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# California's Newly Reformed Residential Care Facilities for the Elderly (RCFE)

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## Abstract

The main issues of this paper address California's residential care facilities for the elderly and its reformation in late September 2014 due to advocacy pressure after 29 years of non-compliance. There are approximately 36,000 assisted living (AL) and residential care (RC) facilities in the United States, which house over a million people. Although the federal government standardized nursing home guidelines, the AL and RC industry is state regulated. These facilities are comprised of a wide variety of facilities serving a range of people needing various levels of medical and personal assistance. California's Residential Care Facilities for the Elderly (RCFE) comprise the AL and RC industry. To examine the differences between federal and state housing standards of aging individuals, the authors chose the state of California because of its high population of residents in RCFEs and to discuss some of the reform measures from the RCFE Reform Act of 2014.

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## Aging in Place

The rapid growth of the aging population in the United States is unprecedented in the nation's history. As a result, the number of Americans age 65 and older is projected to exceed 89 million by 2050, and Americans age 85 years and older are expected to exceed 20 million by 2050 (CDC 2013; Miller, Mor, and Clark 2010). At some point in the life course many older people experience decreased physical and psychological abilities that affect their social and cultural independence. According to a report by Maisel, Smith, and Steinfeld (2008), nearly 70 percent of Americans live in single family homes and the overwhelming majority of this housing has barriers (steps, narrow doorways) that make it difficult or impossible for someone with a physical disability or in a wheelchair to enter or exit the home.

In recognition of the cost of long-term care for dependent older adults and the widely held desire among older people to live independently in their homes, the US government formed the National Aging-in-Place Council (NAIPC). NAIPC coordinates local chapters, service providers, consultants, community planners, and builders to help older individuals remain independent (NAIPC 2014) to avoid the high costs of nursing home residency. However, many older adults do not have the money to renovate their homes, and do not have relatives to help with home renovation or to provide housing (NAIPC, 2014). According to Lawton (1980b), there are five living environments to describe the interaction between a person and his or her environment (p. 41). Lawton (1980a) emphasizes that as people age they are increasingly sensitive to environmental change, more so following midlife because of reduced competence such as decreased cognition, motor skills, and status.

The assisted living device industry has responded with innovative products to help older individuals perform routine activities of daily living (ADL) such as bathing, grooming, meal preparation, and independent activities of daily living (IADL) such as housekeeping and shopping (Faletti 1984). Designers fit products to an individual's ability to perform ADL/IADL tasks so older people can more easily live independently in a supportive home and community (Faletti 1984). Despite federal and state governance of home remodeling, and innovative products to assist older adults to age at home, many older adults, especially individuals older than age 85, need to relocate to alternative housing for assistance with impairments of the aging process.

# Aging Housing Policy Issues

## Federally Regulated Long-Term Nursing Home Facilities

Because of widespread elder abuse and neglect, the federal government has enacted laws to protect vulnerable older adults. The Centers for Medicare and Medicaid Services (CMS 2014) define statutes §1819(a) and §1919(a) for a "skilled nursing facility" and a "nursing facility." Both facilities are "primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or services to individuals (above the level of room and board), which can be made available to them only through institutional facilities" (CMS 2014, §1819). Institutional providers that do not meet statutory definitions can't participate in Medicare or Medicaid programs (CMS 2014).

CMS provides telephone numbers for ombudsman offices by state and the Federal Office of Ombudsman is located in the Federal Bureau of Investigation (FBI) Headquarters to assist ombudsmen from each state (FBI 2014). The U.S. Printing Office provides up-to-date electronic code of Federal Regulations (e-CFR) for Title 42 – Chapter 1 – Public Health Service, and Subchapters A-M that delineates skilled nursing and nursing facilities that the Department of Health and Human Services governs (USPO 2014).

Individuals in the care of skilled nursing facilities and nursing facilities often sustain injuries such as decubitus ulcers (open wounds), malnutrition and dehydration, physical, emotional, sexual or verbal abuse, fractures from repeated falls or traumatic brain injuries, and wandering or elopement (CDC 2014).

