No citizen of California should be required to surrender basic constitutional rights and civil protections to secure a bed in a nursing home or as a condition for adequate care. This is particularly true when the citizens who are being asked to sign arbitration agreements suffer from a variety of physical and mental ailments, and when neither they nor their family members understand what they are signing.

Yet, this is exactly what is happening in California today. In an effort to prevent residents from being able to sue for resident rights violations, abuse or neglect, nursing homes are asking residents or their family members to sign admission agreements that include binding arbitration provisions.

When a resident of a nursing home signs an admission agreement that includes an arbitration provision, the parties are agreeing to give up their constitutional right to have a dispute decided in a court of law in front of a jury. They are agreeing to the use of binding arbitration before the dispute even happens. This means that the decision of the arbitrator is final and there is no appeal. This means that, rather than having the issue decided in public by a jury of their peers in front of a judge, the matter will be decided in private, by a private (and very expensive) arbitrator. Arbitration proceedings are not part of the public record and not subject to judicial review.

The time has come for long-term care consumers to fight back against the use of arbitration agreements. The time has come to Don’t Sign It!

Why is arbitration bad for consumers?

Consumers lose! Arbitrators need cases to make a living. A nursing home resident bringing a neglect case is a one-time customer for the private arbitrators, while corporate defendants and insurance companies will be involved in cases again and again. Some judges take this into account: if they want repeat business, they know if they impose a high compensatory award - let alone punitive damages - the corporate defendant or its insurance company won’t use their services again. Studies bear out arbitrators’ pro-business bias – consumers tend to win less often and are awarded less money in arbitration than in the courts.

Arbitration is expensive! Nursing home residents who are on Medi-Cal or SSI qualify for fee waivers in court, meaning they don’t pay court costs. Plus, the trial judge is a public official paid by the taxpayers. Arbitrators, on the other hand, charge the parties for their services. This “neutral” arbitrator is a private judge whose services can cost anywhere from $400 to $1,000 an hour or more. Arbitration may be cheaper for the nursing home, since the money’s coming out of the pocket of their insurance company, but arbitration is certainly not cheaper for consumers.

Arbitration Agreements .................. (continued on page 3)
CANHR News

Staff News

CANHR is pleased to welcome two new employees in 2013. Our new Receptionist/Office Manager, Armando Rafailan, has a history of remarkable customer service with experience in both retail and hotel management. He will be the friendly voice you hear next time you call so be sure to say hello.

Also joining us in the New Year is Web and Print Designer, Avigail Tucker. With an international resume and a long-time interest in aging issues, Avigail will be applying her skills to brighten up CANHR’s printed materials and to maintain and improve our web sites. A big welcome to them both!

Make a Donation Without Writing a Check!

Did you know you could make a secure online donation to CANHR with your credit card?

Simply by clicking on the yellow “Donate Now” button on CANHR’s website at www.canhr.org,

you can help CANHR to continue to provide valuable services to residents of long term care and their families. Even better, you can even make a recurring donation and help through out the year!

If you select “I want to make a recurring donation”, you will be registering to make a credit card donation every month, 3 months, or year. After you complete this initial donation, future donations will be made automatically. For example, if you choose to make a recurring monthly donation of $10.00, your next donation of $10.00 will be automatically charged to your account one month from the date of your initial donation.

You will receive an email receipt for each recurring donation. As soon as you complete this initial donation, you will receive a separate email containing a password and a link to a site where you can review and change your donation options (amount, frequency, billing information) at any time. Of course, you will also be able to cancel your recurring donation at any point in the future.

Help CANHR Save Resources

Another way you can help us save resources is by requesting your Advocate subscription be sent to you via email. Contact our office with your current email address and we can easily convert your subscription from paper to electronic. You still receive the same great newsletter, CANHR reduces our printing and mailing costs and the trees will thank you too!

