negligence per se. Under this doctrine, a regulatory violation which proximately causes an injury of the type the regulation was designed to prevent (injuring a person for whose protection the regulation was adopted) creates a presumption of negligence. The burden then shifts to the defendant to show that he "did what might reasonably be expected of a person of ordinary prudence, acting under similar circumstances. . . ." Cade v. Mid-City Hospital Corp., 45 Cal.App.3d 589, 597, 119 Cal.Rptr. 571 (1975); BAJI 3.45 (6th Ed., 1977).

Personal torts such as assault, battery, false imprisonment, intentional/negligent infliction of emotional distress, negligence and invasion of privacy do encompass those "patients' rights" affecting the person. Actions for conversion and trespass to chattels similarly protect the "patients' rights" regarding personal possessions. Notably, existing case law dealing with the tort of emotional distress has construed this cause of action liberally: "'mental suffering' includes nervousness, grief, anxiety, worry, shock, humiliation and indignity as well as physical pain." Crisci v. Security Insurance Company, 66 Cal.2d 425, 426 P.2d 173, 58 Cal.Rptr. 13 (1967); BAJI 12.72 (6th Ed., 1977). The standards imposed by Section 72527 clearly avail a private plaintiff-patient of an action for damages.

The damage award to a successful plaintiff may be compensatory or punitive. A compensatory award represents a measure of the actual loss suffered, and can consist of actual or special damages. Actual (or general) damages are those which necessarily result from the act complained of, and are implied by law to have thereby accrued to plaintiff (e.g., pain and suffering, emotional anguish); they need not be specifically pleaded or proved. Special damages are the actual, but not the necessary, result of the injury which follows it as a natural and proximate consequence in each particular case (e.g., medical expenses, loss of earnings); they must be

specifically pleaded and proved. It appears that a proposed substitution of words in Senate Bill 1930 will erroneously allow it to read "The licensee shall be liable for actual damages according to proof. . . ." (emphasis added). Apparently the word "actual" was inserted instead of the correct "actual and special damages according to proof."

Incorrect "actual" is not in bill.

It is the generally accepted rule that attorneys' fees are not recoverable as damages, compensatory or punitive, in the absence of express statutory or contractual authority. In Re Marriage of Reyes, 97 Cal.App.3d 876, 159 Cal.Rptr. 84 (1979); Camp v. Swoap, 94 Cal.App.3d 733, 156 Cal.Rptr. 600 (1979). Cases which have permitted an award of attorneys' fees for tortious conduct concern themselves primarily with public interest suits or injuries to large numbers of persons (e.g., common fund exception, private attorney general exception, substantial benefit doctrine, or shareholders' suits). Senate Bill 1930 falls into none of the limited, existing exceptions, yet proposes an award of attorneys' fees. Such a provision not only stands in direct opposition to existing case law, but also effectively grants a unique advantage to patient-plaintiffs injured in the health care facility setting which is not afforded to individual plaintiffs injured in any other setting; a similarly unique burden is placed on health care providers which is not shared by defendants in similar tort actions.

#2 Eric's response

Punitive or exemplary damages may be awarded in addition to actual damages as punishment to the wrongdoer. Such an award is, however, governed by Civil Code Section 3294 (West Supp. 1982), which allows recovery of punitive damages only "where the defendant has been guilty of oppression, fraud or malice."

#3

Therefore, any of the civil actions available to a patient-plaintiff under current law present the opportunity for a punitive damage award if the requisite mental state can be shown. California case law has consistently adhered to the now statutory requirement that "malicious" conduct be "intended by the defendant to cause injury to the plaintiff or conduct which is carried on by the defendant with a conscious disregard of the rights or safety of others." (Emphasis added.) Civil Code Section 3294(c)(1). "Oppression" requires "subjecting a person to cruel and unjust hardship in conscious disregard of that person's rights." (Emphasis added.) Civil Code Section 3294(c)(2).

Senate Bill 1930 stands opposed to these established guidelines, as it proposes punitive damage liability "in the case of intentional or repeated violations" of patient rights.

Such legislation would open the door to punitive awards for consecutive acts of negligence, although it has been consistently held that "[m]ere negligence or recklessness will not suffice." Johns-Manville Sales Corp. v. Workers' Comp. Appeals Board, 96 Cal.App.3d 923, 931, 158 Cal.Rptr. 463 (1979). Without the limitations of Section 3294, the Bill ignores the settled principle that "every proved tort does not per se entitle the wronged person to punitive damages." Mason v. Mercury Casualty Company, 64 Cal.App.3d 471, 474, 134 Cal.Rptr. 545 (1976).

An equally important consideration is the fact that California courts approach the area of punitive damages itself with some trepidation. "Such damages are never awarded as a matter of rights . . .; they are not favored by the law and they should be granted with the greatest of caution . . .; they will be allowed only in the clearest of cases. . . ." Henderson v. Security National Bank, 72 Cal.App.3d 765, 771, 140 Cal.Rptr. 388 (1977). "[Punitive] damages constitute a windfall, which, though supported by law in proper cases . . ., creates the anomaly of excessive compensation which makes the remedy an unappealing one." Rosener v. Sears Roebuck and Company, 110 Cal.App.3d 740, 750, 168 Cal.Rptr. 237 (1980). The Bill's expansive approach to punitive damage awards, in light of existing law, suggests that this legislation is neither desirable nor necessary.

A final aspect of Senate Bill 1930 causing us great concern is the provision imposing liability on the care facility licensee for the acts of his or her employees. While an employer may be liable for an employee's tort under the doctrine of respondeat superior, Civil Code Section 3294(b) states that there can be no employer liability for punitive damages based upon an act of an employee unless the employer: knew of the employee's unfitness, authorized or ratified the wrongful conduct, or was personally guilty of oppression, fraud or malice. Again, the absence of such a provision in the proposed legislation affords an unprecedented advantage to patient-plaintiffs and imposes potentially limitless liability on innocent licensees -- for a contract to insure against a wilful and malicious act (i.e., a punitive damage award) is prohibited by Insurance Code Section 533 (West, 1972). #4

We have no argument with the value of valid tort actions as useful tools to make health care facilities more accountable to their residents. The Patients' Bill of Rights, as established by statute commencing with Health and Safety Code Section 1599 and as set forth in Section 72527 of the California Administrative Code, provide an effective standard

on which to base a civil action under existing law. However, Senate Bill 1930 expands the potential for recovery so far beyond existing statutory law and case doctrine as to render it untenable and replete with unpleasant consequences.

A substantial increase in patient lawsuit litigation would undoubtedly follow an adoption of this Bill. The potential for windfall recovery above and beyond other tort actions, as well as lessened pleading and proof requirements (obtained through the effective writing-out of Section 3294 from the legislation) would make the "new" cause of action an attractive one to patients or their guardians. #5

Unfortunately, a Bill of this sort invites a plethora of suits over relatively minor items which would otherwise remain outside the courtroom. The "Patients' Bill of Rights" was clearly never intended to provide an avenue for vexatious litigants in search of a pot-of-gold predicated on a negligently placed coffee cup. Current statutory provisions and relevant case law, largely ignored by Senate Bill 1930, provide an important check against meritless suits and overinflated awards.

Today's health care facilities would, of course, be forced to recognize and plan to absorb the added litigation expenses incurred in defending Senate Bill 1930 lawsuits. Ultimately, the burden rests with patients themselves, as they will be faced with rising costs of care to offset care facilities' attorney fees and damage awards. Excessive punitive awards might affect funds otherwise available for facility upgrading, expansion of offered services, or needed improvements.

I hope that the foregoing has adequately expressed our concerns regarding Senate Bill 1930. If you should have questions regarding this letter, please do not hesitate to give us a call.

Very truly yours,

Robert J. Gerst

RJG:tp

WESTERN CENTER ON LAW AND POVERTY, INC.
Northern California Office
1900 "K" Street, Suite 200, Sacramento, California 95814
Telephone (916) 442-0753

June 14, 1982

Honorable Nicholas Petris
Member of the Senate
State Capitol, Room 5080
Sacramento, CA 95814

Re: SB1930

Dear Senator Petris:

Several years ago legislation was enacted to guarantee that nursing home residents would retain basic rights of dignity and self-respect notwithstanding their residency in nursing homes. The resulting Patient Bill of Rights (Section 72527 of Title 22) establishes such basic human dignities as the right to have visitors, communicate in private, practice religion, and refuse medical treatment (all unless medically contraindicated).

To establish a clear mechanism to enforce these rights, SB1930 establishes a private course of action and awards damages, attorneys' fees and injunctive relief to a prevailing plaintiff. Additionally, punitive damages may be awarded, but only if the violation were repeated or intentional.

Agreement with CAHF

Before Senate Judiciary, an agreement was reached with CAHF whereby you would restrict the scope of the bill, substitute punitive damages for the fine provision of the bill, and require a patient, with respect to punitive damages, to prove that the violation was repeated or intentional. Thus, you amended the bill:

(a) to delete the bill's coverage of all the health requirement contained in H&S 1599, other than the patient bill of right portion;

(b) to delete in its entirety the provision that a fine of up to $2,500 could be awarded (without any showing of intent or repeated conduct);

(c) in lieu of the fine, substituted punitive damages, BUT ONLY IF the patient could show that the violations were repeated or intentional.

In return, CAHF agreed not to oppose the bill.

In mid May, CAHF decided to oppose the bill, but never informed us. This opposition has now been followed up with a letter of "legal" objections from Bob Gerst of Weissburg and Aronson.

Gerst Letter

The Gerst letter poses various objections to SB1930, set forth below with my response:

1. Nursing Home Patients should use Tort Theories

   The patient bill of rights are basic rights which guarantee human dignity and self-respect. Refusal of a nursing home to allow a resident to have visitors or private communications is NOT a traditional tort (such as negligence or assault and battery). While lawyers can think up tort theories to fit most anything -- in this case, it would be pushing tort theory to the far limit.

   The tort theories listed by the letter -- false imprisonment, infliction of emotional distress, assault, demonstrate the writer's creative lawyering more than they provide nursing home residents with a meaningful remedy. Moreover, to prevail on these theories, the nursing home resident would, in most instances, need to prove that the licensee had intentionally violated his rights or that he had suffered a physical injury (in addition to emotional upset and loss of dignity). Proof of an intentional tort, based upon an ill-fitting, far fetched tort theory is hardly a substitute for the private cause of action contained in SB1930.

2. The Bill Changes the Law by Providing for Attorneys' Fees

   This is correct. Without the bill, a nursing home resident would probably not be entitled to an award of attorneys' fees even if he won the suit. Since most nursing home residencts are poor, and violation of the bill of rights will rarely result in large damages, residents cannot afford, and attorneys will not take, these cases absent the provision for an award of fees.

   There is nothing unusual about statutes providing for attorneys' fees and dozens of California statutes do so. For example, the Unruh Act (covering retail installment contracts) and the Rees-Levering Act (car purchases) provide for attorneys' fees, and the rights protected by those statutes are far less important than the human dignity protected by SB1930.

3. CAHF Objects to the Standard for Punitive Damages

   Your bill originally provided for up to $2,500 as a fine regardless of whether the violations were intentional or repeated. The present punitive damage provision -- which CAHF now objects to, was put in at the urging of CAHF itself.

SB1930 does not require -- it merely allows -- an award of punitive damages in the event of repeated or intentional violations. Since the nursing home resident has the burden of proof, the "repeated" standard is an attempt to provide an objective criteria by which the plaintiff can prove intent without having to undertake the great expense of trying to prove what was in the mind of the nursing home when committing the violations.

CAHF's disingenuous opposition to its own punitive damage language is hardly credible. As any lawyer well knows, punitive damage awards are hard to come by and are only awarded in any amount when the defendant's conduct is particularly outrageous and despicable. SB1930 does not change this fact of legal life.

4. The Licensee Should Not be Liable for the Conduct of the Nursing Home's Employees

Unless the licensee is liable for the conduct of its employees, the bill will do little good. Nursing home residents are taken care of by employees, not licensees, and any violation of the patient bill of rights will be committed by the employees (be it the management or staff). By establishing licensee liability for what goes on in the homes, SB1930 provides an incentive for nursing home operators to self-regulate their own industry.

5. The Bill Will Cause a Plethora of Suits

On the one hand, CAHF argues that the bill is not needed because present law is fully adequate. On the other hand, it argues that this allegedly duplicate remedy will result in a plethora of suits.

While anyone can conjure dire scenarios, the fact of the matter is that most attorneys, as well as nursing home residents, are not motivated to pursue trivial lawsuits. Elderly residents of nursing homes are not, by nature, litigious. And, attorneys know that most courts award attorneys' fees according to a scale that provides for fees of no more than one-third the total recovery. Thus, the attorney who brings a trivial suit can anticipate little compensation.

SB1930 is sound legislation, providing a remedy for the elderly to redress violations of fundamental human rights. CAHF's initial objections were addressed through your amendments, and CAHF must be held to its agreement not to oppose the bill.

Very truly yours,

ERIC P. GOLD

JJ

WESTERN CENTER ON LAW AND POVERTY, INC.
Northern California Office
1900 "K" Street, Suite 200, Sacramento, California 95814
Telephone (916) 442-0753

June 21, 1982

Ruben Lopez, Consultant
Assembly Judiciary Committee
Room 6031, State Capitol
Sacramento, CA 95814

Re: SB1930

Dear Mr. Lopez:

In 1979, the Legislature enacted the nursing home patient's Bill of Rights (Stats. 1979, c. 893, p. 3087), which, in the words of the Legislature, was "...to expressly set forth fundamental human rights which all patients shall be entitled to..." (Health & Safety Code, section 1599).

These rights of human dignity and self respect are set forth in 22 Cal. Adm. Code section 72527. Included are the following:

1. The right to visit, at reasonable times, with relatives and friends;
2. The right to be visited at any time if critically ill;
3. The right to have private communications and telephone calls;
4. The right to be visited by clergy and engage in worship;
5. The right to know of, and refuse medical treatment and not be subjected to unauthorized medical experiments.

