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CERTIFIED FOR PARTIAL PUBLICATION*

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FIVE

CATHRYN KOTLER, et al.,

Plaintiffs and Respondents,

v.

ALMA LODGE, etal.,

Defendants and Appellants.

B108471

(Super. Ct. Nos. BC119601,
BC127977, and BC133390)

APPEAL from a judgment of the Superior Court of Los Angeles County.

Paul G. Flynn, Judge. Affirmed.

Law Offices of James C. Beal, and Peter A. Saporito; Musick, Peeler & Garrett, and Harry W.R. Chamberlain, II, and Cheryl A. Orr for Defendants and Appellants.

Arthur H. Zacks for Plaintiff and Respondent Cathryn Kotler.

Breidenbach, Buckley, Huchting, Halm & Hamblet, and Francis Breidenbach, Kendall Caudry, and Mark W. Waterman for Plaintiffs and Respondents Jim Holt and Beverly Holt.

* Parts 1 through 6 of Discussion (and appropriate footnotes) of this opinion are not certified for publication. (See Cal. Rules of Court, rules 976(b) and 976.1.)

Defendants Alma Lodge, Sheila Dawn Egan doing business as Alma Lodge and Mamie Russell doing business as Alma Lodge appeal the judgment entered after jury verdicts for plaintiffs Cathryn Kotler, Jim Holt and Beverly Holt. For the reasons set forth below, we affirm the judgment.

FACTS AND PROCEDURAL HISTORY

Alma Lodge, located in the Eagle Rock area of Los Angeles, is licensed by the State of California as a residential facility providing board, care and supervision to mentally ill adults. Alma Lodge is owned by Sheila Dawn Egan, but has been run by its administrator, Mamie Russell, since 1978 when Egan became senior. The staff psychiatrist at Alma Lodge was Dr David Foos.

In August 1994 Rick Mabry (Mabry) and David Holt (Holt) were roommates in unit 14 at Alma Lodge. Holt, age 37, and Mabry, age 26, were both diagnosed as schizophrenics. Unit 14 was one of several second story units located over a garage. The room was not air conditioned and did not have a fan. On the evening of August 12, 1994, Mabry returned to Alma Lodge after being hospitalized by Foos for more than three weeks because he had stopped eating.

Also in mid-August 1994 the Los Angeles area was gripped by a strong heat wave. According to meteorologist Jay Rosenthal, the temperature in Eagle Rock reached 106 degrees on August 12 and 104 degrees on August 13, the latter being the

¹ Because resolution of this matter turns primarily upon the existence of substantial evidence to support the judgment, we state the facts in the manner most favorable to respondents, resolving all evidentiary conflicts in their favor. *Aceves v. Regal Pale Brewing Co.* (1979) 24 Cal.3d 502, 507, overruled on other grounds by *Privette v. Superior Court* (1993) 5 Cal.4th 689, 696.) Where necessary, we also state those facts which respondents rely upon as grounds for reversal.

² Alma Lodge, Russell and Egan will sometimes be referred to collectively as “appellants.”

sixth consecutive day of temperatures near or above 100 degrees. Rosenthal said the heat wave was compounded by high humidity and low winds, which also led to high nighttime temperatures. These factors combined to create category 3 conditions on the heat stress index prepared by the National Oceanic Atmospheric Administration. That is a “danger” category which can lead to sunstrokes, heat cramps, heat exhaustion and heatstroke.

At around 6:20p.m. on August 13, 1994, another Alma Lodge resident named Tracy entered unit 14. He found Mabry dead in his bed, lying under the covers. Holt was gripping his stomach and moaning. Tracy summoned help, but when paramedics arrived about 10 minutes later, Holt was found dead on a balcony outside the unit.

Holt’s parents, Jim and Beverly Holt, and Mabry’s mother, Cathryn Kotler, sued appellants and Foos for the wrongful deaths of their children.³ Respondents alleged the various antipsychotic medications which Foos prescribed for Holt and Mabry reduced their bodies’ ability to deal with heat and that Foos committed malpractice by failing to ensure that Holt and Mabry took steps to stay cool during the heat wave. As a result, Holt and Mabry died from hyperthermia. Alma Lodge was negligent, respondents alleged, for also failing to protect Mabry and Holt from the effects of their medication during the heat wave. They also contended that Alma Lodge violated certain state regulations which placed an 85-degree limit on room temperatures and which called for proper supervision and observation of its residents. Respondents’ separately filed actions were later consolidated.

Meteorologist Rosenthal testified that the peak outdoor temperature of 104 degrees would have occurred between 2 p.m. and 3 p.m. on August 13, 1994. The peak indoor temperature would have lagged behind by three hours. He visited unit 14

³ Plaintiffs and respondents Jim and Beverly Holt will sometimes be referred to collectively as “the Holts.” Plaintiff and respondent Kotler and the Holts will sometimes be referred to collectively as “respondents.”

and said the roof would have received intense heat while the garage below would have pushed more heat to the living quarters above. At its peak, the temperature inside unit 14 would have been at least as high as 104 degrees. At some point, as the evening progressed, the room temperature would be higher than the outdoor temperature.

Daniel Aikin, a deputy coroner investigator for Los Angeles County, arrived at unit 14 sometime after 9p.m. on August 13, 1994. Using a thermometer, he measured the temperature at 96 degrees inside the room as of 10:05p.m. and at 88 degrees outside the room as of 10:46p.m. He recalled the heat as being sweltering. At 10:10p.m. he measured the temperature of Mabry's liver as 111 degrees. At 10:46 p.m., he measured Holt's liver temperature as 105 degrees. Aikin estimated that Mabry died around 4:10p.m.

Jose Carillo, a detective with the Los Angeles Police Department, arrived at unit 14 around 9:05p.m. and stayed three or four hours. He, too, recalled the heat inside unit 14 was sweltering and said he was perspiring heavily. His investigation found no signs of suicide or foul play.

Christopher Rogers, M.D., was the Los Angeles County deputy medical examiner who autopsied Mabry and Holt. Rogers testified that Holt and Mabry died from hyperthermia—excessive body heat—due to environmental heat. Rogers had performed five to ten previous autopsies on victims of hyperthermia during Los Angeles heat waves. His opinion was confirmed by the results of a subsequent Chicago heat wave which led to many heat-related deaths. The Chicago coroner set out three criteria which had to be satisfied before hyperthermia could be blamed as the cause of death: The person's body temperature had to be at least 105 degrees, he had to be in an environment where he could become very hot, and there should be no other plausible cause of death. All three criteria were met in this case, Rogers testified. Hyperthermia does not occur suddenly and requires some time for the body's temperature to rise. Visible symptoms during this period would include

mental confusion, unresponsiveness, lethargy, looking flushed and shortness of breath.

