

**SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA**

810



FROM: Executive Office

SUBMITTAL DATE:
August 24, 2004

SUBJECT: Response to the Grand Jury Report: Riverside County Mental Health/Public Guardian

RECOMMENDED MOTION: That the Board of Supervisors:

- 1) Approve with or without modifications, the attached response to the Grand Jury's recommendations regarding the Riverside County Mental Health/Public Guardian.
- 2) Direct the Clerk of the Board to immediately forward the Board's finalized response to the Grand Jury, to the Presiding Judge, and the County Clerk-Recorder (for mandatory filing with the State).

BACKGROUND: On July 13, 2004, the Board directed staff to prepare a draft of the Board's response to the Grand Jury's report regarding the Riverside County Mental Health/Public Guardian.

Section 933 (c) of the Penal Code requires that the Board of Supervisors comment on the Grand Jury's recommendations pertaining to the matters under the control of the Board, and that a response be provided to the Presiding Judge of the Superior Court within 90 days.

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ATTACHMENTS FILED WITH THE CLERK OF THE BOARD

Departmental Concurrence

Rhonda King
RHONDA KING
Deputy County Executive Officer

FINANCIAL DATA	Current F.Y. Total Cost:	\$ N/A	In Current Year Budget: Budget Adjustment: For Fiscal Year:
	Current F.Y. Net County Cost:	\$	
	Annual Net County Cost:	\$	

SOURCE OF FUNDS:	Positions To Be Deleted Per A-30	<input type="checkbox"/>
	Requires 4/5 Vote	<input type="checkbox"/>

C.E.O. RECOMMENDATION: APPROVE.

County Executive Office Signature *[Signature]*

- Dep't Recomm.: Consent Policy
- Per Exec. Ofc.: Consent Policy

3004 VTC 10 6/15/11
FOR THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, CALIFORNIA

RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH RESPONSE TO FINDINGS AND RECOMMENDATIONS

BACKGROUND INFORMATION:

The Background information included in the 2003-2004 Grand Jury Report (Report) contains information that is inaccurate or incomplete.

Specifically, the first paragraph of the Report states that the Public Guardian is designated by the Board of Supervisors to serve only in the capacity of conservator under the authority of the Welfare & Institutions Code, which codified the Lanterman, Petris and Short Act (LPS). This is incorrect.

In fact, the Public Guardian has been designated to serve as conservator in conservatorships established under the authority of the Welfare & Institutions Code as well as the Probate Code:

- The Welfare & Institutions Code provides authority for the Public Guardian to serve individuals suffering from mental illness and unable to provide for their own basic needs.
- The Probate Code provides authority for the Public Guardian to serve individuals that are subject to undue influence or otherwise unable to manage their personal care and/or their financial resources. In general, the persons subject to conservatorship under the terms of the Probate Code are elderly.

Further, the second paragraph of the Report sets forth the Public Guardian's responsibilities, in part, in all conservatorships whether commenced on basis of the Welfare & Institutions Code or the Probate Code.

Finally, the third paragraph of the Report states, "*There are two types of conservatorships, temporary and probate.*" This is a misleading statement in that all conservatorship proceedings, whether established pursuant to the terms of the Welfare & Institutions Code or the Probate Code, may commence by a temporary appointment of conservator and proceed to a permanent appointment.

It is more accurate to identify the two types of conservatorships according to the basis by which they are established, either by the terms of the Welfare & Institutions Code or by the Probate Code. Those conservatorships established pursuant to the Welfare & Institutions Code are often referred to as LPS Conservatorships. Those conservatorships established pursuant to the Probate Code are often referred to as probate conservatorships.

TIMELINE INFORMATION:

The Report, at page two, sets forth a timeline which is case specific to the particular Conservatee (Client) that is the subject of the report.

The Client was admitted to Riverside County Regional Medical Center under provisions pursuant to the Welfare & Institutions Code. This admission provided for a 72-hour detention for treatment. Immediately following the 72-hour period of time, a further government 14-day detention was made for continuing treatment.

Upon investigation of the Client's circumstances, the Department of Mental Health and Conservator Investigation Office accurately determined this elderly Client deserved the protections of an LPS Conservatorship. A Temporary LPS Conservatorship was obtained on November 19, 2002.

