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Understaffed and Overworked: Poor Working Conditions and Quality of Care in Residential Care Facilities for the Elderly

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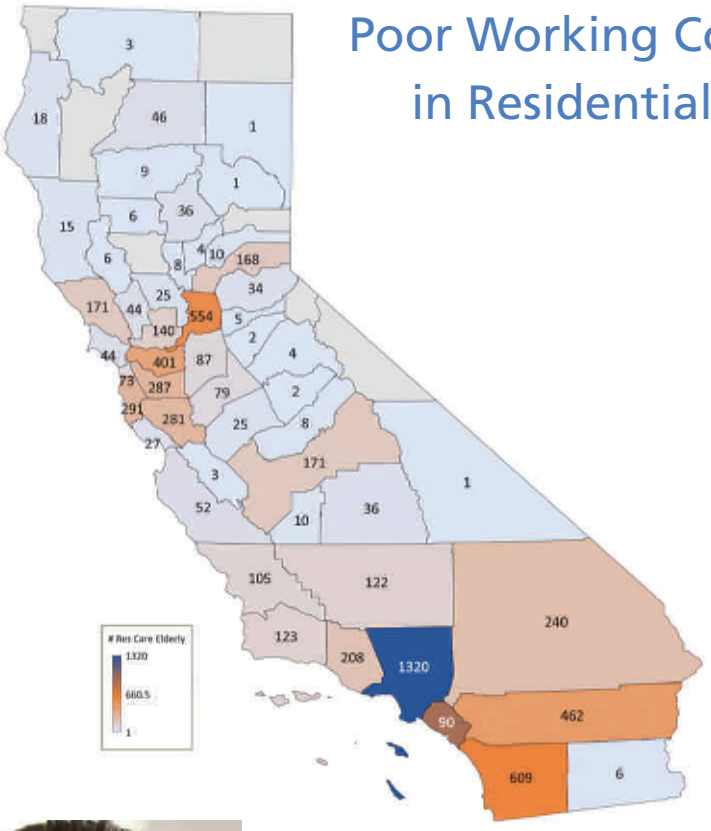

By: Hina Shah

Coalition for a Fair and Equitable Caregiving Industry

May 2017

The Coalition For a Fair and Equitable Caregiving Industry is made up of legal service providers, worker centers, unions, community-based nonprofit organizations and consumer advocates who are invested in reforming the caregiving industry to ensure that workers and consumers of care receive fair and equitable treatment. The Coalition includes the following organizations: Asian Americans Advancing Justice – Asian Law Caucus, Consumer Advocates for RCFE Reform, Filipino Advocates for Justice, Filipino Community Center, Katharine and George Alexander Community Law Center, Legal Aid at Work, Pilipino Association of Workers and Immigrants, Pilipino Workers Center, Santa Clara County Wage Theft Coalition, SEIU Local 2015, and Women's Employment Rights Clinic of Golden Gate University School of Law.

This report was written by Hina Shah, Associate Professor of Law and Director, Women's Employment Rights Clinic, Golden Gate University School of Law. Over a course of a year and a half, the report was meticulously researched and public records data analyzed by students in the Women's Employment Rights Clinic including Cara Alsterberg, Annie Banh, Eden Bautista, Theresa Brick, Sherri Bridgeforth, Marcela Calderon, Dustin Cameron, Jamie Cooperman, Ava Elong, Andrew Gabriel, Emily Genge, Lauren Fazio, Regina Feliciano, Kelsey Ibarrola, Lindsey Lepire, Valerie Leones, Christina Liang, Mary Loung, Ryan Ng, Huyen Nguyen, Shane Sagisi, Ishtar Saiyady, Donald Smith, Caitlin Verano, Sarah Wintermute, Mark Winthrop, as well as Jocelyn Caballero, undergraduate intern from the University of San Francisco and Jennifer Sta.Ana, volunteer attorney.

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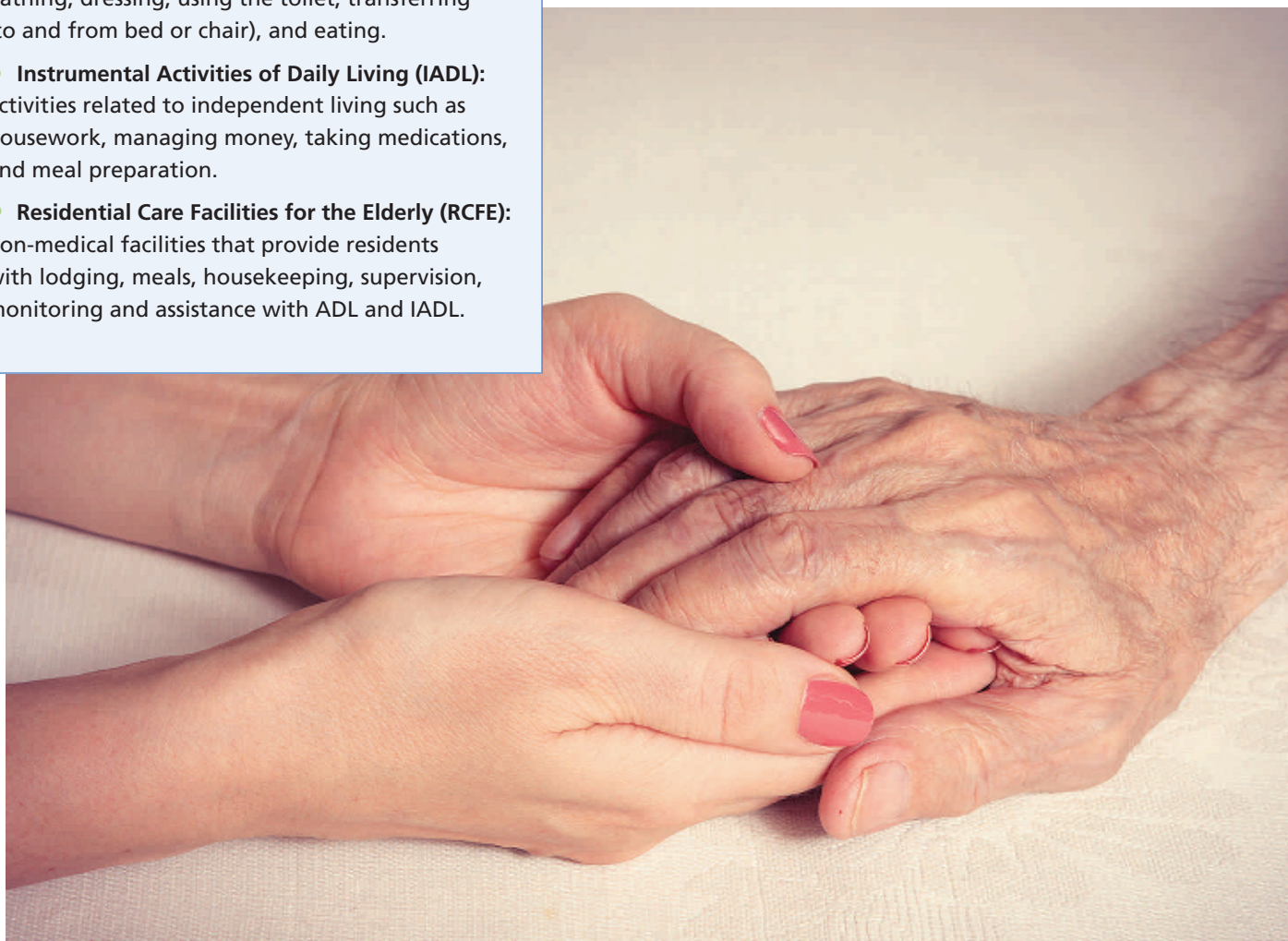
Executive Summary

The United States is experiencing unprecedented growth in its elderly population. As Americans live longer and cope with chronic health conditions, the need for long term services and support (LTSS) has increased. The vast majority of elderly persons need assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to physical and mental impairments. LTSS are provided in a continuum of care from the individual's home to institutional settings. There is a range of options from highly regulated skilled nursing facilities, also called nursing homes to residential care facilities for the elderly (RCFE), also called assisted living facilities or board and care homes.

This report explores how the structural and exploitative nature of working conditions in RCFEs contributes to poor quality of care and life outcomes for residents. Working conditions are an integral and essential component to residents' well-being. A sustainable and fair work environment for caregivers in RCFEs, thus, is a health care necessity.

- **Long Term Services and Support (LTSS):** Describes a continuum of medical and social service care, with a vast majority being non-skilled, non-medical assistance with ADL and IADL.
- **Activities of Daily Living (ADL):** routine fundamental care activities such as bathing, dressing, using the toilet, transferring (to and from bed or chair), and eating.
- **Instrumental Activities of Daily Living (IADL):** activities related to independent living such as housework, managing money, taking medications, and meal preparation.
- **Residential Care Facilities for the Elderly (RCFE):** non-medical facilities that provide residents with lodging, meals, housekeeping, supervision, monitoring and assistance with ADL and IADL.