Evidence concerning how often Alma Lodge employees observed Holt and Mabry on the day they died came from three witnesses: Alma Lodge Program Director Joan Jimenez, Alma Lodge nurse's aide Biruta Fomenko, and administrator Russell. Jimenez worked from 7:30a.m. to 1:30p.m. that day. She testified that she dispensed morning medications to the residents at 8:30a.m., including Holt, who took breakfast in the air conditioned dining room. At 9a.m., after noting that Mabry had not taken his morning medications, Jimenez said she walked to unit 14 to get Mabry. She entered the room, saw Mabry in bed, and told him it was time for breakfast and his medications. Mabry replied that he would be right down. Mabry came to the dining room about 9:30a.m., ate breakfast, then left to sun himself on an outdoor patio.

Jimenez was able to observe Mabry on the patio until he left for his room at 11:30 a.m. Sometime between 11a.m. and 11:30a.m., Jimenez asked Mabry how he was doing and Mabry replied "fine." He returned at noon to sun himself again for another 45 minutes. Jimenez believed the temperature was no higher than the typical summer day, around 80 degrees. Jimenez had worked each of the preceding three days and did not believe there was a heat wave at the time. She last saw Mabry when she went to the dining room around 12:45p.m. Mabry did not come down for his lunchtime medications, which were handed out between 1p.m. and 1:30p.m. When Jimenez went off duty at 1:30p.m., she was relieved by Fomenko. Jimenez told Fomenko that Mabry had not come down for his lunchtime medications.

Jimenez said Holt left the dining room around 10:30a.m. and spent the next half hour or so talking with Mabry, who was sunning himself outside. Holt left briefly and returned with a soft drink and spent an undetermined amount of time in the same area as Mabry. She saw Holt again when he came down for his afternoon medications around 1:30p.m. She never saw Holt again.

According to Jimenez, Alma Lodge had a general practice of watching the residents more during the summer and during her 11 years there, she had been told to have the residents shower and drink water during the summer in order to stay cool.

Fomenko, a nurse's aide at Alma Lodge, went on duty at 1:30 p.m. on August 13, 1994. A direct care supervisor, she was responsible for observing the residents. While a cook was also on duty, the cook was busy with her job chores and Fomenko was the only employee available to keep tabs on the 60 or so residents. As part of her duties, Fomenko also hands out the residents' daily medications. Before Jimenez left, she told Fomenko that a few residents had not taken their afternoon medications. Jimenez did not mention Mabry by name, but she knew from the medications which were left out that Mabry was one of those persons. Fomenko placed the medications, which were kept in paper cups, atop a refrigerator near the kitchen.

Fomenko walked over to the building which included unit 14, stood by the garage, and yelled up that Mabry should come down for his medications. A voice which she recognized as Mabry's replied that he would be right down. Of the several residents Fomenko went to remind about their medications, Mabry was the only one she did not actually see. She returned to the dining room to clean the dishes and though she saw the other residents she had just reminded about taking their lunchtime medications, she never saw Mabry take his. Instead, because she later observed that the cup containing his medications was empty, Fomenko assumed Mabry had taken them. She did not see Mabry at lunch and did not know if he ate his lunch.

Between 2 p.m. and 3:30 p.m. Fomenko was setting up medications in the dining room and was unable to observe the residents. At 3:30 p.m. she began doing the residents' laundry, but in between loading and unloading the washer and dryer, was able to see the residents. She never saw Mabry, however, who did not come down for his 5 p.m. round of medications. By 5:30 p.m., Fomenko realized that Mabry had not taken those medications. She admitted having testified at her

deposition that, had it not been for her kitchen duties, she would have gone directly to Mabry's room at that time. Fomenko said she saw Holt only one time before his death, between 5 p.m. and 5:30 p.m. when he took his evening meal and medications.

Fomenko testified that after 6 p.m. she left the kitchen and went to the office. At 6:20 p.m., an alarm bell hooked up to a unit next to unit 14 went off. Fomenko immediately went toward that building, where she saw Holt face down on the balcony. He did not appear to be breathing. Fomenko ran back to the office and first dialed 911, then called Russell who lived next door.

Asked whether August 13, 1994, had been a very hot day, Fomenko agreed it had been hot, but declined to commit herself to whether it had been very hot, stating "Well, I am a heavy person. I'm hot. So I can't, you know."

Contrary to the testimony of Jimenez, Russell testified that she entered unit 14 at 8 a.m. on August 13, 1994, to wake up both Holt and Mabry for their morning medications and that she saw Mabry take his medications at around 8:30 a.m. At her deposition, however, Russell testified that the first time she saw Mabry that day was at breakfast in the dining room. Russell claimed that Mabry ate breakfast and finished at 9:30 a.m., then went outside to sit in the sun for around 30 minutes. Russell testified that she left the area and next saw Mabry around 1:30 p.m. when he came down for his afternoon medications and lunch. She next saw him around 2 p.m. with Holt and claimed she spoke with both men at that time. That was the last time she saw either Holt or Mabry alive. When she received Fomenko's phone call about 6:20 p.m., she rushed over to unit 14.

Russell testified at trial that she believed the high temperature on August 13, 1994, was "in the eighties." She admitted testifying at her deposition that it was no hotter than 85 degrees that day because she believed Eagle Rock was cooler than nearby Glendale and Pasadena. Asked at trial how hot it was outside at 6:20 p.m., she said she could not answer. She admitted testifying at her deposition,

however, that she believed the temperature was about 70 degrees both outside and inside unit 14 at that time.

Central air conditioning was installed in the Alma Lodge dining room in 1991 because of the heat on hot days. Air conditioning was not installed in the residential units, however. Alma Lodge bought fans for some of the rooms, but unit 14 did not have one, Russell testified.