During the term of the Temporary LPS Conservatorship, the Client was represented by the Public Defender's Office. However, prior to permanent appointment of conservator in the LPS proceedings, the Public Defender and the Conservator Investigator agreed the client was more suited for the protection of a probate conservatorship. Any further proceedings in the LPS matter were continued to accommodate the investigation, preparation and filing of a probate petition for conservator.

On December 12, 2002, the Public Guardian Investigator properly submitted a report supporting a probate conservatorship. (Please note the Grand Jury Report incorrectly provides at page 3, entry dated 12/12/02, that the Public Guardian Investigator "*submitted a report to the supervising Deputy Public Guardian recommending a probate conservatorship...*" rather than correctly stating the report was submitted to the supervisor of the Conservatorship Investigation Office.)

In establishing a probate conservatorship, a petitioner may submit a doctor's declaration to the court. The doctor's declaration, in part, may evidence the proposed conservatee lacks mental capacity to provide informed consent for medical treatment and suffers from dementia. The declaration, absent any objections by other parties, is generally sufficient evidence to support the court's finding of incapacity to give informed consent and that the proposed conservatee suffers from dementia. Upon the finding of dementia, the court may authorize the petitioner to place the conservatee in a secured facility and consent to the administration of dementia medications.

A portion of the recommendation, after investigation by the Conservator Investigation Office and the Public Defender's Office, was that the Client was more suited for a less restrictive placement than that which was actually being provided under the authority of the Temporary LPS Conservatorship. (See Report at page 3, entry dated 12/12/02). In November 2002 and continuing to January 2003, at the time of filing the petition for Probate Conservator, the Public Guardian did not have a sufficient doctor's declaration to support allegations or findings of dementia. Therefore, the Petition for appointment of

Probate Conservator, filed on January 10, 2003, did not include allegations of dementia or request powers to place this client in a secured facility. The hearing was set for February 27, 2003.

After the filing of the petition for Probate Conservator, and prior to the termination of the Temporary LPS Conservatorship, the Client was moved from Vista Pacifica Rehabilitation Center (a locked facility) to Villa La Roe (an unlocked facility). (See Report at page 4, entry dated 02/07/03). At this point in time there was no court finding of dementia. Therefore, there was no necessity to place Client in a facility with dementia waiver.

On February 27, 2003, the Public Guardian provided transportation for the Client to appear at hearing on the appointment for probate conservator. The Client specifically objected to the appointment. On that basis, the court immediately appointed the Client an attorney and continued the hearing to March 27, 2003. The continuance was for the sole purpose of providing the Client an opportunity to meet and confer with her newly appointed counsel. (Please note, the Report, at page 4, entry dated 03/27/03, indicates a Deputy Public Guardian was only assigned to the Client's case on March 27, 2003. In fact, a Deputy Public Guardian had been assigned to this case almost two months prior to this hearing date, had already visited the Client in her prior facility and had transported the Client from Villa La Roe on February 27, 2003.)

At hearing on February 27, 2003, the court specifically inquired as to whether the Client wanted to continue residing at Villa La Roe. The Client answered the court by stating, "Yes, for a while. I don't know how long, but yes." (See attached Reporter's Transcript, dated February 27, 2003, at page 4, lines 8-14).

Subsequently, Deputy County Counsel, on behalf of the Public Guardian, further discussed the Client's circumstances with her court-appointed counsel. On March 26, 2003, and as a result of further investigation, the Public Guardian amended its petition to allege Client lacked capacity to give informed consent for medical treatment and suffered from dementia. In March 27, 2003, the Public Guardian filed a sufficient doctor's declaration to support these allegations.

At a hearing on March 27, 2003, the Public Guardian sought conservatorship with the additional powers to obtain restricted placement and consent to the administration of dementia medications without objection by the Client's counsel.

The Client's court appointed attorney also filed a report with the court on or about March 27, 2003. This report states the attorney visited the Client at Villa La Roe on March 18, 2003. He also spoke directly to some of the Client's caregivers at that facility. The attorney made no objections to the Client's placement at Villa La Roe.

