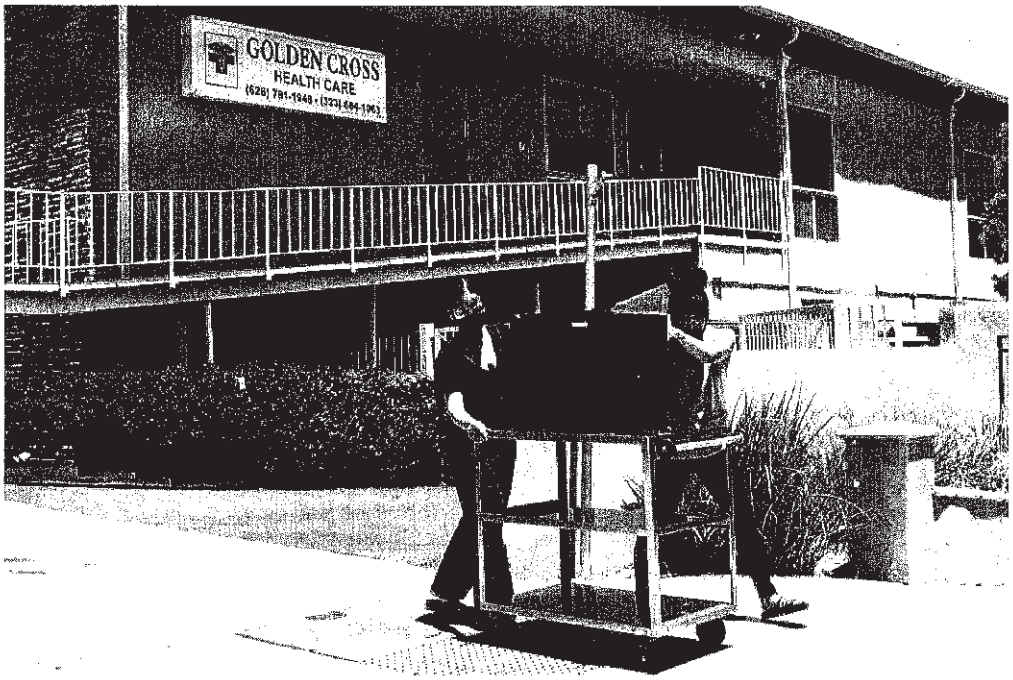
ATTACHMENT K

Pasadena Star News article, dated June 18, 2020

NEWS • News

Inside the 'anarchy' of Pasadena's evacuated nursing home



Belle Piedrasanta, left, and Mira Alvarez remove belongings of a relative who worked at the Golden Cross Health Care facility as it was evacuated because the operators were failing to provide even the most basic health services in Pasadena on Friday, June 12, 2020. (Photo by Keith Birmingham, Pasadena Star-News/ SCNG)

By **BRADLEY BERMONT** | bbermont@scng.com | Pasadena Star-News

PUBLISHED: June 18, 2020 at 3:29 p.m. | UPDATED: June 19, 2020 at 6:59 a.m.

State nursing home investigators had been in and out of Pasadena-based Golden Cross Health Care for 11 days when they walked into a resident's room just after 6 p.m. on May 26 to find him sitting alert in bed with dark red stains on his shirt.

They were "old blood stains," the man told state investigators, stemming from a dialysis treatment some time earlier, though he couldn't remember the exact date. The man — who needed assistance to walk, bathe and change his clothes — said he hadn't showered in two weeks.

He felt afraid and forgotten, he told investigators. His clothes were dirty because the nursing home staff wouldn't wash them, he said.

By far, he was not the only one, investigators discovered.

Facility staff were reluctant to even enter Golden Cross' coronavirus unit, which is where the man was living after he tested positive for the virus, according to investigative reports provided by the California Department of Public Health.

Neither lawyers nor the facility's owners responded to multiple requests for comment from this newsgroup.

The reports are the legal foundation for the state's move to evacuate the facility and suspend its operating license last week, a first for California during the coronavirus pandemic.

The documents detail the alleged failings of a nursing home whose leaders didn't adequately train employees, refused to communicate with medical advisers and fell short providing the most basic levels of care for residents — not to mention significant infection control violations — leaving dozens of residents malnourished, dehydrated and vulnerable to COVID-19.

Making matters worse, nursing home advocates say the state had known about systematic failings in the facility going back to 2011.