Residential care facilities such as Alma Lodge are licensed and regulated by the state's Department of Social Services (the Department). (Health & Saf. Code, §§ 1502, subds. (b), (c), 1508, 1509.) The Department's administrative regulations for these facilities are found at title 22, California Administrative Code, section 80000, et seq. Under those regulations, Alma Lodge was required to observe each resident for changes in their physical, mental and emotional condition (Cal. Admin. Code, tit. 22, § 85075.3, subd.(a)); bring any such observed changes, including deterioration of health condition, to the attention of the resident's doctor or authorized representative (Cal. Admin. Code, tit. 22, § 85075.3, subd. (c)); maintain a comfortable temperature for residents at all times (Cal. Admin. Code, tit. 22, § 80088, subd.(a)); and in rooms occupied by residents, maintain a temperature between 68 and 85 degrees, except that in areas of extreme heat, maintain a maximum temperature of 30 degrees below the outdoor maximum temperature. (Cal. Admin. Code, tit. 22, § 80088, subds.(a)(1)(A).)

Benjamin Gacad, a licensing program analyst for the Department, testified that Alma Lodge was cited for violations of these sections in connection with the events of August 13, 1994. A citation was issued for violating the maximum temperature regulation, based on the coroner investigator's thermometer reading of 96 degrees inside unit 14 at 10p.m. It was not based on the room temperature at any other time, however. A citation was also issued for failing to properly observe Mabry

and Holt. The latter citation was based in part on having had only one person to observe 60 residents, Gacad testified⁴

As to the various antipsychotic medications prescribed by Foos for Holt and Mabry, there was a great deal of conflicting evidence. Generally, various medical experts testified that the medications might have an anticholinergic effect on some patients, which, among others, could inhibit a person's ability to perspire and therefore keep cool. The same medications might also cause the opposite, known as procholergic effects, however. While some experts opined that Holt and Mabry's deaths were partly due to the anticholinergic effects of their medications, Foos and his expert testified otherwise. If their medications had caused an anticholinergic reaction, Holt and Mabry would have had dry mouth, blurred vision, constipation and urine retention. The autopsy showed no signs that either Holt or Mabry had been constipated or retaining urine. Foos testified that he prescribed an anticholinergic drug for Holt and Mabry in order to counteract the procholergic effect the other drugs were having on them and that the anticholinergic drug had not totally done so. David Paster, M.D., a psychiatric expert called by Foos, testified there was no evidence that either Holt or Mabry had suffered anticholinergic effects and that their medications played no part in their deaths.

The case was called for trial on October 3, 1996. On October 23, 1996, the jury returned its special verdict, finding: that Alma Lodge had been negligent, but Foos had not been negligent; that Alma Lodge's negligence caused the deaths of Holt and Mabry; and that Alma Lodge was 100 percent at fault. The jury awarded \$600,000 as damages to the Holts and \$600,000 to Kotler. Judgment was entered on the special verdicts the same day.

⁴ Alma Lodge was also cited for leaving residents' medications on top of a refrigerator, instead of under lock and key.

Appellants later moved for a judgment notwithstanding the verdict (JNOV) on the ground that there was insufficient evidence to support the verdicts. They also moved for a new trial on the following grounds: (1) respondents' counsel committed misconduct during the closing arguments; (2) the jury committed misconduct in its deliberations; (3) the court erred in permitting the introduction of evidence that Alma Lodge was cited by the Department for various regulatory violations in connection with the deaths of Holt and Mabry; (4) there was insufficient evidence to support the verdicts; (5) the jury awarded excessive damages because it failed to deliberate separately as to each plaintiff and instead agreed in advance to award the same amount to both sets of plaintiffs; and (6) the damages were excessive because Alma Lodge was a health care provider subject to the \$250,000 cap on noneconomic damages set forth in Civil Code section 3333.2. Both motions were denied on December 4, 1996.

On December 6, 1996, the court entered an amended judgment, incorporating the parties' previous stipulation to the amount of funeral expenses incurred by respondents. This timely appeal followed, with appellants raising essentially the same issues asserted in their JNOV and new trial motions.

DISCUSSION

1. Substantial Evidence Supports The Verdicts

Under Evidence Code section 669, a defendant's negligence will be presumed if the plaintiff's injuries were caused by the defendant's violation of a statute or regulation.⁵ The jury was given the various Department regulations

⁵ The full text of Evidence Code section 669 states: "(a) The failure of a person to exercise due care is presumed if: [¶] (1) He violated a statute, ordinance, or regulation of a public entity; [¶] (2) The violation proximately caused death or injury to person or property; [¶] (3) The death or injury resulted from an occurrence of the nature which the statute, ordinance, or regulation was designed to prevent; and [¶] (4) The person suffering the death or the injury to his person or property was one

concerning the care and observation of and room temperature for residents of Alma Lodge and instructed pursuant to Evidence Code section 669. Appellants contend there was insufficient evidence to show that they breached those regulations or that any such breach caused the deaths of Holt and Mabry.

Appellants point to the following in support of their contention: (1) Gacad, the Department licensing analyst who cited Alma Lodge for violating the Department's regulations, had no personal knowledge of the facts on which the citation was based; instead, he relied on the results of investigations conducted by other persons; (2) Gacad was never asked and did not testify whether the Department concluded the violations contributed to Holt's and Mabry's deaths and no witness, either lay or expert, so testified; (3) to the extent the verdict is based on Alma Lodge's breach of the duty to continuously observe its residents, the undisputed testimony of Jimenez, Fomenko and Russell showed that Holt and Mabry were observed numerous times throughout the day, including Fomenko's testimony that Holt was in the air conditioned dining room about an hour before his death; (4) there was no evidence to show how long either Holt or Mabry were inside unit 14 before they died and therefore no evidence how long they were exposed to temperatures greater than 85 degrees; (5) the only direct evidence on the temperature inside unit 14 came from Fomenko and Russell, who believed it was below 85 degrees; and (6) none of respondents' experts could testify about the "supposed effect" that any room temperature had on Mabry's and Holt's conditions.

of the class of persons for whose protection the statute, ordinance, or regulation was adopted. [¶] (b) This presumption may be rebutted by proof that: [¶] (1) The person violating the statute, ordinance, or regulation did what might reasonably be expected of a person of ordinary prudence, acting under similar circumstances, who desired to comply with the law; or [¶] (2) The person violating the statute, ordinance, or regulation was a child and exercised the degree of care ordinarily exercised by persons of his maturity, intelligence, and capacity under similar circumstances, but the presumption may not be rebutted by such proof if the violation occurred in the course of an activity normally engaged in only by adults and requiring adult qualifications."

Coroner Rogers testified that, even assuming a room temperature of 96 degrees after 10 p.m., the temperature alone could not have caused the deaths, a psychiatrist named Elders said it was impossible for him to answer the question “[Y]ou can’t say what effect, if any, room temperature had on the deaths, isn’t that correct?” and a toxicologist named Edelman testified that his opinions about the room temperature were based on supposition.