   (All, unless medically contraindicated)

Notwithstanding the clear legislative intent to ensure that nursing homes respect the fundamental human rights of their residents, the legislation failed to provide for any enforcement mechanism. In introducing SB1930, it is the author's intent to remedy this ommission. SB1930 does three things:

1. It provides a method to enforce the nursing home Patient's Bill of Rights by establishing a clear, private right of action. Under present law, a nursing home resident cannot sue to enforce his rights since courts allow suits based upon regulations only when individual law suits are authorized by the legislature. Under present law, the Department of Health cannot enforce violations of the Patients Bill of Rights since they are not directly related to health or safety within the homes. See H&S Code Sec. 1423. Even if such enforcement were permitted, the Department does not have the resources or expertise to

enforce such non-health related rights.

2. Since most elderly residents of nursing homes cannot afford an attorney to protect these important rights, the bill provides for an award of attorneys' fees -- but only if the resident proves that the nursing home in fact violated his rights .

3. Since damages caused by violation of a resident's rights to self-respect and human dignity are very difficult to prove, and to encourage nursing homes to obey the Bill of Rights, SB1930 allows for an award of punitive damages. Such an award, however, may be made only if the resident proves that the nursing home repeatedly or intentionally violated the Patient's Bill of Rights.

It is a legal adage that every wrong must have a remedy. It is the author's intent to provide for such a remedy when the fundamental rights set forth in the Patient's Bill of Rights are violated.

Sincerely,

ERIC P. GOLD

jj

WESTERN CENTER ON LAW AND POVERTY, INC.
Northern California Office
1900 "K" Street, Suite 200, Sacramento, California 95814
Telephone (916) 442-0753

June 21, 1982

Ruben Lopez, Consultant
Assembly Judiciary Committee
Room 6031, State Capitol
Sacramento, CA 95814

Re: SB1930

Dear Mr. Lopez:

In 1979, the Legislature enacted the nursing home patient's Bill of Rights (Stats. 1979, c. 893, p. 3087), which, in the words of the Legislature, was "...to expressly set forth fundamental human rights which all patients shall be entitled to..." (Health & Safety Code, section 1599).

These rights of human dignity and self respect are set forth in 22 Cal. Adm. Code section 72527. Included are the following:

1. The right to visit, at reasonable times, with relatives and friends;
2. The right to be visited at any time if critically ill;
3. The right to have private communications and telephone calls;
4. The right to be visited by clergy and engage in worship;
5. The right to know of, and refuse medical treatment and not be subjected to unauthorized medical experiments.

   (All, unless medically contraindicated)

Notwithstanding the clear legislative intent to ensure that nursing homes respect the fundamental human rights of their residents, the legislation failed to provide for any enforcement mechanism. In introducing SB1930, it is the author's intent to remedy this ommission. SB1930 does three things:

1. It provides a method to enforce the nursing home Patient's Bill of Rights by establishing a clear, private right of action. Under present law, a nursing home resident cannot sue to enforce his rights since courts allow suits based upon regulations only when individual law suits are authorized by the legislature. Under present law, the Department of Health cannot enforce violations of the Patients Bill of Rights since they are not directly related to health or safety within the homes. See H&S Code Sec. 1423. Even if such enforcement were permitted, the Department does not have the resources or expertise to

enforce such non-health related rights.

2. Since most elderly residents of nursing homes cannot afford an attorney to protect these important rights, the bill provides for an award of attorneys' fees -- but only if the resident proves that the nursing home in fact violated his rights.

3. Since damages caused by violation of a resident's rights to self-respect and human dignity are very difficult to prove, and to encourage nursing homes to obey the Bill of Rights, SB1930 allows for an award of punitive damages. Such an award, however, may be made only if the resident proves that the nursing home repeatedly or intentionally violated the Patient's Bill of Rights.

It is a legal adage that every wrong must have a remedy. It is the author's intent to provide for such a remedy when the fundamental rights set forth in the Patient's Bill of Rights are violated.

Sincerely,

ERIC P. GOLD

jj

July 7, 1982

Mr. Bruce Yarwood, Executive Vice-
President
California Association of Health
Facilities
1401 21st Street, Suite 202
Sacramento, California 95814

Dear Bruce:

Since there has been some confusion regarding the California Association of Health Facilities support of Senate Bill 1930, I thought it would be prudent to put our verbal agreements into writing.

It is my understanding that in the May 12th version of the bill, page 2 lines 26 ff, we have agreed to amend it to read:

> "liable for up to $500.00 or three times the damages, whichever is greater, and for costs and attorney fees, and may be enjoined from permitting the violation to continue."

These amendments would delete the punitive damages language and reduce the fine from $2500 to $500, as per our discussions.

I am assuming CAHP will support SB 1930 once these changes are implemented. If you have any problems please notify me before July 14th as I will be sending the request to Legislative Counsel on that date.

Thank you.

Sincerely,

FELICE TANENBAUM

FT:ig
Enclosure
cc: Tom Truax, CAHF

July 7, 1982

Mr. Bruce Yarwood, Executive Vice-
President
California Association of Health
Facilities
1401 21st Street, Suite 202
Sacramento, California 95814

Dear Bruce:

Since there has been some confusion regarding the California Association of Health Facilities support of Senate Bill 1930, I thought it would be prudent to put our verbal agreements into writing.

It is my understanding that in the May 12th version of the bill, page 2 lines 26 ff, we have agreed to amend it to read:

> "liable for up to $500.00 or three times the damages, whichever is greater, and for costs and attorney fees, and may be enjoined from permitting the violation to continue."

These amendments would delete the punitive damages language and reduce the fine from $2500 to $500, as per our discussions.

I am assuming CAHP will support SB 1930 once these changes are implemented. If you have any problems please notify me before July 14th as I will be sending the request to Legislative Counsel on that date.

Thank you.

Sincerely,

FELICE TANENBAUM

FT:ig
Enclosure
cc: Tom Truax, CAHF

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF AGING
1020 19th STREET
SACRAMENTO, CALIFORNIA 95814

(916) 322-5290
(TDD 445-1788)

August 2, 1982

Honorable Nicholas C. Petris
Member of the Senate
State Capitol, Room 5080
Sacramento, CA 95814

Dear Senator Petris:

The Department of Aging is in support of your bill SB 1930 which creates private right of action for violation of nursing home residents' personal rights.

Enforcement of long-term care residents' personal rights has been difficult. Existing law does not spell out specific rights of action and damages when the rights of nursing home residents have been violated. This bill addresses the problem for this very vulnerable population by creating a specific private right of action. We have long felt the need for a statutory base, such as SB 1930, for the enforcement of patients' rights.

Thank you for your continued support for senior services and the rights of seniors.

Most sincerely,

Janet J. Levy

JANET J. LEVY
Director

AUG 9 RECD

AMERICAN
ASSOCIATION
OF RETIRED
PERSONS

AARP STATE LEGISLATIVE COMMITTEE

August 2, 1982

Senator Nicholas C. Petris
California Legislature
State Capitol
Sacramento, Ca. 95814

RE: SB 1930 Nursing Home Violations

Honorable Sir:

We concur with you in recommending this legislation. In your appearances in seeking favorable consideration of SB 1930, please inform your colleagues that in concurrence with you regarding it.

Sincerely,

Frank Freeland

Frank Freeland, Chairman
429 Dunster Dr. #2
Campbell, Ca. 95008

408 379-0782

California
Rural Legal
Assistance
Foundation

MAIN OFFICE
1900 K Street, Suite 200
Sacramento, CA 95814
(916) 446-7904

August 4, 1982

TO: Assembly Judiciary Committee Members

RE: SB 1930 (Petris) - Support

We urge you to vote for SB 1930, which will help residents of nursing homes defend their rights. SB 1930 allows residents to bring civil actions if their basic human rights under the Health & Safety Code are violated. These rights include the opportunity to receive and visit with persons of their choice, being fully informed of possible financial charges, the opportunity to participate in the planning of medical treatment, transfers or discharges only for medical reasons, managing personal financial affairs or, at least, timely accounting, freedom from mental and physical abuse, confidential treatment of personal and medical records.

Without passage of SB 1930, there is generally no practical way for a resident to enforce his/her rights under the Health & Safety section. SB 1930 would allow private attorneys to fill this gap when residents' rights are violated.

We urge an "Aye" vote.

Sincerely,

Emma S. Gunterman

EMMA E. GUNTERMAN
Advocate

EEG/rh

August 4, 1982

CONFIDENTIAL

to

NICHOLAS C. PETRIS

RE: 1930

We have worked and worked with the California Association of Health Facilities to get their support. We have it now. IF THEY SAY ANYTHING IN OPPOSITION, WE WILL GO BACK TO THE MAY 12th VERSION WITH "PUNITIVE DAMAGES" ETC.

We have changed the liability several times to meet CAHF objections.

1) Originally had $2500 Fine or treble damages (Pg 2, line 17, March 17 version) - they didn't like that.

2) So, changed it to "punitive damages" - their suggestion - then they decided they didn't like that. (May 12 version)

3) Went back to the Fine, but down to $500 or treble damages - based on a meeting with them. Never in print.

4) Only to find out they didn't want to treble the damages. SO! This is it!

We have: Damages, $500 Fine only, and attorney fees.

NO MORE CHANGES!

SB 1930

SUPPORT

Clavreul-Caviness Management Consultants	Los Angeles
✓Calif. Commission on Aging	Concord
Legal Aid Society	Alameda
✓Calif. Rural Legal Assist. Foundation	Sacramento
Family Services Agency	S.F.
West CCC Gray Panthers	El Cerrito
Legal Services Section	S.F.
AARP State Leg. Committee	Washington

* Calif. Asso. of Health Facilities
* Gray Panthers
Dept. of Aging

September 14, 1982

The Honorable Edmund G. Brown Jr.
Governor of California
State Capitol
Sacramento, California 95814

Dear Governor Brown:

Senate Bill 1930 is presently on your desk. I urge your signature on this measure.

SB 1930 is a bill to protect and insure the private rights of persons living in nursing homes. It is so tragic when basic rights such as privacy in medical treatment, freedom from mental and physical abuse, accessibility to visitors, or ability to make confidential phone calls are violated and there is no where to turn for help. Presently, the government has the responsibility of enforcing an individual's civil rights. This bill would allow a resident or patient of nursing facility to personally bring suit against the facility. Since the State has made major cuts in services to people, it is more important than ever to allow the institutionalized individual the ability to protect their own constitutional rights in the private sector. My bill would provide that greatly needed avenue of relief.

There was no opposition to this bill as I worked closely with all groups concerned to reach a compromise on the contraversial sections. Please support this vital bill.

Sincerely,

NICHOLAS C. PETRIS

NCP:shf

This page was left intentionally blank.

July 14, 1982

TO: Legislative Counsel

FROM: Felice Tanenbaum

RE: Amendments to SB 1930

Strike:

Page 2 lines 28 through line 31 up to "."

Insert:

Page 2 lines 26 after "liable for" insert: "up to $500.00 or three times the damages, whichever is greater, and for costs and attorney fees, and may be enjoined from permitting the violation to continue."

PLEASE REFER TO:
SACRAMENTO ADDRESS
STATE CAPITOL, ROOM
SACRAMENTO
95814
445-6577

LEGISLATIVE ADDRESS
1111 JACKSON STREET
SUITE 7016
OAKLAND, CALIFORNIA
94607
464-1333

NICHOLAS C. PETRIS
NINTH SENATORIAL DISTRICT
ALAMEDA COUNTY

COMMITTEES
RULES
FINANCE
JUDICIARY
JOINT LEGISLATIVE BUDGET
JOINT RULES
SELECT COMMITTEE ON HOUSING AND URBAN AFFAIRS
SELECT COMMITTEE ON MARITIME INDUSTRY

CALIFORNIA LEGISLATURE

Senate

February 9, 1982

TO: LEGISLATIVE COUNSEL

FROM: Felice Tanenbaum

SUBJECT: Bill Request

EXISTING LAW PROVIDES:

That patients in Intermediate Care Facilities and Skilled Nursing Facilities are guaranteed certain expressed fundamental human rights and that willful or repeated violations of those rights may subject a facility or its personnel to civil and criminal proceedings (Health and Safety Code Section 1599 - 1599.4.22, California Administrative Code Section 72523). It further provides that patients may submit grievances and complaints free from reprisal (Health and Safety Code Section 1599.2). However, existing law does not provide adequate mechanisms to ensure these fundamental rights are not abused. Currently, violations are "C" citations and, therefore, not subject to fine or to the civil remedies available to private citizens and the Attorney General as set out in Section 1430 of the Health and Safety Code.

In order to create a remedy for abuse of these rights so that in a time of decreasing regulation and cutbacks, private citizens will be able to enforce their own rights,

THIS BILL WOULD:

Amend H&S Code 1430 to create a private right of action, making a licensee of a Skilled Nursing Facility or Intermediate Care Facility liable to a resident for any intentional or negligent act or omission of their agents or employees which abridges, violates or infringes the resident's rights as set forth in the "Patient Bill of Rights" (Health & Safety Code 1599-1599.4.22, Cal Admin. Code Section 72523). The licensee

LA Council 2-9-82

668

shall be liable for up to $2,500 or three times the actual damages, whichever is greater, and costs and attorney's fees to a resident whose rights, as specified in Section 72523, are violated. A resident may maintain an action under this Act for any other type of relief, including injunctive and declaratory relief, permitted by law. Exhaustion of administrative remedies shall not be required prior to commencement of suit hereunder. Furthermore any waiver by a resident or her legal representative of the right to maintain such an action shall be null and void.

