1991 WL 80896
United States District Court, E.D. California.

VALDIVIA
v.
CALIFORNIA DEPARTMENT OF HEALTH SERVICES.

Civ. No. S–90–1226EJG EM. | Feb. 25, 1991.

Opinion

Memorandum of Decision

GARCIA, District Judge.

***1** On January 11, 1991, this court issued a preliminary injunction order, effective until conclusion of trial of this matter. The order enjoined the state defendants, their agents, servants, employees, and all other persons acting under the authority of the California Department of Health Services from failing to comply with, and failing to implement, all provisions of the federal nursing home reform law, including 42 U.S.C. §§ 1395i–3(a)–(h) and 1396r(a)–(h), and the regulations attendant thereto, 42 C.F.R. §§ 483.1–483.80. The order also required the state to immediately take all necessary measures to correct its apparent noncompliance in specific areas, and set a timetable for notification of certified nursing regarding the terms of the order and for the filing of a compliance report by the state defendants. Plaintiffs were not required to post a security bond.

Now, in accordance with Federal Rules of Civil Procedure 52(a) and 65(d), the court sets forth its findings of fact and conclusions of law which constitute the basis for issuance of the preliminary injunction.

I. STATUTORY BACKGROUND

This action involves a challenge to California's alleged failure to implement a new federal nursing home reform law and the federal government's alleged failure to enforce the law.

The case is set against the complex legal back-drop of two federal health insurance programs, Medicare and Medicaid. Both were enacted by Congress in 1965. Medicaid, codified as Title IX of the Social Security Act, 42 U.S.C. §§ 1396–1396s, is a cooperative federal-state program. Medicaid provides federal matching funds to states to help them provide their needy residents with necessary medical services. State participation in Medicaid is not mandatory. However, a state which opts to participate must submit to the Secretary of Health and Human Services (HHS) a "state plan for medical assistance" which meets all relevant federal requirements. 42 U.S.C. §§ 1396, 1396a. Once the Secretary approves a state's plan, that state is entitled to federal financial participation (FFP), which means that HHS pays the state a certain percentage of each amount expended under the plan. 42 U.S.C. § 1396b. California participates in Medicaid through a state plan known as "Medi–Cal", Cal.Welf. & Inst.Code §§ 14000 *et seq.,* which is administered by the California Department of Health Services (DHS).

Medicare, a federal health insurance program for aged and disabled persons, is codified as Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq*. Medicare is funded by payroll taxes and by premiums, deductibles and copayment charges imposed on beneficiaries. Medicare (unlike Medicaid) eligibility is unrelated to income level.

Both Medicare and Medicaid authorize payment for some nursing home services provided to eligible individuals. In 1987, in the Omnibus Budget Reconciliation Act of 1987 ("OBRA 87"), Congress enacted a comprehensive set of nursing home reforms, applicable to facilities which have provider agreements under either Medicare or Medicaid and therefore qualify for federal funding on behalf of residents through either program.[1] These reforms were phased in gradually, and took full effect on October 1, 1990; they are codified at 42 U.S.C. § 1395i–3 (Medicare) and 42 U.S.C. § 1395i–3 (Medicare) and 42 U.S.C. § 1396r (Medicaid).[2]

***2** The reforms can be summarized as follows:[3] Each nursing home must care for its residents so as to promote maintenance or enhancement of each resident's quality of life. 42 U.S.C. § 1395i–3(b)(1). To this end, each facility must formulate a written plan of care for each resident, which describes the medical, nursing and psychosocial needs of the resident and how these needs will be met. 42 U.S.C. § 1395i–3(b)(2). Each care plan, in turn, is based on a "resident assessment," which must be conducted at least annually, and which must describe the resident's ability to perform daily life functions and significant impairments in functional capacity. 42 U.S.C. § 1395i–3(b)(3).

