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DEPARTMENT OF
FINANCE

BETTY MASUOKA
DIRECTOR

CITY OF SACRAMENTO
CALIFORNIA

February 15, 1989
FA:89028:BM:KMF

CITY HALL
ROOM 14
915 I STREET
SACRAMENTO, CA
95814-2685

916-449-5736

DIVISIONS:
ACCOUNTING
BUDGET
REVENUE
RISK MANAGEMENT

Budget and Finance Committee
Sacramento, California 95814

Honorable Members in Session:

SUBJECT: Councilmember Request for Funding For Residential Care Ombudsman

SUMMARY:

The attached report from Councilmember Robie requests \$50,000 from the General Fund on an annual basis beginning in the current year to augment funding for the Residential Care Ombudsman program.

BACKGROUND:

In October, 1988, the County Board of Supervisors allocated \$49,400 to create a second full time ombudsman position through the Senior Ombudsman/Advocacy Project (SOAP), a non profit organization funded by federal, state and county sources. The organization is also staffed with approximately 20 volunteers. The justification for the County augmentation was to increase the Ombudsman/Advocacy program in Sacramento County (including the City) as it relates to the investigation of complaints and monitoring of residential board and care facilities. There are approximately 365 residential care facilities in the County of which about 160 are within the City limits.

As stated in the attached report, Councilmember Robie has requested that the City provide on-going funding for a third full-time Ombudsman to augment the monitoring and complaint investigation of residential care facilities specifically within the City of Sacramento. Prior to the County augmentation, approximately 20 board and care facilities countywide were monitored. The additional County funding allowed for an additional 100 facilities to be monitored. The requested funding from the City would allow for the monitoring of additional 90 facilities bringing the total to 210. Of the total monitored, 100 would be within the City of Sacramento

POLICY CONSIDERATIONS:

At issue here is, given the City's fiscal condition, should it expand its area of responsibilities to encompass the monitoring of board and care facilities. It should also be noted that this added responsibility would be an augmentation of a program already currently funded by the County.

FINANCIAL:

The only available source for the requested \$50,000 is from the General Fund. Funding the program in the current year would require an equal reduction elsewhere in the budget, assuming adoption of the Midyear Review recommendations. In future years, funding could be provided from the Public Safety Utility Users Tax increment based on this being a public safety program (as opposed to a social service program).

RECOMMENDATION:

This report is presented for information only, pending action from the Committee.

Respectfully submitted,



BETTY MASUOKA
Director of Finance

RECOMMENDATION APPROVED:



JACK R. CRIST
Deputy City Manager

Attachment

Contact Person: Betty Masuoka, Director of Finance
449-5736

Office of the Sacramento City Council

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MEMORANDUM

February 7, 1989

TO: Betty Masouka, Finance Director

FROM: Lynn Robie, Councilmember, District 8

SUBJECT: **FUNDING FOR RESIDENTIAL CARE OMBUDSMAN**

Attached is some additional information regarding the merits of the City providing \$50,000 in funding for the Residential Care Ombudsman Program.

I think the key points this information brings up are:

- * This is a public safety program, not a social service program
- * Under Federal and State law, only the Senior Ombudsman/Advocacy Project can perform the types of protective functions we require
- * Funding this program can help PREVENT the tragedies like "F Street" from occurring in the City.
- * Using matching funds from the County of Sacramento and the Sierra Foundation, a study of local conditions in board and care homes will be conducted in order to develop a comprehensive local management plan
- * Local and state legislation will be developed to give local government more clout in determining where board and care homes are placed in existing neighborhoods

I recognize that the City has some severe financial constraints that make it difficult to consider funding new activities while we are cutting back existing programs. However, the human cost of not moving forward with this program will be much greater than most cutbacks the City must consider. We don't need another "F Street" to prod us into action.

I really appreciate your assistance in this matter. Please call me should you have any questions.

LR/SP/drn

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**RESIDENTIAL CARE OMBUDSMAN THROUGH THE
SENIOR OMBUDSMAN/ADVOCACY PROJECT**

Introduction

More than 160 residential care facilities serve more than 2800 elderly, mentally, and developmentally disabled people in the City of Sacramento.

This is an industry that is largely unregulated, has been the source of serious abuses of residents, and has produced a constant stream of constituent complaints.

The worst that can happen is the recent "F Street" case, where seven elderly board and care residents were found murdered.

Although usually perceived as a social service function, the monitoring and investigation of board and care homes has clearly been elevated into a public safety concern. All over the City, disadvantaged citizens are potentially being robbed, beaten, and criminally neglected.

The fact is, the City does not know what is happening in its board and care homes.

Recent funding from the County to monitor board and care homes does not provide sufficient funds to adequately protect City residents. That is why the City must move forward and become responsible for the inadequate public protection it is providing to residents in the City's board and care.

Budget Request

\$50,000 would fund one full-time residential care ombudsman/advocate position. This position would provide quality of care monitoring, complaint investigation, and reporting of alleged abuse for board and care residents located in the City of Sacramento. A line-item budget is attached to this report.

The City residential care ombudsman/advocate would be responsible for the following specific goals:

- * To reduce the level of abuse and neglect in City residential care facilities by responding to complaints from residents, family members, and public agencies
- * To improve the quality of care in City facilities by on-going monitoring
- * To prevent abuse and neglect through education of patients, family members, and board and care operators.
- * To improve the coordination of public agency response to reported incidents of neglect or abuse

- * To gather data to develop a local plan to improve board and care homes
- * To work with local legislators to develop both local and state legislation which will improve local government's ability to regulate and monitor board and care homes and their impact on existing neighborhoods

Administration

The funding would be administered by Area 4 Agency on Aging on behalf of the Senior Ombudsman Advocacy Project (SOAP). Under authority of State and Federal law, SOAP is the only community or public agency that has the responsibility and authority to investigate and resolve **any** complaint by **any** resident of **any** licensed or unlicensed facility.