Based on the above, appellants contend there was no evidence, just surmise, supposition and speculation, to support a finding of either breach or causation. Their argument, and the evidence upon which it rests, suffers from two fatal defects.

First, contrary to fundamental tenets of appellate practice, the facts stated and the inferences drawn in appellants’ brief are those most favorable to them. They have, in fact, failed to mention most of the evidence set forth in our statement of facts, which, as discussed *post*, is more than enough to sustain the jury’s verdict. For example, when they state that no direct evidence showed the temperature in unit 14 ever exceeded 85 degrees, they fail to mention or acknowledge the undisputed testimony of meteorologist Rosenthal that the temperature inside the room would have lagged behind the outdoor temperature by two or three hours and would eventually have at least reached the daily high of 104 degrees. They ignore that the jury was entitled to—and probably did—disregard the testimony of Jimenez, Fomenko and Russell concerning how often they saw Mabry and Holt.

The statement attributed to Rogers that a 96 degree temperature, by itself, would not cause hyperthermia, is taken out of context. Rogers was being questioned about the side effects of the medications Mabry and Holt were taking when he was asked: “Now, if the drugs within the bodies of these two men had nothing to do with their deaths, would a 96 degree temperature in and of itself cause hyperthermia?” It ignores Rogers’s earlier testimony that hyperthermia occurs over time, not suddenly upon entering a hot room, and his later testimony that he knew the effect room temperature had on the deaths of Holt and Mabry because both had “quite high body

temperatures in roughly the same area,” because the coroner’s investigator had evidence that the temperature was at some point greater than 96 degrees, and because “you could draw the conclusion that the room might have been warmer than the body temperature of these people.”

They have also attacked the validity of the temperatures registered by Aikin’s thermometer, contending that the thermometer had been in a briefcase in Aikin’s car all day long in 100 degree heat and that Aikin did not check the thermometer before using it. Appellants failed to mention Aikin’s testimony that the thermometer, issued by the coroner’s office, was calibrated regularly, that he believed it to be accurate, that the thermometer had been in a briefcase in the air-conditioned passenger compartment of his car, and that he took the thermometer out of his briefcase, set it down for awhile, then looked at the dial.

As a result, we deem waived appellants’ contention that there was no substantial evidence to support the jury findings that they breached their duty of care, causing the deaths of Holt and Mabry. (*Oliver v. Board of Trustees* (1986) 181 Cal.App.3d 824, 832.)

Second, appellants misunderstand the application of the substantial evidence standard of review when interpreting the evidence introduced at trial. First, all explicit conflicts in the evidence must be resolved in favor of respondents and we must presume all favorable inferences in favor of the judgment. Second, we must determine whether the evidence is substantial. The evidence must be reasonable, credible and of solid value. While substantial evidence may consist of inferences, those inferences must be the product of logic and reason. The ultimate test is whether a reasonable trier of fact could have found for the respondent based on the whole record. (*Kuhn v. Department of General Services* (1994) 22 Cal.App.4th 1627, 1632-1633.) As discussed below, we alternatively hold that ample substantial evidence supported the jury’s verdict on the issues of breach and causation.

Alma Lodge was under a regulatory duty to ensure that the temperature in the rooms which its residents occupied did not exceed 85 degrees. The day Holt and Mabry died was the sixth in a row of near or above 100 degree heat. The temperature on August 12 was 106 degrees and the high in Eagle Rock on August 13 was 104 degrees, which was reached between 2 p.m. and 3 p.m. Unit 14 sat over a garage and had neither air conditioning nor a fan. Meteorologist Rosenthal, who visited unit 14, testified that the room temperature would have lagged behind the outdoor temperature by two or three hours and would have eventually at least equaled the outdoor high of 104 degrees. As the evening progressed, the temperature inside unit 14 would, at some point, exceed the diminishing outdoor temperature. This was borne out by coroner's investigator Aikin, who measured the outdoor temperature at 88 degrees at 10:46 p.m., while the indoor temperature was 96 degrees at 10:05 p.m. Both Aikin and Detective Carillo said the temperature inside the room was sweltering. Based on both the evidence and common sense, the jury could easily find that the temperature inside unit 14 well exceeded the regulatory 85 degree maximum before and at the time Holt and Mabry died, a clear breach of appellant's statutory duty.

Alma Lodge was also under a statutory duty to continuously observe its residents for changes in their mental and physical health. Appellants' contention that they fulfilled this obligation rests on the testimony of Jimenez, Russell and Fomenko, each of whom claimed to have seen Holt or Mabry several times throughout the day. Jimenez and Fomenko still worked for Alma Lodge, as did Russell, who was a defendant. Each therefore had a presumed bias for appellants. While their evidence was uncontradicted, the jury was free to disregard it. (Evid. Code, §§12, subd. (b), 780, subd. (f); *Ortzman v. Van Der Waal* (1952) 114 Cal.App.2d 167, 170-171 ["[I]n passing on credibility, the trier of the facts is entitled to take into consideration the interest of the witness in the result of the case. [Citation.] Provided the trier of the

facts does not act arbitrarily, he may reject *in toto* the testimony of a witness, even though the witness is uncontradicted. [Citations.]”.)

Their testimony was also subject to being discredited in other respects. While it was undisputed that the temperature on August 3, 1994, reached 104 degrees and that Southern California was in the midst of a high humidity heat wave, each was equivocal at best about the extent of the heat. Jimenez thought it was a typical summer day of around 80 degrees and did not believe there was a heat wave. Fomenko was willing to agree it was a hot day, but when pressed as to whether it was very hot, said she could not say because she was so heavy. At trial, Russell testified that the high that day was in the eighties but said she could not say how hot it was outside when Holt and Mabry were found at 6:20 p.m. At her deposition, however, she testified that the high was no greater than 85 degrees on August 3, 1994, and that the temperature both inside and outside unit 14 was 70 degrees at 6:20 p.m. The jury could certainly infer from this that the witnesses were intentionally trying to minimize the true extent of the heat on the day Holt and Mabry died and therefore disregard their other testimony. (Evid Code, §780, subd. (f) [trier of fact may determine witness credibility based on existence of bias or motive]; Evid. Code, § 780, subd. (i) [finding of witness credibility may be based on existence of nonexistence of any fact testified to by him].)