Key Findings

- California has almost six times more RCFEs than nursing homes.
- There is growing evidence that RCFEs are accepting residents with acute medical needs or cognitive impairment that require on-going medical monitoring, similar to those residents in skilled nursing facilities.
- There is no requirement that RCFEs have skilled licensed staff either on-site or on-call. Currently, there are no staffing ratios for RCFEs other than for minimal staffing on the night shift.
- A common practice among small RCFEs (facilities with 6 or fewer beds) is to hire one to two caregivers as live-in or 24 hour shift workers, pay flat daily or monthly rate without accounting for hours worked or minimum wage or overtime rules. Many caregivers often work around the clock, without proper pay, adequate sleeping facilities or sufficient sleep. Frequently, small RCFEs do not keep records or keep inaccurate or false records of hours worked. Misclassification of workers as independent contractors and retaliation is prevalent.
- Basic labor standards and wage compliance remains elusive for many caregivers in RCFEs. The Department of Labor and California Labor Commissioner's Office have conducted targeted investigations into RCFEs, finding rampant wage and hour violations. Since 2011, caregivers have filed 526 wage theft claims with the Labor Commissioner's Office. Of those cases that went to hearing, workers were found to be owed $2.5 million dollars. However, approximately seventy-one percent of the judgment amounts due ($1.8 million) remain unpaid.
- Abuse, neglect and overall poor quality of care and life for residents in RCFEs are results of structural systemic problems. Shortage of staff combined with long hours results in worker fatigue, which increases the risk for errors. Caregivers have not been properly trained and supervised to deal with the acute levels of care needed by residents.
- Understaffing and poor training compounded by rampant wage violations creates high levels of stress for caregivers that impact the quality of care and life for RCFE residents.

I take very much pride in my work of providing care to the elderly, sick, and people with physical and mental disabilities, but in order to provide the best care for them, workers like me should also have humane living and working conditions. – N.G., caregiver for 18 years.

Recommendations:

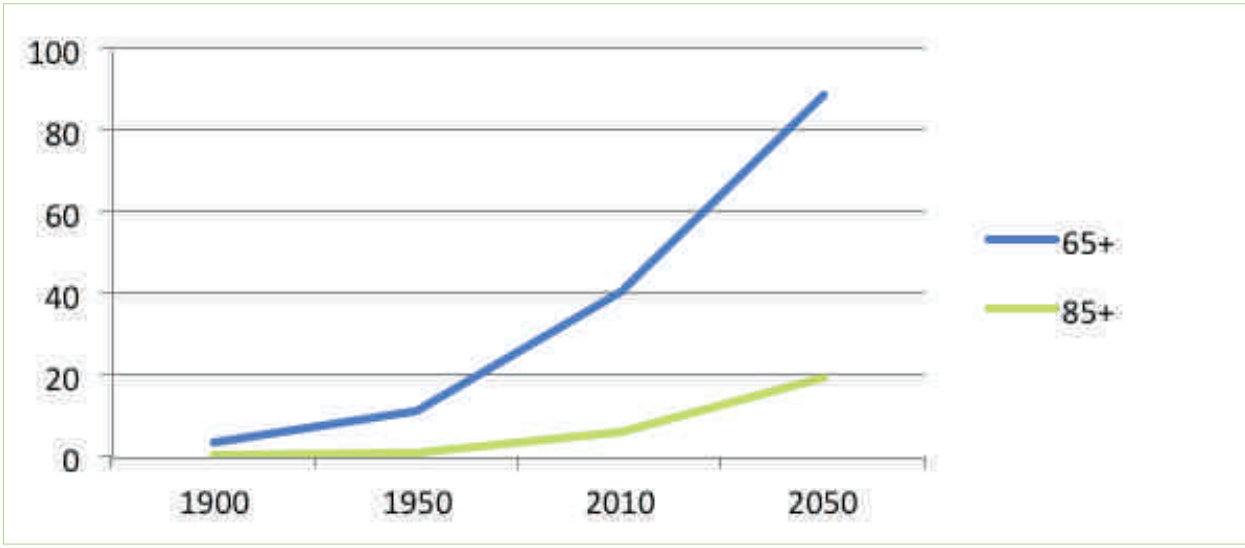
Quality of care and life in RCFEs cannot be improved without incorporating an effective strategy to improve the working conditions of caregivers. There is an opportunity for shared alliance and responsibility between consumers, their families and caregivers. Reforming the RECFE industry will require a multi-faceted approach, which includes:

- Mandated RCFE Staffing Ratios based on acuity levels
- Coordinated Inspections and Increased Enforcement Funding between Community Care Licensing Division, Labor Commissioner's Office and Department of Labor.
- Mandatory Denial or Revocation of RCFE Licenses for Unpaid Judgments
- Mandatory Wage and Hour Compliance Training
- Technological Infrastructure Updates to Community Care Licensing Division
- Re-Conceptualizing RCFEs to a mixed skill level staffing facility

The Need for Long Term Services and Support (LTSS)

By 2030, people 65 and older are projected to be twenty percent (20%) of the United States population.[1] Life expectancy has increased by sixty percent (60%) since the 1900s, from 47 years to 78 years.[2] California mirrors the national increase, doubling its 60 plus population by 2020.[3] By the same time, those 85 and older will have tripled in 26 of the state's 58 counties.[4]

Population Aged 65+ and 85+ from 1900-2050 (in the Millions)[5]



The aging and longevity of Americans is greatly expanding the need for management of chronic health conditions, which are long-term illnesses such as diabetes and heart disease. As a result, more than two-thirds of people 65 years and older will need long term services and support (LTSS) at some point in their life.[6]

Most elderly persons (those 65 and older) need assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to chronic health conditions.

Of those 65 years and older:

- Three in four persons have multiple chronic conditions[7]
- Twenty-one percent (21%) have diabetes and fifty percent (50%) have pre-diabetes[8]
- Seventy-seven percent (77%) have cardiovascular diseases[9]
- More than half suffer from arthritis[10]
- One in nine have Alzheimer's disease[11]

The need for assistance with ADL and IADL increases significantly with age. Of those in the home or in community-based facilities, eighteen percent of people 65 or older report difficulty performing one or more ADL and IADL; by the time they are 85 or older, the number triples to fifty-four percent (54%).[12] Similar to functional limitations, cognitive impairment such as memory loss increases with age. One of every six people age 85 or older report cognitive limitation, compared with one of 20 for people aged 65 or older.[13] Not surprisingly, the need for care increases when people have multiple functional and/or cognitive limitations.

Today, the vast majority of elderly receive care in their home or in community-based settings.[14] Informal caregivers, such as family and friends, provide more than half of the care to the elderly.[15] Of the paid care, direct care workers such as personal care aides and home health aides provide seventy to eighty percent (70-80%) of the day to day long-term care.[16] Personal care aide is the fastest growing occupation in the United States. By 2020, the demand for home and community-based aides will outstrip the demand for nursing home and hospital aides by more than two to one.[17]

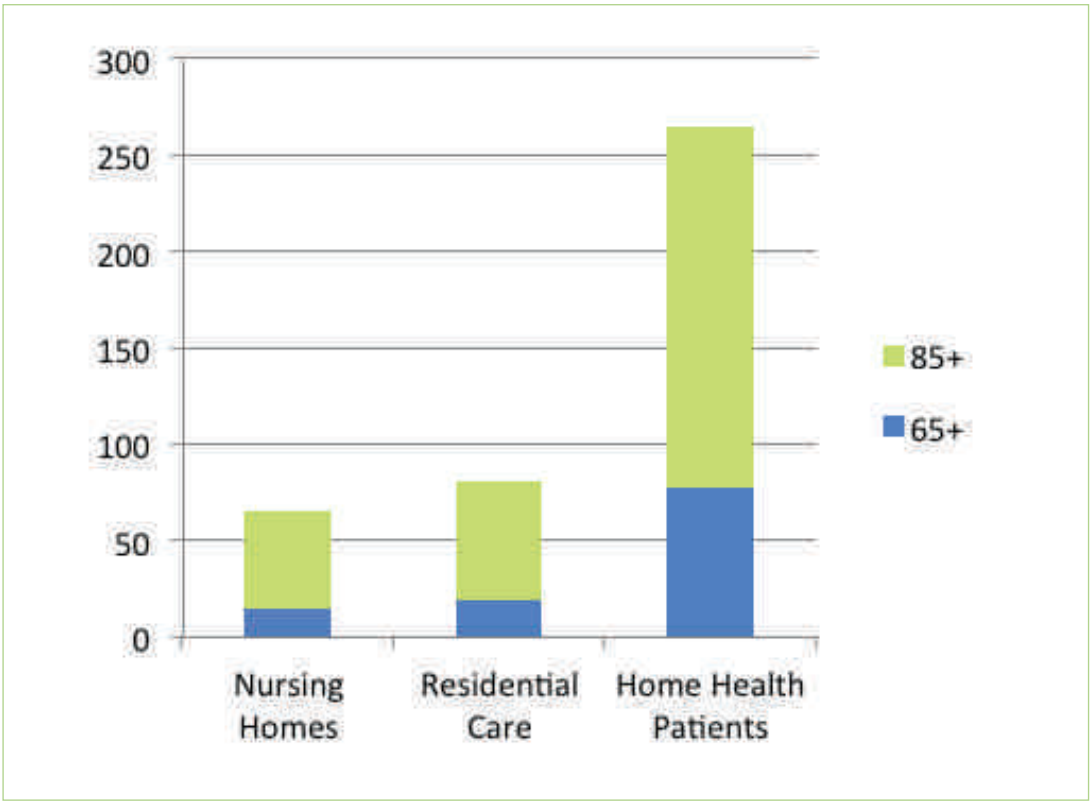
Residential Care Facilities for the Elderly (RCFE)