In the Client's case, and on March 27, 2003, the court made a finding of dementia and authorized the Public Guardian to place the Client in a care or nursing facility pursuant to Probate Code Section 2356.5(b). This section provides the Conservator may

authorize the placement of a conservatee in a secured perimeter residential care facility for the elderly or a locked and secured nursing facility which specializes in the care and treatment of people with dementia. However, in conformity with the spirit of the law, the conservator should always place the conservatee in the least restrictive placement appropriate to the needs of the conservatee.

FINDINGS:

The Department of Mental Health and Public Guardian's Office take extreme exception to the Report's introductory paragraph at page 5 as follows: *"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."*

While the detriment caused to the Client in her last days at her facility was without excuse and deserving of great attention, the Grand Jury's investigation and subsequent Report do not support this introductory statement.

Elder abuse and neglect are serious allegations of breach of civil duties and criminal activity. Here, the findings by the Grand Jury of abuse or neglect are based entirely on the conduct of Villa La Roe, the board and care facility in which the client resided. The agencies charged with recommendations of the Grand Jury, including the Public Guardian, the Department of Mental Health, Community Care Licensing, Adult Protective Services, and the Ombudsman's Office did not commit any acts constituting abuse or neglect. To the extent that the introductory statement may be taken as a poor reflection on the Public Guardian's Office in particular, the Public Guardian disputes this comment and flatly rejects it. A rational evaluation of the facts supports the Public Guardian's position on this particular issue.

Specifically, since being placed at Villa La Roe on February 27, 2003, the Client was visited or checked on at Villa La Roe on at least the following days:

<u>Date</u>	<u>Contact</u>
02/27/03	Deputy Public Guardian who visited the Client at the facility, spoke to care providers and staff and transported Client to Court.
03/18/03	Court-Appointed Counsel for Client visited Client at the facility and spoke to care providers and staff.
03/27/03	Public Guardian Nurse visited Client.
06/16/03	Clinical Nurse telephoned Villa La Roe.
06/19/03	Villa La Roe contacted Public Guardian to inform Public Guardian the client was not taking medications.
06/23/03	Clinical nurse made an unannounced visit to Villa La Roe and discovered poor circumstances of the Client's care.

Further, on or about June 20, 2003, in response to the first call by Villa La Roe staff on June 19, 2003, the Public Guardian had arranged for the Client to be moved to a skilled nursing facility. The Deputy Public Guardian responded immediately to this call and

arranged for a new facility to pick up Client on the next business day, Monday, June 23, 2003.

Each finding set forth in the Report is specifically addressed as follows:

Finding Number 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".

Response:

Respondent disagree partially with the finding.

The recommendation was made on February 5, 2003. At the time of the recommendation there was no evidence the facility "lacked staff" to handle the care needs required by the Client.

Finding Number 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.

Response:

Respondent disagrees partially with the finding.

On June 19, 2003, Villa La Roe reported to the Deputy Public Guardian that the Client was not taking medications. Villa La Roe did not identify any emergency conditions. Regardless, the Deputy Public Guardian immediately, and by the following day, had arranged for the Client to be moved to a skilled nursing facility which would have provided a higher level of nursing care. The telephone call was received on a Thursday, the arrangements were completed the following Friday and the new facility agreed to pick up the Client from Villa La Roe the next business day, Monday, June 23, 2003. The Public Guardian is not aware of any other communications by Villa La Roe to other agencies and/or doctors.

Finding Number 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."

Response:

Respondent agrees with the finding.

The Public Guardian's Office has verified this comment by reviewing notes made outside of the Public Guardian's Office. Additionally, this communication by Villa La Roe of satisfactory condition and circumstances was made three days before Villa La Roe contacted the Deputy Public Guardian to communicate the exact opposite condition and circumstances. Notably, within one day the Deputy Public Guardian responded to the June 19, 2003 telephone call by Villa La Roe and located a bed at a skilled nursing facility for the Client. Arrangements were made for the new faculty to pick up the Client on the next working day. This response by the Deputy Public Guardian was actually more prompt than is required by Public Guardian policies and procedures.

Finding Number 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.***

Response:

Respondent agrees with the finding.

The Public Guardian's Office has verified this comment by reviewing notes made outside of the Public Guardian's Office.

The statement made by the referenced male staff member that the Client had not eaten for four or five days "except for a bite or two" is consistent with the communication by Villa La Roe made to the Deputy Public Guardian on June 19, 2003.