Furthermore, Jimenez and Russell gave differing accounts of seeing Holt and Mabry in the morning and Russell varied her deposition testimony by adding that she woke up both men at 8 a.m. to tell them to get their medications. Fomenko was the only person on duty to observe the 60 Alma Lodge residents, which one board and care facility expert testified was below the standard of care. She was often occupied with other chores and admitted at her deposition that she would have gone to check on Mabry around 5 p.m. had she not been busy with those tasks.

Therefore, there was ample substantial evidence that appellants failed to continuously observe Holt and Mabry. There was also sufficient evidence to support a finding that these breaches of regulatory duty caused their deaths as well.

The coroner testified that Holt and Mabry died from hyperthermia due to excessive environmental heat over some period of time. Mabry did not come down for his medications at either 1:30p.m. or 5 p.m. He was found dead, in his bed, under the covers. If the jury disregarded, as it was entitled to do, the testimony of Russell, Jimenez and Fomenko about observing Mabry, it could certainly infer that Mabry had been in his overheated room the entire afternoon and that the heat caused his death. The same is true of Holt. While there is no direct evidence how long Holt had been in his room, he was found there just minutes before his death. Since hyperthermia requires some time to build up, the jury could infer he had spent the necessary amount of time in his room.

Even absent evidence or inferences concerning how much time Holt and Mabry spent in their room, the jury could still reasonably conclude that their deaths from hyperthermia were caused by appellants' failure to observe Holt and Mabry as required. As noted earlier, hyperthermia takes some time to occur and Holt and Mabry would have been exhibiting various symptoms during that period. If the staff had continuously observed their conditions, those symptoms would have been evident. Jimenez said it was Alma Lodge's policy to watch residents more in the summer and have them shower and drink water to stay cool. If the jury disregarded the testimony that Holt and Mabry were in fact seen numerous times throughout the day, it could also reasonably conclude that those symptoms would have been noticed and steps taken to cool down Holt and Mabry had there been sufficient staff on duty.

2. Duty To Avoid Effect Of Medications

Appellants contend that, as a matter of law, they had no duty to anticipate the effect of the various prescription medications taken by Holt and Mabry on their

ability to deal with the heat. They have not, however, attacked the jury's finding that Foos was not negligent and that they were 100 percent at fault. Foos and his expert testified that Holt and Mabry were not suffering any anticholinergic effects from the medications. The autopsy did not show signs that they had either.

Viewing the evidence as we must in favor of the judgment, the jury could well have concluded that because the medications had not induced an anticholinergic reaction in Holt and Mabry, Foos did not breach his duty of care to alert appellants about the effects of the medications. As a result, the jury could have found that their deaths were due to the excessive heat alone and no other causes. Because we have already held that there was ample evidence to support the verdict based on appellants' breach of their regulatory duties, we need not consider whether appellants owed a duty of care in regard to the effects of the medications prescribed by Foos.

3. Misconduct Of Counsel Claim

Appellants contend that counsel for respondents committed misconduct by making various improper statements during closing argument. These included the following disputed comments by Kotler's lawyer: That "this was a violation of statute, it's negligence, it's below the standard of care to not have fans or something that keeps the room below 85 degrees, and it is a cause of the injury, the deaths in this case"; and argument concerning Foos's liability for failing to warn Alma Lodge about the side effects of the drugs he prescribed, followed by the assertion that even though Alma Lodge had a swimming pool where the residents could cool off, it did no good since the pool was closed because there was only one direct care supervisor. Appellants also contest the following disputed comments by the Holts' lawyer: the Holts' lawyer asked the jury whether its members would want their loved ones treated as Holt and Mabry were treated by Foos and Alma Lodge; Holt and Mabry should have been encouraged to take a shower to cool off; and the lawyer would be unhappy if the jury did not return a substantial award to compensate for the Holts'

huge loss. We need not consider whether these remarks amounted to misconduct. Since no objection was made to those remarks, appellants' objections are waived. (*Simmons v. Southern Pac. Transportation Co.*(1976) 62 Cal.App.3d 341, 355.)

Objections were made by Foos's lawyer to the following remarks⁶, which appellants now assert constituted prejudicial misconduct: (1) Kotler's lawyer argued that Russell said the temperature was 70 degrees when the bodies were discovered, but meteorologist Rosenthal said the temperature was 96 degrees; and (2) the Holts' lawyer argued that the jury should feel empathy for the Holts, which he defined as "putting yourself in the shoes of someone else."

Objection was made to the first remark on the ground that it misstated the testimony. The judge overruled the objection, but admonished the jury that its recollection of the testimony was controlling. A jury will be presumed to have followed such an admonition and it is only the exceptional case where the improper comments are so bad that an admonition would be ineffective. (*People v. Pitts, supra*, 223 Cal.App.3d at p.692.) Assuming for discussion's sake only that the lawyer's remark did misstate the testimony, the remark was not so egregious that the court's admonition could not cure it⁷. Instead, we presume it did and that no prejudice occurred.

Objection was made to the second remark on the ground it was "improper argument." The objection was overruled. Appellants contend the comment was a

⁶ There is authority for the proposition that the objection by co-defendant Foos was sufficient to preserve the issue for appeal even though appellants themselves did not object. (*People v. Pitts* (1990) 223 Cal.App.3d 606, 693.)

⁷ Based on our reading of the record, we believe the Holts' lawyer did misstate the meteorologist's testimony, but did so in appellants' favor. While according to the lawyer, the meteorologist said it was 96 degrees in unit 14 when the bodies were discovered at 6:20p.m., Rosenthal testified that the temperature inside would have reached the outside high of 104 degrees sometime between 5 and 6 p.m., meaning that the temperature was probably more than 100 degrees at the time.

variation of the so-called “golden rule” argument, a prohibited device by which the jury is asked to put itself in the plaintiff’s position when determining how much damages to award. We will again assume for discussion’s sake alone that the argument was improper. Even so, after examining the entire record, we do not believe it resulted in any prejudice to appellants. First, other than the ipse dixit assertion that such argument is inherently prejudicial, appellants raise no argument on this issue. Second, this was not an extreme case of prejudicial bad conduct. It was a lengthy trial dealing with emotional issues and it is sometimes inevitable that the lawyers will get swept up by their emotions and overstep the bounds of permissible argument. The trial did not degenerate into a free-for-all and the court kept control over the proceedings, admonishing counsel when necessary. *Hilliard v. A. H. Robins Co.* (1983) 148 Cal.App.3d 374, 407.) Also, as we have already held, there was substantial evidence to support the verdict. *Id.* at p. 408.) Finally, we are also swayed by the fact that the court impliedly found no prejudice from the remarks when it denied appellants’ new trial motion. A trial judge is in a better position than an appellate court to determine whether a verdict resulted in whole or in part from the asserted misconduct of counsel and we will not disturb its conclusion unless, under all the circumstances, it is plainly wrong. *Id.* at p. 407.)