Under the provisions of the federal Older Americans Act and the state Welfare and Institutions Code (Sec. 9700), the Ombudsman has greater access rights into these facilities than any City agency, including the Police Department. Under law, the Ombudsman may talk privately with residents and investigate their complaints. The Ombudsman has access rights to review all of the pertinent records. The Ombudsman can do this without probably cause or legal basis to ensure that these frail and dependent people are being treated properly.

The intent of the law is to ensure that the Ombudsman is aware of problems in these facilities. Recently the Ombudsman has been designated by the Welfare and Institutions Code as the Investigator of Elder and Adult-Dependent Abuse. These responsibilities empower the Ombudsman to pursue investigations in **any** licensed and unlicensed residential care facility. Complaints are referred to the Ombudsman from hospitals, doctors, health care providers, City police officers, and many others in the community. These individuals and agencies are, in fact, required by state Law to report these complaints to the Ombudsman.

One-third of the Ombudsman 30 monthly complaints about abuse of elder and adult-dependent people occur from residents of facilities located in the City. Another 60 complaints monthly come from City facilities and relate to problems other than life-threatening abuse.

Rationale

PUBLIC SAFETY. This is not a social service program. As evidenced by the "F Street" case and other cases of criminal neglect, this is a public safety issue. By law, the Police Department is not authorized to investigate complaints without probable criminal cause. Only the Ombudsman/Advocate can investigate complaints and **prevent** criminal actions before they

occur. Without adequate protection by a City-funded Ombudsman, abuse and criminal neglect in City board and care facilities will continue.

SOAP AS SOLE SOURCE GRANTEE Under state and federal law, only the Senior Ombudsman/Advocacy Project is authorized to perform the type of monitoring, investigation, and enforcement that is required to reduce the level of abuse and neglect. Although other non-profit agencies may provide valuable social service activities, they are not authorized, by law, to perform the public safety functions of the Ombudsman.

PROTECTION. Residents of board and care homes must be protected from criminal neglect and abuse. This can only be done through on-going monitoring of homes and education of consumers, family members, and facility operators. The funding provided by the City will ensure that quality facilities are rewarded, sub-standard facilities are up-graded or closed down, and that patients and their families will have adequate information to make informed choices about the type of care they desire.

PREVENTION. Prevention of abuse and criminal neglect in board in board and care facilities is the ultimate goal of this program. This will be accomplished by gathering data about existing conditions and developing a long-term plan to improve board and care homes. In addition, with matching funds provided the County of Sacramento and the Sierra Foundation, the City Ombudsman/Advocate will advise on the development of local and state legislation which will protect both neighborhoods and board and care home residents from sub-standard conditions.

RESIDENTIAL CARE OMBUDSMAN/ADVOCATE

ANNUAL BUDGET

| | |
|----------------------------------|----------|
| Advocate/Ombudsman | \$30,000 |
| Secretary (part-time) | 7,000 |
| Benefits | 5,000 |
| Travel | 4,000 |
| Rent (existing space, shared) | 1,500 |
| Supplies | 500 |
| Postage | 300 |
| Office equipment rental | 1,100 |
| | <hr/> |
| | \$49,400 |

Buried in the files

"Sins of Omission," the report of the independent county patient rights group investigating what went wrong in the F Street boarding house deaths, concludes that the safety net of social welfare agencies is largely an "illusion." Many within the network of agencies — police, parole agents and social workers — failed to do their job, the report says.

The characterization is too strong. The system obviously failed the seven people found buried in Dorothea Puente's back yard — and perhaps others. But many within that system, as even the report acknowledges, are dedicated and work hard to protect those least able to protect themselves. For people assisted by these workers, the safety network is not an illusion.

Nonetheless, in the case of F Street serious mistakes were made:

In August 1987, Sacramento police investigated the drug overdose death of a 58-year-old tenant at Puente's boarding house. A check of law enforcement computers would have informed them that Puente was an ex-felon on parole for overdosing elderly patients and stealing their government checks who was forbidden by the conditions of her parole from caring for the elderly. No check was made.

In June 1988, a Sacramento social worker from Adult Protective Services alerted other caseworkers about Puente's criminal past and urged them not to place clients in her care; yet no one from the agency bothered to visit Puente's home or to contact parole

officials. State parole agents not only knew that ex-felons were rooming with Puente but frequently referred parolees to her in direct violation of the conditions of her parole.

Almost as disturbing are the responses of the agencies criticized by the report. The Police Department, instead of acknowledging shortcomings disclosed — warnings ignored, crimes overlooked — quibbles about discrepancies in the recollection of events by individual officers and other witnesses. Similarly, the chief U.S. probation officer, defending the performance of his department, says that Puente was on high-activity supervision, but makes no attempt to reconcile that assertion with the embarrassing fact that parole agents for years were conned by Puente and failed to recognize that she was operating a boarding house for the elderly in violation of parole conditions. And from other agencies there came a catalog of bureaucratic buck-passing: not our job, beyond the scope of this agency, etc., etc.

The hope, of course, is that these evasive responses were made only for public consumption and conceal a deeper concern and a determination to act on it. The Puente case was one in a million. But what it reveals about the routine activities of public agencies suggests that a lot of other, less dramatic things may be falling through the same cracks. One hopes that despite what they say in their responses to the report, the agencies understand that, too.