## US State-Regulated AL and RC Facilities

Because the number of adults 85 and older is increasing each year, the number of residents in assisted living (AL) and residential care (RC) facilities is increasing faster than residency of long-term skilled nursing home facilities (Robnett and Chop 2014). AL and RC are transitory facilities that fill the gap between living independently at home, and 24-hour, seven days a week nursing facilities (Robnett and Chop 2014). However, policies governing ALs and RCs are often generally defined. For example, because there is no standard cost index for products and services in AL and RC facilities, many states prefer to allow AL and RC facility managers to negotiate costs with potential elderly residents and their families (NCAL 2013; Stevenson and Grabowski 2010).

According to the National Center for Assisted Living (NCAL 2012), the increase in assisted living residency is driven by consumers' need for adaptive products and professional services that support chronic diseases and dementia impairments in a built-environment design that is intrinsic to new universally designed homes in the US for aging-in-place. Stevenson and Grabowski (2010) report that elders who need in-depth care prefer residency in AL or RC facilities to a nursing home by six to one. Assisted living is a relatively new concept that first took form in the early 1980s and has subsequently gained wide acceptance (Wilson 2007). AL/RC settings are fully accessible to meet the needs of elders who can live independently with adaptive environmental supports such as wide doorways and showers that accommodate wheelchair access, lowered kitchen counters and cabinets, and raised toilets, (Marsden 1999; Wilson 2007).

Most of the million residents currently residing in AL and RC facilities in the US are unable to live in their own homes because of physical and/or mental impairments. US home builders did

not formally begin architecturally defining home improvement to older homes, universally designed (UD) homes, or built-environments of new homes for aging-in-place until the late 1990s and refinement continues into the 21st century. UD follows the Architectural Barriers Act of 1968, the Rehabilitation Act of 1973, Fair Housing Amendments Act of 1988, and the Americans with Disabilities Act of 1990 (NARIC 2014).

There are seven principles of universal design**:** equitable use, flexibility, simple and intuitive use, perceptible information, tolerance for error, low physical effort size, and space for approach and use (NARIC 2014). If new or renovated housing designs addressed the barriers older adults face with current housing environments, and neighborhoods provided quality resources, older adults' level of functioning would improve and be congruently in-balance (Lawton 1980b). But, because cohort effects, period effects, and historical effects shape individual development and are different from person-to-person, the results will be different and complex (Settersten 2003).

There is little consensus on the definition of assisted living in the United States, and according to Zimmerman and Sloane (2007), " a single, universally agreed-upon definition of assisted living does not exist" (p. 36); while Hedrick et al., (2007) argue that assisted living is defined as "group housing with additional services" (p. 366). Additional services might be prepared meals, social activities, transportation, and some degree of 24-hour protective oversight and assistance with ADLs and IADLs (Marsden 1999; Robnett and Chop 2014; Zimmerman and Sloane 2007).

Unlike federallygoverned nursing home standards, AL and RC facilities sharply differ by state because of the range of adaptive environmental needs and professional supportive services available (Grabowski, Stevenson, and Cornell 2012; NCAL 2013). Federal policy allows broad state-to-state variety of "assisted living" that cannot be defined in any meaningful way. Indeed, the federal government currently assumes no significant role in setting standards for assisted living facilities (Grabowski et al. 2012; Hawes and Phillips 2007; NCAL 2013).

Interchangeable standards among AL and RC facilities might be a strength or a weakness depending on the facility and the adaptive needs of older adults. Due to a hands-off approach to government regulation, the loosely defined state protection of aging Americans in AL/RC facilities has come under state legislative pressure by advocacy groups and families of aging residents such as The National Long-Term Care Ombudsman Resource Center (NORC 2014).

**California State-Regulated Residential Care Facilities for the Elderly (RCFE)**

The California Department of Aging (CDA) (2014) promotes independence and well-being for older adults, adults with disabilities, kinship caregivers, and residents in long-term nursing facilities. Funding is administered under the Older Americans Act, the Older Californians Act, and Medi-Cal through contracts with the Administration on Aging (CDA 2014). CDA reports its core values are integral to administration**:** leadership, diversity, advocacy, accountability, quality, innovation, collaboration, integrity, empowerment, and respect (CDA 2014). CDA's older population increased from 1.6 million adults in 1950 to 6.1 million in 2010, and the state projects an increase from 8.5 million in 2020 to 15.3 million in 2060.