Villa La Roe's lack of a dementia waiver is not the condition that created the dire condition and poor circumstances for the Client. Implication that the very poor care of the Client is a result of the facility not having a dementia waiver is without merit.

The abuse and neglect that led to Client's demise are not related to the Client's diagnosis of dementia. The abuse and neglect were a result of failure to provide basic care to the Client.

The Community Care Licensing would cite any facility for conditions that were similar to the conditions, which existed at Villa La Roe in June 2003. Any reasonable person would know better than to create or tolerate such conditions. Certainly, the Deputy Public Guardian, on his prior visit to the facility, would have noticed the same poor conditions had they existed at that time. Certainly, the Client's court-appointed attorney would have noticed the same poor conditions had they existed at that time. Certainly, the Public Guardian Nurse would have noticed the same poor conditions had they existed at that time. The problems that were created by Villa La Roe was not the result of lacking a dementia waiver, it was neglect. The Public Guardian has not been able to verify why the care suddenly and significantly became insufficient, but believes there was

conduct at Villa La Roe that suddenly and significantly put the Client at risk without any warning or notice to any other agencies or persons.

Finding Number 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.

Response:

Respondent disagrees with the finding.

The Clinical Nurse reported the conditions of the Client appropriately. Specifically, she called for emergency police assistance (911), immediately reported the poor conditions to the Ombudsman; immediately contacted Community Care Licensing and followed up with a written report. A representative of the Ombudsman’s Office has confirmed that, in general, the Ombudsman cross-reports suspected elder abuse to law enforcement.

Therefore, the Clinical Nurse did report the conditions of the Client in a manner conforming to the requirements of the Department of Mental Health Policy #218 and by elder abuse reporting law, pursuant to Welfare and Institutions Code Sections 15630-15632 (see attached excerpt from the Welfare and Institutions Code).

Finding Number 6:

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

Response:

Respondent agrees with the finding.

The Public Guardian’s Office has verified this comment by reviewing notes made outside of the Public Guardian’s Office.

Finding Number 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.

Response:

Respondent agrees with the finding.

The Public Guardian's Office has verified this comment by reviewing notes made outside of the Public Guardian's Office.

Finding Number 8:

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

Response:

Respondent agrees with the finding.

The Public Guardian's Office has verified this comment by reviewing notes made outside of the Public Guardian's Office.

The Welfare & Institutions Code Section 15630(b)(1)(A) provides that if the suspected abuse occurs in a long-term care facility, a report by a mandated reporter should be made to the local Ombudsman or the local law enforcement. Adult Protective Services appropriately did not intervene since they were not the appropriate responding agency in these circumstances.

Finding Number 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.

Response:

Respondent agrees with the finding

The Public Guardian's Office has verified this comment by reviewing notes made outside of the Public Guardian's Office.

Finding Number 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.

Response:

Respondent disagrees with the finding.

The Public Guardian had first hand knowledge, by and through his counsel, that the conservatorship had been established on March 27, 2003. The Department of Mental Health did not bear this duty.

Finding Number 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).

Response:

Respondent disagrees with the finding.

The Public Guardian's Office did not neglect to consult with Community Care Licensing. This is not a practice, policy or legal obligation of the Public Guardian's Office.

The Public Guardian is responsible for placing hundreds of clients every year. Facilities are responsible to communicate the services they provide in connection to their licenses. If a client is referred to a facility that is not licensed to manage the particular needs of a specific client, it is the obligation of the facility to so inform Public Guardian. This appropriate business practice has been the standard within this industry over many, many years.

The Community Care Licensing Manual for Residential Care Facilities for the Elderly includes regulation 87724 CARE OF PERSONS WITH DEMENTIA, which reads, in part, as follows: "(a) Licensees who accept and retain residents with dementia shall be responsible for the following: (1) Ensuring that...staffing is adequate to provide supervision for residents with dementia...[and] (4) Ensuring that facility staff are trained...in dementia care, identifying and reporting resident abuse and neglect, and the behavioral effects of medication on residents with dementia."

In normal business fashion, facilities are generally concerned to maintain their licenses, and this is the incentive to inform the Public Guardian when a facility is not licensed to take or retain a conservatee.

Most facilities have some deficiencies, although not serious enough to warrant withholding placement of a conservatee. In fact, the Department of Mental Health has been sued for withholding placements from a facility whose deficiencies did not meet Community Care Licensing's criteria for withdrawing or otherwise restricting the facility's license.