Every facility must protect and promote its residents' rights, including the right to choose a personal attending physician and be informed in advance about care and treatment, the right to be free from restraints, the right to privacy, and the right to confidentiality of personal and clinical records. 42 U.S.C. § 1395i–3(c)(1). Each resident also has certain rights with regard to his transfer or discharge from a facility, including advance notice of and limitations on permissible reasons for transfer or discharge. 42 U.S.C. § 1395i–3(c)(2). No facility can require a waiver of rights to Medicare or Medicaid benefits as a condition of admission, nor can a third party guarantee of payment be required. 42 U.S.C. § 1395i–3(c)(5). Residents' funds are also protected: residents cannot be required to deposit their personal funds with the facility, but can authorize the facility to manage and account for their funds. If a resident chooses to do so, the facility is required to follow certain procedures in safeguarding the funds. 42 U.S.C. § 1395i–3(c)(6). And with respect to the use of psychopharmacologic drugs, the law allows the administration of such drugs only on a physician's orders as part of a plan designed to eliminate or modify the symptoms for which the drugs are prescribed. 42 U.S.C. § 1395i–3(c)(1)(D).

Each state is responsible for certifying the compliance of facilities (other than state-owned facilities, which are certified by the federal government) with these requirements. 42 U.S.C. § 1395i–3(g)(1). The certifications are based on standard surveys of the nursing homes, which are conducted without prior notice. 42 U.S.C. § 1395i–3(g)(2). Each state must have procedures and staff to investigate complaints of violations of the requirements and must regularly monitor compliance with the requirements by those facilities which have previously violated the law. 42 U.S.C. § 1395i–3(g)(4). As to enforcement, if a state finds that a facility is not in compliance with the law, the state can recommend certain civil penalties to the HHS Secretary, who is then authorized to deny payments to individuals in the facility, impose financial penalties, or appoint temporary management to oversee the operation of the facility. 42 U.S.C. § 1395i–3(h).

II. PROCEDURAL HISTORY

***3** Plaintiffs, two residents of California nursing homes and a California congressman who was apparently one of the chief sponsors of the reform law, filed this action and the preliminary injunction motion on October 1, 1990, the day that the law took full effect. The gist of plaintiffs' complaint is that the state has refused to implement the new law, while the federal government has failed to address the state's non-compliance and therefore has failed to enforce the law. The complaint cites six specific areas in which the state is allegedly not in compliance:

(1) The resident assessments and care plans;

(2) The quality of care provisions;

(3) Restraints and drug therapy;

(4) Residents' rights;

(5) Transfer and discharge rights; and

(6) Social services.

Plaintiffs seek declaratory and injunctive relief against both the state and federal defendants. On December 6, 1990, this court heard oral argument on plaintiffs' class certification and preliminary injunction motions, and on California Association of Health Facilities' (CAHF) motion to intervene and application for a temporary restraining order. Pursuant to Fed.R.Civ.P. 23(b)(2), the court certified a plaintiff class of "all persons in California who are or will be residents in Medicare or Medicaid certified nursing facilities." We granted CAHF's intervention motion as of right, and denied their application for a temporary restraining order. The preliminary injunction motion was continued to provide the state defendants an opportunity to submit a supplemental brief, and ordered submitted on receipt of that brief. On January 11, 1991, the court issued an order of preliminary injunction against the state defendants; we now present in detail the reasons for issuance of the injunction.

III. PRELIMINARY INJUNCTION

A. *The Legal Standard.* The Ninth Circuit uses a "sliding scale" analysis to weigh preliminary injunction motions. An injunction can issue if the movant meets either of the following standards, which are actually not two separate tests but are merely extremes of "a single continuum":

(1) A combination of probable success on the merits and the possibility of irreparable injury, or

(2) That serious questions are raised and the balance of hardships tips sharply in the movant's favor. *Los Angeles*

Memorial Coliseum Commission v. National Football League, 634 F.2d 1197, 1201 (9th Cir.1980).

The "balance of hardships" is the key to the analysis: if the balance weighs heavily for the movant, he need not show as great a chance of success on the merits as when the balance tips less decidedly. *Benda v. Grand Lodge of the International Association of Machinists and Aerospace Workers,* 584 F.2d 308 (9th Cir.1978). However, the plaintiff must always show *some* chance of success. "The irreducible minimum has been described by one court as a fair chance of success on the merits, while another has said the questions must be serious enough to require litigation. The difference between the two formulations is insignificant. Therefore, we accept either as satisfactory." *Benda,* 584 F.2d at 315.