In 1973, California passed the Community Care Facilities Act to provide residents of state institutions safe, alternative, community-based housing.[18] In 1985, the California Residential Care Facilities for the Elderly Act was adopted to deal specifically with the growing demand for housing and health and social care needs of the elderly.[19] RCFEs are non-medical facilities that provide residents with lodging, meals, and housekeeping. In addition, RCFEs provide care and supervision including assistance with ADL and IADL such as taking medications and money management.[20]

RCFEs are licensed by the Community Care Licensing Division ("CCL") of the California Department of Social Services.[21] CCL is responsible for approving or denying license applications, enforcing licensing laws and regulations, maintaining public files on licensed facilities, investigating complaints, revoking licenses and imposing fines when necessary.[22] California has more residential care facility operators than nursing home operators. As of 2016, there were 7,288 RCFEs, providing 148,892 beds.[23] As of 2014, the most recent data for nursing homes, there were 1,217 certified nursing facilities in California, with 119,866 beds.[24]

Use Rate of Long-Term Care Services by Individuals aged 65 and over

per 1,000 persons and by individuals aged 85 and over per 1,000 persons, 2013-2014 in California[25]



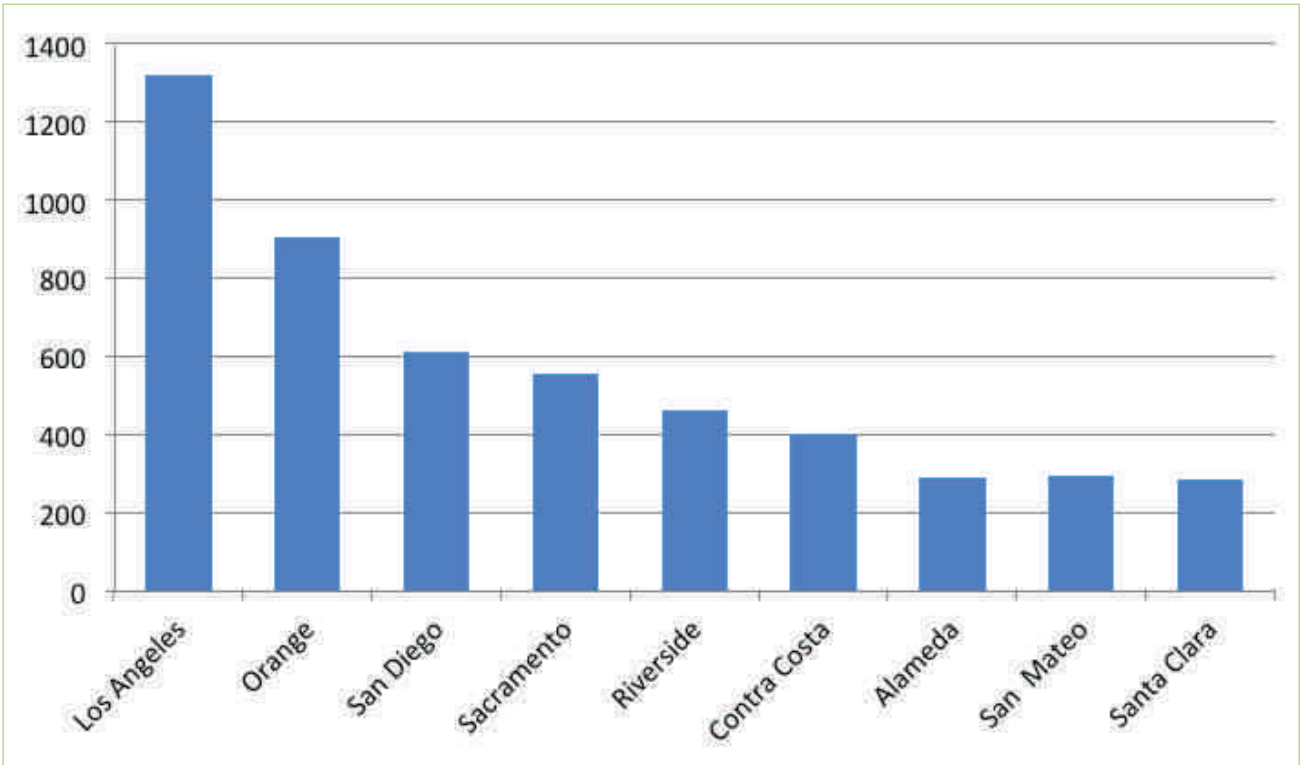
	California Residential Care Facilities for the Elderly[26]	National – Residential Care Facilities[27]	Skilled Nursing Facilities (National)
Bed Capacity	148,892 beds[28]	713,300 beds (National)	119,866 Beds (CA)[29]
Funding Source	Mostly private[30]; Medi-Cal through the waiver program in select counties[31]	32 states allow for Medicaid funds through the wavier program	Medicare if medically necessary; Medicaid; private pay
Regulated by	Dept. of Social Services	Varies – 37 states overseen by health departments[32]	U.S. Dept. of Health & Human Services Centers for Medicare and Medicaid Services & state health dept.
Direct Care Staffing Requirements	Staff in sufficient number to meet resident needs. Night staff varies depending on size	19 states have staffing ratios, depending on the work shift (day v. night) or based on the number of residents or the type of resident needs (e.g. dementia)	No federal minimum requirements but varies among states;[33] CA requires minimum of 3.2 hours of nursing care per resident per day[34]
Skilled Staffing Requirements	None	24 states require a licensed nurse or other licensed professional be available; 14 states require them to be on staff	Physician supervised care; licensed nurse on site 24/7[35]
Training for Direct Care Staff	40 hours (6 hours specific to dementia care) + 20 hours annually (8 hours specific to dementia care)[36]	40 states require orientation ranging from 1 to 80 hours and continuing education (ranging from 4-16 hours)	Various training requirements on a range of issue including abuse, neglect[37]
Medication	Unlicensed staff can assist residents with self-administration of medication (must be trained)	36 states allow for unlicensed staff to administer medication	Administered by licensed nurses or medical personnel[38]
Inspections	Once every 5 years; 20% of facilities inspected annually. By 2019, annually	Varies from annual, 15 months, 2 years, etc.	CA inspects Medicare and Medical certified facilities every 6 to 15.9 months over a 3-4 day period[39]

Owners are really looking to make a profit so they don't properly assess the residents carefully. They are just seeing dollar signs to fill the house. – G.R., caregiver for 30 years.

Seventy-nine percent (79%) of RCFEs have six or fewer beds (hereinafter "small facilities").[40] Over ninety percent (90%) of RCFEs in California are owned and operated by for-profit providers.[41] The larger bed facilities (100+) are predominately run by corporate chains.[42]

RCFEs have doubled in the past 20 years, given the growth of the elderly population and the opportunity to profit.[43] Due to limited public-funding, most RCFE residents pay out of pocket.[44] Costs range from $698 per month to as much as $10,650 per month for specialized care, with a median of $3,750 per month.[45] A study of RCFEs in San Diego and Imperial Counties from 2000 to 2009 showed that RCFEs profited substantially, ranging from 12% to 72.2%. per month.[46] The average monthly profit for small facilities in this study was 31%.[47]

Top 10 Counties with Highest Number of RCFEs



I was not trained at all in the first facility I worked at. I was just thrown in. It was so overwhelming. Nobody taught me how to care for the residents properly. The caregivers were just told generally the residents' problems, what to feed them, when to give them their medicine and that's it. We were given no other guidance. – R.C., caregiver for 5 years.

CCL regulations set out a uniform standard of care for RCFEs, regardless of the resident population. Large RCFEs usually do not house residents with high acute needs.[48] These facilities are set up more like hospitality chains and generally do not provide intense one on one care.[49] Small RCFEs, thus, have become the main providers in community-based setting for residents with acute needs.

As demand has grown to house residents that require higher level of care, CCL has loosened its regulations. Before 2001, RCFEs were not allowed to care for most bedridden residents.[50] Today, they can house such seniors with approval and a documented plan.[51] RCFEs were once required to get waivers or permits to care for residents with dementia.[52] In 2004, the state replaced the waiver rule by issuing standards for dementia care.[53] These changes make it easier to accept residents who require higher levels of care, without a corresponding increase in staff or requiring more skilled staff.

I worked at one facility for only four months because the conditions were a nightmare. The state came many times to investigate. They were sanctioned. I was totally shocked that it was not shut down. – D.E., caregiver for 25 years.

RCFEs have no requirement for on-staff skilled medical professionals and minimal staff to resident ratio.[54] Facilities are not allowed to provide skilled nursing services unless the service is performed by a credentialed licensed staff.[55] RCFEs are required to have staff "in sufficient numbers and competent" to meet residents' care needs.[56] The current minimal staffing requirements for RCFEs are limited to the night shift and depends on the number of licensed beds.