When a facility's deficiencies are sufficient to warrant revocation of its license, Community Care Licensing informs the Public Guardian in advance so that appropriate measures can be taken to timely move any clients already placed in that specific facility. The Public Guardian may also avoid making any further placements in that particular facility.

Villa La Roe had clear knowledge it was not licensed to care for demented clients in their facility. In March 2003, while caring for the Client, Villa La Roe was actually cited by Community Care Licensing for also caring for another person that suffered from dementia. This person was not a client of the Public Guardian. However, if not prior to Client's placement, at least in March 2003, Villa La Roe had knowledge of its own licensing provisions and should have disclosed the same to the Public Guardian.

The Public Guardian is not obligated and/or otherwise required to review and/or implement Community Care Licensing (CCL) regulations. However, in an effort to completely respond to this Report the Public Guardian has conducted independent research regarding licensing and the issuance of waivers.

There are at least seven different types of waivers or exceptions a facility may obtain. A cursory glance at CCL regulations evidences the regulations are numerous and complex. Moreover, they are frequently revised. Very recently, a Supervisor in the Riverside Office of Community Care Licensing informed the Public Guardian that the state is planning on discarding dementia waivers entirely. If this takes place, any licensed Residential Care Facilities for the Elderly will be able to accept clients with dementia.

The Public Guardian's Office does not have the staff, time or budget to be trained in all these regulations and would not be able to monitor constant changes and modifications. The Public Guardian must rely on the business customs and practices presently in place and in the moral ethics of all agencies and care facilities to also adhere to their respective obligations, responsibilities and duties.

Finding Number 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.

Response:

Respondent disagrees partially with the finding

The Public Guardian's Policies and Procedures Manual has not been updated since 1998. However, this statement does not support the conclusion that, current operating procedures are not properly delineated.

Many current operating procedures are reflected in the Policies and Procedures Manual. Many other current operating procedures are reflected in the several other manuals that are used to train, educate, and manage behavior of employees of the Public Guardian's Office. These other manuals include the Board of Supervisors' Policy Manual, the Department of Mental Health Policy Manual, and multiple manuals associated with specific units within the office.

All of the above-identified manuals were offered to the Grand Jury, but they declined to see or review them. Instead the Grand Jury chose to only review the Public Guardian Policies and Procedures Manual and one policy from the Department of Mental Health Policy Manual (the policy on Reporting of Elder and Dependent Adult Abuse/Neglect).

The Grand Jury incorrectly stated that the policy on reporting of elder abuse was not followed when it was, in fact, precisely followed. The Grand Jury also failed to recognize the immediate action taken by the Deputy Public Guardian to remove the Client from Villa La Roe and to place her in a higher level of nursing care; action taken more swiftly than policy required to move the Client. Specifically, the Deputy Public Guardian opined that the Client needed a higher level of care and took it upon himself to make arrangements for her move rather than assigning the matter to the Public Guardian Nurse and waiting for her demanding schedule to provide an opportunity to begin the process of seeking placement. While certainly a departure from policy, the Deputy's action constitutes a rather minor deviation and is one that furthered the Client's best interests in a creative and industrious manner.

Finding Number 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.

Response:

Respondent agrees with the finding

Finding Number 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.

Response:

Respondent agrees with the finding

The Public Guardian's Office has verified this comment by reviewing records generated by Community Care Licensing staff.

Finding Number 15:

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

Response:

Respondent agrees with the finding.

The Public Guardian's Office has verified this comment by reviewing records generated by Community Care Licensing staff.

RECOMMENDATIONS:

Recommendation Number 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.*

Response:

The recommendation has been implemented.

Recommendation Number 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.

Response:

The recommendation does not require action by the Public Guardian's Office or by the Department of Mental Health.

Recommendation Number 3:

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

Response:

The recommendation has been implemented and has been the practice of the Public Guardian.