California's Residential Care Facilities for the Elderly (RCFE) are licensed and regulated by California Code of Regulations, Title 22, Division 6, Chapter 8 (2010), which includes portions of the Health and Safety Code and are unique to California as there is no national definition of assisted living (Hawes and Phillips 2007). Under Title 22, an RCFE is defined as a,

> housing arrangement chosen voluntarily by the resident. . . . or other responsible person; where 75 percent of the residents are 60 years of age or older and where varying levels of care and su-

pervision are provided, as agreed to at time of admission or as determined necessary at subsequent times of reappraisal (CCR, §87101 2010, p. 20).

California's combined assisted living facilities, retirement homes, and board and care homes fall under the RCFE title. Currently, California oversees 7,500 RCFEs that accommodate approximately 175,000 residents; the largest number of facilities in any state (Carlson and Orlowski 2014). According to the California Advocates for Nursing Home Reform (CANHR 2013), the vast majority of RCFEs (79 percent) have six or fewer beds, while most RCFE residents (71 percent) live in one of the 50 or more bed RCFEs (Table 1). The majority of RCFE residents pay out-of-pocket expenses for personal, specialized care that costs from $2,500 to $8,000 per month (CANHR 2013). California's public policy on funding RCFEs through Medi-Cal and Supplemental Security Income (SSI) welfare systems is extremely limited, so access to care through an RCFE is generally limited to those who can afford to pay privately (CANHR, 2013).

The National Senior Citizens Law Center (NSCLC 2014) recommends California implement ceilings for care in its RCFEs as other states have done where care levels determine the type of housing by resident**:** (1) skilled nursing care 24-hours a day, 7 days a week; (2) deficits of ADLs; (3) medication administration; (4) creates danger to one's self or to others; (5) requires physical restraints; (6) specified medical conditions; (7) home health care; and (8) hospice provides care. At present, California operates all RCFEs under a single-tier system, which means there is only one license to operate all RCFEs regardless of the facility's residency demographics. In general, any licensed RCFE facility may accept and retain a resident provided he or she meets the eligibility criteria and does not have a disqualifying medical condition (Carlson and Orlowski 2014; NCAL 2013).

California's 1985 one-tier licensing system for RCFEs originally envisioned housing its older individuals who needed room, board, supervision, and assistance with ADLs but *did not* require on-site health care, which skilled nursing home facilities typically provide (Carlson and Orlowski 2014). However, increasingly unhealthy individuals are being accepted into RCFE housing with impairments requiring physical and mental medical attention, despite the admissions criteria checklist. This indicates that nonmedical professionals are (1) administering or setting up medication protocols, (2) participating in assessments, (3) participating in care planning, and (4) coordinating or supervising care, especially dementia care (NSCLC 2014). It is speculative how California will manage the steady increase in the number of aging Baby Boomers with physical and mental impairments in the near future. This influx of individuals needing assistance will affect the state's housing and healthcare delivery systems up to year 2030 when all boomers fully retire. The oldest of the Boomer cohort is already applying for RCFE residency and their numbers will no doubt force legislators to accept residents with multiple physical and mental impairments due to the rising costs of skilled care.

*California's Governance of RCFEs*

California may be the most lagging state when it comes to regulating AL/RC facilities. It still operates with a little-changed assisted living law enacted in 1985. A one-size-fits-all model approach does not meet the needs of those who cannot age independently and have increasing care needs. Public health and advances in medicine have increased the life expectancy of aging Americans by 30 years (CDC 2013). This dramatic increase in the life span of older adults comes with an increasing prevalence of chronic diseases (CDC 2013). The 10 most common chronic conditions among those in RCFEs are high blood pressure (57 percent), Alzheimer's disease or other dementias (42 percent), heart disease (34 percent), depression (28 percent), arthritis (27 percent),

**Table 1. Title 22 Adaptation of Regulations by Facility Size.**

| | Strata 1<br>1-6 beds | Strata 2<br>7-16 beds | Strata 3<br>16-49 beds | Strata 4<br>50-99 beds | Strata 5<br>100+ beds |
|---|---|---|---|---|---|
| Administrator Qualifications (§87564) | High school diploma or GED certificate;<br>No residential care experience | High school diploma or GED certificate;<br>No residential care experience | 15 college units, CE Semester or equivalent quarters with passing grade;<br>1 year residential experience | 2 years college;<br>3 years in residential care | 2 years college; 3 years in residential care |
| Food Preparation (§87576) | No requirements;<br>Caregiver staff prepare meals | No requirements;<br>Caregiver staff prepare meals | 1 person designated with primary responsibility for food planning, preparation, and service with training | 1 full-time person qualified by formal training or experience in food service. Requires regular consult with dietician. | 1 full-time person qualified by formal training or experience in food service. Requires regular consult with dietician. |