Linens were often dirty, residents' clothing went unchanged and many were left laying in their own urine for hours at a time, the state's investigative reports say.

Bed sores were a common sight and one resident was at risk for a limb amputation because his or her wounds were left untreated for so long.

Other allegations of assault and abuse went unreported by facility leadership until the state intervened, including a nurse who was allowed to keep working after he allegedly "slapped and pushed" a resident into bed, one report says.

Fruit flies buzzed around the kitchen area where a full food cart was reportedly left next to an open door with a dumpster just beyond it; meanwhile, kitchen workers were observed failing to wash their hands before handling residents' meals.

Later, those workers told investigators they didn't know the proper way to clean the food cart after it had been exposed to the facility's coronavirus wing.

Patients across the facility complained food often arrived late and cold, if it arrived at all, and sometimes meals were taken away before they were able to finish, according to a written testimony from the facility's state-assigned temporary manager Karen Lapcewich, who was sent in June 2 to help fix the situation.

She found the facility in disrepair with a dysfunctional air filtration system and blown circuits linked to an overuse of oxygen devices, leaving one patient hypoxic.

Both systems are critical while managing coronavirus outbreaks, experts say, as the virus tends to travel on small droplets through the air and frequently attacks its hosts' respiratory systems.

All but seven of Golden Cross' 64 residents were infected or awaiting test results when state investigators were onsite between May 15 and 28, according to an analysis of city data and state reports. Seven other residents had already died.

By June 2, state health officials had taken over leadership at the facility, putting Lapcewich in charge, backed by state resources and a specialized team.

Calling it a "grave concern," Lapcewich wrote that the facility was lacking even a "basic functioning" infection control program.

By the time the facility was evacuated on June 10, an eighth resident, a Latino, had died while infected with coronavirus.

There are five other nursing homes in Pasadena that have seen similar case and death numbers as Golden Cross, but none has required this level of intervention.

'Anarchy' and infection control

If a facility is following state, federal and local guidelines, patients who have tested negative for coronavirus are allowed to live in one area of the facility while everyone else is supposed to be isolated or quarantined separately.

The distinction between isolation and quarantine is common knowledge among medical workers who deal with infectious diseases: Isolation is for folks who are infected. Quarantine is for those who may be infected.

Golden Cross didn't differentiate between the two, the state reports say, and the facility's interim administrator couldn't tell investigators what the difference was.

She said people who tested negative were sent to one part of the facility — including folks who tested negative, but were later exposed to the virus — while everyone else was on the other side, whether they were awaiting test results or already knew they were infected.

Not to mention, the plastic barrier meant to separate the two zones had a broken zipper, and it was left "unzipped and open," the reports say. When asked when it would be fixed, the facility's activity director said she didn't know.

Alongside several nurses and housekeepers working in the coronavirus wing, the interim administrator couldn't say which residents were positive and which were awaiting test results.

Later that day, when investigators went into the facility's coronavirus wing, they found a hallway full of open doors.

Against all government protocols, residents were allowed to walk around unencumbered, whether they had the virus or were awaiting test results, but the interim administrator hadn't been up there to see it.

She was afraid to go into the coronavirus unit, she told inspectors. She didn't want to get infected herself.

The facility leaders' fear of catching coronavirus "speaks volumes of the confidence they placed in their own systems to protect the staff and residents when they themselves refused to engage in it," argued Tony Chicotel, a staff attorney for California Advocates for Nursing Home Reform.

"I read bad reports all the time," Chicotel said in an interview Tuesday. "This goes beyond anything we've seen so far, especially COVID-19-related. It seems like this facility just disintegrated. It was anarchy."

There was one instance in which a coronavirus-positive resident who suffers from schizophrenia cursed at workers and said he was leaving. He walked down the driveway, then back into the area meant for residents who had tested negative.

The facility's activity director told investigators they had no control over the resident and didn't know what to do with someone who didn't comply with their orders. She said she'd have to discharge him from the facility, though it's not clear that actually came to pass.

'No leadership'

When facility leaders found themselves short-staffed and needing nurses, they turned to a registry service that sends out nurses for hire. It's a common practice used by many facilities which found themselves short-staffed during coronavirus. But in this case, those nurses were poorly trained by facility leaders, if they were trained at all, the reports say.