Night Staffing[57]

≤ 15 beds:	1 staff on call
16-100 beds:	1 staff awake, 1 on-call staff able to respond within 10 minutes
101-200 beds:	1 staff awake, 1 on-call staff on premises, 1 on-call able to respond 10 min

Due to budget cuts and the growth of RCFEs, inspection rates have been slashed from twice per year in 1970s and 1980s to once per year in the 1990s to every 5 years by 2014.[58] Not only has the frequency of inspections decreased, but so has the comprehensive nature of inspections.[59] Recently, due to an increase in their budget, CCL will increase the frequency of inspection to annually by January 2019 for RCFEs and other residential facilities.[60]

Working Conditions of Caregivers[61]

While specific statewide data for personal care aides who work in residential care facilities is not available, aggregate data for all direct care workers including residential care facility workers demonstrates the economic vulnerability of this predominately female workforce. Despite the growing demand, direct care workers are paid considerably lower than the median average for U.S. workers in the private sector ($26.14).[62] The national median hourly wage for personal care aides is $10.92 and in California, $12.09.[63] One in four direct care workers live below the federal poverty level.[64] Nearly half of all direct-care workers (49%) live in households that receive one or more public benefits such as food stamps and Medicaid.[65]

Basic labor standards and wage compliance remains elusive for most direct care workers. In small RCFEs, the violations are more prevalent because of the staffing and pay structures. Many small RCFEs staff with a skeleton crew, with little experience required of their caregivers and accept residents without proper assessment of the level of care needed.

In one facility, I was the only staff caring for 6 residents 24-7. Two of them had Alzheimer's, which requires a lot of one on one supervision. Sometimes I would work thirty days straight, round the clock, without getting a day off. To make matters worse, I would often get paychecks with insufficient funds and couldn't cash them. – G.R.

It was so hard taking care of 8 people. Half could take care of themselves, half were bed bound. Four suffered from Alzheimer's and needed a lot of attention and care. I was awake practically the whole time I worked at this facility.
– L.N., caregiver for 8 years.

Residents in RCFEs: Sicker and Older

Nationally, more than half of the residents in community-based facilities are 85 years and older, forty percent (40%) have Alzheimer's or dementia and forty-six percent (46%) have cardiovascular diseases.[66] California mirrors the national characteristics: fifty-three percent (53%) of residents in community-based facilities are 85 years and older, forty percent (40%) have Alzheimer's or dementia and thirty-nine percent (39%) have cardiovascular diseases.[67]

There is growing evidence that RCFEs are accepting residents with acute medical needs or cognitive impairment that require on-going medical monitoring, similar to those residents in skilled nursing facilities.[68] Residents in small RCFEs are sicker, often 85 years and older, need assistance with 3 or more ADLs, and are taking multiple, complex medications to manage chronic medical conditions.[69] It is not uncommon for RCFE residents to be on hospice, have dementia, require oxygen administration, need urinary catheters, or be bedridden.[70] The changing acuity levels of residents pose structural challenges to the core design of RCFEs as non-medical housing alternative to nursing homes.

Doing 24-7 shifts is more draining. I'm up for 18 to 19 hours, taking care of 6 people. There was never any down time. You don't get enough sleep at night because you're constantly up. – D.E.

Understaffed, Overworked

While RCFEs have always been required to provide twenty-four hour supervision to residents, the severity of the residents' medical needs increases the burden of providing adequate care and supervision. Most facilities are staffed by caregivers. There is no requirement that RCFEs have skilled professionals, such as nurses, either on-site or on-call. [71] Currently, there are no staffing ratios for RCFEs other than for the night shift.[72]

Caregivers juggle a multitude of responsibilities and the work is unrelenting. The industry norm in small RCFEs is to hire one to two live-in caregivers, to provide round the clock care. These caregivers work back-to-back 24 hours shifts, five to seven days a week.[73] Caregivers assist residents with ADL including bathing, personal hygiene, grooming, assisting with toileting or changing diapers, dressing, transferring from one place to another, feeding, performing common exercises or therapies for physical and cognitive strengthening, assisting with medications, and providing constant supervision, including at night. Larger facilities usually have designated night shift caregivers but many small facilities require live-in caregiver to respond to residents' needs throughout the night.

Routinely, caregivers on night duty get interrupted by residents' needs including toileting, falling, discomfort or medical emergencies. Facilities with Alzheimer's or dementia residents require more night time vigilance as these residents are prone to wander and leave the facility. Caregivers who work live-in or 24 hour shifts do not get sufficient sleep. Because of the frequent night interruptions, many caregivers report that they get less than five hours of sleep at night.

Caregivers complain of trouble falling and staying asleep because they must stay alert. They report that it is hard to get deep sleep because they are worried that they will not be able to respond quickly to a resident's night time needs. Numerous research studies link working the night shift to sleep problems, overall poor health, depression, and increased risk for workplace injuries.[74] In a recent study of live-in caregivers working in private homes, the study concluded that poor quality of sleep posed risk for both work-related injury and errors in consumer care.[75]

In small facilities, caregivers are also responsible for housekeeping, laundry and food preparation. Caregivers are responsible for cleaning the entire facility including residents' rooms, common areas, bathrooms and kitchen. They do the residents' laundry and towels and linens for the facility. In addition, some caregivers take residents to medical appointments, do grocery shopping, cook for residents and staff and perform yardwork and maintenance. Some caregivers also are designated as administrators of the facilities, even though the regulations require administrators to have "sufficient freedom from other responsibilities … to permit adequate attention to the management and administration" of the RCFE.[76]

When I work with clients who are on hospice and eventually die, it really is mentally draining. The image stays with you and it's really emotional dealing with the family and all the end of life issues. It's hard for me to get right back to work when one of the resident dies, but you don't really have the luxury to take a few days off. – G.R.

Lack of Dignity and Care for Workers

The work of a caregiver is physically demanding, requiring bending, stooping, lifting, pushing, pulling, reaching and walking for long periods of time. Caregivers are often responsible for lifting and transferring residents without any mechanical aids or assistance from other caregivers. Caregivers complain of physical pain including in the back, wrist, shoulder, arm, hip/waist and leg and knee.[77]

Live-in caregivers are also denied adequate sleeping facilities.[78] Most are not provided with a private room. The most common type of accommodation is a staff room that must be shared with multiple caregivers, sometimes co-ed. In violation of CCL regulations, some caregivers report sleeping in the hallway, kitchen, or living room on a cot or fold out bed and in the most egregious cases, sleeping in the resident's room to be closer to deal with night time needs.[79]

Studies of informal caregivers have found that caregiving results in chronic stress, impacting the physical and psychological health of the caregiver.[80] Similarly, professional caregivers experience stress, anxiety, loneliness and/or other mental health problems. In a study of caregivers in the Bay Area, a large percentage of those surveyed complained of mental health problems including experiencing sadness and anger.[81]

Finally, no attention is paid to the caregivers' mental health when a resident dies. Often times, the caregiver is providing support to the resident as she dies and then dealing with the family's grief and logistics.

I slept either in the garage or on the sofa. The garage was not converted into a room. It was a storage room for supplies and equipment. It also stored cleaning supplies and chemicals. Sometimes, I slept in the resident's room, when the resident needed additional supervision.
– H.B., caregiver for 9 years

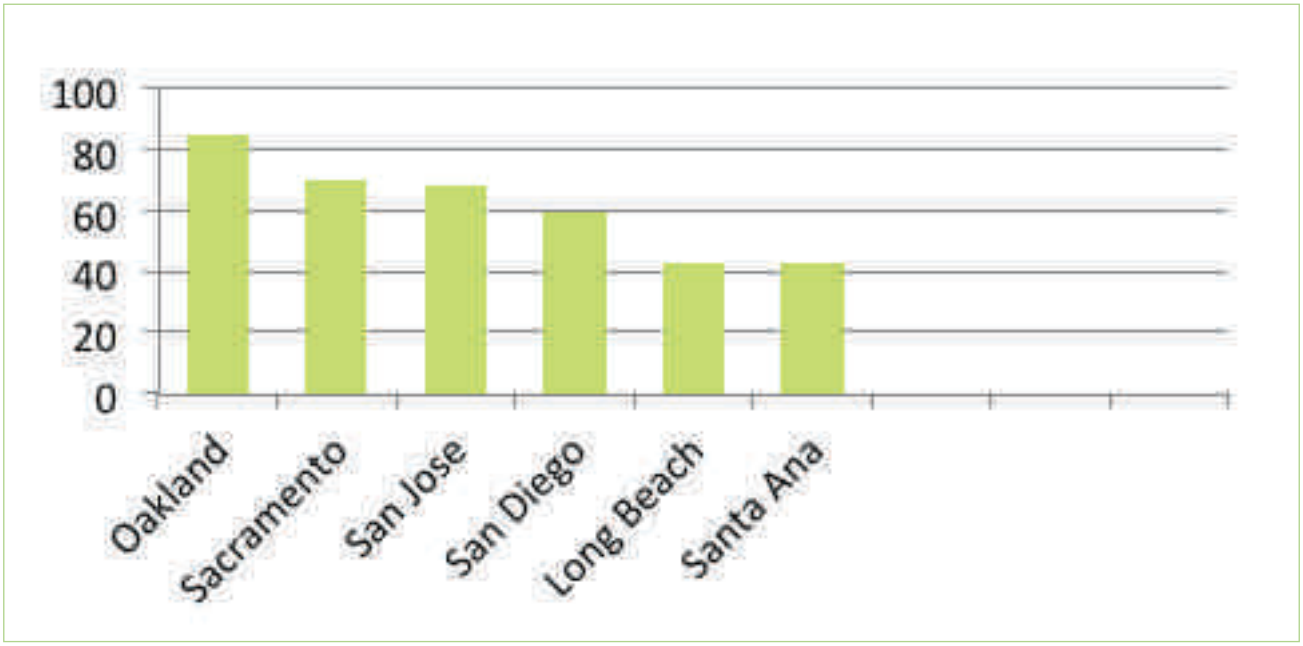
Wage Theft:
The Need for Basic Statutory Compliance

Common practices among a number of small RCFEs, such as hiring workers to provide twenty-four hour, round the clock care, have resulted in violations of basic minimum labor protections, resulting in large unpaid wage liabilities. Both the federal Department of Labor ("DOL") and the California Division of Labor Standards Enforcement ("Labor Commissioner") have focused their resources on addressing wage theft issues in residential care facilities.[82] A recent compliance study conducted by the DOL in the Bay Area found gross wage and hour violations in residential care facilities. Since 2011, the DOL has recovered $6.8 million dollar in damages for residential care workers.[83] In 2015 alone, the DOL's San Francisco District office concluded more than 100 investigations of residential care facilities and nursing homes, resulting in $3 million in back wages and damages for more than 475 workers.[84] Similarly, the Labor Commissioner has aggressively pursued RCFE violators, recovering millions of dollars in unpaid wages.[85] Since 2011, caregivers in RCFEs have filed 526 wage theft claims with the Labor Commissioner.[86] Of those cases that went to hearing, workers were found to be owed $2.5 million dollars.[87] However, approximately seventy-one percent of the judgment amounts due ($1.8 million) remain unpaid.[88]

> "I have worked in five countries as a caregiver: Saudi Arabia, Dubai, Hong Kong, Singapore, and the United States. Of all of these countries, I have faced the most extreme exploitation here working in the residential care facility." – N.G.