*Source:* California Code of Regulations (CCR) (2010). Title 22 Social Security, Division 6 Licensing of Community Care Facilities, Chapter 8 Residential Care Facilities for the Elderly (RCFE). Retrieved from <http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/rcfeman1.pdf>.

osteoporosis (21 percent), diabetes (17 percent), chronic obstructive pulmonary disease and allied conditions (15 percent), cancer (11 percent), and stroke (11 percent) (Caffrey et al. 2012).

With these diseases in mind, the need for quality long-term care services and supports including RCFEs will be a requirement for older adults' continued health and well-being. The days of a simple board and care model for California are over. RCFEs need to start incorporating a satisfying home life environment, good quality of life, and capable health care into the evolving needs of the California aging community.

*Unresolved and Pertinent RCFE Reform Issues in California*

Although 10 of 20 proposed state bills regarding California RCFE reform were signed into law in late September 2014, it is uncertain whether California's 29-year history of negligence of RCFEs will continue. In particular, the state's outdated, one-tier model approach does not fit the increasing needs of the aging population. Areas replete with cases of neglect and abuse are facility inspections and enforcement of state regulations overseeing RCFEs (Elder Law Advocacy). Facilities also fall short when investigating health and safety issues filed by residents and families, collecting fines for civil penalties, licensing compliance, and increased training of administrators and direct-care staff (Elder Law Advocacy 2014).

Over the last decades, RCFEs have distinguished themselves from nursing homes by keeping a solid line differentiating residents who have medical needs from those who do not. The line that was drawn became smudged and California's regulatory structure became unrecognizable. It is unknown when, why, and how RCFEs grew into noncompliance shelters, but they are currently accepting older adults who have physical and mental impairments that require assistive prod-

ucts and assistive caregiver services within adaptive environments to meet impairment needs. The pattern may mean RCFEs are actually functioning as nursing homes to avoid federal oversight. RCFE policies govern property leasing/investors' adaptive living home environments and special care amenities for elders to age in-place, semi-independently, for as long as possible to avoid nursing home residency.

**Who is Accountable?**

According to Carlson and Orlowski (2014), the California Department of Social Services Community Care Licensing Board (CCL) regulates RCFEs, and although it acknowledges many residents need certain health care services, the CCL reported they have not had the "resources for policy and regulatory changes to keep pace with the public's changing expectations" (p. 3). At some future point, the state will have to accept accountability for almost three decades of a broken system.

California's Community Care Licensing (CCL) board oversees the training of RCFE administrators and staff, facility inspections, and investigates health and safety issues filed by residents and families (CANHR 2014). CCL is also charged with overseeing noncompliant RCFEs, collecting imposed facility fines, and ensuring public transparency of RCFEs "deficiencies, complaints, civil penalties, licensing, and facility ownership" (Elder Law Advocacy 2014, p. 1). To date, 28 of 50 states require facility inspections every 12–15 months, where California only requires RCFE inspections every five years (CANHR 2013; NORC 2014).

The CCL acknowledges it is too understaffed to meet the state's five-year inspection quota (CANHR 2013). Because of understaffing and time constraints, inspectors cannot conduct comprehensive inspections. Instead, the board uses checklists of 32 "key indicators" (Figure 1) to resolve the problem of understaffing, inspection time allowances, and wages (CANHR 2013; Carlson and Orlowski 2014). It is unclear whether inspectors are meeting the statutory policy standards because there are no government transparency reporting requirements of RCFEs to the public, residents, or advocates who seek this information (CANHR 2013).

At present, the *maximum* fine is $150 per day for noncompliant RCFE facilities (CANHR 2013; Carlson and Orlowski 2014), compared to California nursing homes fines that are assessed from $2,000 to $100,000 for noncompliance, but it is unknown whether this fine is per day (CANHR 2013). During a recent five-year period, California fined RCFEs approximately $2 million, but CCL collected only $1 million because of understaffing, thus, noncompliant RCFEs continued operating without paying fines (Thompson 2014). More importantly, incidents of RCFE negligence are not penalized because CCL does not hold facility owners accountable for their employees' behaviors. For example, an incident gained media attention when an RCFE employee collected mushrooms from the RCFE lawns and fed them to residents; four residents died, and many others were hospitalized, yet, the RCFE owner and employee were not criminally charged with homicide, negligence, or penalized (CANHR 2014).