The director of nursing acknowledged to investigators many of the nurses were new but couldn't say who trained them. There was no full-time staff developer helping train or monitor staff, the report says.

In numerous cases, investigators heard contradicting accounts from staff when they asked about the facility's procedures, even those considered the most basic of practices, such as tracking medications or delivering food to residents.

Some patients — including those suffering from cancer, schizophrenia, diabetes, bipolar disorder, anxiety, depression and a litany of other ailments — were given the wrong doses of their medications. Sometimes they received less than what physicians had requested, sometimes more. Sometimes none at all.

There were times medications simply couldn't be located, according to the reports.

The facility's medical director, who works offsite as a type of consultant, told investigators the facility was "in bad shape" and had "no leadership." The interim administrator wouldn't communicate with him regarding current issues at the facility, he said.

At least three workers, all hired from registries — two certified nurse assistants and one licensed vocational nurse — didn't have coronavirus training before heading to the facility to work with coronavirus patients. It's something for which the facility was supposed to screen before filling the positions, according to the reports.

One of the assistants told investigators she never received any orientation for the facility.

Investigators witnessed multiple staff members improperly wearing personal protective equipment while working in the facility's coronavirus wing. They also took it off and put it on in inappropriate environments, often mixing dirty and clean gear together, they detailed in the reports.

At least one certified nursing assistant told officials he didn't know how or where to change his protective equipment.

Three others said they "had to reuse the disposable blue gowns (used as protective equipment) for an entire week," one of the reports says.

Meanwhile, some workers were seen taking shortcuts through the wing meant for coronavirus-negative patients without washing their hands or changing out of their potentially contaminated equipment.

The lack of training and leadership support impacted significantly more than the facility's coronavirus response, however. It affected even the most basic levels of care, leaving patients dehydrated, malnourished and stewing in their own filth.

A pattern of neglect

When Lapcewich arrived at the facility, she found more than a dozen patients who were dehydrated to the point of needing intravenous fluids because the facility didn't have a program in place to track residents' hydration, she wrote in her testimony.

One assistant told investigators that the "facility did not provide fresh water to the residents because the kitchen staff would not step inside the COVID area to bring water."

The assistant said workers would fetch water from the sink when it was requested, but didn't have a response when investigators asked what they did for folks who couldn't get out of bed or call for assistance.

One resident didn't like how the sink water tasted and asked investigators for a drink of cold, fresh water. She told them staff didn't routinely provide water, adding that she was "sad and stressed," one report says.

There was no weight management program either, Lapcewich said, noting that about nine out of 10 patients in the facility had recently lost weight because the facility's kitchen wasn't following menus or portion control, and they weren't offering evening snacks until the state took over on June 2.

Similarly, there was no "skin management program to prevent residents from getting pressure ulcers," she wrote, explaining that bed-ridden residents weren't getting turned on a regular basis and their bed sores were worsening.

One resident, a quadriplegic with dementia who is entirely dependent on staff for care, had open wounds that were yellow and oozing. Gauze around the wound was dark brown and falling off, according to the reports. The director of nursing couldn't tell investigators how long the wound had been there; the patient's medical record was missing and no physician had been notified.

When asked by investigators, facility staff couldn't say who was supposed to provide the wound treatments or why it hadn't been done. And it wasn't just this man, there were others too.

The programs meant to monitor for these situations and ensure no one gets left behind "are the lifeblood of nursing homes," Chicotel said. "You're continually assessing and all that self-reflection was just gone here. The wheels completely fell off."

But this didn't come as a huge surprised for Chicotel or his colleagues at the California Advocates for Nursing Home Reform. The state had already investigated this facility once in 2011 and found many of the same issues.

'A record of shame'

With a program called Operation Guardians, the state sent doctors to make surprise visits at nursing homes around California in 2011. Golden Cross was among those they visited.

Even then, investigators found issues with dehydration, nutrition, understaffing, medical record inconsistencies, medication mix ups and more.

The report, which was acquired by the advocacy group through a public records request and made available to this newsgroup, concluded there were "significant and troubling" findings that had harmed residents.

It's infuriating for Chicotel, who wanted to blame state officials as much as the people running the facility.

The state saw these issues in 2011, he said, "but they went unexplored."

While the California Department of Public Health is responsible for oversight and enforcement of these facilities across California, Los Angeles County is different. Here, the state contracts with the county's health department to handle nursing home inspections.