This is not surprising given that only seventeen percent (17%) of workers in all industries recover their unpaid wages.[89] Some RCFE facilities, like other employers, evade collection by shutting down the facility and reopening it under a different name or under the name of family members. Others file bankruptcy in the hopes of discharging the wage debt completely.

Highest Number of Wage Claims Against RCFEs By Labor Commissioner District Office



Long Hours, 24 Hour Shifts and Flat Rate

A major contributing factor to non-compliance with wage requirements is that small RCFE employers may pay a flat daily or monthly rate that does not account for all hours worked. The rate also does not take into account California minimum wage and overtime rules. Rates are as low as $900 to $1600 a month for work in excess of 8 hours a day and 40 hours in a week.[90] The Labor Commissioner's enforcement policies are clear that residential care facilities must pay for all hours an employee is required to remain on the premises.[91]

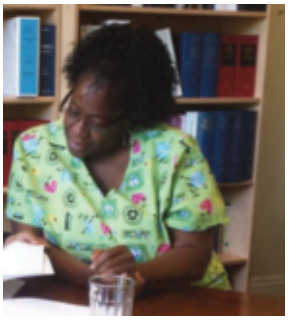
The Department of Labor in its investigations in the Bay Area found that employees who are hourly often worked 10 to 14 hours a day, six days per week, but were paid for only 8 hours.[92] Various community-based participatory (CBP) research studies in the Bay Area found that a significant number of caregivers worked more than 60 hours a week.[93] One study found that seventy-seven percent (77%) of caregivers worked more than 8 hours in a day and a majority of them did not receive overtime pay.[94]

Caregivers who work live-in shifts or 24 hour shifts are required to stay on the premises overnight to provide on-going monitoring and supervision of the residents.[95] Caregivers get up often at night to assist residents.

Many small RCFE employers fail to comply with these requirements and do not properly compensate for overnight shifts.[97] Multiple investigations by the Labor Commissioner have found that caregivers who work 24 hour shifts are paid well below the California minimum wage.[98] In August 2015, the Labor Commissioner cited the owners of three residential care facilities in San Diego county $2.2 million for egregious wage theft violations.[99] The investigation revealed that nine caregivers were forced to work 24-hour shifts, six to seven days a week, for $1.25 to $1.80 per hour. [100] The workers provided around-the-clock care for elderly residents who suffered from "advanced-stage dementia or Alzheimer's, many of them bedridden or receiving hospice care."[101]

California and federal law provides that for workers who reside on the premises or work 24 hour shifts, an employer may deduct sleep time only if:

1. the employer and employee have reached an agreement in advance that sleep time is being deducted;
2. adequate sleeping facilities are furnished;
3. if interruptions occur, employee in fact got at least five hours of sleep during scheduled sleep time;
4. employee get compensated for any interruptions to sleep; and
5. no more than eight hours of sleep time is deducted for each full 24-hour on-duty period.[96]



Misclassification

Caregivers are often misclassified as independent contractors. True independent contractors are workers with economic independence who are in business for themselves, and typically do not perform the same duties as regular employees. That is seldom the case for caregivers, who are hired to provide the core essential services of the facility under the supervision of the owner or administrator. In a 2015 investigation by the DOL, seven facilities in San Mateo, South San Francisco, and Burlingame were found to have misclassified some of its workers as independent contractors.[102] Facility owners find ingenious ways to misclassify workers; in some instances, they set up a limited liability company and call the workers "owners."[103] By labeling them as independent contractors, facility owners circumvent the statutory protections provided to employees, including overtime and worker's compensation. In addition, employers save money by not paying the employer's share of Social Security and Medicare taxes and unemployment compensation taxes. This leaves a worker without a safety net when she retires or finds herself unemployed. It also leaves her with the sense that she is not covered by state and federal labor laws.

Lack of Accurate Record Keeping

Employers are required by law to keep accurate time records, showing when employees began and end each work period and recording any meal breaks.[104] Many facilities fail to keep any records of the hours worked by caregivers. Generally, there are no time clocks, timesheets or other methods to record the start and end of each work period or meal periods. Recently, in Northern California, after a slew of DOL audits of RCFEs, some facilities have begun to keep falsified time records and instruct workers to fill out timesheets that only show eight (8) hours of work, regardless of the number of hours actually worked.

Facilities self-report their staffing to CCL by submitting an LIC 500 Personnel Report. The report specifically states that the staffing levels must show coverage for twenty-four hours. LIC 500s are often poorly filled out or patently false. Caregivers have reported that some owners include family members on the LIC 500, even when they do not work at the facility, to show twenty-four (24) hour compliance. Facilities must also send updated LIC 500 whenever there is personnel change. Most facilities seldom comply with this requirement. Furthermore, there is no independent verification of these reports by CCL through time cards or payroll records review. The reports are not available on the CCL website. To get a copy of the LIC 500 requires having to go to the CCL regional office to review the file, which can take anywhere from two to three weeks to set up.

> I have to do what I have to do to make a living and put food on my table. The facilities pay very little for my services. When I'm not paid properly, it is stressful. I have sued two of my former employers because of wage theft. – D.E.

Undocumented workers are the most exploited. They are isolated and have no place to go. Even if working conditions are bad, you just accept it because what else can you ask for. – R.C.

Retaliation

The real threat of retaliation prevents many caregivers from speaking up about the poor working conditions in RCFEs. Some fear losing their job and not being able to work in the industry.

The DOL, in its compliance and enforcement initiative in the Bay Area, found that employees were threatened or harassed if they questioned their working conditions, and some were specifically instructed to not cooperate with the DOL investigation.[105] The DOL further found that some caregivers were intimidated and retaliated against for speaking up.[106] Workers in Santa Clara County believe that there is a list circulating among RCFE owners of workers who have filed wage claims.[107] Those workers find it difficult to get hired at another care facility. Finally, immigration and threats of deportation hang over the heads of workers without proper authorization. Under the current national anti-immigrant climate and increased immigration enforcement, immigrant caregivers are even more fearful of challenging their working conditions.

Migrant Workers

While exact demographic profile of workers in RCFEs is not available, enforcement actions and individual Labor Commissioner cases suggest that migrant workers are doing this work alongside African-American women. In Northern California, Filipino owners dominate the RCFE industry, hiring predominately Filipino/a workers through social networks of other Filipino/a immigrants. In the Bay Area, the workers are Asian immigrants and African-American women, with a large concentration of Filipino/a workers. In Southern California, the industry is larger and is more ethnically diverse.

While there is a perception that migrant workers are undocumented, RCFEs have a mix of undocumented workers, green card holders and U.S. citizens. In some instances, the facility owners file immigration petitions on behalf of the workers to help them adjust status. Many of these petitions, however, are without merit and workers pay thousands of dollars to an immigration advocate that the owners have hired. Instead, the carrot of legal status becomes "a modality of labor control."[108]

Facility owners from the same cultural background as the workers are more sophisticated at exploiting the familiarity, trust and loyalty to create almost a feudal relationship. The owners provide food, lodging and work and in exchange they want total loyalty. One owner of a six bed facility stated, "We treat each other like family living in the same household. And our caregivers are more than happy to have a roof over their heads and their living expenses fully paid by us…."[109]

In the most egregious cases, workers are trafficked into the United States either directly by the facility owner or placed in the facility to work off a debt to the labor trafficker. In one highly publicized case, a facility owner recruited a Filipina caregiver to work in her two RCFEs.[110] The owner confiscated the caregiver's passport and told the worker that she had to work at her caregiving facility for 10 years to pay off the $12,000 debt.[111] The caregiver did not complain at first because it was her "utang na loob, or debt of gratitude", toward the owner, for bringing her to the United States.[112] The owner told her to not talk to anyone, including other Filipinos, holding the threat of deportation over her head.[113]

Quality of Care and Resident Life

Consumers and their families choose small RCFEs over larger facilities because they want a home-like environment. Consumers assume that a small facility means more customized and responsive care, where staff can provide thorough, prompt and compassionate care. While there are ample studies on the quality of care in hospitals and nursing homes, there is a dearth of evidence on the quality of care and life in residential care facilities and other community-based and home care settings.[114] Some studies suggest that there is great variation among residential care facilities in terms of quality of care, ranging from highly individualized care to neglect and poor oversight.[115]

In California, recent investigative reports provide a glimpse on quality of care in RCFEs.[116] Poor oversight by staff and lack of training have been the major causes of injury or death in RCFEs. Almost sixteen percent (16%) of the recorded violations in a study of San Diego and Imperial County RCFEs were due to medication errors, lack of medical care and lack of first-aid training. [117] From 2009 to 2012, the number of complaints alleging poor care in residential care homes increased by thirteen percent (13%), to nearly 3,000.[118] Most resident complaints about facilities have stemmed from lack of supervision.[119] In a study of RCFEs in San Diego and Imperial counties, six bed and smaller facilities were found to have received sixty-three percent (63%) of Type A violations among all RCFE facilities.[120] Type A violations are severe violations that immediately or substantially threaten the health or safety of residents. [121]

Usually, individual workers are blamed for abuse and neglect, pitting consumers against caregivers. Yet, abuse, neglect and overall poor quality of care and life are results of structural systemic problems. The overwhelming reality of how RCFEs are staffed and managed is far from the consumers' expectations and needs. Many small RCFE facility owners provide very little oversight and management in the facilities.