In late September 2014, California's Governor Jerry Brown took the first steps when he signed a bill that will enforce a 100-fold increase in RCFE fines. Once this law goes into effect, the maximum penalty will be raised from the current paltry sum of $150 per day to $15,000 per day for violations that cause death, and $10,000 per day for violations of negligence that lead to severe injury and abuse (Schoch 2014). On the heels of violation enforcement, Governor Brown signed a bill that requires facilities to fix state inspection problems within 10 days of filing a report. The law requires paper inspection reports to be available to the public online by the year

**Figure 1. Residential Care Facility for the Elderly Key Indicator Tool(kit) # 1**

RESIDENTIAL CARE FACILITY FOR THE ELDERLY
KEY INDICATOR TOOL (KIT) # 1

Compliance areas not listed on this tool, but observed as deficient during the facility review, will be cited on the visit report

| REVIEW CATEGORY | REGULATION | COMPLIANCE INDICATOR DESCRIPTION |
|---|---|---|
| PHYSICAL PLANT | 87202(a) | **(Zero Tolerance)** All facilities shall be maintained in conformity with the regulations adopted by the State Fire Marshal for the protection of life and property against fire and panic. |
| | 87204 (a) | **(Zero Tolerance)** Facility shall not operate overcapacity or beyond any conditions and limitation on the license. |
| | 87307 (e) | **(Zero Tolerance)** All pools and bodies of water will be appropriately secured. |
| | 87309 (a)(3) | **(Zero Tolerance)** Ammunition shall be stored and locked separately from firearm. |
| | 87303(b) | Facility must maintain a comfortable temperature for residents. |
| | 87307(d)(6) | All outdoor and indoor passageways shall be kept free of obstruction. |
| | 87303 (e)(2) | Hot water temperature must be between 105 degrees F and 120 degrees F. |
| | 87303(e)(4) | Licensee shall ensure presence of grab bars for each toilet, bathtub and shower used by residents. |
| | 87303(e)(5) | Bathtub or shower must have non skid mats or strips. |
| | 87303(i) | Facilities with a capacity of 16 or more shall have a signal system that operates from each resident's living unit. |
| FOOD SERVICE | 87555(a) | The total daily diet shall be of the quality and in the quantity necessary to meet the residents needs. |
| | 87555(b)(26) | Minimum of one week supply of nonperishable foods and 2 days of perishable foods. |
| | 87555(b)(23) | All readily perishable foods or beverages capable of growth of micro-organisms must be stored in covered containers at appropriate temperature. |
| CARE & SUPERVISION | 87411(a) | **(Zero Tolerance)** The facility shall ensure sufficient and competent staff to provide the services needed to meet resident needs. |
| | 87705(k)(8) | Delayed egress devices shall not substitute for trained staff in sufficient numbers to meet the needs of all dementia residents and to escort residents who leave the facility. |
| | 87705 (f) | Items that could constitute a danger shall be stored inaccessible to dementia residents. |
| | 87411(c) | Staff assisting residents with ADLs shall receive required training. |
| RECORD REVIEW | 87411(g) | Criminal Record Clearance for all required persons is associated to the license. |
| | 87411(c)(1) | Staff responsible for direct care and supervision shall have current first aid training. |
| | 87458(a) | Prior to a person's acceptance as a resident, the licensee shall obtain and keep on file, documentation of a medical assessment, signed by a physician within the last year. |
| | H&S Code 1569.626 | Facilities that advertise or promote special care, special programming or special environment for persons with dementia shall meet the additional training requirements for all direct care staff. |
| ADMINISTRATION | 87212(a) | Each facility shall have a disaster and mass casualty plan. The plan shall be in writing and be readily available. |
| | 87777(a) | **(Zero Tolerance)** Excluded Person - The Department may prohibit an individual from serving **on** a board of directors, as executive director, or officer; being employed or allowed in a licensed facility. |
| | 87755(a) | **(Zero Tolerance)** Employees of CCLD shall be allowed to enter the facility to conduct inspections. |
| | 87405(a) | A certified administrator must be on the premise for a sufficient number of hours to manage and oversee the business operation. |
| | H&S Code 1569.627 | Licensees that advertises or promotes special care, special programming, or a special environment for persons with dementia shall disclose to the department the special features of the facility in its plan of operation. |
| | 87209 (b) | Exceptions and Waivers - Unless prior written approval of the licensing agency is received, all community care facilities shall maintain continuous compliance with the licensing regulations. |
| | 87411(h) | All services requiring specialized skills shall be performed by personnel qualified as appropriately skilled professional. |
| MEDICAL RELATED SERVICES | 87615 | Persons who have a prohibited health condition shall not be admitted or retained in a residential care facility for the elderly. |
| | 87465(c)(2) | Medications must be given per the physician's directions. |
| | 87465(e) | There shall be a signed and dated written order from a physician for every prescription and nonprescription PRN medication. |
| | 87465(h)(2) | Centrally stored medicines shall be kept in a safe and locked place. |