Requested by: February 17, 1982

PLEASE REFER TO:
☐ SACRAMENTO ADDRESS
STATE CAPITOL, ROOM 5080
SACRAMENTO
95814
(916) 445-6577

☐ LEGISLATIVE ADDRESS:
1111 JACKSON STREET
SUITE 7016
OAKLAND, CALIFORNIA
94607-4978
(415) 464-1333

NICHOLAS C. PETRIS
NINTH SENATORIAL DISTRICT
ALAMEDA AND CONTRA COSTA COUNTIES

COMMITTEES
RULES
FINANCE
JUDICIARY
JOINT LEGISLATIVE BUDGET
JOINT RULES
SELECT COMMITTEE ON HOUSING AND URBAN AFFAIRS
SELECT COMMITTEE ON MARITIME INDUSTRY

CALIFORNIA LEGISLATURE

Senate

July 7, 1982

Mr. Bruce Yarwood, Executive Vice-
President
California Association of Health
Facilities
1401 21st Street, Suite 202
Sacramento, California 95814

Dear Bruce:

Since there has been some confusion regarding the California Association of Health Facilities support of Senate Bill 1930, I thought it would be prudent to put our verbal agreements into writing.

It is my understanding that in the May 12th version of the bill, page 2 lines 26 ff, we have agreed to amend it to read:

> "liable for up to $500.00 or three times the damages, whichever is greater, and for costs and attorney fees, and may be enjoined from permitting the violation to continue."

These amendments would delete the punitive damages language and reduce the fine from $2500 to $500, as per our discussions.

I am assuming CAHP will support SB 1930 once these changes are implemented. If you have any problems please notify me before July 14th as I will be sending the request to Legislative Counsel on that date.

Thank you.

Sincerely,

Felice

FELICE TANENBAUM
Administrative Assistant

FT:ig
Enclosure
cc: Tom Truax, CAHF

This page was left intentionally blank.

FROM THE OFFICE OF
Senator Nicholas C. Petris
State Capitol, Room 5080
Sacramento, California

Press Release #28
March 16, 1982

Contact: Felice Tanenbaum
(916) 445-6577

NURSING HOME VIOLATIONS CURBED

Today, Senator Nicholas C. Petris (D-Oakland) introduced Senate Bill 1930 a bill to protect and insure the private rights of people residing in nursing homes.

Petris remarked, "It is so tragic when basic rights such as privacy in medical treatment, freedom from mental and physical abuse, accessibility to visitors, or ability to make confidential phone calls are violated and there is no where to turn for help." Presently, government has the responsibility of enforcing an individual's civil rights. This bill would allow a resident or patient of a nursing facility to personally bring suit against the facility. Petris continues, "since the State is making major cuts in services to people, it is more important than ever to allow the institutionalized individual the ability to protect their own constitutional rights in the private sector. My bill would provide that greatly needed avenue of relief."

This page was left intentionally blank.

OPENING STATEMENT

SENATE BILL 1930

SB 1930 is a bill to protect and insure the private rights of persons living in nursing homes. It is so tragic when basic rights such as privacy in medical treatment, freedom from mental and physical abuse, accessibility to visitors, or ability to make confidential phone calls are violated and there is no where to turn for help. Presently, the government has the responsibility of enforcing an individual's civil rights. This bill would allow a resident or patient of a nursing facility to personally bring suit against the facility. Since the State has made major cuts in services to people, it is more important than ever to allow the institutionalized individual the ability to protect their own constitutional rights in the private sector. My bill would provide that greatly needed avenue of relief.

There is no known opposition to the bill.

(D) The functions of the pharmaceutical service committee shall include, but not be limited to:

1. Establishing, reviewing, monitoring and approving policies and procedures for safe procurement, storage, distribution and use of drugs and biologicals.

2. Reviewing and taking appropriate action on the pharmacist's quarterly report.

3. Recommending measures for improvement of services and the selection of pharmaceutical reference materials.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code.
Reference: Section 1276, Health and Safety Code.

DO NOT WRITE IN THIS SPACE

72527. Patients' Rights.

(a) Written policies regarding the rights of patients shall be established and shall be available to the patient, to any guardian, next of kin, sponsoring agency or representative payee and to the public. Such policies and procedures shall ensure that each patient admitted to the facility shall have the following rights and be notified of the facility's obligations:

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

R-19-77

DO NOT WRITE IN THIS SPACE

(1) To be fully informed, as evidenced by the patient's written acknowledgement prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(2) To be fully informed, prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or not covered under Titles XVIII or XIX of the Social Security Act.

(3) To be fully informed by a physician of his or her medical condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of medical treatment and to refuse to participate in experimental research.

(4) To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.

(5) To be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment for his or her stay and to be given reasonable advance notice to ensure orderly transfer or discharge. Such actions shall be documented in the patient's health record.

(6) To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice

grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

(7) To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept written delegation of this responsibility subject to the provisions of Section 72529.

(8) To be free from mental and physical abuse and to be free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician or other person lawfully authorized to prescribe care for a specified and limited period of time, or when necessary to protect the patient from injury to himself or to others.

(9) To be assured confidential treatment of personal and medical records and to approve or refuse their release to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third party party payment contract.

(10) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.

(11) Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.

DO NOT WRITE IN THIS SPACE

(12) To associate and communicate privately with persons of the patient's choice, and to send and receive personal mail unopened, unless medically contraindicated.

(13) To meet with others and participate in activities of social, religious and community groups, unless medically contraindicated.

(14) To retain and use personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients and unless medically contraindicated.

(15) If married, to be assured privacy for visits by the patient's spouse and if both are patients in the facility, to be permitted to share a room, unless medically contraindicated.

(16) To have daily visiting hours established.

(17) To have visits from members of the clergy at any time at the request of the patient or the patient's guardian.

(18) To allow relatives, or persons responsible, to visit critically ill patients at any time, unless medically contraindicated.

(19) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

DO NOT WRITE IN THIS SPACE

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

R-19-77

(20) To have reasonable access to telephones and to make and receive confidential calls.

(b) A patient's rights, as set forth above, may be denied or limited only for good cause which shall be evidenced by the written order of the attending physician, and may only be denied or limited if such denial or limitation is otherwise authorized by law. Reasons for denial or limitation of such rights shall be documented by the attending physician in the patient's health record.

(c) All rights specified in Section 72527 (a) (1) through (4) as they pertain to a patient adjudicated incompetent in accordance with state law, to a patient who is found by his physician to be medically incapable of understanding these rights, or to a patient who exhibits a communication barrier, shall devolve to such patient's guardian, next of kin, sponsoring agency or representative payee (except when the facility itself is representative payee).

DO NOT WRITE IN THIS SPACE

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1599, 1599.1, 1599.2 and 1599.3, Health and Safety Code.

72529. Safeguards for Patients' Monies and Valuables.

(a) Each facility to whom a patient's money or valuables have been entrusted shall comply with the following:

This bill is about the fundamental rights and dignity of old and disabled persons living in nursing homes. The typical resident of a California nursing home is an eighty year old woman with disabilities that make her dependent on the nursing facility for bathing, toileting, and assistance with eating. As you can imagine, a person who has worked hard all her life to remain independent and free finds it difficult to be so dependent on others, especially strangers. In fact she must rely on State and on nursing home management to protect her.

In existing law there is no meaningful enforcement of her private rights. These rights include:

--the right to voice grievances
--to associate privately with persons of her choice
--to participate in the planning of her care
--to participate in religious groups, and
--to be treated "in full" recognition of her dignity, individuality, and privacy"

In the context of reduced state and federal resources for the regulation of nursing homes, and because nursing homes and interests are sometimes in conflict with the interests of their patients, we offer SB 1930, which will allow patients to enforce their own dignity and civil rights in the courts.

WITNESSES FOR SENATE BILL 1930

1) David Schulke, Director
United Neighbors in Action

2) Eric Gold, Attorney
Legal Aid Society Alameda County

3) Bernice Easley
Friend of Nursing Home patient who died

SUPPORT

California Rural Legal Assistance Foundation
West Contra Costa County Grey Panthers
Russell S. Balisok, Attorney
Los Angeles
Grey Panthers of Berkeley
Legal Services Section State Bar of California
Legal Aid Society of Alameda County
Western Center on Law and Poverty
California Grey Panthers Legislative Committee
CA Ombudsman Program

OPPOSED

California Association of Health Facilities

Added Stats 1978 ch 1312 § 1.
Rape prevention programs for state employees: Gov C §§ 18320 et seq.

§ 1598.1. Provision for grants for centers by department: Eligibility

The State Department of Social Services shall provide grants to proposed and existing local rape victim counseling centers. Such centers shall maintain a 24-hour telephone counseling service during normal business hours, and maintain other standards or services which shall be determined to be appropriate by the advisory committee established pursuant to Section 13836 of the Penal Code as grant conditions. The advisory committee shall identify the criteria to be utilized in awarding the grants provided by this chapter before any funds are allocated.

In order to be eligible for funding pursuant to this chapter, the centers shall demonstrate an ability to receive and make use of any funds available from governmental, voluntary, philanthropic, or other sources which may be used to augment any state funds appropriated for purposes of this chapter. Each center receiving funds pursuant to this chapter shall make every attempt to qualify for any available federal funding.

State funds provided to establish centers shall be utilized when possible, as determined by the advisory committee, to expand the program and shall not be expended to reduce fiscal support from other public or private sources. The centers shall maintain quarterly and final fiscal reports in a form to be prescribed by the advisory committee. In granting funds, the advisory committee shall give priority to centers which are operated in close proximity to medical treatment facilities.

Added Stats 1978 ch 1312 § 1; Amended Stats 1980 ch 917 § 3.

Amendments:
1980 Amendment: (1) Substituted "advisory committee established pursuant to Section 13836 of the Penal Code" for "administering agency" in the first paragraph; (2) substituted "advisory committee" for "administering agency" in the third sentence of the first paragraph and wherever it appears in the third paragraph; and (3) deleted the former fourth sentence which read: "No grant shall be made pursuant to this chapter which shall exceed up to one-half of the cost of operating a local rape victim counseling service during the first two years and up to one-third of the cost of operating a local rape victim counseling service thereafter."

Review of Selected 1980 Legislation. 12 Pacific LJ 341.

§ 1598.3. Report to Legislature

The State Department of Social Services shall report to the Legislature, on or before January 1, 1980, with respect to the names of the organizations receiving funds pursuant to this chapter and the purposes for which the funds have been utilized.

Added Stats 1978 ch 1312 § 1.

§ 1598.5. Appropriations

The sum of one hundred thousand dollars ($100,000) is hereby appropriated from the General Fund to the State Department of Social Services for expenditure during the 1978–79 fiscal year. Only 5 percent of such funds shall be used for the state administration of the grant program. After the 1978–79 fiscal year, the grant program provided pursuant to Section 1598.1 shall be funded through the regular budgetary process. The funds shall be administered through the Violent Crime Victim Assistance Commission, if created.

Added Stats 1978 ch 1312 § 1.

CHAPTER 3.9

Skilled Nursing and Intermediate Care Facility Patient's Bill of Rights

[Added by Stats 1979 ch 893 § 1.]

this is what your bill enforces

§ 1599. Legislative intent

It is the intent of the Legislature in enacting this chapter to expressly set forth fundamental human rights which all patients shall be entitled to in a skilled nursing or intermediate care facility, as defined in Section 1250, and to ensure that patients in such facilities are advised of their fundamental rights and the obligations of the facility.

Added Stats 1979 ch 893 § 1.
Review of Selected 1979 California Legislation. 11 Pacific LJ 537.

§ 1599.1. Establishment of written policies: Notice to patients of facility obligations

Written policies regarding the rights of patients shall be established and shall be made available to the patient, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. Such policies and procedures shall ensure that each patient admitted to the facility shall have the following rights and be notified of the following facility obligations, in addition to those specified by regulation:

[1 H&S Code]

(a) The facility shall employ an adeq
of the facility.

(b) Each patient shall show evidence
measures shall be used to prevent and

(c) The facility shall provide food of
with physicians' orders.

(d) The facility shall provide an acti
each patient and to encourage self-c
to participate in activities suited to t

(e) The facility shall be clean, sanita

(f) A nurses' call system shall be i
and audible signal communication
patient's bed shall be readily access

Added Stats 1979 ch 893 § 1.
Review of Selected 1979 California Legi

§ 1599.2. Preamble or preliminary

Written information informing pat
in substantial form as follows:

(a) Further facility requirements
California Administrative Code.

(b) Willful or repeated violation
criminal proceedings.

(c) Patients have the right to vo
complaints to the State Departme

Added Stats 1979 ch 893 § 1.
Review of Selected 1979 California Le

§ 1599.3. Rights under chapter w

Any rights under this chapter o
his physician to be medically in
cation barrier, shall devolve to
representative payer, except whe

Added Stats 1979 ch 893 § 1.
Review of Selected 1979 California

§ 1599.4. Additional obligations

In no event shall this chapter
obligations or standards on skil
regard to the notification and e

Added Stats 1979 ch 893 § 1.

§ 1600. Context as affecting m
36 Cal Jur 3d Healing Arts and Ins

§ 1600.1. "Biologics"
Review of Selected 1974 California

§ 1600.6. "Department"
"Department" means the Stat
Amended Stats 1977 ch 1252 § 25

Amendments:
1977 Amendment: Added "Servic

§ 1600.7. "Carrier donor"
Review of Selected 1974 Californ

§ 1600.8. "Possible carrier d
Review of Selected 1974 Californ

§ 1600.9. "Carrier of viral h
Review of Selected 1974 Californ

§ 1603.1. Laboratory tests
hepatitis: Finding presence
36 Cal Jur 3d Healing Arts and
Review of Selected 1974 Califor

[1 H&S Code]

(a) The facility shall employ an adequate number of qualified personnel to carry out all of the functions of the facility.

(b) Each patient shall show evidence of good personal hygiene, be given care to prevent bedsores, and measures shall be used to prevent and reduce incontinence for each patient.

(c) The facility shall provide food of the quality and quantity to meet the patients' needs in accordance with physicians' orders.

(d) The facility shall provide an activity program staffed and equipped to meet the needs and interests of each patient and to encourage self-care and resumption of normal activities. Patients shall be encouraged to participate in activities suited to their individual needs.