***4** The public interest is an additional consideration: the court must be satisfied that issuance of the injunction will serve the public interest. *Martin v. International Olympic Committee,* 740 F.2d 670, 675 (9th Cir.1984). Furthermore, where the requested injunction would change rather than preserve the status quo, the movant's burden is greater. "Mandatory preliminary relief, which goes well beyond simply maintaining the status quo *pendente lite,* is particularly disfavored, and should not be issued *unless the facts and law clearly favor the moving party." Anderson v. United States,* 612 F.2d 1112, 1114 (9th Cir.1976) (emphasis added).

B. *Plaintiffs' Preliminary Injunction Motion.* In their reply brief, plaintiffs properly concede that they seek *mandatory* preliminary relief, i.e., relief that would alter the status quo. However, after a thorough review of the record, the court is satisfied that plaintiffs have met the resultant heightened burden by showing a probability of success on the merits and a likelihood of irreparable harm, and by showing that the relevant facts and law are clearly in their favor. Thus, a preliminary injunction should issue.

1. *Probability of Success.* The state's principal contention is that its own statutory and regulatory scheme already complies with the requirements of the reform law, so that plaintiffs cannot succeed on their claims. However, this is simply incorrect; in fact, state defendants' counsel, with commendable candor, acknowledged some areas of noncompliance at oral argument. The state's assertions to the contrary notwithstanding, the disparities between the state and federal requirements are not insignificant, and the state's argument that it is simply awaiting detailed guidance from the federal government in some areas does not change the fact of noncompliance. The court's analysis focused on the following areas:

Comprehensive Resident Assessments—These assessments provide the bases for the care plans every facility is required to formulate for each resident. The reform law requires the assessments to meet four basic criteria. First, each assessment must describe the resident's ability to perform daily life functions and significant impairments in functional capacity. 42 U.S.C. § 1395i–3(b)(3)(A). To this end, each assessment must include information in at least the following thirteen categories: medically defined conditions and prior medical history; medical status measurement; functional status; sensory and physical impairments; nutritional status and requirements; special treatments or procedures; psychosocial status; discharge potential; dental condition; activities potential; rehabilitation potential; cognitive status; and drug therapy. 42 C.F.R. § 483.20(b)(2).

California requires an "initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient." 22 C.C.R. § 72311. However, plaintiffs contend that the state's assessment procedure does not address five of the thirteen areas listed in the federal regulation, and this contention is apparently correct. The state scheme is simply silent as to discharge potential and special treatments or procedures.[4]

***5** As to dental condition, the state cites 22 C.C.R. § 72301, which requires each facility to make arrangements for obtaining all necessary diagnostic and therapeutic services prescribed by "the attending dentist," as well as arrangements for an "advisory dentist" to participate at least annually in the staff development program and to approve oral hygiene policies and practices. Plainly, this does not match the federal requirement of an initial and, subsequently, periodic dental assessment.[5]

Next, as to rehabilitation potential, California cites 22 C.C.R. § 72311(a)(1)(A), which requires "identification of care needs," but does not specifically use the phrase "rehabilitation potential." While the court may lack sufficient expertise in the field to know whether the former is generally deemed to encompass the latter, the plain meanings of the two phrases are clearly dissimilar, and the state has not provided evidence sufficient to support a contrary finding.

Finally, as to drug therapy, the state cites three regulatory provisions: 22 C.C.R. §§ 72303(b)(4–5), 72311(a)(1)(A), and 72527(a)(3–4). However, the court is unable to find any mention of drug therapy in any of these regulations.

The reform law's second requirement regarding resident assessments is that each assessment must use an assessment "instrument" that is based on a uniform minimum data set ("MDS") of "core elements and

common definitions for use by nursing facilities in conducting the assessments." 42 U.S.C. §§ 1395i–3(b)(3)(A)(ii), 1395i–3(f)(6)(A). The state cites a May 14, 1990 letter from a federal official, which included an explicit statement that facilities would *not* be required to conduct assessments using instruments based on an MDS until publication of a final federal regulation. Plaintiffs cite HHS Transmittal No. 241. However, this document is not before the court; thus, plaintiffs have not shown a probability of success on the MDS issue.

