2003-2004 GRAND JURY REPORT
Mental Health / Public Guardian

Background

In February 1968, the Riverside County Board of Supervisors designated the Office of the Public Guardian (PG) as the county office to serve as conservator under Lanterman-Petris-Short Act (LPS), which was enacted in 1967. The LPS Act contains procedures for the involuntary treatment of persons with psychiatric disabilities.

The PG operates under the direction of the Department of Mental Health (DMH), County of Riverside to:

1. Administers the financial affairs (fee for service basis) of DMH Clients who are unable to manage their own funds due to consequence of their illness. The PG, Conservatorship Investigation Branch, evaluates referrals to determine whether there is a need for conservatorship; produces a report with recommendation that is sent to County Counsel for review prior to submission to the Superior Court for a decision by a judge to appoint a conservator.

2. Provide conservatorship services for persons who have been deemed by the Superior Court as being unable to manage on their own and for whom there is no viable alternative.

There are two types of conservatorships, temporary and probate. A Deputy Public Guardian (court appointed manager/conservator) is assigned to manage the financial and/or personal needs of an individual (conservatee) who is either physically or mentally incapable of meeting those needs.

A large number of persons with psychiatric disabilities reside in Residential Care Facilities for the Elderly (RCFE), licensed under the Community Care Facility Act (CCFA). The California Legislature passed the CCFA in 1973 to promote “a coordinated and comprehensive statewide service system of quality community care” for persons with disabilities.

RCFE's are classified as facilities of any capacity that provide "non-medical care to persons under 60 years of age and over, or persons 18 thru 60 with compatible needs; elderly residents requiring varying levels and intensities of care and supervision, or personal needs, elderly who may be frail and/or disabled and cannot, or do not desire to take care of their own needs".

Source: Community Care Licensing, Pacific Inland Office, Riverside, California.

Regulations relating to RCFE's for the elderly are promulgated in Community Care Licensing (CCL) Manual, Title 22, Division 6, Chapter 8 found in Section 1569.30, Health and Safety Code.

The specific responsibilities of CCL are to:

- Approve or deny application for licensee to provide care;
- Enforce licensing laws;
- Maintain public files on licensed facilities;
- Investigate complaints; (Agencies, Family Members, Ombudsman);
- Impose fines and revoke licenses when necessary.

The following timeline documents the case of an 87-year old person who became disabled with dementia. This person will be referred to as the "Client". Establishing Dementia Probate Conservatorship (DPC) for a person is a lengthy legal process. Clear supporting evidence is required to demonstrate that this alternative is necessary. The timeline identifies the steps that were necessary to establish the DPC for this Client.

- **10/31/02** Client was admitted to Riverside Psychiatric Emergency Room, Riverside County Regional Medical Center (RCRMC) for evaluation and treatment for 72 hours under the Welfare and Institution Code §5150. The Client was later transferred to Los Alamitos Medical Center (LAMC), Los Alamitos, California for continued care.

  "When a person, as a result of mental disorder becomes a danger to themselves or others, or gravely disabled, may be taken into custody by peace officer or other professional person designated by the Court) and placed into a facility approved by the State Department of Mental Health for 72-hour treatment and evaluation."

- **11/03/02** A fourteen (14) day Certification was authorized and a referral made to the Public Guardian's Office.

  "*The fourteen (14) day Certification is an extension of provisions of 5150 for continued evaluation and treatment".*

- **11/12/02** The Department of Mental Health, Riverside County petitioned the Superior Court for Dementia Probate Conservatorship for the Client.

- **11/19/02** Client was placed on Temporary Conservatorship (LPS) with a hearing date for December 13, 2002.

- **11/27/02** Client was transferred from LAMC to the Geriatric Psychiatric Unit, Vista Pacifica Rehabilitation Center (VPRC) Riverside, California. VPRC is a locked treatment facility for managing dementia cases. While at VPRC, the Client was "alert, oriented, calm, cooperative, eating well, compliant with prescribed medications, doing well under supervision with no behavior problems and made needs known in an appropriate manner".

- **12/03/02** A Public Guardian Investigator (PGI) visited the Client to commence the conservatorship investigation. The Client was interviewed at VPRC by the PGI to determine the appropriateness of current placement and the need for probate conservatorship.

- **12/12/02** The PGI submitted a report to the supervising Deputy Public Guardian recommending a probate conservatorship and evaluated the Client's suitability for moving to a lower placement level.