(e) The facility shall be clean, sanitary, and in good repair at all times.

(f) A nurses' call system shall be maintained in operating order in all nursing units and provide visible and audible signal communication between nursing personnel and patients. Extension cords to each patient's bed shall be readily accessible to patients at all times.

Added Stats 1979 ch 893 § 1.

Review of Selected 1979 California Legislation. 11 Pacific LJ 537.

§ 1599.2. Preamble or preliminary statement: Contents

Written information informing patients of their rights shall include a preamble or preliminary statement in substantial form as follows:

(a) Further facility requirements are set forth in the Health and Safety Code, and in Title 22 of the California Administrative Code.

(b) Willful or repeated violations of either code may subject a facility and its personnel to civil or criminal proceedings.

(c) Patients have the right to voice grievances to facility personnel free from reprisal and can submit complaints to the State Department of Health Services or its representative.

Added Stats 1979 ch 893 § 1.

Review of Selected 1979 California Legislation. 11 Pacific LJ 537.

§ 1599.3. Rights under chapter where patient judicially determined to be incompetent

Any rights under this chapter of a patient judicially determined to be incompetent, or who is found by his physician to be medically incapable of understanding such information, or who exhibits a communication barrier, shall devolve to such patient's guardian, conservator, next of kin, sponsoring agency, or representative payer, except when the facility itself is the representative payer.

Added Stats 1979 ch 893 § 1.

Review of Selected 1979 California Legislation. 11 Pacific LJ 537.

§ 1599.4. Additional obligations on skilled nursing or intermediate care facilities

In no event shall this chapter be construed or applied in a manner which imposes new or additional obligations or standards on skilled nursing or intermediate care facilities or their personnel, other than in regard to the notification and explanation of patient's rights or unreasonable costs.

Added Stats 1979 ch 893 § 1.

§ 1600. Context as affecting meaning

36 Cal Jur 3d Healing Arts and Institutions § 142.

§ 1600.1. "Biologics"

Review of Selected 1974 California Legislation. 6 Pacific LJ 161.

§ 1600.6. "Department"

"Department" means the State Department of Health Services.

Amended Stats 1977 ch 1252 § 258, operative July 1, 1978.

Amendments:

1977 Amendment: Added "Services" at the end of the section.

§ 1600.7. "Carrier donor"

Review of Selected 1974 California Legislation. 6 Pacific LJ 243.

§ 1600.8. "Possible carrier donor"

Review of Selected 1974 California Legislation. 6 Pacific LJ 243.

§ 1600.9. "Carrier of viral hepatitis"

Review of Selected 1974 California Legislation. 6 Pacific LJ 243.

§ 1603.1. Laboratory tests of all human whole blood received by blood banks to detect presence of viral hepatitis: Finding presence of viral hepatitis or antigen thereof: Report of findings: Procedures

36 Cal Jur 3d Healing Arts and Institutions § 60.

Review of Selected 1974 California Legislation. 6 Pacific LJ 243.

The inspection provisions of Health & Saf. Code, § 1421, which limit entry to officers, employees and agents of the state department to enforce provisions of ch. 2.4, and expressly designate long-term health care facilities as the premises to be inspected, is not overly broad in authorizing entry "at any time." Since long-term health care facilities provide 24-hour skilled nursing services and have no business hours per se, a provision for inspection at any time is not only reasonable, but essential to successful enforcement of the regulatory provisions. People v Firstenberg (1979) 92 CA3d 570, 155 Cal Rptr 80.

§ 1422. Licensure inspections by department

The state department shall, in addition to any inspections conducted pursuant to complaints filed pursuant to Section 1419, conduct at least one licensure inspection and as many additional inspections as may be necessary to rectify problems identified in prior inspections, in every calendar year of all long-term health care facilities in the state without providing notice of such inspections.

Amended Stats 1979 ch 829 § 1.

Amendments:

1979 Amendment: (1) Substituted "one licensure inspection" for "two general inspections"; and (2) added "to rectify problems identified in prior inspections".

Licensing and certification of health facilities and referral agencies: 22 Cal Adm Code §§ 70001 et seq.

36 Cal Jur 3d Healing Arts and Institutions § 26.

§ 1423. Citation for violations

(a) If upon inspection or investigation the director determines that a long-term health care facility is in violation of any statutory provision or rule or regulation relating to the operation or maintenance of such facility, except with respect to violations determined to have only a minimal relationship to safety or health pursuant to Section 1427, the director shall promptly, but not later than 24 hours, excluding Saturday, Sunday, and holidays, after the director determines or has reasonable cause to determine that an alleged violation has occurred, issue a notice to correct the violation and of intent to issue a citation to the licensee. The citation shall be served upon the licensee within three days after completion of the inspection, excluding Saturday, Sunday, and holidays, unless the licensee agrees in writing to an extension of such time. Service shall be effected either personally or by registered mail in accordance with subdivision (c) of Section 11505 of the Government Code. A copy of the citation shall also be sent to each complainant. Each citation shall be in writing and shall describe with particularity the nature of the violation, including a reference to the statutory provision, standard, rule or regulation alleged to have been violated, the particular place or area of the facility in which it occurred, as well as the amount of any proposed assessment of a civil penalty. The name of any patient jeopardized by the alleged violation shall not be specified in the citation in order to protect the privacy of the patient. However, at the time the licensee is served with the citation, the licensee shall also be served with a written list of each of the names of the patients alleged to have been jeopardized by the violation, which shall not be subject to disclosure as a public record. The citation shall fix the earliest feasible time for the elimination of the condition constituting the alleged violation, when appropriate.

(b) Where no harm to patients or guests has occurred, a single incident, event, or occurrence shall result in no more than one citation for each regulation violated.

Amended Stats 1976 ch 785 § 1; Stats 1980 ch 1082 § 1.

Amendments:

1976 Amendment: Substituted "three days, excluding Saturday, Sunday, and holidays," for "one day" in the first sentence.

1980 Amendment: (1) Designated the former section to be subd (a); (2) amended subd (a) by (a) substituting "the director" for "he" after "Section 1427,"; (b) substituting "24 hours" for "three days" after "not later than"; (c) substituting "director determines or has reasonable cause to determine that an alleged violation has occured, issue a notice to correct the violation and of intent to" for "date of inspections," in the first sentence; (d) substituting the second sentence for the former second sentence which read: "The citation shall be served upon the licensee personally or by registered mail in accordance with subdivision (c) of Section 11505 of the Government Code."; (e) adding the third sentence; (f) adding all that part following "have been violated" at the end of the fifth sentence; (g) adding the sixth and seventh sentences; and (h) substituting "alleged violation, when" for "violation, where" in the last sentence; and (3) added subd (b).

Licensing and certification of health facilities and referral agencies: 22 Cal Adm Code §§ 70001 et seq.

36 Cal Jur 3d Healing Arts and Institutions § 26.

§ 1424. Classification of citations

Citations issued pursuant to this chapter shall be classified according to the nature of the violation and shall indicate the classification on the face thereof, as follows:

(a) Class "A" violations are violations which the state department determines present either (1) imminent danger that death or serious harm to the patients or guests of the long-term health care facility would result therefrom, or (2) substantial probability that death or serious physical harm to patients or guests of the long-term health care facility would result therefrom. A physical condition or one or more practices, means, methods, or operations in use in a long-term health care facility may constitute such a violation. The condition or practice constituting a class "A" violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the state department, is required for correction. A class "A" violation is subject to a civil penalty in an amount not less than one thousand dollars ($1,000) and not exceeding five thousand dollars ($5,000) for each and every violation.

Bill of Rts. is not enforced because of this

(b) Class "B" violations ar
relationship to the health,
"A" violations. A class "B
($50) and not exceeding tw
class "B" violation shall sp
"B" violation is corrected w

Amended Stats 1980 ch 1082 §

Amendments:

1980 Amendment: Substituted
long-term health care facility
to patients or guests of the l
long-term health care facility

Licensing and certification of he

36 Cal Jur 3d Healing Arts and

Health & Saf. Code, § 1424
class A offenses under the l
Safety and Security Act of 19
§ 1417 et seq.) as violations th
danger" to the patients or gue
care facility or a "substantial p
"serious physical harm" would
unconstitutionally vague; using
construction, the phrase "imm
immediate threat of injury to
there is no express requirement
the statutory context demands
fact that reasonable persons ma
tions of degree, which are posed
nent" and the implied requiren
render void for vagueness a st
dard. The phrases "substantial
physical harm" are not vague
since their meanings can be
reference to common experience
do not stand alone, but are furth
by regulation. Lackner v St. Jo
tal, Inc. (1980) 106 CA3d 542, 1

Health & Saf. Code, § 1424, s
Code, tit. 22, § 72702, insofar
violations" of the Health and S

§ 1425. Penalty for failure t

Where a licensee has failed
department shall assess the l
such deficiency continues bey
by the state department rega
the proposed deadline for c
determination.

Amended Stats 1980 ch 1082 §

Amendments:

1980 Amendment: Added the sec

Licensing and certification of hea

36 Cal Jur 3d Healing Arts and

§ 1426. Publication of propes

Licensing and certification of hea

36 Cal Jur 3d Healing Arts and

§ 1427. Procedure for issuanc

Licensing and certification of hea

36 Cal Jur 3d Healing Arts and

§ 1428. Contesting citation; A

(a) If a licensee desires to c
licensee shall within five busi
her request for an informal c
long-term health care facility
the receipt of the request, a
modify, or dismiss the citati
modifies or dismisses the cita
particularity in writing his or
to each party to the origina

[1 H&S Code]

(b) Class "B" violations are violations which the state department determines have a direct or immediate relationship to the health, safety, or security of long-term health care facility patients, other than class "A" violations. A class "B" violation is subject to a civil penalty in an amount not less than fifty dollars ($50) and not exceeding two hundred fifty dollars ($250) for each and every violation. A citation for a class "B" violation shall specify the time within which the violation is required to be corrected. If a class "B" violation is corrected within the time specified, no civil penalty shall be imposed.

Amended Stats 1980 ch 1082 § 2.

Amendments:

1980 Amendment: Substituted "either (1) imminent danger that death or serious harm to the patients or guests of the long-term health care facility would result therefrom, or (2) substantial probability that death or serious physical harm to patients or guests of the long-term health care facility" for "an imminent danger to the patients or guests of the long-term health care facility or a substantial probability that death or serious physical harm" in subd (a).

Licensing and certification of health facilities and referral agencies: 22 Cal Adm Code §§ 70001 et seq.

36 Cal Jur 3d Healing Arts and Institutions § 26.

Health & Saf. Code, § 1424, subd. (a), which defines class A offenses under the Long-Term Care, Health, Safety and Security Act of 1973 (Health & Saf. Code, § 1417 et seq.) as violations that present an "imminent danger" to the patients or guests of a long-term health care facility or a "substantial probability" that death or "serious physical harm" would result therefrom, is not unconstitutionally vague; using a common sense, practical construction, the phrase "imminent danger" means an immediate threat of injury to the patient, and although there is no express requirement that the danger be serious, the statutory context demands such interpretation. The fact that reasonable persons may differ in assessing questions of degree, which are posed by both the term "imminent" and the implied requirement of severity, does not render void for vagueness a statute that defines a standard. The phrases "substantial probability" and "serious physical harm" are not vague and lacking in specificity, since their meanings can be objectively ascertained by reference to common experience and since such phrases do not stand alone, but are further specified and amplified by regulation. Lackner v St. Joseph Convalescent Hospital, Inc. (1980) 106 CA3d 542, 165 Cal Rptr 198.

Health & Saf. Code, § 1424, subd. (a), and Cal. Admin. Code, tit. 22, § 72702, insofar as they define "class A violations" of the Health and Safety Code by health care facilities as those violations which present an imminent danger to patients or which create a substantial probability that death or serious physical harm would result, are not unconstitutionally vague. Beach v Western Medical Enterprises, Inc. (1981) 116 CA3d 153, 171 Cal Rptr 846.

In a proceeding to enforce civil penalties assessed against a nursing home under the Health and Safety Code, the evidence was sufficient to establish the existence of a class A violation, one presenting an imminent danger to patients or creating a substantial probability that death or serious physical harm would result, where during an inspection the hallway call lights for four patients' rooms were not functioning, and where the nurses' station, to which was connected the only alternative communication system, was not staffed at all times. There is no requirement that death or serious physical harm must actually result before a citation may be issued. Beach v Western Medical Enterprises, Inc. (1981) 116 CA3d 153, 171 Cal Rptr 846.

The Health and Safety Code, under which a health care facility licensee cited for a violation may pay a minimum fine in lieu of contesting the violation, does not unconstitutionally chill the licensee's right to contest the violation. Beach v Western Medical Enterprises, Inc. (1981) 116 CA3d 153, 171 Cal Rptr 846.

§ 1425. Penalty for failure to correct violation within time specified in citation

Where a licensee has failed to correct a violation within the time specified in the citation, the state department shall assess the licensee a civil penalty in the amount of fifty dollars ($50) for each day that such deficiency continues beyond the date specified for correction. If the licensee disputes a determination by the state department regarding alleged failure to correct a violation or regarding the reasonableness of the proposed deadline for correction, the licensee may request an informal conference and contest such determination.

Amended Stats 1980 ch 1082 § 3.

Amendments:

1980 Amendment: Added the second sentence.

Licensing and certification of health facilities and referral agencies: 22 Cal Adm Code §§ 70001 et seq.

36 Cal Jur 3d Healing Arts and Institutions § 26.

§ 1426. Publication of proposed regulations: Adoption

Licensing and certification of health facilities and referral agencies: 22 Cal Adm Code §§ 70001 et seq.

36 Cal Jur 3d Healing Arts and Institutions § 26.

§ 1427. Procedure for issuance of notice of violation

Licensing and certification of health facilities and referral agencies: 22 Cal Adm Code §§ 70001 et seq.