4. Claimed Jury Misconduct

Appellants moved for new trial in part on the ground of jury misconduct, based on three grounds: (1) the jurors agreed in advance not to deliberate separately but to award the same amount to each family; (2) some jurors expressly refused to deliberate about awarding less than \$600,000 per family; and (3) some jurors speculated that any judgment against Alma Lodge would be covered by insurance. These allegations were supported by the declarations of jurors Wright, Lee, Hernandez and Enriquez.

In sum, these declarations stated that, “[d]uring the deliberations, it was discussed that both sets of family members would be awarded equal amounts of money There was no discussion of deciding on a dollar amount separately for each of the decedents. . . . We decided we were going to fix on a particular figure and award that same amount to each family”; on the second day of deliberations, two jurors, Briggs and Feldstein, said they could not award less than \$600,000; Briggs said if the jury deliberated another day, he would not agree to an award of less than \$750,000; when asked how the appellants could pay for a large damage award, one juror said not to worry because there was insurance to pay for it; after a short discussion about insurance, some jurors suggested the topic was improper and they stopped discussing it; juror Enriquez remembered the argument by the Holts’ lawyer that the jury should feel empathy for the plaintiffs and he disliked arguments by appellants’ lawyer suggesting that Holt and Mabry committed suicide and that nobody knew how hot their room had become or how long they were in the room.⁸

In opposition, Kotler submitted the declaration of juror Fisher, as well as another declaration from the same juror Enriquez whose declaration appellants used in their new trial motion. Fisher stated: “During the deliberations, it was discussed that the loss of Rick Mabry was as great a loss for Mrs. Kotler as the loss of David Holt was for Mr. and Mrs. Holt, since their situations were similar, and neither family was seeking loss of financial support. Therefore, it was decided there would be an equal dollar amount awarded for each death.” In regard to the discussion about insurance coverage, Fisher said that one juror pointed out there had been no evidence on that point and that the discussion was improper. The verdict was reached without

⁸ As far as juror Enriquez’s remembrances about the effect, if any, of the various closing arguments, to the extent they raise issues of lawyer misconduct which we have already rejected, the statements are not relevant. Further, to the extent they reflect the juror’s subjective thought processes, they are not admissible. (Evid. Code, § 1150; *English v. Lin* (1994) 26 Cal.App.4th 1358, 1364.)

considering insurance coverage. Enriquez confirmed that during deliberations the jury discussed how each family's circumstances was the same, prompting a decision to award the same amount to each set of plaintiffs.

In reviewing the denial of a new trial motion based on jury misconduct, we must review the entire record—including the evidence—and independently determine whether the misconduct, if it occurred, prevented the moving party from having a fair trial. Once misconduct is established, a presumption of prejudice arises. The presumption may be rebutted only by “an affirmative evidentiary showing that prejudice does not exist or by a reviewing court’s examination of the entire record to determine whether there is a reasonable probability of actual harm to the complaining party resulting from the misconduct.” [Citations.]” *Glage v. Hawes Firearms Co.* (1990) 226 Cal.App.3d 314, 321.)

If there is conflicting evidence on the issue of whether misconduct occurred, the trial court’s findings will not be disturbed absent an abuse of discretion. (*Bardessono v. Michels* (1970) 3 Cal.3d 780, 795.) When a juror accused of misconduct denies the misconduct in a declaration, that statement is sufficient to support a finding that no misconduct occurred. *Tillery v. Richland* (1984) 158 Cal.App.3d 957, 976-977.)

As to the first two grounds asserted as jury misconduct, the declarations of Fisher and Enriquez in opposition to the new trial motion stated that, during deliberations, the jury discussed how each family’s damages were the same. We read this as an assertion that the jury in fact deliberated on this point and, as a product of its deliberations, decided that each family suffered identical damages. This is far different from appellants’ assertion that the jury decided in advance of its deliberations to render an equal award. Given this conflict in the evidence, we affirm the trial court’s ruling that no misconduct occurred. *Bardessono v. Michels, supra*, 3 Cal.3d at p. 795.)

As to the discussions about insurance coverage, both the supporting and opposing declarations show that the jurors did not reach an express agreement to consider such coverage in their verdict and we are satisfied that the jury's discussions did not improperly influence the verdict. (*Gorman v. Leftwich* (1990) 218 Cal.App.3d 141, 147.)

5. Claimed Evidentiary And Other Trial Court Errors

Appellants' next argument, under a heading which refers to evidentiary rulings and errors of law, is a blend of old and new contentions. First, they challenge the court's decision to admit evidence that the Department cited Alma Lodge for various regulatory violations after the deaths of Holt and Mabry. This ruling was prejudicial, they contend, because it permitted respondents to argue that the jury could simply infer causation from the mere fact of appellants' statutory violations. Next, they contend the court improperly instructed the jury on the elements of breach and causation in terms of the alleged regulatory violations, in effect telling the jury that the Department's citation, by itself, established their liability. Appellants then return to their allegations of misconduct by respondents' counsel, including closing argument that the regulatory violations established liability and argument asking the jury whether it would want its loved ones treated as were Holt and Mabry.

Frankly, we have trouble comprehending much of this argument. The court's instructions included the various regulatory provisions which appellants allegedly violated. After reading those, the court instructed the jury with BAJI No. 3.45, which restates the provisions of Evidence Code section 669, including the requirement that any regulatory violation must have been a cause of the injuries at issue. The court then instructed the jury with BAJI No. 3.76, which defines cause as something which was a substantial factor in bringing about injury or damage. The jury was thus properly instructed that the mere fact of a regulatory violation was not enough to impose liability. Instead, plaintiffs had to prove that the violations caused

the deaths of Holt and Mabry. Even if it were error to admit evidence of the violations, a proposition which we highly doubt, the court's instructions ensured that there was no prejudice.

Neither did the argument by the respondents' lawyer prejudice appellants. Kotler's lawyer pointed out that Alma Lodge was cited by the Department, but as part of his argument, contended that the violations were a cause of the deaths and gave the definition of "cause" contained in BAJI No3.76. This was clearly proper argument. While Holt's lawyer argued that the violation of statute was negligence per se, he also referred to the court's prior instruction on that issue, instructions which properly directed the jury to consider whether the violation caused the deaths of Holt and Mabry.