Many delegate administrator responsibilities to full-time caregivers, who must juggle the daily caregiving responsibilities with regulatory compliance. Caregivers are left to their own devise to figure out how to provide adequate care.

Understaffing is one of the biggest contributors to poor care. Even among caregivers, there is consensus that understaffing leads to poor oversight of residents.[122] Almost ten percent (10%) of currently licensed RCFEs have been cited at least once for insufficient staff.[123] Of the forty-eight (48) RCFEs currently on probation by CCL, a quarter of them (25%) have been cited for insufficient staff.[124]

Shortage of staff combined with long hours results in worker fatigue, which increases the risk for errors. RCFEs that provide dementia and Alzheimer's care should, in fact, have higher staffing levels relative to the rest of the facility. Yet, the minimal required staffing levels do not vary based on resident needs.

When workers are stretched thin, not only are residents not attended to properly, their social and emotional needs are ignored. Several studies report that healthcare workers may have compassion fatigue, which is "physical and psychological exhaustion" as a result of dealing with high-needs individual which can lead to negative feelings.[125] It is interchangeably called secondary and posttraumatic stress disorder.[126] Being understaffed was identified by several study participants as a barrier to providing compassionate care in a nursing facility for the elderly.[127]

> I was left in charge of the whole facility on the second day on the job. The owners went away on vacation and the other caregiver was not scheduled. I had to take care of everyone by myself (8 residents, half had Alzheimer's) for 3 days and 2 nights. There was just enough food for the residents but not for me. – L.N.

While RCFE staffing and quality of care outcomes have not been fully explored, similar studies in nursing homes have a found a correlation between adequate nurse staffing and higher quality of care in nursing homes.[128] The few studies on residential care staffing are inconclusive. The study of RCFEs in San Diego and Imperial counties found that higher staff-to-resident levels were associated with fewer deficiencies and citations.[129] In a national study of residential care and assisted living facilities, a greater proportion of total direct care hours provided by licensed staff was "associated with a substantial reduction in the relative risk of hospitalization."[130] The same study found, however, that a majority (70%) of sixteen beds and smaller facilities did not have licensed staff providing care.[131]

Poorly trained direct care staff further contributes to inadequate care.[132] Caregivers have not been properly trained and supervised to deal with the acute levels of care needed by residents. Given the chronic medical conditions of residents, delay in identifying medical problems and medication errors can be deadly.[133] One study of staffing skill mix in residential care facilities concluded that "greater levels of supervision or involvement in resident care by more highly trained (licensed) staff may result in timely identification of medical problems …and in greater ability to administer treatments…."[134]

Spurred by investigative reports into RCFE industry after twenty-seven San Diego County seniors died from neglect and injuries, the Legislature increased the training requirements for staff and facility administrators, effective 2016.[135] For direct care staff, initial training was increased from 10 hours to 40 hours, and continuing education was increased from 4 hours to 20 hours annually.[136]

Understaffing and poor training compounded by rampant wage violations creates high level of stress for caregivers.[137] It negatively impacts their physical and socio-emotional health and increases the likelihood of work-related injuries. Fatigue and stress directly impacts caregivers ability to provide compassionate, adequate care. This in turn erodes the overall quality of care and life for residents.[138]

Borrowing from the research in nursing homes, it is not a stretch to conclude that working conditions have a direct impact on consumers' quality of care and life.[139] These studies have shown that competent and caring staff and high workforce satisfaction is a strong predicator of resident and family satisfaction.[140]

> When there is not enough staff, especially in facilities with Alzhemier's residents, you are so busy trying to keep the place clean and keep resident fed and dressed, that it is really hard to pay attention to their emotional well-being. I just feel like I'm rushing around trying to catch up. – G.R.

> "The increased training requirements that the state passed is a really good thing. I now work where I have mandatory sessions every 3 to 4 months. It helps to keep me sharp with what I need to know to provide the best care." – D.E.

I now work for a care home that is properly run. The owner is a registered nurse. She has a lot of experience. We have a set routine that the owner has developed as well as a proper care plan. We only work 11 hour shifts and get paid overtime, with specific breaks and specific days off. We are off for at least 24 hours before doing the night shift. I really enjoy working here and can focus on quality of care for the residents. – R.C.

Recommendations

Quality of care and life in RCFEs cannot be improved without incorporating an effective strategy to improve the working conditions of caregivers. Both consumers and caregivers are disserved when workers are overworked and underpaid. There is an opportunity for shared alliance between consumers, their families and caregivers. No one tool or strategy is the panacea. Reforming the RECFE industry will require a multi-faceted approach.

1. Mandated Staffing Ratios

Despite acuity levels being similar among residents of both nursing homes and residential care facilities, only 19 states have some type of mandated assisted living staff-to-resident ratio for RCFEs.[141] In some states, the staff-to-resident ratio is solely based on the number of residents in a facility. In other states, the ratio depends on the residents' needs.

In California, by contrast, RCFEs housing as many as 200 residents need to have only one awake staff and two on-call on the night shift. None of them are required to have any medical training.[142]

The staffing ratio must be based on an acuity-based staffing system which regulates the number of caregivers on a shift according to the residents' needs, and not according to raw resident numbers. The American Medical Directors Association (AMDA) recommends that staffing guidelines take into account:

- The acuity of the patient population;
- The functional level of the patient and the services provided;
- The existence of staffing shortages for some types of staff in some geographic locations, and, for temporary staffing shortages due to such events as employee illness or termination; and
- The quality, education, and training of the staff.[143]

2. Coordinated Inspections and Increased Enforcement Funding

Working conditions in RCFEs can be improved only by coordinated inspections and facility audits between CCL and the federal and state labor agencies (DOL and Labor Commissioner). A coordinated approach to licensing and wage and hour compliance best serves the residents of the facilities. To that end, CCL needs to cooperate and share information with government labor agencies. An annual audit of RCFEs by both CCL and the federal/state labor agencies can ensure greater compliance.

Furthermore, more district attorneys should prosecute wage theft in RCFEs. Wage theft is a crime.[144] In addition to criminal prosecution, the District Attorneys can bring civil enforcement actions under the Business and Professions Code section 17200 et seq. Other government agencies that have oversight on elder abuse and neglect, such as the California Department of Justice Bureau of Medi-Cal and Elder Abuse, should routinely look into working conditions as part of any investigation.

The Legislature needs to increase and specifically allocate additional funding for enforcement. One revenue source is the increased penalties for RCFEs violations.[145] Coordinated and robust government investigation is far less costly then the loss of tax revenue from wage theft and poor quality of care.

3. Mandatory Denial or Revocation of RCFE Licenses for Unpaid Judgments

In 2015, the Legislature passed SB 588 to combat rampant wage theft in California and the widespread challenge of collecting unpaid judgments. Among other things, SB 588 allows CCL to deny a new license or not renew an existing license to RCFEs and other long-term care facilities if there is unpaid judgment against the company and no bond has been posted.[146]

This should become a standard protocol rather than discretionary. RCFEs should be required to mandatory disclose unpaid judgments and compliance with California Labor Cod 238 (bond requirement) to CCL within a specified time period. To date, seventy-one percent (71%) of judgments against RCFEs remain unpaid. CCL should robustly work with the Labor Commissioner and routinely deny or revoke licenses when there is no bond posted for unpaid judgments. Additional legislation can go further by requiring mandatory denial or revocation of RCFE licenses for any unpaid judgments.

4. Wage and Hour Compliance Training

Administrators and facility owners must be trained routinely on basic wage and hour compliance training. The Department of Labor has been engaged in a multi-year compliance assistance and enforcement initiative in the Bay Area targeting residential care facilities and nursing homes.[147] In addition to auditing these facilities, the DOL and the Labor Commissioner's Office have held meetings with industry leaders, including 6Beds, Inc., a newly formed advocacy group for residential care facility owners, to clarify federal and state wage and hour laws. DOL has also included compliance updates in the Community Care Licensing Division's Quarterly Updates.[148] CCL should require as part of licensing and continuing education requirements that administrators and licensees have a minimum number of wage and hour compliance training.

In addition, CCL in coordination with the DOL and the Labor Commissioner's Office can develop and distribute Know Your Rights for workers that are tailored to issues in RCFEs such as sleep deductions and contact information to report labor issues.