36 Cal Jur 3d Healing Arts and Institutions § 26.

§ 1428. Contesting citation; Assessment of penalties; Public notice of dismissals

(a) If a licensee desires to contest a citation or the proposed assessment of a civil penalty therefor, the licensee shall within five business days after service of the citation notify the director in writing of his or her request for an informal conference with the designee of the director for the county in which the cited long-term health care facility is located. The director's designee shall hold, within five business days from the receipt of the request, an informal conference, at the conclusion of which he or she may affirm, modify, or dismiss the citation or proposed assessment of a civil penalty. If the director's designee modifies or dismisses the citation or proposed assessment of a civil penalty, he or she shall state with particularity in writing his or her reasons for such action, and shall immediately transmit a copy thereof to each party to the original complaint. If the licensee desires to contest a decision made after the

United Neighbors in Action

Serving as advocates for the elderly and disabled since 1977.

NURSING HOME RESIDENTS' RIGHTS

A. Section 504 of the Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination against handicapped persons by recipients of federal funds.

Nursing homes receiving federal financial assistance may not:

1. Deny a qualified handicapped person benefits or services;
2. Afford a qualified handicapped person an opportunity to receive benefits or services that is not equal to that offered non-handicapped persons;
3. Provide a qualified handicapped person with benefits or services that are not as effective as the benefits or services provided others;
4. Provide benefits or services in a manner that has the effect of limiting the participation of qualified handicapped persons.

B. The Long Term Care, Health Safety and Security Act amended sections of Title 22 of the California Health and Safety Code and created new requirements concerning nursing home care in California. The law became effective on Jan.1, 1974. It sets minimum standards of care in nursing homes and empowers the state to impose civil penalties upon substandard facilities. Section 72523 of Title 22 specifies patients rights.

"Written policies regarding the rights of patients shall be established and shall be made available to the patient, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. Such policies and procedures shall ensure that each patient admitted to the facility shall have the following rights:

(1) To be fully informed, as evidenced by the patient's written acknowledgement prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(2) To be fully informed, prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(3) To be fully informed by a physician of his medical condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research.

(4) To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.

P.O. Box 1064
Petaluma, CA 94953
(707) 762-2133

491 65th Street
Oakland, CA. 94609
(415)654-1797

(5) To be transferred or discharged only for medical reasons, or his welfare or that of other patients or for nonpayment for his stay and to be given reasonable advance notice to ensure orderly transfer or discharge; such actions shall be documented in his health record.

(6) To be encouraged and assisted throughout his period of stay to exercise his rights as a patient, and as a citizen, and this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of his choice, free from restraint, interference, coercion, discrimination or reprisal.

(7) To manage his personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility subject to the provisions of Section 72557.

(8) To be free from mental and physical abuse and to be free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient from injury to himself or to others.

(9) To be assured confidential treatment of his personal and medical records and to approve or refuse their release to any individual outside the facility, except in the case of his transfer to another health facility, or as required by law or third party payment contact.

(10) To be treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs.

(11) Not to be required to perform services for the facility that are not included for therapeutic purposes in his plan of care.

(12) To associate and communicate privately with persons of his choice, and to send and receive his personal mail unopened, unless medically contraindicated.

(13) To meet with and participate in activities of social, religious, and community groups at his discretion, unless medically contraindicated.

(14) To retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients and unless medically contraindicated.

(15) If married, to be assured privacy for visits by his/her spouse and if both are patients in the facility, to be permitted to share a room, unless medically contraindicated.

(16) To have daily visiting hours established.

(17) To have members of the clergy admitted at the request of the patient or person responsible at any time.

(18) To allow relatives or persons responsible to visit critically ill patients at any time, unless medically contraindicated.

(1) "Not less than three meals shall be served daily.
(2) Not more than fourteen hours shall lapse between the evening meal and breakfast...
(3) ...Bedtime nourishments shall be offered.
(4) Patient food preferences shall be adhered to as much as possible...
(7) Food shall be prepared by methods that conserve nutritive value, flavor and appearance. Food shall be attractively served at appropriate temperatures and in a form to meet individual needs." (72329a) (1,2,3,4 and 7)

"Facilities shall retain a consulting pharmacist...for the purpose of coordinating, supervising and reviewing the pharmaceutical services." (72377)

Each facility shall have an activity program with a trained activity leader. The primary purpose of activity programs is to encourage the patients towards restoration of self care and resumption of normal activities or for those who cannot realistically resume normal activities, to prevent mental or physical deterioration. (72385 and 72389)

"The latest report of inspection by state or local health authorities shall be kept on file in the facility..." (72515)

"All SNFs shall have written...policies which shall include rate of charge for care, charges for extra services,...cause for termination and refund policies ...These policies shall be made available...to the public upon request." (72519a (2))

"No SNF shall deny admission to a patient on account of race, color, religion, ancestry or national origin'...Religious and other organizations may limit or give preference to their own members." (72519a (4))

"Each license shall maintain adequate safeguards and accurate records of patient's monies and valuables entrusted to his care." (72557)

"There shall be sufficient housekeeping personnel to maintain the interior of the facility in a safe, clean, orderly, and attractive manner free from offensive odors." (72673d)

There are also provisions in Title 22 which specify enforcement procedures of the above regulations.

"Any person may request an inspection of any SNF..." (72713a)

"Neither the name of the individual complainant nor other person mentioned in complaint shall be disclosed..." (72713b)

"upon request...the complainant...may...accompany the inspection." (72713c)

"If a citation is issued as a result of a written signed complaint to the Department, a copy of the citation shall be sent to each person or organization who filed a complaint." (72715e)

"A class "A" violation is one which "presents an immenent danger to the patients of an SNF or a substantial probability that death or serious physical harm would result therefrom." (72702)

"A class "A" violations is subject to a civil penalty...not less than $1,000 and not exceeding $5,000 for each and every violation." (72717a)

(19) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

(20) To have reasonable access to telephone booths and make and receive confidential calls.

In addition to these rights, other sections specify the following requirements.

"Skilled nursing facilities shall provide as a minimum, but shall not be limited to, the following required services; physician, skilled nursing, dietary, pharmaceutical and an activity program." (72301a)

"All persons admitted or accepted for care shall be under the care of a physician." (72303a)

Nursing service shall include "notification of the attending physician immediately of any patient exhibiting unusual signs or behavior." (723116)

"Licensed nursing personnel ensure that patients are served" (prescribed diets) and "that patients are provided with necessary and acceptable equipment for eating and that prompt assistance in eating is given when needed." (72311c)

"Any marked or sudden change in weight shall be reported promptly to the attending physician." (72311d)

"All medications shall be administered only by licensed medical or licensed nursing personnel." (72313c)

"Each patient shall be treated as an individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind. (72315b)

"Each patient shall show evidence of good personal hygiene..." (72315d)

"Each patient shall be encouraged and/or assisted to achieve and maintain the highest level of self-care and independence. Every effort shall be made to keep patients active and out of bed..." (72315e)

"Each patient shall be given care to prevent decubiti..." (72315f)

"measures shall be made to reduce and prevent incontinence..." (72317a)

"Restraints shall only be used...to protect the patient from himself or others and only upon a physicians written order. Restraints shall not be used as punishment or as a substitute for more effective care." (72319a)

"Nursing service personnel shall be employed in the number and qualifications...to provide the necessary services for those patients admitted for care." (72323a)

A class "B" violation is one which "has a direct or immediate relationship to the health, safety, or security of the patients...other than class "A" violations." (72705)

"A class "B" violation is subject to a civil penalty in an amount not less than $50.00 and not exceeding $250.00...If a class "B" violation is corrected within a specified time no civil penalty will be imposed." (7217b)

"No licensee shall discriminate or retaliate in any manner against a patient or employee" who has initiated an inspection through a written complaint to the health department. "A licensee who violates this provision is subject to a civil penalty of no more than $500.00." (72727a)

"any attempt to expel a patient from a SNF or any type of discriminatory treatment of a patient upon whose behalf a complaint has been submitted" within 120 days, "shall raise a rebuttal presumption that such action was taken...in retaliation..." (72727b)

This represents a summary of the regulations and enforcement policies governing nursing homes. There is a need for more specific patient rights legislation. Currently the law does not guarantee public access to these "private institutions." Neither a patient's right to present grievances to any member of the nursing home staff without fear of reprisal or the right to organize with others to protect and promote quality care are guaranteed.

Loopholes do exist in the enforcement regulations. Facilities which correct a "B" violation within a specified period of time are not fined for that violation within a specified period of time are not fined for that violation, even if that violation consistantly reoccurs. However, even with the law as it now stands, United Neighbors in Action has been successful in standing up for the rights of abused and neglected convalescent hospital residents.

If you know of a nursing home resident who needs our patient advocacy services, we can help. Contact the UNA office at 654-1797 or 939-3232 (Contra Costa County).

PATIENT'S BILL OF RIGHTS

1. Each patient shall be fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct and responsibilities;

2. Each patient shall be fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not covered under Titles XVIII or XIV of the Social Security Act, or not covered by the facility's basic per diem rate;

3. Each patient shall be fully informed, by a physician, of his or her medical condition unless medically contraindicated (as documented, by a physician, in his or her medical record), and shall be afforded the opportunity to participate in the planning of his or her medical treatment and to refuse to participate in experimental research;

4. Each patient shall be transferred or discharged only for medical reasons, or for his or her welfare or that of other patients, or for non-payment for his or her stay except as prohibited by titles XVIII or XIX of the Social Security Act), and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in his medical record;

5. Each patient shall be encouraged and assisted throughout his period of stay, to exercise his rights as a patient and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. May manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient from injury to himself or to others;

8. Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care institution, or as required by law or third-party payment contract;

9. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

10. Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

11. May associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contra-indicated (as documented by his physician in his medical record);

12. May meet with, and participate in activities of, social, religious, and community groups at his discretion, unless medically contraindicated (as documented by his physician in his medical record);

13. May retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients, and unless medically contraindicated (as documented by his physician in his medical record); and

14. If married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician in the medical record).

All rights and responsibilities specified in paragraphs 1 through 4, as they pertain to (a) a patient adjudicated incompetent in accordance with State law; (b) a patient who is found, by his physician, to be medically incapable of understanding these rights; or (c) a patient who exhibits a communication barrier, devolve to such patient's guardian, next of kin, sponsoring agency(ies), or representative payee (except when the facility itself is representative payee) selected pursuant to Section 205(j) of the Social Security Act.

15. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.

16. To have daily visiting hours established.

17. To have members of the clergy admitted at the request of the patient or person responsible at any time.

18. To allow relatives or persons responsible to visit critically ill patients at any time, unless medically contraindicated.

19. To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

20. To have reasonable access to telephone, both to make and receive confidential calls.

Added Stats 1978 ch 1312 § 1.

Rape prevention programs for state employees: Gov C §§ 18320 et seq.

§ 1598.1. Provision for grants for centers by department: Eligibility

The State Department of Social Services shall provide grants to proposed and existing local rape victim counseling centers. Such centers shall maintain a 24-hour telephone counseling service during normal business hours, and maintain other standards or services which shall be determined to be appropriate by the advisory committee established pursuant to Section 13836 of the Penal Code as grant conditions. The advisory committee shall identify the criteria to be utilized in awarding the grants provided by this chapter before any funds are allocated.

In order to be eligible for funding pursuant to this chapter, the centers shall demonstrate an ability to receive and make use of any funds available from governmental, voluntary, philanthropic, or other sources which may be used to augment any state funds appropriated for purposes of this chapter. Each center receiving funds pursuant to this chapter shall make every attempt to qualify for any available federal funding.

State funds provided to establish centers shall be utilized when possible, as determined by the advisory committee, to expand the program and shall not be expended to reduce fiscal support from other public or private sources. The centers shall maintain quarterly and final fiscal reports in a form to be prescribed by the advisory committee. In granting funds, the advisory committee shall give priority to centers which are operated in close proximity to medical treatment facilities.

Added Stats 1978 ch 1312 § 1; Amended Stats 1980 ch 917 § 3.

Amendments:

1980 Amendment: (1) Substituted "advisory committee established pursuant to Section 13836 of the Penal Code" for "administering agency" in the first paragraph; (2) substituted "advisory committee" for "administering agency" in the third sentence of the first paragraph and wherever it appears in the third paragraph; and (3) deleted the former fourth sentence which read: "No grant shall be made pursuant to this chapter which shall exceed up to one-half of the cost of operating a local rape victim counseling service during the first two years and up to one-third of the cost of operating a local rape victim counseling service thereafter."

Review of Selected 1980 Legislation. 12 Pacific LJ 341.

§ 1598.3. Report to Legislature

The State Department of Social Services shall report to the Legislature, on or before January 1, 1980, with respect to the names of the organizations receiving funds pursuant to this chapter and the purposes for which the funds have been utilized.

Added Stats 1978 ch 1312 § 1.

§ 1598.5. Appropriations

The sum of one hundred thousand dollars ($100,000) is hereby appropriated from the General Fund to the State Department of Social Services for expenditure during the 1978–79 fiscal year. Only 5 percent of such funds shall be used for the state administration of the grant program. After the 1978–79 fiscal year, the grant program provided pursuant to Section 1598.1 shall be funded through the regular budgetary process. The funds shall be administered through the Violent Crime Victim Assistance Commission, if created.

Added Stats 1978 ch 1312 § 1.

CHAPTER 3.9

Skilled Nursing and Intermediate Care Facility Patient's Bill of Rights

[Added by Stats 1979 ch 893 § 1.]

§ 1599. Legislative intent

It is the intent of the Legislature in enacting this chapter to expressly set forth fundamental human rights which all patients shall be entitled to in a skilled nursing or intermediate care facility, as defined in Section 1250, and to ensure that patients in such facilities are advised of their fundamental rights and the obligations of the facility.

Added Stats 1979 ch 893 § 1.

Review of Selected 1979 California Legislation. 11 Pacific LJ 537.