The third basic requirement regarding resident assessments is that facilities must use an assessment "instrument" which is specified by the state and has been either designated or approved by HHS. 42 U.S.C. §§ 1395i–3(b)(3)(A)(ii), 1395i–3(e)(5). Defendants again rely on the May 14 letter, which apparently allowed the state to wait until the publication of final federal regulations regarding the "uniform instrument" before complying with this requirement. Plaintiffs cite an August 15, 1990 letter from a different federal official; however, contrary to plaintiffs' assertion, this letter did *not* explicitly reverse the prior letter. Thus, plaintiffs have also failed to meet their burden on this issue.

The reform law's fourth and final fundamental requirement regarding resident assessments is that each assessment must address the "identification of medical problems." 42 U.S.C. § 1395i–3(b)(3)(A)(iv). The state apparently has a similar requirement, *see* 22 C.C.R. § 72311, and plaintiffs do not dispute the point.

***6** In addition to these four basic assessment requirements, the federal statute also provides that each resident must be assessed promptly upon admission, promptly after a significant change in his physical or mental condition, and at least once every twelve months. 42 U.S.C. § 1395i–3(b)(3)(C)(i). The relevant state regulation requires an "initial written and continuing" assessment, but provides only for a review, evaluation and update of the patient's care plan, rather than a new assessment, at least quarterly and after a change in the patient's condition. 22 C.C.R. § 72311(a)(1)(C). Thus, the state requirement for frequency of assessments is apparently less stringent than the federal requirement.

Finally, federal law requires that each assessment be "conducted or coordinated" by a registered professional nurse. 42 U.S.C. § 1395i–3(b)(3)(B)(i). California requires only that each facility's director of nursing service be a registered nurse. 22 C.C.R. § 72327(a). However, the state describes assessments as "nursing services," *see* 22 C.C.R. § 72311(a); thus, the registered nurse who is director of nursing service must conduct or coordinate the assessments under California's regulatory scheme. California is therefore apparently already in compliance with this provision of the reform law.

Quality of Care. The reform law addresses quality of care only in general terms. *See* 42 U.S.C. § 1395i–3(b)(1)(A). However, the federal regulations are highly specific and detailed. For instance, 42 C.F.R. § 483.25 provides that each resident must receive the nursing, medical and psychological services necessary for him to attain and maintain the highest possible mental and physical functional status. To that end, each facility must ensure that each resident's abilities in "daily living" activities—bathing, dressing and grooming, moving, using the toilet, eating, and using speech or otherwise communicating—do not diminish, unless diminution is unavoidable. Furthermore, each resident who is unable to perform these activities must receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene, and each resident must receive appropriate treatment and services to maintain or improve his abilities in these areas. 42 C.F.R. § 483.25(a).

Similarly, the federal regulations establish minimum care requirements in twelve other areas: vision and hearing, pressure sores, urinary incontinence, range of motion, psychosocial functioning, naso-gastric tubes, accidents, nutrition, hydration, special needs, drug therapy and medication errors.

The state maintains that it has similar requirements in place; however, its arguments are unpersuasive. For instance, 22 C.C.R. § 72315(e) provides, somewhat vaguely, that each patient should be encouraged or assisted to achieve and maintain the highest level of self-care and independence; this does not even approach the specificity of the federal regulations. The state also cites "training module" materials which are used to train state surveyors, who inspect facilities to determine compliance with state and federal requirements. Plainly, however, the state requirement that surveyors be trained in certain areas does not match the federal requirement that nursing homes meet minimum standards of care in these areas. Finally, the state asserts that certain California regulations do address the specific areas listed above; however, this contention is mistaken. For instance, 22 C.C.R. § 72315(f) requires certain measures of care to prevent the formation and progression of bedsores; however, even this provision is less stringent than the federal regulation. *See* 42 C.F.R. § 483.25(c).

***7** *Residents' Rights.* The reform law provides several specific protections of the rights of nursing home residents. First, a resident cannot be transferred or discharged unless transfer or discharge is necessary to meet the resident's welfare, or is appropriate because the

resident no longer needs the facility's services; the resident's presence endangers the health or safety of other individuals in the facility; the resident has failed to pay for his stay; or the facility shuts down. 42 U.S.C. § 1395i–3(c)(2)(A). A California regulation plainly mirrors this provision. 22 C.C.R. § 72527(a)(5). However, the federal law also provides that a resident must receive at least 30 days advance notice of any transfer or discharge. 42 U.S.C. § 1395i–3(c)(2)(B). By contrast, the state regulation requires only "*reasonable* advance notice."[6] 22 C.C.R. § 72527(a)(5). Furthermore, while the reform law requires that the notice inform the resident of his right to appeal and the name, address and telephone number of the state's long-term care ombudsman, California's provision for notification of the ombudsman apparently applies only to involuntary discharges. *See* Cal.Health & Safety Code § 1599.78.