- **12/13/02** The PGI requested a continuance of LPS conservatorship until February 7, 2003, to allow time for a dementia probate conservatorship to be established.

- **02/03/03** Office of the Public Guardian recommended to the Superior Court, that the Client be placed at Villa La Roe.

- **02/07/03** A DMH Case Manager moved the Client from VPRC to Villa La Roe, Banning, California. Villa La Roe is a RCFE. The Client was moved to a lower level facility because of improvement shown in behavior at VPRC. While at Villa La Roe, the Client's mental and physical condition began to deteriorate. The Client experienced five (5) falls during a four (4) month period that required treatment at the Emergency Room at San Gorgonio Memorial Hospital (SGMH).

- **02/27/03** Due to objections by the Client to the conservatorship, the Superior Court appointed an attorney.

- **03/27/03** Under the provision of Probate Code §2356.5, probate conservatorship for the Client was approved and a conservator of person and estate was appointed by the Superior Court. This determination was made because the Client was unable to provide for personal needs, food, clothing, shelter and medical needs related to diabetes mellitus. A deputy PG was assigned as the Client's conservator with the following powers:

  a) Exclusive authority to consent to medical treatment.

  b) Placement of Client in an appropriate RCFE that could provide care for patients with "dementia of the Alzheimer's Type". (A progressive degenerative disease of the brain that leads to dementia.)

Findings:

This report illustrates a case of elder "abuse and neglect" at the hands of agencies responsible for administering to the needs of persons who can no longer care for themselves.

1. On February 3, 2003, the Office of the Public Guardian recommended that the Client be placed at Villa La Roe (VLR), describing that facility as "a facility that provides care and treatment for persons suffering from dementia and need assistance with their daily living activities". The officer making that recommendation stated, "VLR was an appropriate facility". VLR lacked staff to handle dementia patients and did not have a "Dementia Waiver".

2. As required under Title 22, Article 6, Section 87584 (Functional Capabilities) the RCFE did not assess the Clients need for care and ability to perform the function of daily living. The Client was hard of hearing, had no dentures, stopped eating, drinking and taking medication. The RCFE Administrator and staff did not report these changes to the DMH Case Manager, conservator or physician.

3. In mid-June 2003, a Clinical Nurse from the Hemet Mental Health Clinic temporarily replaced the Client's regularly assigned RN/Case Manager. On June 16, 2003, this Clinical Nurse called the Facility's Administrator to discuss the Client's condition. The Facility Administrator reported that the Client was "stable, doing well, eating okay and taking prescribed medication."

4. On June 23, 2003, a Clinical Nurse, and a Behavioral Health Specialist from the Hemet Mental Health Clinic made an unannounced visit to the VLR to meet the Client and Facility Administrator. Pursuant to Welfare & Institution Code, a Clinical Nurse is a mandated reporter.

   (a) "Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care

custodian, health practitioner, or employee of a county adult protective services agency or a local law enforcement agency is a mandated reporter."

Source: *Welfare & Institutions Code, Chapter 11, Article 3, Section 15630 Mandated Reporter.*

They were greeted by an 18-year old male staff member, who escorted them to the Client's room. The male staff member informed the nurse, "The Client had not eaten for 4-5 days". The Clinical Nurse and Behavioral Health Specialist entered the Client's room and observed the following conditions:

a. No bedding.
b. Client lying half off the bed on right side, legs dangling on floor.
c. Nude from waist down.
d. Disoriented.
e. Client moaning, "I'm in pain, I'm diabetic".
f. A bowl of applesauce on the dirty un-vacuumed carpet.
g. Feces smeared towels littered on the bathroom floor.

5. The Clinical Nurse immediately called "911" and the Client was transported by ambulance to SGMH for emergency medical care. The Clinical Nurse did not report the conditions described in 4a – 4g despite provisions of Mental Health Policy #218, that required reporting of possible elder abuse and neglect.

6. The emergency room physician at SGMH stated that the Client had "severe urinary tract infection (urosepis) with mild dehydration and possible neglect and abuse".

7. After the emergency room physician evaluated the Client and established a diagnosis, the Client was admitted to SGMH for treatment and care. The Client's medical condition did not improve and subsequently died on July 1, 2003.

8. The social worker at SGMH reported the possible neglect and abuse. Adult Protective Services did not intervene.

9. VLR Administrator and staff failed to seek medical attention for the Client even after staff observed that the Client would not eat, drink or take medication and was losing weight rapidly.

10. The Department of Mental Health failed to advise the Office of the Public Guardian that Dementia Probate Conservatorship had been approved for the Client on March 27, 2003.