Finally, we have previously addressed the allegations of misconduct during closing argument and see no need to do so again.

6. Claim of Excessive Damages

Appellants contend, based in part on their assertion that the jury committed misconduct by agreeing in advance to award the same amount to both families, that there was insufficient evidence to support the identical awards to each set of plaintiffs. To the extent we have rejected their jury misconduct claim, this argument must fail. What remains is their reliance on evidence that Kotler's relationship with Mabry was not as close as the Holts' relationship with their son. While there was some evidence that Kotler was not as close with Mabry, she contradicted that evidence by testifying that Mabry was her only child, that they loved each other and showed each other affection, that she visited him on average every other week, but sometimes more, that she often spoke with him by phone and that she felt closer and more protective of Mabry in the six years since he had become ill. The jury was free to accept this evidence and conclude that her relationship with Mabry was as strong as the Holts' relationship with their son.

7. Applicability Of MICRA

As part of appellants' new trial motion, they asserted for the first time that the jury's award of noneconomic damages was subject to the \$250,000 cap provided by the Medical Injury Compensation Reform Act (MICRA). (Civ. Code, §333.2.)

MICRA's damages cap applies to actions against health care providers based on professional negligence. (Civ. Code, §333.2, subd. (a).) A health care provider for purposes of MICRA is defined as "any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. . ." (Civ. Code §333.2, subd. (c)(1).)

Alma Lodge is licensed as a residential care facility pursuant to Health and Safety Code section 1502, subdivision (a)(1), a part of the Community Care Facilities Act found at chapter 3 of Division 2 of the Health and Safety Code (hereafter Division 2).⁹ Because the statutory authority for its license is found in Division 2 and because Alma Lodge and other such facilities are permitted by department regulations to centrally store and distribute the residents' medications, assist them with taking their medications, and arrange for and assist with medical and dental care, appellants contend they fall within the ambit of MICRA.

Resolution of this issue requires that we interpret Civil Code section 3333.2, subdivision (c)(1). The fundamental rule of statutory construction is to ascertain the intent of the Legislature in order to effectuate the purpose of the law.

⁹ All further statutory references are to the Health and Safety Code unless otherwise indicated.

(*Decker v. City of Imperial Beach* (1989) 209 Cal.App.3d 349, 354.) In doing so, we first look to the words of the statute and try to give effect to the usual, ordinary import of the language, at the same time not rendering any language mere surplusage. The words must be construed in context and in light of the nature and obvious purpose of the statute where they appear. *Ibid.*) The statute “‘must be given a reasonable and commonsense interpretation consistent with the apparent purpose and intention of the Legislature, practical rather than technical in nature, and which, when applied, will result in wise policy rather than mischief or absurdity.’ [Citations.]” (*Id.* at pp. 354-355.) If the language of a statute is clear, we should not add to or alter it to accomplish a purpose which does not appear on the face of the statute or from its legislative history. (*California Teachers Assn. v. San Diego Community College Dist.* (1981) 28 Cal.3d 692, 698.)

Appellants appear to contend that any entity licensed under Division 2 falls within the ambit of MICRA. The express language of the statute, however, states otherwise: a health care provider under MICRA is “any clinic, health dispensary, or health facility, licensed pursuant to Division 2 . . .” (Civ. Code, §3333.2, subd. (c)(1).) Thus, the only Division 2 licensees entitled to the protections of MICRA are those licensed as clinics, health dispensaries or health facilities. (According to *Coe v. Superior Court* (1990) 220 Cal.App.3d 48, 53, hereafter *Coe* [holding that while a blood bank licensed pursuant to Chapter 4 of Division 2 (§600 et seq.) qualified as neither a clinic nor a health facility as defined in Division 2, it was a health dispensary under MICRA].)

Not only would a contrary holding render surplusage the Legislature’s use of the terms “clinic,” “health dispensary” and “health facility” to specify which Division 2 licensees are covered by MICRA, this limitation also makes sense in light of MICRA’s purpose, which was to remedy a health care crisis attributed to the high cost of malpractice insurance. (*Coe, supra*, 220 Cal.App.3d at p.53.) For example, while Division 2 governs the licensing of entities such as clinics, health facilities and

skilled nursing care facilities, it also includes day care centers (§596.70 et seq.) and family day care homes. (§1597.30 et seq.) By no stretch of law or linguistics could day care facilities be considered health care providers and an interpretation which included such facilities within the protections of MICRA would produce an absurd result. We next examine whether Alma Lodge was either a clinic, health facility or health dispensary under Division 2.

Section 1200 defines a clinic as “an organized outpatient health facility which provides direct medical, surgical, dental, optometric, or podiatric advice, services, or treatment to patients who remain less than 24 hours. . .” Appellants conceded at oral argument that Alma Lodge was not a clinic.

A health facility means “any facility, place, or building which is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation... to which the persons are admitted for a 24-hour stay or longer . . .” (§ 1250.) This includes general acute care hospitals, acute psychiatric hospitals, skilled nursing facilities, intermediate care facilities, special hospitals, congregate living health facilities of no more than six beds which provide 24-hour skilled nursing care and medical supervision, and correctional treatment facilities. (§1250, subs.(a)-(k).)¹⁰

¹⁰ A general acute care hospital “means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care. . .” (§ 1250, subd. (a).) An acute psychiatric hospital “means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care” for the mentally ill. (§ 1250, subd. (b).) A skilled nursing facility “means a health facility that provides skilled nursing care and supportive care to patients” who need such care on an extended basis. (§1250, subd. (c).) An intermediate care facility “means a health facility that provides inpatient care to ambulatory or nonambulatory patients who have recurring need for skilled nursing supervision,” but who do not need such care continuously. (§1250, subd. (d).) An intermediate care facility/developmentally disabled habilitative “means a facility with a capacity of 4 to 15 beds that provides

Appellants contended for the first time during oral argument that they qualified as a health facility under section 1250. Because the argument was not included in their appellate briefs and because they have failed to point us to any specific provision of section 1250 which applies to residential care facilities licensed under section 1502, we deem the issue waived. (*Kandry v. Berryessa Union School Dist.* (1995) 39 Cal.App.4th 691, 699-700; *Unilogic, Inc. v. Burroughs Corp.* (1992) 10 Cal.App.4th 612, 624.) We alternatively conclude that Alma Lodge was not a health facility.