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Source: Community Care Licensing Division (CCL). (2011). Residential care for the elderly key indicator tool(kit) #1. Retrieved from <http://www.myccl.ca.gov/res/docs/RCFE-kit1.pdf>.

2020, though inspection of facilities will remain at intervals of every five years due to costs (Schoch 2014).

Currently, the CCL does not communicate the demographics of its 7,500 RCFEs in operation to the public by either year-end reporting, newsletters, or website. The paucity of information on the RCFE website is limited to the number of beds, facility addresses, and contact persons per facility (CANHR 2013). At present, when potential RCFE residents and their family members wish to obtain in-depth information on an RCFE facility, they must plan for a road trip to one of eight District offices to file an in-person request (CANHR 2013).

CCL's policy presents a major barrier to older, disabled people who cannot drive or do not own a vehicle, or do not know of anyone who can transport them to obtain information. Moreover, family members who wish to investigate a particular facility will have to take their own time to access information that could be easily accessible online. Of the elders who might have Internet connectivity, facility compliance information could be downloaded from the CCL website if documents were made available to the public as other states do. For example, Pennsylvania's assisted living website allows word searches by county or zip code and provides digital copies of each facility and inspection report (Carlson and Orlowski 2014).

Proposed legislation, AB 1571, would have required an online system so consumers could check details on licenses, violations, complaints, and other information on RC facilities that were rejected when it reached the CA senate in late September 2014 (CANHR, AB 1571, 2014). Some counties are taking it upon themselves to start RCFE care rating systems. San Diego County leads the way by agreeing to spend up to $250,000 over the next two years to implement a voluntary rating system for RC facilities in the county (McDonald 2014). The proposed system will alert consumers to the background history of RCFEs in the county and provide other pertinent information about facilities (McDonald 2014).

**Who Is Providing Quality Care in RCFEs?**

Most state assisted living facilities require one to ten hours of training for direct-care staff because state policymakers have not determined the importance of adaptive housing, security, staffing, training, and any level of assistive care that is offered to indigent elders (NCAL 2013). In fact, California's RCFEs are increasingly providing housing to aging residents who have serious impairments that are typically treated in skilled nursing facilities. It is unknown whether long-term care facilities do not have vacancies or California policymakers are avoiding the high costs of nursing care through Medicare, Medicaid, and Medi-Cal policies by authorizing CCL and RCFEs to accept quality of care protocols at a fraction of the cost for unskilled elder care.

California RCFEs are increasingly providing housing to residents who have serious health problems. Many facilities are advertising "memory care" residency units for older individuals diagnosed with dementia. Until five years ago, these dementia patients would have been admitted to skilled nursing homes under the current one-tier "board and care" system (CANHR 2013). This decision is disquieting because RCFEs policies and nursing home policies are governed separately. Thus, whether RCFEs are collecting funding from taxpayers or private funding, the question is whether California or the US government is accountable for medical malpractice or deaths due to unskilled labor.

Another cause for alarm is the policy of staffing for night shifts. Currently, RCFEs must provide an "on call" employee for the security of fewer than 15 residents, whereas other RCFEs must provide an "on call" and "onsite" employee for the security of more than 16 residents

(CANHR 2013). It is unknown whether RCFEs are complying with policies, or CCL is enforcing policies.