Villa La Roe was licensed to handle the sundry medical conditions, including diabetes and hypothyroidism, afflicting the Client. As far as the dementia is concerned, at the time of placement, it was the opinion of the Public Guardian Investigator, a Licensed Clinical Social Worker, that Client was demented which resulted in the probate conservatorship proceeding and appointment of conservator. At the time of the referral and placement of the Client at Villa La Roe, the Public Guardian did not have confirmation of the dementia diagnosis by a professional at a level (psychologist or psychiatrist) that would cause the Court to find Client demented. For this reason, the Villa La Roe may not have even needed a dementia waiver to accept the Client. Prior to appointment of conservator, there was no objection to the Client's placement.

Subsequent to the Report, the Public Guardian has directed all placement staff to request all Residential Care Facilities for the Elderly send the Public Guardian's Office a copy of its license and any waivers or exceptions.

Recommendation Number 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.

Response:

The recommendation will not be implemented.

This recommendation is unreasonable in respect to the onerous burden on resources and duplicity of process that it would create.

The Public Guardian's Office appropriately relies on other trained professionals for assistance in placing clients and monitoring facilities. Other staff than the Conservatorship Branch are equally or better informed about specific facilities. Some placements are even out of the county. Some placements are out of the state. The Public Guardian conducts courtesy visits of conservatees from other counties who are placed in Riverside County, and we expect the reciprocal courtesy from other county employees for our conservatees placed in distant locations.

The implementation of this recommendation would cost many thousands of dollars per year in travel expenses; would reduce services to other conservatees and prospective conservatees because of the absences of staff in conducting visits and would significantly delay placements. A delayed placement may actually cause further detriment to some clients. Further, in one recent case, over 300 separate facilities were contacted in order to secure placement for one client.

Recommendation Number 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.

Response:

The recommendation will not be implemented.

Presently, the Public Guardian conducts quarterly visits, in part, to review facility records. This is a very efficient and effective method to monitor conservatees' finances.

The Public Guardian does, and has, requested facilities surrender all cash upon the death or relocation of a conservatee. Other than the unique circumstances of Villa La Roe's suspicious actions, facilities are prompt to act to this routine request.

Recommendation Number 6:

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

Response:

The recommendation does not apply to the Public Guardian's Office or to the Department of Mental Health.

Recommendation Number 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.

Response:

The recommendation will not be implemented.

Job descriptions are within the jurisdiction of Human Resources. However, the Public Guardian does implement Duty Statements. Duty Statements are generated in the Public Guardian's Office and are updated approximately every two years. The Duty Statements will be updated by October 1, 2004. Staff are held accountable for maintaining performance standards which is reflected in yearly performance evaluations.

Recommendation Number 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.

Response:

The recommendation does not pertain to the Public Guardian's Office or to the Department of Mental Health.

Recommendation Number 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.

Response:

The recommendation will not be implemented.

Community Care Licensing bears the explicit responsibility for insuring "that RCFEs are adequately equipped with qualified staff and are also in compliance with Title 22". The Public Guardian cannot assume this responsibility.

The Public Guardian will verify with Community Care Licensing that a facility has a valid license and is not facing revocation of that license when we place clients.

Recommendation Number 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".

Response:

The recommendation will not be implemented.

As stated, the Public Guardian relies on each facility to inform the Public Guardian if a referral is appropriate or inappropriate. In this case, Villa La Roe knew they did not have a dementia waiver, and chose to accept and to maintain the Client. This decision was maintained even after Villa La Roe was cited by Community Care Licensing for caring for another demented client.

Since the Public Guardian has never instructed staff to determine whether a facility had a dementia waiver, disciplining an employee for not doing so would be inappropriate.

At this present time, the Public Guardian will direct staff to verify whether a facility has a dementia waiver prior to placement of any client and for so long Community Care Licensing continues to issue the same. Specifically, this directive will be accomplished in part through the establishment of a policy which will require that the Public Guardian staff person responsible for approving a placement must acquire a copy of the license and any waiver or exception the facility has prior to authorizing the placement of a client in a board and care facility. The policy will be written and in place by October 1, 2004. Staff have already been informed by memo of this requirement, and failure to meet it will result in such disciplinary action as is approved by Human Resources.

Recommendation Number 11:

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

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

Response:

This recommendation has existed for several years prior to the Grand Jury investigation and published Report.

Staff from Community Care Licensing, Department of Mental Health, Public Guardian, and Adult Protective Services have been meeting as part of the multi-disciplinary CARE Teams for over five years. CARE Team meetings address all purposes stated as part of recommendation 11.