§ 1599.1. Establishment of written policies: Notice to patients of facility obligations

Written policies regarding the rights of patients shall be established and shall be made available to the patient, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. Such policies and procedures shall ensure that each patient admitted to the facility shall have the following rights and be notified of the following facility obligations, in addition to those specified by regulation:

(a) The facility shall employ an adequate number of qualified personnel to carry out all of the functions of the facility.

(b) Each patient shall show evidence of good personal hygiene, be given care to prevent bedsores, and measures shall be used to prevent and reduce incontinence for each patient.

(c) The facility shall provide food of the quality and quantity to meet the patients' needs in accordance with physicians' orders.

(d) The facility shall provide an activity program staffed and equipped to meet the needs and interests of each patient and to encourage self-care and resumption of normal activities. Patients shall be encouraged to participate in activities suited to their individual needs.

(e) The facility shall be clean, sanitary, and in good repair at all times.

(f) A nurses' call system shall be maintained in operating order in all nursing units and provide visible and audible signal communication between nursing personnel and patients. Extension cords to each patient's bed shall be readily accessible to patients at all times.

Added Stats 1979 ch 893 § 1.

Review of Selected 1979 California Legislation. 11 Pacific LJ 537.

§ 1599.2. Preamble or preliminary statement: Contents

Written information informing patients of their rights shall include a preamble or preliminary statement in substantial form as follows:

(a) Further facility requirements are set forth in the Health and Safety Code, and in Title 22 of the California Administrative Code.

(b) Willful or repeated violations of either code may subject a facility and its personnel to civil or criminal proceedings.

(c) Patients have the right to voice grievances to facility personnel free from reprisal and can submit complaints to the State Department of Health Services or its representative.

Added Stats 1979 ch 893 § 1.

Review of Selected 1979 California Legislation. 11 Pacific LJ 537.

§ 1599.3. Rights under chapter where patient judicially determined to be incompetent

Any rights under this chapter of a patient judicially determined to be incompetent, or who is found by his physician to be medically incapable of understanding such information, or who exhibits a communication barrier, shall devolve to such patient's guardian, conservator, next of kin, sponsoring agency, or representative payer, except when the facility itself is the representative payer.

Added Stats 1979 ch 893 § 1.

Review of Selected 1979 California Legislation. 11 Pacific LJ 537.

§ 1599.4. Additional obligations on skilled nursing or intermediate care facilities

In no event shall this chapter be construed or applied in a manner which imposes new or additional obligations or standards on skilled nursing or intermediate care facilities or their personnel, other than in regard to the notification and explanation of patient's rights or unreasonable costs.

Added Stats 1979 ch 893 § 1.

§ 1600. Context as affecting meaning

36 Cal Jur 3d Healing Arts and Institutions § 142.

§ 1600.1. "Biologics"

Review of Selected 1974 California Legislation. 6 Pacific LJ 161.

§ 1600.6. "Department"

"Department" means the State Department of Health Services.

Amended Stats 1977 ch 1252 § 258, operative July 1, 1978.

Amendments:

1977 Amendment: Added "Services" at the end of the section.

§ 1600.7. "Carrier donor"

Review of Selected 1974 California Legislation. 6 Pacific LJ 243.

§ 1600.8. "Possible carrier donor"

Review of Selected 1974 California Legislation. 6 Pacific LJ 243.

§ 1600.9. "Carrier of viral hepatitis"

Review of Selected 1974 California Legislation. 6 Pacific LJ 243.

§ 1603.1. Laboratory tests of all human whole blood received by blood banks to detect presence of viral hepatitis: Finding presence of viral hepatitis or antigen thereof: Report of findings: Procedures

36 Cal Jur 3d Healing Arts and Institutions § 60.

Review of Selected 1974 California Legislation. 6 Pacific LJ 243.

Legislative Research & Intent LLC

1107 9th Street, Suite 220, Sacramento, CA 95814
(800) 530.7613 · (916) 442.7660 · fax (916) 442.1529
www.lrihistory.com · intent@lrihistory.com

Senate Policy Committee Materials

California
Rural Legal
Assistance
Foundation

1900 K Street, Suite 200
Sacramento, CA 95814
P.O. Box 161698
Sacramento, CA 95816
(916) 446-7904

April 22, 1982

TO: Senate Judiciary Committee Members

RE: SB 1930 (Petris) - Support

We urge you to vote for SB 1930, which will help residents of nursing homes defend their rights. SB 1930 allows residents to bring civil actions if their basic human rights under the Health & Safety Code are violated. These rights include the opportunity to receive and visit with persons of their choice, being fully informed of possible financial charges, the opportunity to participate in the planning of medical treatment, transfers or discharges only for medical reasons, managing personal financial affairs or, at least, timely accounting, freedom from mental and physical abuse, confidential treatment of personal and medical records.

Without passage of SB 1930, there is generally no practical way for a resident to enforce his/her rights under the Health & Safety section. At present the only recourse for residents when their rights are violated is administrative. It is not only cumbersome, it is virtually unavailable, because of cutbacks caused by the budget crunches, in the number of nursing home inspectors. SB 1930 would allow private attorneys to fill this gap when residents' rights are violated.

We urge an "Aye" vote.

Sincerely,

Emma E. Gunterman

EMMA E. GUNTERMAN
Advocate

EEG/rh

Legal Aid Society of Alameda County

COMPLIANCE PROJECT

2357 SAN PABLO AVENUE
OAKLAND, CALIFORNIA 94612
Telephone 465-4376

H

April 23, 1982

Senator Omer L. Rains
Senate Judiciary Committee
State Capitol
Room 2187
Sacramento, California 95814

Re: SB 1930

Dear Senator Rains:

On April 27, 1982, Senator Petris' bill, SB 1930, will be heard by the Senate Judiciary Committee. We write in support of this bill.

SB 1930 provides elderly citizens, residing in nursing homes, with a private right of action, statutory fine, and attorneys' fees, in the event their fundamental rights, as set forth in the patient bill of rights, are violated by the nursing home. Such a remedy is needed because there exists no meaningful mechanism by which these rights may now be enforced.

The patient bill of rights, set forth in 22 Cal. Adm. Code § 72527, seeks to preserve the dignity and self-respect of those senior citizens living in nursing homes. Among the rights guaranteed to such nursing home residents are the rights to:

(a) participate in religious services and receive visits from clergy;

(b) refuse participation in medical experiments;

(c) receive personal mail unopened;

(d) visit with family and friends;

(e) have private conversations;

(f) be visited at anytime if critically ill;

(g) have reasonable access to telephones.

[all unless medically contraindicated.]

A copy of section 72527 is enclosed.

These rights are so fundamental that any decent, self-respecting nursing home would honor them. Yet, unfortunately, there is a small minority of homes where these rights are persistently violated and residents are deprived of dignity and privacy.

Although any violation of these rights is abhorrent, present law does not provide for a meaningful method of enforcement, and provides that only those regulatory violations which relate to health, safety, or security may result in a monetary penalty. The rights set forth in section 72527 have been determined not to relate to health, safety, or security, thus carry no penalty, and are not enforced.

Senator Petris' bill seeks to remedy this situation. If enacted, a nursing home resident denied his rights, will have the option of a lawsuit which, if successful, will result in a fine or damages plus counsel fees. The vast majority of nursing homes will, of course, never experience such a lawsuit. The small minority, who refuse to respect the dignity of their residents, will now have an incentive to mend their ways, and a penalty if they choose not to do so.

SB 1930 will help protect the dignity and individuality of our elder citizens and we urge its expeditious passage.

Sincerely,

Eric P. Gold
Attorney at Law

EPG:bjm

cc: Senator Petris
Senator Beverly
Senator Presley
Senator Roberti
Senator Sieroty
Senator Marks
Senator Doolittle
Senator Davis
Richard Thomson

72527. Patients' Rights.

(a) Written policies regarding the rights of patients shall be established and shall be available to the patient, to any guardian, next of kin, sponsoring agency or representative payee and to the public. Such policies and procedures shall ensure that each patient admitted to the facility shall have the following rights and be notified of the facility's obligations.

(1) To be fully informed, as evidenced by the patient's written acknowledgement prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(2) To be fully informed, prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or not covered under Titles XVIII or XIX of the Social Security Act.

(3) To be fully informed by a physician of his or her medical condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of medical treatment and to refuse to participate in experimental research.

(4) To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.

(5) To be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment for his or her stay and to be given reasonable advance notice to ensure orderly transfer or discharge. Such actions shall be documented in the patient's health record.

(6) To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

(7) To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept written delegation of this responsibility subject to the provisions of Section 72529.

(8) To be free from mental and physical abuse and to be free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician or other person lawfully authorized to prescribe care for a specified and limited period of time, or when necessary to protect the patient from injury to himself or to others.

(9) To be assured confidential treatment of personal and medical records and to approve or refuse their release to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third party payment contract.

(10) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.

(11) Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.

(12) To associate and communicate privately with persons of the patient's choice, and to send and receive personal mail unopened, unless medically contraindicated.

(13) To meet with others and participate in activities of social, religious and community groups, unless medically contraindicated.

(14) To retain and use personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients and unless medically contraindicated.

(15) If married, to be assured privacy for visits by the patient's spouse and if both are patients in the facility, to be permitted to share a room, unless medically contraindicated.

(16) To have daily visiting hours established.

(17) To have visits from members of the clergy at any time at the request of the patient or the patient's guardian.

(18) To allow relatives, or persons responsible, to visit critically ill patients at any time, unless medically contraindicated.

(19) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

(20) To have reasonable access to telephones and to make and receive confidential calls.

(b) A patient's rights, as set forth above, may be denied or limited only for good cause which shall be evidenced by the written order of the attending physician, and may only be denied or limited if such denial or limitation is otherwise authorized by law. Reasons for denial or limitation of such rights shall be documented by the attending physician in the patient's health record.

(c) All rights specified in Section 72527(a) (1) through (4) as they pertain to a patient adjudicated incompetent in accordance with state law, to a patient who is found by his physician to be medically incapable of understanding these rights, or to a patient who exhibits a communication barrier, shall devolve to such patient's guardian, next of kin, sponsoring agency or representative payee (except when the facility itself is representative payee).

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1599, 1599.1, 1599.2 and 1599.3, Health and Safety Code.

M

GRAY PANTHERS of the Berkeley area

AGE AND YOUTH IN ACTION

2101 A Woolsey Street, Berkeley, CA 94705 • 845-5208

April 27, 1982

Senator Nicholas C. Petris
Senate Judiciary Committee
State Capitol
Sacramento, Ca. 95814

Dear Mr. Petris:

I am writing to you on behalf of the Berkeley Gray Panthers and the Coalition of Nursing Home Reform Advocates to express our support of SB1930(Petris), which would allow nursing home residents ~~to sue~~ for violations of the Patients' Bill of Rights. As you know, these rights are elementary to human dignity: the right to voice grievances, to meet with advocates, to maintain at least some degree of privacy in a relatively powerless situation.

I would alert you that Health Department Licensing officials in our district have recently indicated to us that patients' rights are not a priority in this time of cutbacks. This unfortunate stance, together with the prospect of further disabling cutbacks in inspections on both the state and federal levels, make prompt passage of this bill, without weakening amendments, of utmost importance to quality patient care.

Finally, SB1930 carries no cost to state or local governments, and provides the right to obtain costs and attorney's fees from the offending party.

We fully support this bill and your efforts to improve nursing home care in California. Please let me know if we can be of assistance in the future.

Sincerely,

Timothy Orr

Timothy Orr
Berkeley Gray Panthers
Coalition of Nursing Home
Reform Advocates

THE STATE BAR OF CALIFORNIA

Office of the Legislative Representative

1210 K STREET SACRAMENTO, CALIFORNIA 95814

TELEPHONE (916) 444-2762

April 28, 1982

The Honorable Nicholas Petris
Senator, 9th District
State Capitol, Room 5080
Sacramento, California 95814

Dear Senator Petris:

RE: Senate Bill 1930

The State Bar Standing Committee on Legal Problems of Aging has reviewed the above-referenced measure and its comments and position are enclosed herewith.

It is the policy of the State Bar to refer various measures which affect the practice of law to the State Bar Committees or Sections for review and comment. The Standing Committee on Legal Problems of Aging composed of legal experts and attorney practitioners in the area of Legal Problems of Aging has reviewed your measure and expressed the enclosed concerns. The comments are intended to provide input to the legislative process from the expertise and legal resources of the constituency of the State Bar. It should be emphasized that its position and comments are those of the Standing Committee on Legal Problsms of Aging and not the State Bar.

The Legislative Representative of the State Bar may be contacted for further information or assistance in obtaining an expert witness to testify before Legislative Committee.

Sincerely,

Peter Jensen
Legislative Representative

enc.

cc(w/enc): Richard Thomson, Consultant
Senate Judiciary Committee

THE LEGAL SERVICES SECTION
OF THE STATE BAR OF CALIFORNIA

MARK N. AARONSON, *Chair*
CHARLES F. PALMER, *Chair-Designate*
PETER H. REID, *Secretary*
JOSEPH A. WALKER, *Treasurer*

555 FRANKLIN STREET
SAN FRANCISCO 94102-4498
TELEPHONE 561-8250
AREA CODE 415

EXECUTIVE COMMITTEE
MARK N. AARONSON, SAN FRANCISCO
YVONNE B. BURKE, LOS ANGELES
ROBERT M. CASSEL, SAN FRANCISCO
ROBERT J. COHEN, SANTA ANA
DAVID C. COLEMAN, III, MARTINEZ
TAMARA C. A. DAIN, AUBURN
JOEL H. GOLUB, SAN FRANCISCO
GREGORY E. KNOLL, SAN DIEGO
FREDERICK C. KRACKE, WALNUT CREEK
RICARDO F. MUNOZ, LOS ANGELES
ROSE M. OCHI, LOS ANGELES
CHARLES F. PALMER, LOS ANGELES
PETER H. REID, REDWOOD CITY
DANIEL N. SILVA, SAN FRANCISCO
JOSEPH A. WALKER, NEWPORT BEACH

April 24, 1982

Honorable Nicholas Petris
State Senate
State Capitol
Sacramento, CA 95814

Dear Senator Petris:

The Standing Committee on Legal Problems of Aging of the Legal Services Section of the State Bar of California wishes to express its support for SB 1930, your Nursing Home Residents' Rights Protection Bill.