Under current CCL policy, the minimal requirement for direct-care staff includes being 18 years of age or older, passing a criminal background investigation, and obtaining from one to ten hours of training for direct care (including first aid training) within the first month of employment, and six hours annually (CANHR 2013; Carlson and Orlowski, 2014). Many topics covered in RCFE training materials are broadly defined in assisting residents with bathing, toileting, feeding, and medication monitoring by someone "knowledgeable in the relevant subject" matter (Carlson and Orlowski, 2014, pg. 24).

RCFE facilities currently do not require administrators to have a college degree or professional license/certification. Rather, a high school diploma or GED equivalent, a 40-hour in-service class, and passing California's state exam is all that is currently required (CANHR 2013). There is no requirement for RCFE employees to achieve an academic degree and be a Licensed Practical Nurse or Registered Nurse to qualify to monitor elderly residents' health, polypharmacy, and dementia behaviors on a routine basis (CANHR 2013). By contrast, in Connecticut, instructors are registered nurses with at least two years of relevant experience supervising direct-care staff, and all instructors are licensed, registered, and/or certified in their caregiver field (NCAL 2013).

To remedy the problem, Governor Brown signed SB 911, which doubled the training mandate for administrators from the current 40-hour required coursework to 80 hours (Schoch 2014). Direct care staff, including staff who work with dementia impaired residents, will require more training, and potential RCFE administrators must undergo a more rigorous testing process (Schoch 2014).

It is no wonder state residents demanded reform. Nevertheless, considering the CCL's past history, it is dubious whether there will be much change since Governor Brown's RCFE reform of September 2014. According to Elder Law Advocacy (2014), the reform focuses on health and safety issues**:** (1) administrator and staff training; (2) annual inspections; (3) admissions; (4) resident bill of rights; (5) complaint investigations; (6) family councils; (7) increased fines; (8) licensee ownership disclosure; (9) online consumer information system; (10) resident councils; (11) staffing for higher acuity; and (12) suspension and revocation. These legal issues are pertinent to the increasing demand for affordable housing by healthy and unhealthy older individuals.

## Discussion

There is limited research on the quality of care offered by RCFEs. There are even fewer government resources to assist advocates, consumers, and potential residents when evaluating a facility (Stevenson and Grabowski 2010; Zimmerman et al. 2005; Zimmerman et al. 2003). By increasing staff training and the number of medical professionals in RCFE facilities, elderly residents are more likely to age-in-place. Implementing policy change can significantly increase the quality of care, and easy access to up-to-date information in each RCFE facility would greatly benefit residents, care providers, and the community. In this way, RCFEs can better serve elderly Californians and their families as they arrive at decisions that best match the choices of potential residents.

Not all assisted living/residential (AL/RC) facilities are created equal. Facilities differ considerably from state to state. Even within a state, individual assisted living facilities may bear

relatively little resemblance to one another. It is well-known that AL/RCs are not equivalent to nursing home care, and nursing home standards should not be imposed on AL/RCs.

One could deliberate this change of policy as a method of averting costly, federally regulated nursing homes in favor of relatively inexpensive state-regulated RCFEs. It is unknown why CCL approves the warehousing of dementia patients without the supervision, security, and federal oversight this vulnerable cohort requires. The older population is at risk to abuse and neglect that requires control by medical clinicians and elder law advocates. In particular, older adults with cognitive impairment need assistive products, and safe, adaptive environments that degreed, licensed, and professionally trained clinicians provide 24-hours a day, seven-days a week.

California has the largest number of assisted living facilities in the nation and should set the bar for residential care and cease to operate under substandard care conditions that ultimately endanger the lives of a vulnerable, rapidly expanding population. Advocates of housing reform and other states remain in a holding pattern on whether policymakers have established a standard model that other states can emulate. Namely, how to provide efficient and effective quality living standards to the aged and disabled who are trying to live independently in nurturing, adaptive housing that promotes health and wellness.

This mission would send a loud message, especially to older individuals, that Californians care about their aging citizens' health and safety. For now, the nation is on standby while California attempts to reverse its 29-year history of noncompliance in regard to the AL/RC community. Although this paper is an attempt to acknowledge California's RCFE reform is moving in the right direction, advocates had hoped for more comprehensive changes when 20 bills were simultaneously presented at the recent legislation session. The impact of change is now on the table of California's Department of Social Services, which has an almost 30-year track record of limited abilities at implementing compliance of RCFEs. There will be more demand by advocates, RCFE residents, and families in proving that California is properly caring for its at-risk elderly population.

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