24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer developmentally disabled persons” who need nursing services on a recurring, intermittent basis. (§1250, subd. (e).) A special hospital “means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical or dental staff that provides inpatient or outpatient care in dentistry or maternity.” (§250, subd. (f).) Intermediate care facility/developmentally disabled “means a facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to developmentally disabled clients whose primary need is for developmental services and who have a recurring but intermediate need for skilled nursing services.” (§ 1250, subd. (g).) Intermediate care facility/developmentally disabled—nursing “means a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for developmentally disabled persons who have intermittent recurring needs for skilled nursing care. . . The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay . . .” (§ 1250, subd. (h).) Congregate living health facility “means a residential home with a capacity... of no more than six beds, that provides inpatient care, including the following basic services: medical supervision, 24-hour skilled nursing and supportive care, pharmacy, dietary, [and] social recreational. . . . This care is generally less intense than that provided in general acute care hospitals but more intense than that provided in skilled nursing facilities.” (§ 1250, subd. (i).) Correctional treatment center “means a health facility operated by the Department of Corrections . . that . . . provides inpatient health services to that portion of the inmate population who do not require a general acute care level of basic services.” (§1250, subd. (j).) Nursing facility “means a facility that is certified to participate as a provider of care in the federal medicaid program” and is licensed as a skilled nursing facility or an intermediate care facility. (§250, subd. (k).)

The statutory provisions which govern residential care facilities such as Alma Lodge go to great lengths to separate those facilities from others which provide medical and health-related care. Section 1501 sets forth the legislative intent and declaration behind the Community Care Facilities Act. Among its purposes is to “insure continuity of care between the medical-health elements and the supportive care-rehabilitation elements of California’s health systems . . .” (§ 1501, subd. (b)(4).) Residential facilities such as Alma Lodge are statutorily defined as providing “*nonmedical care* of persons in need of personal services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of the individual.” (§1502, subd.(a)(1), italics added.) Nothing in this language compares with the medical, dental, psychological, nursing and other such services rendered by the various entities defined as health facilities by section 1250, subdivisions (a) through (k). (See *ante*, fn. 10.)

Appellants’ reliance on the limited class of health-related services which they are permitted to provide as proof that Alma Lodge falls within the ambit of MICRA is misplaced. The Department’s regulations set forth certain health related services which residential facilities may provide. These include observing the residents for changes in their physical or mental conditions, and assistance with bathing and personal needs or with obtaining a doctor. The regulations also permit facilities such as Alma Lodge to ensure that residents are assisted as needed with the self-administration of medications, but they may not administer injections. (Cal. Admin. Code, tit.22, § 80075, subd.(a)(2)(A).) Residents’ medications are to be centrally stored in a safe, locked place if they must be refrigerated or if the facility administrator or the resident’s physician determines they would be dangerous for the resident to possess. (*Id.* at subd. (h)(1)-(3).)

While residential care facilities may provide incidental medical services, if such services constitute a substantial component of the total services provided, the facility must also become licensed as either a clinic under section 1200 or a health

facility under section 1250. (§1507.) These permitted incidental medical services include changing or emptying colostomy and urinary catheter bags, or feeding, hydrating and adding prescribed medication to persons with gastrostomies. (§507, subd. (b)(1)-(3).) At the same time, health clinics and health facilities are exempt from the licensing requirements imposed on residential care facilities such as Alma Lodge. (§ 1505, subs. (a), (b).)

Statutory sections relating to the same subject must be read together and harmonized. (*Industrial Risk Insurers v. Rust Engineering Co.* (1991) 232 Cal.App.3d 1038, 1042.) Sections 1505 and 1507, when read together, suggest to us that a residential care facility is not the same as a health facility merely because it provides certain incidental, health-related services. If health facilities under section 1250 are exempt from the statutes which govern residential care facilities, and if a residential care facility need not be licensed as a health facility when providing incidental medical services, but a residential care facility which provides more than incidental medical services must become licensed as a health facility, the only logical conclusion which can be drawn is that a residential care facility which provides only incidental medical services *is not* a health facility.

Accordingly, we hold that residential facilities licensed pursuant to section 1502, subdivision (a)(1) are not licensed health facilities in Division 2 and are therefore outside the reach of MICRA.

Since Alma Lodge was neither a clinic under section 1200 nor a health facility under section 1250, if it is to qualify for the damage ceiling supplied by MICRA, it must do so as a health dispensary licensed under Division 2. It does not.

The term “health dispensary” is not defined by either the Health and Safety Code or MICRA. The only reported decision to consider its meaning was *Soe*, *supra*, 220 Cal.App.3d 48, which held that while a blood bank licensed pursuant to Chapter 4 of Division 2 (§1600 et seq.) qualified as neither a clinic nor a health facility as defined in Division 2, it was a health dispensary. In so holding, the *Soe*

court relied on rules of statutory construction to conclude that the Legislature intended the term “health dispensary” in MICRA to mean something separate and apart from clinics and health facilities and that health dispensaries were an additional and separate category of Division 2 licensees covered by MICRA. *Id.* at p. 53.) Noting that blood banks were defined within Division 2 as any place where human blood is collected, prepared, tested and stored, or from which human blood is distributed (*id.* at p. 53, fn. 4), the court held that blood banks were health dispensaries because they “dispense a product and provide a service inextricably identified with the health of humans.” *Id.* at p. 53.)

With these various provisions in mind, we hold that Alma Lodge was not a health dispensary for purposes of MICRA. Unlike the blood bank in *Goetz*, *supra*, 220 Cal.App.3d 48, facilities such as Alma Lodge are not licensed to distribute health products inextricably identified with human health. Instead, they are expressly defined as nonmedical board and care facilities which provide a supervised and structured place to live for persons in need of such assistance. Helping those residents take medications which a physician has prescribed, storing those medications for safekeeping, making sure that residents get medical help if needed, and arranging for transportation in connection with that care, do not make such facilities health dispensaries. Since MICRA does not apply to Alma Lodge, the trial court did not err in refusing to reduce the jury’s verdict according to MICRA’s terms.

DISPOSITION

For the reasons set forth above, the judgment is affirmed. Respondents Jim Holt, Beverly Holt and Cathryn Kotler to recover their costs on appeal.

CERTIFIED FOR PARTIAL PUBLICATION.

GODOY PEREZ, J.

We concur:

TURNER, P.J.

ARMSTRONG, J.