The Standing Committee on Legal Problems of Aging is comprised of attorneys and lay advocates experienced in extending legal protections to isolated, poor, and disabled old persons living independently and in nursing homes throughout California. A key goal of the Committee is to improve aged and disabled persons' access to legal remedies when their rights and safety are imperiled.

Research suggests that litigation is severely underutilized as a means of redressing incidents of nursing home neglect. There are several reasons for the paucity of private lawsuits in this important area, which we believe SB 1930 will address.

Attorneys are understandable reluctant to undertake expensive and time-consuming litigation because damages are limited under the present private right of action clause in the Health and Safety Code to the amount of a State Licensing citation, generally in the range of $50-$250.

Conventional methods for calculating damages in personal injury suits result in extremely small "actual damages" awards when the typical plaintiff is an eighty year old, severely disabled woman residing in a nursing home. Neither the resident nor the lawyer in such a suit stands to gain much for the amount of anxiety and hard work involved in pursuing the litigation.

Major damages (and even attorneys' fees) can theoretically be won for violations of a person's civil rights under 42 USC section 1983 (and 1985). The large awards granted in such cases are commensurate with the seriousness of the act of depriving a helpless, dependent person of her/his rights. In these actions, however, the plaintiff must be able to prove the licensee acted in the capacity of the state in violating her/his civil rights.

This relatively new and untested area of law is presently being explored by the vanguard of the legal profession. The language of SB 1930 ensures that the civil rights afforded nursing home residents under California law can be enforced in a simple and equitable fashion by any member of the Bar.

Nursing home residents need to be able to sue for violations of their rights by nursing home operators and their agents. SB 1930 clears the principal barriers to the appropriate use of legal remedies by nursing home residents.

The views expressed herein are expressed on behalf of the Executive Committee of the Legal Services Section and its Committee on Legal Problems of Aging, and not on behalf of the State Bar. The Bar's Board of Governors has not reviewed or taken a position on this legislation.

Sincerely,

Susan Mattox
Section Administrator
on Behalf of the Executive Committee
of the Legal Services Section
of the State Bar of California

cc: Peter Jensen,
Legislative Representative
State Bar of California

72527. Patients' Rights.

(a) Written policies regarding the rights of patients shall be available to the patient, to any guardian, next of kin, sponsoring agency or representative payee and to the public. Such policies and procedures shall ensure that each patient admitted to the facility shall have the following rights and be notified of the facility's obligations:

(1) To be fully informed, as evidenced by the patient's written acknowledgement prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(2) To be fully informed, prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or not covered under Titles XVIII or XIX of the Social Security Act.

(3) To be fully informed by a physician of his or her medical condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of medical treatment and to refuse to participate in experimental research.

(4) To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.

(5) To be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment for his or her stay and to be given reasonable advance notice to ensure orderly transfer or discharge. Such actions shall be documented in the patient's health record.

(6) To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

(7) To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept written delegation of this responsibility subject to the provisions of Section 72529.

(8) To be free from mental and physical abuse and to be free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician or other person lawfully authorized to prescribe care for a specified and limited period of time, or when necessary to protect the patient from injury to himself or to others.

(9) To be assured confidential treatment of personal and medical records and to approve or refuse their release to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third party payment contract.

(10) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.

(11) Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.

(12) To associate and communicate privately with persons of the patient's choice, and to send and receive personal mail unopened, unless medically contraindicated.

(13) To meet with others and participate in activities of social, religious and community groups, unless medically contraindicated.

(14) To retain and use personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients and unless medically contraindicated.

(15) If married, to be assured privacy for visits by the patient's spouse and if both are patients in the facility, to be permitted to share a room, unless medically contraindicated.

(16) To have daily visiting hours established.

(17) To have visits from members of the clergy at any time at the request of the patient or the patient's guardian.

(18) To allow relatives, or persons responsible, to visit critically ill patients at any time, unless medically contraindicated.

(19) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

(20) To have reasonable access to telephones and to make and receive confidential calls.

(b) A patient's rights, as set forth above, may be denied or limited only for good cause which shall be evidenced by the written order of the attending physician, and may only be denied or limited if such denial or limitation is otherwise authorized by law. Reasons for denial or limitation of such rights shall be documented by the attending physician in the patient's health record.

(c) All rights specified in Section 72527(a)(1) through (4) as they pertain to a patient adjudicated incompetent in accordance with state law, to a patient who is found by his physician to be medically incapable of understanding these rights, or to a patient who exhibits a communication barrier, shall devolve to such patient's guardian, next of kin, sponsoring agency or representative payee (except when the facility itself is representative payee).

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1599, 1599.1, 1599.2 and 1599.3, Health and Safety Code.

California Association of Health Facilities

Statement in OPPOSITION To SB 1930 (Petris)
Senate Judiciary Committee
Tuesday, May 4, 1982

The California Association of Health Facilities (CAHF) which represents nearly 900 licensed nonprofit and proprietary skilled nursing facilities, intermediate care facilities, community care facilities, employing over 100,000 Californians and providing care for approximately 85,000 residents, urges your opposition to SB 1930 when it is heard by the Senate Judiciary Committee on Tuesday, May 4, 1982.

This bill would set up an entirely new right of action for patients who reside in nursing homes when the nursing home, or any of its employees violates the patients' rights as spelled forth in regulations by the Department of Health Services. We are opposed to SB 1930 for several reasons.

1. At the present time any facility which is found to be in violation of the patients' rights as spelled forth in regulations are subject to a citation and possible fine under the present citation system administered by the Department of Health Services for nursing homes. Depending upon the degree of severity of the violation (as determined by the licensing surveyor of the Department of Health Services) a facility may receive a fine of any where from $50 to $5,000.

2. Under existing law, any patient who is physically abused may bring civil suit against the facility and/or its employees.

3. Under existing tort law, any guardian of any patient may bring suit against any facility or its employees for harm caused to that patient as a result of actions by the facility or its employees. Patients who do not have families or conservators may be represented in such actions by the public guardian in their respective areas.

Our Association does not condone in any way the violation of patients' rights in nursing homes. However, because of the wide-ranging scope of those rights and the varying degrees of potential violations of those rights, we feel that this bill is unwarranted and unnecessary. Attached for your information is a copy of the existing regulations on patients' rights. As you can see, these rights cover a wide-range of various and degrees of violations. We feel that the existing inspection and citation system, as well as the role of the State Ombudsmen in nursing homes, provide adequate protection and punitive action against violators of patients' rights. Implementation of this bill will create chaos in the court system and would lead to extremely unnecessary and expensive court actions.

We urge your NO vote on SB 1930 when it comes before the Senate Judiciary Committee on Tuesday, May 4, 1982.

This page was left intentionally blank.

04226 MAR 8 1982 82067 20:24

RECORD # 20 BF: SN 82 002867 PAGE NO. 1

AUTHOR'S COPY

1930

An act to amend Section 1430 of the Health and Safety Code, relating to health facilities.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1430 of the Health and Safety Code is amended to read:

1430. (a) Except where the state department has taken action and the violations have been corrected to its satisfaction, any licensee who commits a class "A" or "B" violation may be enjoined from permitting the violation to continue or may be sued for civil damages within a court of competent jurisdiction. Such actions for injunction or civil damages, or both, may be prosecuted by the Attorney General in the name of the people of the State of California upon his or her own complaint or upon the complaint of any board, officer, person, corporation or association, or by any person acting for the interests of itself, its members or the general public. The amount of civil damages which may be recovered in an action brought pursuant to this section shall not exceed the maximum amount of civil penalties which could be assessed on account of the violation or violations.

(b) A resident or patient of a skilled nursing facility, as defined in subdivision (c) of Section 1250, or intermediate care facilities, as defined in subdivision

(d) of Section 1250, may bring a civil action against the licensee of a facility who violates any rights of the resident or patient under the provisions of Chapter 3.9 (commencing with Section 1599). The suit shall be brought in a court of competent jurisdiction. The licensee shall be liable for up to two thousand five hundred dollars ($2,500) or three times the actual damages, whichever is greater, and for costs and attorney fees, and may be enjoined from permitting the violation to continue. An agreement by a resident or patient of a skilled nursing facility or intermediate care facility to waive his or her rights to sue pursuant to this subdivision shall be void as contrary to public policy.

(c) The remedies specified in this section shall be in addition to any other remedy provided by law.

- 0 -

April 21, 1982

TO: Legislative Counsel

FROM: Alice Tanenbaum

RE: Amendments to SB 1930

AMENDMENT I

page 2 line 13 strike; under the provisions of Chapter 3.9 (commencing with Section 1599).

Insert: as set forth under the provisions of Chapter 3.9 commencing with Sections 1599. Such actions shall be limited to those rights set forth in the Patients Bill of Rights, Title 22, Section 72527.

AMENDMENT II

page 2 line 15 following "jurisdiction."

Insert: The licensee shall be liable for the acts of the employees.

REQUESTED BY: URGENT April 23, 1982

This page was left intentionally blank.

THE OFFICE OF
Senator Nicholas C. Petris
State Capitol, Room 5080
Sacramento, California

Press Release #28
March 16, 1982

Contact: Felice Tanenbaum
(916) 445-6577

or Carlina

NURSING HOME VIOLATIONS CURBED

Today, Senator Nicholas C. Petris (D-Oakland) introduced Senate Bill 1930 a bill to protect and insure the private rights of people residing in nursing homes.

Petris remarked, "It is so tragic when basic rights such as privacy in medical treatment, freedom from mental and physical abuse, accessibility to visitors, or ability to make confidential phone calls are violated and there is no where to turn for help." Presently, government has the responsibility of enforcing an individual's civil rights. This bill would allow a resident or patient of a nursing facility to personally bring suit against the facility. Petris continues, "since the State is making major cuts in services to people, it is more important than ever to allow the institutionalized individual the ability to protect their own constitutional rights in the private sector. My bill would provide that greatly needed avenue of relief."

Legislative Research & Intent LLC

1107 9th Street, Suite 220, Sacramento, CA 95814
(800) 530.7613 · (916) 442.7660 · fax (916) 442.1529
www.lrihistory.com · intent@lrihistory.com

Assembly Policy Committee Materials

Legislative Research & Intent LLC hereby certifies that the accompanying record/s is/are true and correct copies of the original/s obtained from one or more official, public sources in California unless another source is indicated, with the following exceptions : In some cases, pages may have been reduced in size to fit an 8 ½" x 11" sized paper. Or, for readability purposes, pages may have been enlarged or cleansed of black marks or spots. Lastly, for ease of reference, paging and relevant identification have been inserted.

Gray Panthers

AGE AND YOUTH IN ACTION

California Gray Panthers
◇P.O. Box 19424,
Sacramento, Ca. 95819
~~◇700 Gale Dr. #211D,~~
~~Campbell, Ca. 95008~~

401 Reynolds Circle #8
San Jose, CA. 95112
June 7, 1982

Assemblyman Elihu Harris, Chairman
Assembly Judiciary Committee
State Capitol
Sacramento, CA. 95814

Dear Assemblyman Harris:

On behalf of the California Gray Panthers, I would like to express our support for SB1930 by Senator Petris. We need this bill so that residents of nursing homes can secure their rights. At present, they have no right to sue if their rights are violated by the home. By allowing this private right of action, SB1930 will give patients another avenue to make sure their civil rights are protected. I am urging you to pass SB1930 out of your committee.

We would like to hear your position on this issue. Your co-operation is appreciated.

Sincerely,

Richard Gregory

Richard Gregory
Legislative Chairman

WESTERN CENTER ON LAW AND POVERTY, INC.
Northern California Office
1900 "K" Street, Suite 200, Sacramento, California 95814
Telephone (916) 442-0753

(415) 486-

June 21, 1982

Ruben Lopez, Consultant
Assembly Judiciary Committee
Room 6031, State Capitol
Sacramento, CA 95814

Re: SB1930

Dear Mr. Lopez:

In 1979, the Legislature enacted the nursing home patient's Bill of Rights (Stats. 1979, c. 893, p. 3087), which, in the words of the Legislature, was "...to expressly set forth fundamental human rights which all patients shall be entitled to..." (Health & Safety Code, section 1599).

These rights of human dignity and self respect are set forth in 22 Cal. Adm. Code section 72527. Included are the following:

1. The right to visit, at reasonable times, with relatives and friends;
2. The right to be visited at any time if critically ill;
3. The right to have private communications and telephone calls;
4. The right to be visited by clergy and engage in worship;
5. The right to know of, and refuse medical treatment and not be subjected to unauthorized medical experiments.

   (All, unless medically contraindicated)

Notwithstanding the clear legislative intent to ensure that nursing homes respect the fundamental human rights of their residents, the legislation failed to provide for any enforcement mechanism. In introducing SB1930, it is the author's intent to remedy this ommission. SB1930 does three things:

1. It provides a method to enforce the nursing home Patient's Bill of Rights by establishing a clear, private right of action. Under present law, a nursing home resident cannot sue to enforce his rights since courts allow suits based upon regulations only when individual law suits are authorized by the legislature. Under present law, the Department of Health cannot enforce violations of the Patients Bill of Rights since they are not directly related to health or safety within the homes. See H&S Code Sec. 1423. Even if such enforcement were permitted, the Department does not have the resources or expertise to

enforce such non-health related rights.

2. Since most elderly residents of nursing homes cannot afford an attorney to protect these important rights, the bill provides for an award of attorneys' fees -- but only if the resident proves that the nursing home in fact violated his rights.