> I take my work as a caregiver seriously and feel that my role is an important one. I work hard and put the residents' needs first. – H.B.

5. Technological Infrastructure Updates to Community Care Licensing

There is a lack of aggregate data on RCFEs. Unlike the reporting requirements for nursing homes and the availability of that information online, CCL is stuck in the 1970s infrastructure. All facility files are accessible to the public; yet, much of this information is not available online. Investment in 21st century technologies and systems to streamline processes and provide data analysis is critical.

There have been incremental improvements in automation. Since August 2014, CCL has provided the public with on-line access to citations and complaint information of all licensed facilities. Visitors can review a particular facility and access the number of inspections/visits conducted by CCL and citations issued and licensing status.[149]

Much more remains to be done. CCL needs to provide access to LIC-500 forms online. Making staffing reports accessible online provides for greater transparency and allows the DOL and Labor Commissioner to access them easily to verify with a facilities' time records when conducting an investigation or audit.

6. Re-Conceptualizing RCFEs

More comprehensive data collection and analysis needs to be undertaken to understand the changing demographics of RCFE residents. If the trend continues to allow sicker and older residents in RCFEs, then the RCFE model must include skilled licensed staff. This invariably will impact the costs of RCFEs. There are a range of options for a mixed skill level facility including skilled medical technicians in lieu of RNs and LVNs. Skilled licensed staff are necessary to deal with the more acute conditions. Having a mixed skill facility also creates a pathway for caregivers to advance into higher skilled and better paying work.

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[3] Richard Kipling, "Getting ready for emergency care for the elderly," Sacramento Bee (Mar. 20, 2014), available at http://centerforhealthreporting.org/article/getting-ready-emergency-care-elderly

[4] Ibid.

[5] Fed. Interagency Forum on Aging-Related Statistics, Older Americans 2012: Key Indicators of Well-Being (2012), available at https://agingstats.gov/docs/PastReports/2012/OA2012.pdf

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[7] Centers for Disease Control & Prevention, Multiple Chronic Conditions, available at https://www.cdc.gov/ chronicdisease/about/multiple-chronic.htm.

[8] Older Americans 2012, supra note 5, at 27; Carl Caspersen et al., Aging, Diabetes, & the Public Health System in the U. S., Am. J. Public Health, v.102(8): 1482-1497 (Aug. 2012); available at https://www.ncbi.nlm.nih.gov/ pmc/articles/PMC3464829/

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[10] Older Americans 2012, supra note 5, at 27.

[11] Alzheimer's Ass'n., 2015 Alzheimer's Disease Facts and Figures, p. 16, available at https://www.alz.org/facts/downloads/facts_figures_2015.pdf

[12] Congressional Budget Office, Rising Demand for Long-Term Services and Supports for Elderly People, p. 12 (Jun. 2013), available at https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44363-ltc.pdf

[13] Id. at 15.

[14] Id. at 1.

[15] Id. at 2.

[16] Paraprofessional Healthcare Inst., Facts 3: America's Direct Care Workforce, p. 1 (Nov. 2013), available at http://phinational.org/sites/phinational.org/files/phi-facts-3.pdf

[17] Id. at 3.

[18] Cal. Health & Safety Code §1569.1(c).

[19] Cal. Health & Safety Code §1569 et seq.

[20] Cal. Health & Safety Code §1569.312.

[21] CCL is responsible for the oversight of four programs: Child Care, Child Residential, Adult Care, and, RCFEs.

[22] Cal. Research Bureau, Lisa K. Foster, Residential Care Facilities in the Neighborhood: Federal, State, and Local Requirements, p. 18 (Dec. 2002), available at https://www.library.ca.gov/crb/02/18/02-018.pdf

[23] Cal. Dept. of Social Services, Number of State Licensed Facilities, by County (Jun. 30, 2016), available at http://www.ccld.ca.gov/res/pdf/countylist.pdf

[24] Health United States, supra note 2, Table 92: Nursing homes, beds, residents, and occupancy rates, by state: United States, selected years 1995–2014, p. 291, available at: https://www.cdc.gov/nchs/data/hus/hus15.pdf#092

[25] Centers for Disease Control & Prevention, Long-Term Care Providers and Services Users in the United States—State Estimates Supplement: National Study of Long-Term Care Providers 2013–2014 , available at https://www. cdc.gov/nchs/data/nsltcp/2014_nsltcp_state_tables.pdf

[26] U.S. Dept. of Health & Human Services, Compendium of Residential Care and Assisted Living Regulations and Policy: 2015 Edition – California, available at https://aspe.hhs.gov/basic-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition#CA

[27] Ibid.

[28] Number of State Licensed Facilities, by County, supra note 23.

[29] Heath United States, supra note 2, Table 92, supra note 24.

[30] Cal. Advocates for Nursing Home Reform, Residential Care in California: Unsafe, Unregulated & Unaccountable, p. 4 (2013), available at http://www.canhr.org/reports/Residential_Care_in_California.pdf

[31] Cal. Dept. of Health Care Services, The Assisted Living Waiver (ALW) Program Fact Sheet, Jan. 1, 2017, available at: http://www.dhcs.ca.gov/services/ltc/Documents/ProgramdescriptandElig2017.pdf

[32] Ibid.

[33] See Charlene Harrington, Nursing Home Staffing Standards in State Statutes and Regulations (Dec. 2010), http://theconsumervoice.org/uploads/files/issues/Harrington-state-staffing-table-2010.pdf

[34] Cal. Health & Safety Code §1276.5(a).

[35] 42 U.S.C. §§ 483.30; 483.35.

[36] Cal. Health & Safety Code §1569.626 (effective 2016).

[37] See 42 C.F.R. §483.95;

[38] 22 C.C.R. §72313(a)(5).

[39] CA. Dept. of Public Health, About US- Licensing & Certification, available at: http://hfcis.cdph.ca.gov/aboutus.aspx

[40] Residential Care in California, supra note 30; see also Centers for Disease Control & Prevention, 2014 National Study of Long-Term Care Providers Web Tables of State Estimates about Residential Care Communities Supplement, Table 1, available at https://www.cdc.gov/ nchs/data/nsltcp/State_estimates_for_NCHS_Data_Brief_222.pdf

[41] Residential Care in California, supra note 30.

[42] Ibid.

[43] Deborah Schoch et al., "Deadly Neglect at Some San Diego Assisted Living Facilities," Center for Health Reporting, U-T San Diego (Sept. 8, 2013), available at http://centerforhealthreporting.org/article/deadly-neglect-some-san-diego-county-assisted-living-facilities

[44] Residential Care in California, supra note 30.

[45] Genworth, Cost of Care Survey California, Assisted Living Facilities Monthly Rates (2015), available at https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/cost-of-care/118928CA_040115_gnw.pdf

[46] Chris Murphy, An Exposition of Irregularities in Residential Care Facilities for the Elderly (RCFE) in San Diego and Imperial Counties, Thesis, San Diego State University, p. 54 (Spring 2011), available at http://sdsu-dspace.calstate.edu/bitstream/handle/10211.10/1149/Murphy_Christine.pdf?sequence=1

[47] Ibid.

[48] Interview with Chris Murphy and Christina Selder, Consumer Advocates for RCFE Reform, Mar. 30, 2017 (notes on file with author).

[49] Id.

[50] Deborah Schoch, "Rules let sicker clients into living centers,"U-T San Diego (Dec. 14, 2013), available at http://centerforhealthreporting.org/article/rules-let-sicker-clients-living-centers

[51] Ibid.

[52] Ibid.

[53] Ibid.

[54] Residential Care in California, supra note 30, at 10-11.

[55] Cal. Health & Safety Code §1569.725.

[56] 22 C.C.R. §87411.

[57] 22 C.C.R. §87415.

[58] Residential Care in California, supra note 30, at 5-6.

[59] Residential Care in California, supra note 30, at 6.

[60] Community Care Licensing Division's Quarterly Update, Adult and Senior Care (Summer 2015), p. 1.

[61] The data in this section relies on the experience and patterns that the Coalition has seen in their advocacy of caregivers in residential care facilities for the elderly. In addition, several community-based participatory (CBP) research studies of Filipino caregivers for the elderly and people with disabilities in the Bay Area, including caregivers in Santa Clara and San Francisco counties, conducted by Pilipino Association of Workers and Im/migrants (PAWIS) in partnership with academics and community-organizers, provide both qualitative and quantitative analysis of working conditions in residential care facilities. While the CBP's include both RCFE and adult residential facilities, the conditions of the caregivers are analogous.

[62] U.S. Dept. of Labor, Bureau of Labor Statistics, Table B-3 - Average hourly and weekly earnings of all employees on nonfarm payrolls by industry sector, seasonally adjusted, (last modified April 7, 2017) available at https://www.bls.gov/news.release/empsit.t19.htm

[63] U.S. Dept. of Labor, Bureau of Labor Statistics, Occupational Employment and Wages, May 2016, Personal Care Aides, available at https://www.bls.gov/oes/current/oes399021.htm#st.

[64] Abby Marquand, "A Salute to America's Elder Care Workers," Forbes (Sept. 18, 2016), available at https://www.forbes.com/sites/nextavenue/2016/09/18/a-salute-to-americas-elder-care-workers/#4df4f7ea417f; see also America's Direct Care Workforce, supra note 16, at 4.

[65] America's Direct Care Workforce, supra note 16, at 4.