11. The Office of the Public Guardian neglected to consult with CCL regarding the licensee status or suitability of placement for dementia residents at VLR (RCFE).

12. Evidence shows that the Policies and Operating Procedures that were established in 1988 in the PG's Policy and Procedure Manuals have not been updated since 1998. Current Operating Procedures are not reflected in the manual.

13. VLR violated Article 3, Section 87227 of the CCL Manual Policies and Procedures by failing to surrender all cash (from Client's spending account) resources, personal property and valuables to the Office of the Public Guardian upon the death of Client.

14. On July 7, 2003, a CCL Licensed Program Analyst conducted an investigation at Villa La Roe and substantiated "client neglect care" allegations through the examination of RCFE documents.

15. The following data summarizes deficiencies documented by CCL at Villa La Roe from February 14, 2002 through September 19, 2003.

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16. Table I summarizes the deficiencies that were found by Licensed Program Analyst (LPA), CCL.

Table 1
FACILITY DEFICIENCIES OBSERVED BY CCL
DURING UNANNOUNCED VISITS AND INSPECTIONS

DATE	CODE VIOLATION	INSPECTION TYPE	DEF	DESCRIPTION
2/14/02	87101 (r)(4)	Case Management	A	**Non-Compatible Residents** Exceeded the number of allowed adults (ages 18-59) living in this elderly facility.
3/25/02	87575 (h)(2)	Case Management	A	**Medication & Centrally Stored Medication Records** Prescribed medication for one resident was found on the top of a filing cabinet in an office with the door unlocked.
	87575 (a)(6)		A	The RCFE did not consistently or adequately monitor a resident's self-administered medication.
			A	A bubble pack prescription for one resident had pills missing. The RCFE was not consistent in assisting residents with self-administered medication.
	87575 (h)(6) A,B,C,D,E,F		A	A resident's medication was not properly documented on the Centrally Stored Medication Record.

DATE	CODE VIOLATION	INSPECTION TYPE	DEF	DESCRIPTION
4/5/02	87703 (b)(3)(B)	Case Management	A	**Oxygen Administration** The RCFE does not have the required signs posted which reads "No Smoking Oxygen in Use".
	87703 (b)(3)(E)		A	Four (4) oxygen tanks were placed in bedroom #2 without being secured in a stand or to the wall.
	87575 (b)(3)(F)		A	An unauthorized extension to the standard seven (7) foot plastic tubing from nasal cannula on mask to the main source of the oxygen tank
11/08/02	87691 (i)(A)(B)(C)	Annual	A	**Maintenance and Operations** The signal system in a resident's bedroom was inoperative.
	87691 (a)		A	The Carpeting in a resident's room and throughout the common areas of the facility was dirty and stained.
	87691 (a)		A	Toilet seat in a resident's bedroom was loose and not secured to the toilet seat.
	87691 (a)(b)		A	Door leading to the outside of a resident's room was not properly fitted to the frame, allowing cold air to enter.

DATE	CODE VIOLATION	INSPECTION TYPE	DEF	DESCRIPTION
11/08/02	87691 (a)(b)	Annual	A	**Maintenance and Operations** Cold Air coming through the vents of the air conditioning units located in a resident's window.
	87691 (a)(e)(5)		B	The floor mats in a majority of the resident's bath tub/shower were dirty and worn.
			A	Freezer in hallway blocking the exit to a resident's bedroom.
03/01/03	87572 (a)(1,2,3)	Case Management	A	**Personal Rights** An elderly resident was sharing a room with an adult resident (under 60) who was loud, confrontational and intimidating with other residents.
	87101 (r) (4)		A	**Definitions: "Residential Care Facility for the Elderly"** The facility exceeded the number of adults (ages 18-59) allowed to be living with the elderly.
03/10/03	87677 (A)(2)(C)	Case Management	A	**Personal Accommodation & Services** **One resident was using another resident's bedroom as a passageway to the bedroom and toilet.**

03/11/03	87582 (B)(6) 87724 (c)		A A	**Limitations** Three adult residents yelled, cursed, threatened staff, and intimidated the elderly population living in the RCFE. **Care of Persons with Dementia** An elderly resident was not able to demonstrate with mental competence or physical ability that she could exit the facility in case of an emergency.
07/07/03	87569(a)(b)(1)(2)(4)	Complaint Investigation		**Medical Assessment** Facility transfer document on files dated 2/27/03 revealed that EM had a diagnosis of diabetes and was prescribed" sliding scale insulin" yet medical assessment on file at facility completed by the physician makes no mention of diabetes or what diabetic care is required
07/02/03	87575 (a)(1)	Complaint Investigation	A	**Incidental Medical & Dental Care** The RCFE administrator and/or staff failed to seek appropriate medical care for the resident EM when she stopped eating, drinking and taking medication.

