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UNITED STATES BANKRUPTCY COURT
CENTRAL DISTRICT OF CALIFORNIA
LOS ANGELES DIVISION

In re:	Case No. 2:17-bk-13634 WB
BALDWIN PARK CONGREGATE HOME, INC.	Chapter 11
	SECOND REPORT OF THE PATIENT CARE OMBUDSMAN
Debtor.	(No Hearing Required)

Pursuant to the order directing the appointment of a Patient Care Ombudsman entered by this court on June 12, 2017, Peter C. Anderson, the United States Trustee duly appointed Joseph Rodrigues, the California State Long-Term Care Ombudsman, as the Patient Care Ombudsman in this case.

In compliance with the notice of appointment, the Patient Care Ombudsman is submitting his second 60-day report.

October 17, 2017 Respectfully submitted,

/s/Joseph Rodrigues
Joseph Rodrigues
State Long-Term Care Ombudsman

SECOND REPORT OF THE PATIENT CARE OMBUDSMAN

WISE & Healthy Aging is the designated Long-Term Care (LTC) Ombudsman Program for Los Angeles County and is the local representative of the Office of the State LTC Ombudsman. As mandated by the federal Older Americans Act (42 U.S.C. 3058g), LTC Ombudsman representatives identify, investigate and resolve complaints that are made by, or on behalf of residents of LTC facilities that relate to action, inaction or decisions that may adversely affect the health, safety, welfare or rights of residents. Lizette Arzola, MSW, MSG is the local Ombudsman representative assigned to this facility.

Baldwin Park Congregate Home is located at 3462 Vineland Avenue, Baldwin Park, California. The California Department of Public Health, Licensing and Certification, licenses this facility as a Congregate Living Health Facility (CLHF). CLHFs provide the following basic services: inpatient care including medical supervision, 24-hour skilled nursing and supportive care, pharmacy, dietary, social and recreational. The primary need of the CLHF resident shall be for availability of skilled nursing care on a recurring, intermittent, extended, or continuous basis. This care is less intense than that provided in general acute care hospitals but more intense than that provided in skilled nursing facilities.

The following information describes the number of visits made to the facility (complaint and non-complaint related), observations about staffing, food, supplies, the environment, the general status of the residents, any complaints made by or on behalf of residents to the LTC Ombudsman Program, and any changes in the census of the facility.

The licensed capacity of the facility is 12, with a current occupancy of 11 as of October 11, 2017. Staffing schedules for September and October 2017 were analyzed and from review and during unannounced visits, the staffing appeared sufficient to meet the needs of the residents.

The local Ombudsman Program has not received any concerns involving vendors, utilities, or external support factors that may impact resident care.

The Ombudsman representative has made efforts to communicate with the Department of Public Health - Los Angeles County Home Health Agency Unit regarding the facility. Follow-up information has not been received at this time. Any information received will be submitted in the next report to the court.

The local Ombudsman Program has conducted three visits during

this reporting period, covering August, September, and October 2017. All visits during this reporting period were during the 7:00 a.m. to 7:00 p.m. shift and occurred on August 25, September 14, and October 5, 2017.

During the three visits, the facility appeared to have sufficient staff and there appeared to be sufficient fresh food. The environment was clean and there were no safety hazards noted. All residents appeared comfortable and clean and did not express any concern regarding their care or supervision. During each Ombudsman visit, there were outside visitors present, the majority of which did not express any concerns regarding care or supervision.

On August 24, 2017, the facility reported via a verbal phone report to the local Ombudsman office regarding a concern of resident abandonment by the family. The facility also reported possible concern that the resident was being financially abused as the family member who was refusing to pick up the resident was also the recipient of the resident's Social Security payments. The local LTC Ombudsman office recommended that the facility report any concerns regarding suspected abuse via a formal written Report of Suspected Dependent Adult/Elder Abuse form and provided the Administrator, Joseph Cambe, with information regarding mandated reporting guidelines.

On August 25, 2017, the Ombudsman representative made efforts to meet with the resident regarding the situation. He was asleep and not easily roused. On September 14, 2017, the Ombudsman representative made efforts again to follow-up with the resident, but the resident was no longer at the facility. The resident was discharged home to a family member on September 8, 2017. As of September 18, 2017 a formal written report of suspected abuse had not been received by the local LTC Ombudsman Program. On that same date, the Ombudsman representative contacted the Administrator to determine if a report had been created. The Administrator stated that the resident's family member came to pick up the resident and that he did not report financial abuse because after further interaction with the resident's family member, he determined that the family member was not financially abusing the resident. According to the Administrator, the resident was happy to leave with his family member.