The second "residents' rights" provision of the new law gives each resident the right to choose a personal attending physician and be fully informed in advance about care and treatment and any changes in care and treatment that may affect the resident's well-being, and the right to participate in planning care and treatment and changes therein. 42 U.S.C. § 1395i–3(c)(1)(A)(i). California regulations do provide the right to choose a personal physician. 22 C.C.R. § 72303(a). However, the right to be informed is limited to those situations where full disclosure is not "medically contraindicated."[7] 22 C.C.R. § 72527(a)(3). Furthermore, this right applies to the resident's *medical condition,* which is not necessarily the same as his care and treatment plan.

The third "residents' rights" protection concerns resident funds: the reform law requires each facility to hold, safeguard and account for a resident's personal funds if the resident requests it. The facility must deposit the funds in a separate interest bearing account, and provide a complete separate accounting record of the funds. 42 U.S.C. § 1395i–3(c)(6). The state admits that it has no such requirement, and therefore is not in compliance with federal law.[8]

Similarly, the state admits its noncompliance with the federal "bedhold" requirement. Federal regulations require every facility to give each resident notice, before transferring the resident to a hospital, of its "bedhold" policies.[9] 42 C.F.R. § 483.12(b). The state provision matches this. 22 C.C.R. § 72520(b). However, the federal regulation also requires each facility to give the next available bed to any resident whose hospital stay exceeds the bedhold period. 42 C.F.R. § 483.12(b)(ii)(3). California concedes that it has no such requirement; thus, again, the state's noncompliance is undisputed.[10]

***8** Finally, both federal and state law prohibit facilities from requiring individuals to waive their rights to Medicare and Medicaid benefits as a condition of admission. 42 U.S.C. § 1395i–3(c)(5)(A)(i); Cal.Health & Safety Code § 1599.69(a).[11] However, while the reform law also prohibits facilities from requiring a third party guarantee of payment as a condition of admission, state law provides this protection only for Medi–Cal recipients. *See* 42 U.S.C. § 1395i–3(c)(5)(A)(ii); Cal.Health & Safety Code § 1599.65(b); Cal.Welf. & Inst.Code § 14110.8. Thus, the federal protection is plainly broader than the state protection.[12]

Restraints and Drug Therapy. The reform law gives nursing home residents the general right to be free from physical or chemical restraints, with some qualifications. Physical restraints cannot be imposed for purposes of discipline or convenience and must be necessary for medical treatment. Restraints can be imposed only to ensure the physical safety of the resident or other residents, *and* only upon the written order of a physician which specifies the duration and circumstances under which the restraints are to be used. 42 U.S.C. § 1395i–3(c)(1)(A)(ii). By contrast, California regulations provide that restraints can be used only with a written order of a physician *or other person lawfully authorized to prescribe care,* and place no further requirements on the contents of this order. 22 C.C.R. § 72319(b). Moreover, while the state prohibits the use of restraints as punishment or for staff convenience,[13] it does not limit the use of restraints to those situations in which restraints are necessary for residents' physical safety. In fact, California's regulation specifically authorizes the use of physical restraints for "behavior control." 22 C.C.R. § 72319(i)(2).

Similarly, the reform law provides that drugs cannot be used for discipline or convenience or if unnecessary to treat a resident's medical symptoms, and can be used only upon a physician's written order and only to ensure residents' physical safety. 42 U.S.C. § 1395i–3(c)(1)(A)(ii). Furthermore, federal regulations require each resident's drug regimen to be free from unnecessary drugs, and prohibit the new administration of antipsychotic drugs unless necessary to treat a specific condition. The regulations also require gradual dose reductions, drug holidays or behavioral programming for residents who use anti-psychotic drugs. 42 C.F.R. § 483.25(l).