"There's a lot to be desired from the state" when it comes to nursing home enforcement, he said, "but Los Angeles County has a record of shame. They do a very poor job of enforcing our quality-of-care standards, and they're notorious for doing it poorly."

Officials from Los Angeles County's health department did not respond to multiple requests for comment from this newsgroup.

Although the responsibility to inspect these nursing homes falls on the county, there's no record indicating that county officials took action to help the residents in this facility.

Chicotel questioned the efficacy of recent inspections in March and May, conducted by Los Angeles County officials, which found no deficiencies in Golden Cross' coronavirus management practices or its overall management.

Pasadena officials have said they were the ones who sounded the alarm and alerted state officials to the problems they were seeing. It took weeks of prodding and cajoling with multiple complaints, city officials say.

"They were trying to utilize the system, but the system wasn't responsive," Chicotel said.

There were systems in place meant to prevent this level of deterioration, he said. Representatives for the state health department told the Legislature they were calling every facility every day, forcing them to fill out surveys and sending inspectors to the sites.

"All these systems were in place to prevent this from happening, and yet it happened," he said.

Officials' defense

A spokesperson for the state health department responded to Chicotel's critiques via email.

"At the start of the pandemic, we were onsite at Golden Cross Health Care and identified quality-of-care issues that needed to be immediately addressed," the spokesperson wrote. "Throughout the following weeks, we were in communication with Golden Cross Health Care daily and revisited the nursing home 18 additional times. We attempted to work with their management team to improve care for their residents. These critical improvements were not being made, and this was putting residents in danger."

The spokesperson continued, arguing they provided resources and staffing "for weeks," but despite "significant levels of support from the state, this nursing home was not meeting quality-of-care standards."

That's why they brought in a temporary manager — "the most significant enforcement action we have," the spokesperson said. That manager was meant to stabilize the facility or advise officials if they should relocate the patients.

But Chicotel said the action should have come sooner, especially because state officials knew about the more serious quality-of-care issues back in 2011. The spokesperson, however, did not respond to questions about the 2011 investigation.

Even though the Pasadena Public Health Department isn't responsible for inspecting nursing homes in the city, Vice Mayor Tyron Hampton believes locals also should have acted more quickly.

The city does have the legal authority to prosecute these facilities and their owners, but it doesn't have the authority to suspend its license or evacuate its residents. That lies solely with the state.

Even so, Hampton has called for city health officials to be on the ground, in these nursing homes and assisted living facilities — not just inspecting them virtually — documenting failures and pushing the state to act.

Health officials have consistently pushed back on his requests, arguing that's exactly what they've done, holding up Golden Cross as an example of their efficacy. Hampton still says it should've come sooner.

When asked for a response, city spokeswoman Lisa Derderian replied via email:

"We reject any effort to politicize the tragedy of COVID in skilled nursing facilities by blaming the Public Health Department and damaging the credibility of those working the hardest for the most vulnerable within our community. The Health Department has been front and center in protecting our residents and in helping address systemic problems that are being seen nationwide."

Derderian argued that the city had visited the facility in-person "over a dozen times," starting in January, but "mostly in May."

She said the local health department had "provided extensive, hands-on technical assistance on COVID-19 prevention and control to Golden Cross."

Health officials trained the facility workers "regarding implementation of infection control best practices, including proper use of personal protective equipment and testing for COVID-19."

She continued: "Pasadena public health nurses and (health Director Dr. Ying-Ying Goh) were onsite and aggressively advocated for action to protect the residents, and facilitated communication with the (state health department) and the Office of the Ombudsman in the interest of residents.

"Were it not for the joint effort of Public Health and the Fire Department, it is probable that this facility would not have been shut down or that depopulation would not have occurred so quickly and professionally," Derderian added.

Tags: **Coronavirus**, **public health**, **Top Stories LADN**, **Top Stories PSN**, **Top Stories SGVT**

Bradley Bermont | Reporter

Bradley Bermont is a reporter in Los Angeles. He covers city hall and school board meetings for Pasadena, Pico Rivera and El Monte. His work has been featured on KPCC, KQED, the Daily Beast and others. He graduated with a Master's of Science in Journalism from the University of Southern California. Prior to journalism, he worked in nonprofit copywriting and fundraising.

bbermont@scng.com

Follow Bradley Bermont @bradleybermont