During the August 25, 2017 visit, the local Ombudsman Program received a complaint regarding the facility staff and/or physician not providing the necessary assistive medical devices for a non-verbal, paralyzed resident. There was limited action taken by the Ombudsman representative as she did not receive consent from the resident’s conservator prior to the resident being transferred from the facility to an acute hospital on August 25, 2017. As of October

5, 2017 the resident had not returned to the facility.

During the Ombudsman visit on September 14, 2017, there were no complaints received from residents or visitors. The Ombudsman representative noted that there appeared to be a limited supply of gastrostomy tube (g-tube) formula. During this visit, the facility had 10 residents, seven of whom required g-tube formula. The Ombudsman representative observed there to be approximately one to one and a half boxes of each formula. The Ombudsman representative was informed by facility staff that that the current supply should last approximately two days for the current needs of the residents. The Ombudsman representative was further notified that an order was made on September 14, 2017 to Beachwood Medical for the g-tube formula and that it was expected to arrive by September 15, 2017. Per the Ombudsman representative's request, the facility provided a copy of the invoice dated September 15, 2017 indicating that the facility made the order.

On October 5, 2017, the Ombudsman representative noted that there again appeared to a limited supply of g-tube formula. On this same date, the facility had 10 residents, approximately six of whom required g-tube formula. The Ombudsman representative again observed there to be limited supply of g-tube formula. The Ombudsman representative was again informed that the current supply

would last approximately two days and that an order would be made the following day, October 6, 2017. Per the Ombudsman representative's request, the facility provided a copy of the invoice dated October 5, 2017, indicating that the order was made. On October 11, 2017, the Ombudsman representative discussed this concern with the Administrator as this was the second time she had observed the concern. The Administrator stated that supply orders are generated on Thursdays with deliveries on Fridays. The Ombudsman representative did acknowledge that the September 14 and the October 5, 2017 visits were made on Thursdays, however the Ombudsman representative recommended that the facility increase the amount of g-tube formula that is readily available, especially in light of emergency preparedness considerations.

On October 5, 2017, the Ombudsman representative noted that the temperature throughout the facility was much warmer than usual. Upon reviewing the two thermostats, the Ombudsman representative noted that the temperatures were 82 degrees Fahrenheit and 79 degrees Fahrenheit at approximately 6:30 p.m. The Ombudsman representative documented this by taking photographs of the thermostats. The Ombudsman representative brought the temperature concern to Licensed Vocational Nurse (LVN) Stephanie Manalo, who reported that staff has been instructed not to change the locked thermostats. The Ombudsman representative immediately contacted the

Administrator who stated that he would go to the facility the next day to ensure that the air conditioning unit was working properly. On October 6, 2017, the Ombudsman representative spoke with the Administrator who reported that the air conditioning units were working appropriately. On October 11, 2017, after further review of the thermostat photographs taken by the Ombudsman representative on October 5, 2017, the Ombudsman representative noted that the air conditioning units were turned off. On this same date, the Ombudsman representative contacted the Administrator, who denied turning off the air conditioning and denied knowledge of staff turning off the units. He stated that he would investigate further. According to the Administrator there are two keys to the thermostats, one of which he has in his possession, and one is in the nurse's station. The Ombudsman representative reminded the Administrator of the importance of ensuring that the facility is set to a comfortable and safe temperature at all times.

On October 5, 2017, the Ombudsman representative noted a concern regarding nail care for a resident. The Ombudsman representative noted the toe nails of a confused resident appeared to be long and unkempt. The Ombudsman representative notified the LVN of the concern. The Ombudsman representative also contacted the resident's spouse who stated that she would follow-up with the facility regarding podiatry care.

It is the recommendation of the Patient Care Ombudsman that the facility follow mandated elder and dependent abuse reporting laws, stock adequate g-tube food supplies for daily use and enough to get them through an emergency, and ensure proper temperatures within the building at all times.

October 17, 2017

/s/Joseph Rodrigues
Joseph Rodrigues
State Long-Term Care Ombudsman