California, by contrast, permits chemical restraints authorized in writing by a physician, regardless of whether they are necessary to protect the resident or others from injury. 22 C.C.R. § 72527(a)(8). And again, state law, unlike federal law, permits the use of drugs to

restrain or control behavior. 22 C.C.R. § 72319(j). The state also cites 22 C.C.R. § 72375(c), which merely requires a pharmacist to review the drug regimen of each patient at least monthly, and does not provide the protection from unnecessary drugs that the federal law and regulations provide.

***9** *Facility Compliance and Enforcement.* Under the reform law, each state is responsible for conducting unannounced standard surveys of nursing homes, and then certifying the facilities' compliance (or citing their noncompliance) with the statutory requirements. 42 U.S.C. § 1395i–3(g). Surveys must be based upon a federally approved protocol. 42 U.S.C. § 1395i–3(g)(2)(C). California instead chose to submit its own survey and certification plan, which was rejected by federal officials. The state now asserts that it will begin to use the new federal survey forms; however, as of the date of this court's preliminary injunction order, there was no indication that it had yet done so.

Reimbursement Rates. The reform law also required each state to submit a state Medicaid plan amendment for reimbursement of nursing facilities that takes into account the costs of complying with the new law. 42 U.S.C. § 1396a(a)(13)(A); Pub.L. No. 100–203, § 4211(b)(1)(A). However, California's proposed state plan amendment failed to comply with this requirement, and was rejected by HHS. Again, as of the date of the preliminary injunction order, the state had not yet submitted an approvable state plan amendment.

We as a nation have chosen to shift the burden of caring for our elderly from families to long term care facilities. The wisdom of this cultural decision can be debated. Unfortunately, few will disagree with the proposition that the quality of care and level of humaneness at many of these facilities leave something to be desired. In 1987, Congress attempted to address this problem. The resultant nursing home reform law is a clear, comprehensive and remarkably detailed congressional enactment. In the face of this detailed federal statutory and regulatory scheme, California's contention that the law is more a change in focus than one of substance bewilders this court. Equally inexplicable is the state's decision to rely on its own requirements, which are in many instances, on their face, less stringent than the requirements of the reform law. As to California's assertion that negotiations with federal officials continue and should bear fruit shortly, the court notes that Congress phased in the law over a three year period specifically to prevent this situation.

In light of the disparities between state and federal law, plaintiffs have made a sufficiently strong showing as to the state's apparent noncompliance with the reform law to establish a probability of success on the merits. Because plaintiffs satisfy the first prong of the preliminary injunction test, the court now turns to the likelihood of irreparable harm.

2. *Irreparable Injury.* Plaintiffs' declarations evidence the potentially severe impact of California's apparent failure or refusal to implement federal law. For instance, plaintiff Valdivia's physical, occupational and speech therapy were discontinued; apparently, his condition subsequently deteriorated. The therapy may have been halted simply because Valdivia was no longer benefiting from it. However, under federal law, the facility would have been required to maintain plaintiff's highest practicable level of physical, mental and psychosocial well-being; plainly, this might have included continuing therapy. And the declaration of a long term care ombudsman who met with Valdivia shows that he suffers from a skin infection and that his dentures need adjustment; the reform law has specific provisions that might have addressed or prevented these problems.

***10** Similarly, plaintiff Kaski apparently has been physically restrained and has also been given psychotropic medication for purposes of restraint. This treatment violates federal law. The state's contention that it also violates state law is unpersuasive; the state did not even learn of the violations until after this lawsuit was filed. Furthermore, if the state had implemented the federal law, Kaski would have received gradual dose reductions or "drug holidays."

The state apparently believes that these and the other examples of irreparable harm cited by plaintiffs are too speculative, and that plaintiffs have failed to establish a nexus between the alleged violations of the reform law and the harm to them. However, it is equally speculative to posit that full implementation of the law would *not* have prevented plaintiffs' injuries. In the final analysis, plaintiffs need only show that irreparable harm *may* result if the injunctive relief they seek is denied, and they have plainly met this burden.