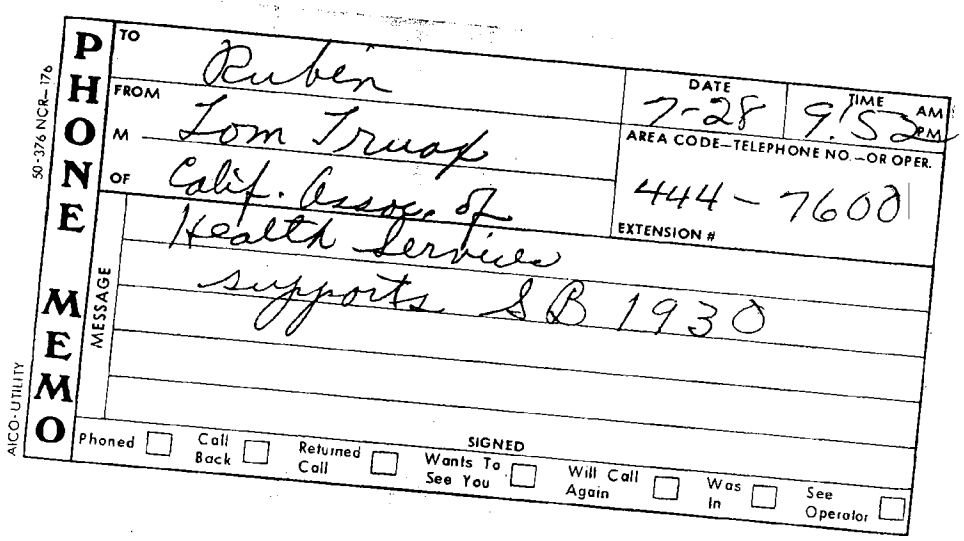
3. Since damages caused by violation of a resident's rights to self-respect and human dignity are very difficult to prove, and to encourage nursing homes to obey the Bill of Rights, SB1930 allows for an award of punitive damages. Such an award, however, may be made only if the resident proves that the nursing home repeatedly or intentionally violated the Patient's Bill of Rights.

It is a legal adage that every wrong must have a remedy. It is the author's intent to provide for such a remedy when the fundamental rights set forth in the Patient's Bill of Rights are violated.

Sincerely,

ERIC P. GOLD

jj



PHONE MEMO

50-376 NCR-176

AICO-UTILITY

TO Ruben

FROM

M Tom Truax

OF Calif. Assoc. of Health Services

DATE 7-28

TIME 9:52 AM PM

AREA CODE—TELEPHONE NO.—OR OPER. 444-7600

EXTENSION #

MESSAGE

supports SB 1930

Phoned ☐ Call Back ☐ Returned Call ☐ Wants To See You ☐ Will Call Again ☐ Was In ☐ See Operator ☐

SIGNED

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF AGING
1020 19th STREET
SACRAMENTO, CALIFORNIA 95814

(916) 322-5290
(TDD 445-1788)

August 2, 1982

Honorable Elihu Harris
Chairman, Assembly Judiciary Committee
Member of the Assembly
State Capitol, Room 6031
Sacramento, CA 95814

Dear Mr. Harris:

The Department of Aging is in support of bill SB 1930 which creates private right of action for violation of nursing home residents' personal rights.

Enforcement of long-term care residents' personal rights has been difficult. Existing law does not spell out specific rights of action and damages when the rights of nursing home residents have been violated. This bill addresses the problem for this very vulnerable population by creating a specific private right of action. We have long felt the need for a statutory base, such as SB 1930, for the enforcement of patients' rights.

We urge your support for SB 1930 and want to thank you for your continued support for senior services.

Most sincerely,

Janet J. Levy

JANET J. LEVY
Director

This page was left intentionally blank.

82200 11:36
RECORD # 20 BF:

09217 PAGE NO. 1
RN 82 012595
Substantive

AMENDMENTS TO SENATE BILL NO. 1930
AS AMENDED IN SENATE MAY 12, 1982

Amendment 1

On page 2 of the printed bill, as amended in Senate May 12, 1982, strike out lines 28 to 31, inclusive, and insert:

up to five hundred dollars ($500) ~~or three times the damages, whichever is greater~~, and for costs and attorney fees, and may be enjoined from permitting the violation to continue. An

- 0 -

This page was left intentionally blank.

Staff Analysis of Assembly Bill 1203 (Levine)
As Amended June 21, 1979

SUBJECT

Patient's Bill of Rights

PURPOSE

To provide a "Bill of Rights" for patients in skilled nursing (SNF) and intermediate care facilities (ICF)

BACKGROUND

The Lanterman-Petris-Short (LPS) Act provides for legal and civil rights for persons involuntarily detained under LPS, and those admitted as voluntary patients.

The Department of Health Services has adopted regulations which govern the obligations of the facility (adequate staffing, nurses call system) through the facility licensing process.

ANALYSIS

This bill requires that upon admission to the facility, patients shall be notified of the following patient rights and facility obligations:

1. The facility shall employ an adequate number of qualified personnel to carry out all of the functions of the facility.

2. Each patient shall show evidence of good personal hygiene.

3. The facility shall provide food of the quality and quantity to meet the patients' needs in accordance with physicians' orders.

- MORE -

4. The facility shall provide an activity program staffed and equipped to meet the needs and interests of each patient and to encourage self-care and resumption of normal activities.

5. The facility shall be clean, sanitary, and in good repair at all times.

6. A nurses' call system shall be maintained in operating order in all nursing units and provide visible and audible signal communication between nursing personnel and patients.

The bill also devolves such rights to specified parties when the patient is judicially determined to be incompetent, found by his physician to be medically incapable of understanding such information or exhibits a communication barrier.

SUPPORT

California Association for the Retarded

OPPOSE

None known

QUESTIONS AND COMMENTS

(1) Does the phrase "who exhibit a communication barrier" refer to some who is mute, deaf, has a lisp, stutters or does not speak the majority language?

(2) Who will enforce the provisions of this measure?

****

Hearing Date: July 18, 1979

ASSEMBLY COMMITTEE ON HEALTH
Art Torres, Chairman

EC
AB 1203

ANALYSIS - AB 1203 (LEVINE)

AS AMENDED APRIL 25, 1979

HEARING: Monday, April 30, 1979, 8:00 A.M. and 1:30 P.M., Room 2133 State Capitol

SUBJECT: Patient's Bill of Rights

ABSTRACT: At issue is whether the Legislature should prescribe a "Bill of Rights" for patients in skilled nursing and intermediate care facilities.

SUMMARY: This bill does the following:

1. Prescribes a "Bill of Rights" to patients in skilled nursing and intermediate care facilities.

2. Makes a willful violation of such rights a misdemeanor.

3. Devolves such rights to specified parties when the patient is judicially determined to be incompetent, found by his physician to be medically incapable of understanding such information or exhibits a communication barrier.

BACKGROUND: In 1967, the Legislature enacted the Lanterman-Petris-Short Act. This law, which went into effect July 1, 1969, was intended to put a stop to the inappropriate and indefinite commitment of mentally disordered persons. The thrust of that act is to promote voluntary treatment.

Under previous law, anyone who was considered to be "in need of treatment, care supervision, or restraint" could be involuntarily committed for indefinite periods of times. In addition, the Lanterman-Petris-Short Act codified specific legal and civil rights for patients involuntarily detained.

The list of rights for patients in skilled nursing and intermediate care facilities however is not prescribed in legislation, but is in regulation under Title 22, California Administrative Code. This measure would place these patient rights into statutes.

COMMENTS: This legislation has been introduced in order to streamline the process of informing patients of their civil and legal rights as stipulated under the Health and Safety Code and Title 22 (Social Security Act) of the California Administrative Code. According to the sponsor of this legislation, patients in nursing homes are not made aware of their rights upon admission into such facility as prescribed in existing regulations.

Skilled nursing facility is defined as a health facility which provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis.

Intermediate care facility is defined as a health facility which provides the following basic services: 24-hour care to residents who have a recurring need for skilled nursing supervision and need supportive care but do not require availability of continuous skilled nursing care.

Section 1599.3 contains language which specifies these conditions in which the prescribed patient's rights will be devolved to specified parties. As written, this language is unclear and ambiguous.

Under present law, a person can be adjudicated incompetent under two provisions:

1. Probate Code (Division 5)

2. Lanterman-Petris-Short Act Conservatorship for gravely disabled persons (Welfare and Institutions Code, commencing with Chapter 3, Section 5350).

The following phrases also under Section 1599.3 remain unclear:

1. "medically incapable of understanding such information".

2. "who exhibits a communication barrier".

FISCAL IMPACT: An unspecified amount is appropriated to the Controller for allocation and disbursement for local agencies and school districts to reimburse for costs incurred.

QUESTIONS:

1. Does the phrase "medically incapable of understanding such information" refer to drugged, senile, comatosed or other such terms?

2. Does the phrase "who exhibit a communication barrier" refer to some who is mute, deaf, has a lisp, stutters or does not speak the majority language?

3. Who will enforce the provisions of this measure?

POSITIONS: Support: California Association for the Retarded

Oppose: None known

* * * * * * * * *

AB 1203 (Levine)

Support:

Jewish Legal Services
Board of Medical Quality Assurance

Support in principle with some recommendations as to language:

California Nurses' Association

This page was left intentionally blank.

Brown stated, "This new department will match the health care needs of seniors and the disabled to services available. Gone are the days when sending someone to "a home" was a given.

SB 1324 (Mello, D-San Luis Obispo) Extends the Senior Campanion program an additional five years until January, 1988. This program offers volunteer opportunities for seniors in a variety of settings and compensates them with a small stipend and a meal.

AB 2997 (Felando, R-Torrance) Expands the functions and responsibilities of the Long-Term Care Ombudsman who investigates and resolves complaints of residents of nursing homes and other community care facilities.

AB 1536 (Berman, D-Los Angeles) Authorizes the superior court to appoint a receiver to temporarily operate a skilled nursing facility due to death of the licensee or temporary suspension of the license.

SB 1930 (Petris, D-Oakland) Creates a private right of action for violation of the personal rights of nursing home residents.

AB 2585 (Agnos, D-San Francisco) Requires the Department of Social Services to notify responsible parties and advocates of violations of community care faciliteis laws in cases of physical or sexual abuse and other specified instances.

(a) Written policies regarding the rights of patients shall be established and shall be available to the patient, to any guardian, next of kin, sponsoring agency [illegible] ensure that each patient admitted to the facility shall have the following rights and be notified of the facility's obligations:

(1) To be fully informed, as evidenced by the patient's written acknowledgement prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(2) To be fully informed, prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or not covered under Titles XVIII or XIX of the Social Security Act.

(3) To be fully informed by a physician of his or her medical condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of medical treatment and to refuse to participate in experimental research.

(4) To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.

(5) To be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment for his or her stay and to be given reasonable advance notice to ensure orderly transfer or discharge. Such actions shall be documented in the patient's health record.

(6) To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

(7) To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept written delegation of this responsibility subject to the provisions of Section 72529.

(8) To be free from mental and physical abuse and to be free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician or other person lawfully authorized to prescribe care for a specified and limited period of time, or when necessary to protect the patient from injury to himself or to others.

(9) To be assured confidential treatment of personal and medical records and to approve or refuse their release to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third party payment contract.

(10) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.

(11) Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.

(12) To associate and communicate privately with persons of the patient's choice, and to send and receive personal mail unopened, unless medically contraindicated.

(13) To meet with others and participate in activities of social, religious and community groups, unless medically contraindicated.

(14) To retain and use personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients and unless medically contraindicated.

(15) If married, to be assured privacy for visits by the patient's spouse and if both are patients in the facility, to be permitted to share a room, unless medically contraindicated.

(16) To have daily visiting hours established.

(17) To have visits from members of the clergy at any time at the request of the patient or the patient's guardian.

(18) To allow relatives, or persons responsible, to visit critically ill patients at any time, unless medically contraindicated.

(19) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

(20) To have reasonable access to telephones and to make and receive confidential calls.

(b) A patient's rights, as set forth above, may be denied or limited only for good cause which shall be evidenced by the written order of the attending physician, and may only be denied or limited if such denial or limitation is otherwise authorized by law. Reasons for denial or limitation of such rights shall be documented by the attending physician in the patient's health record.

(c) All rights specified in Section 72527(a)(1) through (4) as they pertain to a patient adjudicated incompetent in accordance with state law, to a patient who is found by his physician to be medically incapable of understanding these rights, or to a patient who exhibits a communication barrier, shall devolve to such patient's guardian, next of kin, sponsoring agency or representative payee (except when the facility itself is representative payee).

ASSEMBLY STANDING COMMITTEE ON JUDICIARY
RECORD OF ROLL CALLS

Date of Hearing 8/4/82																	
Bill No.	AB 3784		SB 500		ACA 87		SB 1930		AB 3807		SB 1150		AB 3771				
ACTION VOTED ON	AMEND DO PASS W&M		FAILED PASSAGE		HELD IN COMMITTEE		DO PASS Recommend Consent		DO PASS Recommend Consent		DO PASS		HELD IN COMMITTEE				
	Aye	No	Aye	No	Aye	No	Aye	No	Aye	No	Aye	No	Aye	No			
Berman	x			x			x		x		x						
Hart	x		x				x		x		x						
Ingalls	x			x			x		x		x						
Leonard	x		x				x		x		x						
McAlister	x		x				x		x		x						
Moorhead	x		ab				x		x		x						
Robinson	x		nv				x		x		x						
Stirling, Dave	x		ab				x		x		ab						
Stirling, Larry	x		x				x		x		x						
Torres	x			x			x		x		x						
Waters, Maxine	x			x			x		x		x						
Wyman	x		x				x		x		x						
Imbrecht (V.Chairman)	x		x				x		x		x						
Harris (Chairman)	ab		ab				ab		ab		ab						
	Ayes: 13 Noes: 0		Ayes: 6 Noes: 4		Ayes: Noes:		Ayes: 13 Noes: 0		Ayes: 13 Noes: 0		Ayes: 12 Noes: 0		Ayes: Noes:				

N.V. — Not voting
Ab. — Absent
CEIVED: _____

Signed: Elihu M. Harris
Chairman

LRI