	87591	Resident Observation	A	**Observation of Resident** The RCFE did not provide appropriate assistance in a timely manner when a resident's condition was deteriorating and she was loosing weight.
09/10/03	87691 (1)	Case Management	A	**Maintenance & Operations** The RCFE's stove/oven in the kitchen was not in proper working condition. The oven thermostat was inoperative resulting in incorrect oven temperature.
09/10/03	Health & Safety Code 1569.155 87576 (b)(26)	Case Management	A B	**Provisions & Upkeep of Regulations** There was no proof on file that the licensee subscribed to an appropriate regulation subscription services. **Food Service** There was an insufficient supply of perishable food on hand to meet the needs of 14 residents for two (2) days.

				Maintenance & Operations
09/19/03	87691 (a)		B	The flooring in one resident's bedroom had numerous missing tiles and the area where the tiles were missing was dirty.
09/19/03	87691(a)			The carpeting in six (6) resident's bedrooms was dirty, worn and stained. A citation for this violation was issued on 11/08/02.

Type A:
Deficiency Violations of the regulations and/or Health and Safety Codes, that if not corrected, has a direct and immediate risk health, safety and personal rights or clients in care.

Type B:
Deficiency Violations of the regulations and/or the Health and Safety Codes that, without correction, could become a risk to the Health, safety or personal rights of clients, a record keeping violation that would impact the care of clients and/or protections of their resources, or a violation that would impact those services required to meet the client's needs.

Recommendations

Riverside County Board of Supervisors
Riverside County Counsel
Riverside County Public Guardian
Riverside County Department of Mental Health
Riverside County Adult Protective Services
Community Care Licensing

1. Upon a conservatee entering a RCFE, the Office of Public Guardian and Department of Mental Health provide a list of service expectations and communication requirements for a conservatee. The following must be provided:

    a. Notify the Public Guardian immediately when a conservatee experiences an accident or injury.

    b. Notify the Public Guardian and/or caseworker when a conservatee refuses to eat, drink or take medication.

    c. Notify the Public Guardian when the health of the conservatee dramatically changes.

    d. Notify the Public Guardian when a conservatee is taken to the hospital emergency room for treatment or admitted to the hospital as a patient.

2. Community Care Licensing develop and implement a computer based RCFE rating system that would be accessible to the PG and DMH staff to assist them in selecting the appropriate RCFE that would best meet the conservatee's needs.

3. Placement of a conservatee shall not be made by the PG and DMH until a suitable and qualified RCFE is selected.

4. Public Guardian - Conservatorship Branch personally visit selected placement RCFE's prior to submitting a recommendation to the County Counsel and the Superior Court and on a regular scheduled basis thereafter.

5. Public Guardian RCFE's to submit a quarterly spending account report to the Office of the Public Guardian and surrender any cash upon the death of the conservatee.

6. Community Care Licensing enforce the RCFE licensing and certification standards for licensees and administrators to be in strict compliance with all licensing requirements.

7. Office of the Public Guardian revise and/or update all job descriptions and hold each staff member accountable for maintaining the performance standards within the scope of their duties and responsibilities.

8. CCL reinforce policies and implement stiffer monetary penalties for RCFE's non-compliance with licensing laws by establishing criteria and consequences based on the severity of the deficiency and/or repeated recurrence of the same deficiency.

9. The Office of the Public Guardian be held responsible to insure that RCFE's are adequately equipped with qualified staff and are also in compliance with Title 22, Article 8, Section 87724 for the clients placed in their facilities.

10. That formal disciplinary action be taken against the person or persons responsible for placing the Client into a RCFE that did not have trained staff to handle dementia patients or a "Dementia Waiver".

11. The Department of Mental Health and Office of the Public Guardian take the lead to initiate an annual workshop that bring together representatives from the following agencies:

- Community Care Licensing
- Mental Health Nurses and caseworkers
- Public Guardian Deputies and Nurses
- Adult Protective Services

The purpose of this annual workshop is to share ideas, establish and/or recommend policy changes, improve communication, and share data so that the service delivery to the elderly clients in RCFE's will be maintained at the highest quality and delivered with dignity and compassion.

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