3. *Facts and Law Clearly Favor Plaintiffs.* Plaintiffs have also satisfied the heightened burden imposed on them by virtue of the fact that they seek relief that would change the status quo. In light of the foregoing discussion, the facts and law relevant to this case clearly favor plaintiffs. Plaintiffs have offered compelling evidence of the state's failure to comply with federal law and the possible effect of this noncompliance on the plaintiff class, and defendants' arguments are entirely unpersuasive. Thus, a change in the status quo is warranted. *See, e.g., Perez–Funez v. District Director, I.N.S.,* 611 F.Supp. 990 (C.D.Cal.1984); *Orantes–Hernandez v. Smith,* 541

F.Supp. 351 (C.D.Cal.1982).

4. *The Public Interest.* This injunction will plainly serve the public interest. Injunctive relief that merely compels compliance with federal Medicaid law and the underlying Congressional mandate cannot possibly *disserve* the public interest. *Illinois Hospital Association v. Illinois Department of Public Aid,* 576 F.Supp. 360, 371 (N.D.Ill.1983). Here, the injunction issued will enable elderly residents of California's Medicare- and Medicaid-certified nursing homes to receive the level of care to which they are legally entitled. This result falls within any reasonable conception of the admittedly subjective term "public interest."

C. *Waiver of the Bond Requirement.* Fed.R.Civ.P. 65(c) requires the applicant for a preliminary injunction to post security in such sum as the court deems proper. However, the bond requirement may be waived when its imposition would effectively deny access to judicial review. *People ex rel. Van De Kamp v. Tahoe Regional Planning Agency,* 766 F.2d 1319 (9th Cir.1985). Many class members in the instant case are Medi–Cal recipients and are therefore by definition indigent. Thus, the court finds that waiver of the Rule 65 bond requirement is appropriate.

IV. CONCLUSION

***11** The court concludes that plaintiffs have a strong probability of success on the merits of their claim, that plaintiff class may suffer irreparable injury if preliminary relief is denied, that the relevant facts and law clearly favor plaintiffs, and that issuance of an injunction is in the public interest. Therefore, IT IS ORDERED that the preliminary injunction issued by this court on January 11, 1991 shall remain in force and effect pending a resolution of this matter on the merits.

IT IS SO ORDERED.

[1] In an effort to stem the tide of unnecessary acronyms, the court will refer to the new law as the "reform law," rather than "OBRA '87."

[2] 42 U.S.C. §§ 1395i–3 and 1396r are virtually identical. Unless otherwise noted, any reference in this opinion to a provision contained in § 1395i–3 shall be construed as a reference to both that provision and the corresponding provision of § 1396r.

[3] This summary highlights what appear to be the most significant provisions of the law, and is not intended to be exhaustive.

[4] The state contends that 22 C.C.R. § 72311 addresses discharge potential. However, the only provision of that regulation which could conceivably be construed as relevant is subsection (a)(1)(C), which requires each facility to review, evaluate and update the care plan at least quarterly, and more often *if there is a change in the patient's condition.* The court is not persuaded that this language matches the federal regulation's specific attention to discharge potential.

[5] However, plaintiffs' contention that the federal regulation requires assessments *by a dentist* is misguided; apparently, the dental assessments could also be conducted by a registered nurse.

[6] The state cites a letter from a state official as support for its contention that "reasonable" notice means 30 days notice; however, this letter does not have the force of a statute or regulation, and apparently only applies to transfers *within* a facility.

[7] The state's contention that the "medically contraindicated" qualification simply protects patients' health misses the point; regardless of whether this limitation makes sense medically, its effect is to create yet another disparity between the state and federal protections.

[8] California contends that it is negotiating with HHS, and expects to soon reach agreement on an acceptable procedure for protection of resident funds; while this may be true, it does not change the fact of noncompliance.

[9] "Bedhold" refers to whether and for how long a resident's nursing home bed is "held" for him during his hospital stay.

[10] And again, the state's assertion that it is "taking steps to correct" the noncompliance does not negate plaintiff's obvious likelihood of success on the merits on this issue.

[11] The California provision actually prohibits facilities from requiring residents to maintain "private pay status," which has the same effect.

[12] As to the state's contention that 22 C.C.R. §§ 72527(a)(7) and (10) prohibit third party financial disclosure, these subsections by their plain language contain no such prohibition. The letter from a state official supporting the state's interpretation of these provisions is unpersuasive; the letter does not have the force of the regulation, and it was written after this action was filed.

[13] *See* 22 C.C.R. 72319(d).