[66] Nat'l Center for Assisted Living, Facts & Figures: Residents, available at https://www.ahcancal.org/ncal/facts/Pages/Residents.aspx

[67] 2014 Nat'l Study of Long-Term Care Providers Web Tables of State Estimates about Residential Care Community Residents, available at https://www.cdc.gov/nchs/data/nsltcp/ State_estimates_for_NCHS_Data_Brief_223.pdf

[68] A. C. Thompson, et al., "Elderly, At Risk, and Haphazardly Protected," Pro Publica and Frontlines (Oct. 29, 2013), available at https://www.propublica.org/article/elderly-at-risk-and-haphazardly-protected?utm_source=et&utm_medium=email&utm_campaign=dailynewsletter; An Exposition of Irregularities in Residential Care Facilities for the Elderly, supra note 46, at 6.

[69] Residential Care in California, supra note 30, at 5; Interview with Chris Murphy and Christina Selder, supra note 48 (based on review of more than 700 LIC 203s – facility licenses).

[70]An Exposition of Irregularities in Residential Care Facilities for the Elderly, supra note 46, at 6.

[71] U.S. Dept. of Health and Human Services, Compendium of Residential Care and Assisted Living Regulations and Policy: 2015 Edition – California, available at https://aspe.hhs.gov/system/files/pdf/110416/15alcom-CA.pdf; Cal. Health & Safety Code §1569.725.

[72] Ibid; 22 C.C.R. §87415.

[73] Press Release, U.S. Labor Department Conducts Compliance and Enforcement Initiative in Bay Area Nursing Homes, Residential Care Facilities (Apr. 7, 2015), available at https://www.dol.gov/whd/media/press/whdpressVB3.asp?pressdoc=Western/20150407_1.xml

[74] Lee C. Yong et al., Sleep-related problems in the US working population: prevalence and association with shiftwork status, Occup. & Environ. Med., Vol. 74:93-104 (2017), available at http://oem.bmj.com/ content/oemed/74/2/93.full.pdf; "Shift workers, sleep-deprived at greater risk of heart woes, study finds," Chicago Tribune (Jun. 8, 2016), available at http://www.chicagotribune.com/lifestyles/health/ct-shift-workers-sleep-health-0608-20160608-story.html; Christopher L. Drake et al., Shift Work Sleep Disorder: Prevalence and Consequences Beyond that of Symptomatic Day Workers, SLEEP 2004, 27(8):1453-62, available at http://www.journalsleep.org/articles/270801.pdf

[75] Kevin Riley et al., 24-Hour Care: Work and Sleep Conditions of Migrant Filipino Live-In Caregivers in Los Angeles, Am. J. of Industrial Medicine (July 19, 2016), published online in wileyonlinelibrary.com.

[76] 22 C.C.R. §87405.

[77] Kristal Tayag et al., U.C. Berkeley Labor Occupational Health Program, Bay Area Caregiver Community Based Participatory Research Project (2011) (17 caregiver survey respondents) (on file with author).

[78] Labor Department Conducts Compliance and Enforcement Initiative, supra note 73.

[79] Ibid.

[80] Richard Schulz et al., Physical and Mental Health Effects of Family Caregiving, Am. J. Nurs. Sep.; 108 (9 supp): 23-27, author manuscript available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2791523/#R1

[81] Bay Area Caregiver Community Based Participatory Research Project, supra note 77.

[82] Labor Department Conducts Compliance and Enforcement Initiative, supra note 73.

[83] Ibid.

[84] "Court rulings provide more than $1M in back wages to more than two dozen Bay Area workers damages," FilAmStar (Jul. 7, 2016), available at http://filamstar.com/court-rulings-provide-more-than-1m-in-back-wages-to-more-than-two-dozen-bay-area-workers-damages/

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[88] Ibid.

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[92] Labor Department Conducts Compliance and Enforcement Initiative, supra note 73.

[93]Bay Area Caregiver Community Based Participatory Research Project, supra note 77; The CARE Project, Caregiver Research Fact Sheet (50 caregiver interviews) (on file with author).

[94] Ibid; The Caregiver Research (CARE) Project – Santa Clara County, supra note 90.

[95] Labor Department Conducts Compliance and Enforcement Initiative, supra note 73.

[96] 29 C.F.R. §785.23; U.S. Dept. of Labor, Enforcement Policy Fair Labor Standards Act (FLSA), Hours Worked in Residential Care (Group Home) Establishments-Sleep Time and Related Issues-Enforcement Policy, 1988 WL 614199 (Jun. 30, 1988).

[97] Labor Department Conducts Compliance and Enforcement Initiative, supra note 73.

[98] San Diego Residential Care Company Violated Overtime, Minimum Wage Laws, supra note 85; Labor Commissioner Cites Residential Care Facility $2.2 Million for Wage Theft, supra note 85.

[99] Labor Commissioner Cites Residential Care Facility $2.2 Million for Wage Theft, supra note 85.

[100] Ibid.; California News in Brief, 25 No. 10 Cal. Emp. L. Letter 11 (Aug. 24, 2015).

[101] Ibid.

[102] California News in Brief, 25 No. 10 Cal. Emp. L. Letter 11 (Aug. 24, 2015).

[103] Margo Roosevelt, "O.C. assisted living chain Agape Cottages liable for $195,000 in back wages, overtime," The Orange County Register (Nov. 5, 2015), available at http://www.ocregister.com/articles/wages-691373-workers-labor.html

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[105] Labor Department Conducts Compliance and Enforcement Initiative, supra note 73.

[106] Ibid.

[107] Interview with Ruth Silver Taube, Senior Staff Attorney, Legal Aid at Work (Mar. 31, 2017) (notes with author)

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[111] Ibid.

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[113] Ibid.

[114] The Nat'l Academies of Sciences, Health and Medicine Division (formerly Institute of Medicine), Improving the Quality of Long Term Care (2001), p. 2 available at http://nationalacademies.org/hmd/~/media/Files/ Report%20 Files/2003/Improving-the-Quality-of-Long-Term-Care/LTC8pagerFINAL.pdf

[115] Ibid.

[116] Jeff McDonald, "Medical Errors plague care homes," U-T San Diego (Dec. 14, 2013), available at http://centerforhealthreporting.org/article/main-story-medical-errors-plague-care-homes

[117] An Exposition of Irregularities in Residential Care Facilities for the Elderly, supra note 46, at 60-61.

[118] Deadly Neglect at Some San Diego Assisted Living Facilities, supra note 43.

[119] Residential Care Facilities in the Neighborhood, supra note 22, at 19; Deadly Neglect at Some San Diego Assisted Living Facilities, supra note 43.

[120] An Exposition of Irregularities in Residential Care Facilities for the Elderly, supra note 46, at 59.

[121] 22 C.C.R. §87758.

[122] In one study in Santa Clara county, eighty-five percent (85%) of caregivers surveyed felt that their care homes were understaffed, leaving too many residents in the hands of too few workers. The Caregiver Research (CARE) Project, supra note 90.

[123] Interview with Chris Murphy and Christina Selder, supra note 48 (analyzing PRA data on RCFEs).

[124] Ibid.

[125] Margo van Mol et al., The Prevalence of Compassion Fatigue and Burnout among Healthcare Professionals in Intensive Care Units: A Systematic Review, PLoS One, v.10(8); 2015, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4554995/#pone.0136955.ref029

[126] Ibid.

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[129] An Exposition of Irregularities in Residential Care Facilities for the Elderly, supra note 46, at 70.

[130] Sally Stearns et al., Determinants and effects of nurse staffing intensity and skill mix in residential care/assisted living settings. Gerontologist 47(5):662– 71 (2007).

[131] Ibid.

[132] Deadly Neglect at Some San Diego Assisted Living Facilities, supra note 43.

[133] Ibid.

[134] Determinants and effects of nurse staffing, supra note 130, at 670.

[135] Ibid.

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[139] MyInnerView, 2008 National Survey of Consumer and Workforce Satisfaction in Nursing Homes, p. 5 & 18, (May 2009), available at https://www.ahcancal.org/research_data/staffing/documents/mivconsumerworkforcesatisfaction2008.pdf; Stephanie Chamberlain et al., Individual and organizational predictors of health care aide job satisfaction in long term care, BMC Health Serv Res. 2016; 16: 577, available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5064796/; Mary Ball et al., They Are the Reason I Come to Work": The Meaning of Resident-Staff Relationships in Assisted Living, J Aging Stud. 2009 Jan; 23(1): 37–47, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2635489/

[140] Ibid.

[141] An Exposition of Irregularities in Residential Care Facilities for the Elderly, supra note 46, at 16.

[142] 22 C.C.R. §87415.

[143] American Medical Directors Association, Position of Direct Care Staffing in Nursing Homes (Mar. 2002), available at https://www.paltc.org/amda-white-papers-and-resolution-position-statements/position-direct-care-staffing-nursing-homes-0

[144] See Cal. Labor Code § 1199 (misdemeanor for minimum wage violations); Cal. Labor Code § 553 (misdemeanor for certain violations including overtime, meal periods, days of rest);

[145] AB 2236 – Care Facilities: Civil Penalties (2013-2014), available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB2236

[146] Cal. Labor Code §238.4.

[147] Labor Department Conducts Compliance and Enforcement Initiative, supra note 73.

[148] See Community Care Licensing Division's Quarterly Update, Adult and Senior Care (Spring 2016), p. 7.

[149] See Community Care Licensing Division's Quarterly Update, Adult and Senior Care, (Winter/Spring 2015), p. 5.