Request a Speaker for Your Next Meeting or Event

A reminder to our readers that CANHR staff members are available to speak to groups of 20 or more about CANHR services and long term care issues. Contact our office if you would like to discuss having a CANHR speaker at your next meeting or event. CANHR does request and honorarium from professional groups to cover costs.

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About CANHR
Since 1983, California Advocates for Nursing Home Reform (CANHR), a statewide nonprofit 501(c)(3) advocacy organization, has been dedicated to improving the choices, care and quality of life for California’s long term care consumers.

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Arbitration agreements are rarely “voluntary”. In the nursing home context, residents or their representatives are usually asked to sign an arbitration agreement as one page of a 40+ page admission agreement in a “take it or leave it” setting. Family members often feel compelled to sign such agreements to ensure that the care of their family member is not compromised. If they don’t sign the agreement, they probably won’t be admitted to the facility in the first place. Few of the residents or their representatives understand the consequences of the agreement, nor are they represented by counsel. Yet they are asked to sign a legal document drafted by the facility’s legal counsel relinquishing their right to a trial by jury. What bargaining power does a Medi-Cal resident or an aged or disabled consumer have in this marketplace?

Take the story of Donna C. Donna C. was admitted to a nursing home following a minor surgery to fix a broken ankle. Within a few weeks, Donna was barely conscious, over-drugged on pain medication and tranquilizers. She developed bedsores and later developed pneumonia from her inability to swallow her food. Donna was eventually re-hospitalized and nearly died. She never recovered her former vigor.

When Donna’s family looked at a possible lawsuit, they learned it was impossible because of an arbitration agreement Donna’s daughter had unwittingly signed. The family did eventually find an attorney and went through the arbitration process. The arbitrator awarded a small amount to Donna that failed to cover her arbitration costs, despite the fact that the nursing home had been understaffed and had failed to act on the family’s expressed concerns about her deterioration.

How Can You Avoid an Arbitration Agreement?

Don't sign it! Under California law, it is illegal to force prospective nursing home residents to sign an arbitration agreement as a condition of admission, and the arbitration agreement is required to be separate and apart from the admission agreement. The easiest way to preserve your right to use the courts is to refuse to sign an arbitration agreement.

While facilities might (illegally) refuse to accept a resident who won’t sign an arbitration agreement using some pretext or another, they often accept residents who have not yet signed their admission papers. One way to avoid arbitration agreements is to get admitted first and then refuse to sign the arbitration piece. Nursing homes are prohibited from evicting residents unless one of a narrow range of reasons has been satisfied. Failing to sign an arbitration agreement is not one of those reasons – in fact, it is against the law. So once a resident has been admitted, she/he can simply refuse to sign.

What if I Already Signed an Arbitration Agreement?

Nursing home residents or their legal representatives may rescind an arbitration agreement by giving written notice to the facility within 30 days of their signature. (California Code of Civil Procedure §1295) If more than 30 days have passed since you or a loved one signed an arbitration agreement, there is no harm in revoking the clause after the fact. You could send a letter to the facility explaining that you did not understand the implications of signing an arbitration agreement, and therefore you are revoking your consent. Be sure to keep a copy of the letter and obtain proof of delivery.

How to Prevent Being Bound to an Arbitration Agreement

In many cases, nursing home or assisted living residents do not sign their arbitration agreements. A substitute, often a family member or an agent under a power of attorney or health care directive, will sign the admission agreement and the arbitration agreement on behalf of the resident. By not granting your surrogate the power to sign arbitration agreements on your behalf, you can retain your right to consent or refuse arbitration.

The nursing home industry – a multi-billion dollar industry – spends considerable time and money on efforts to deny residents their rights in order to avoid accountability for abuse and neglect of residents. Only by being aware of your rights, by being vigilant, by reading the fine print and by refusing to sign such agreements can residents’ rights prevail.

For more information on CANHR’s Don’t Sign it Campaign, contact the CANHR office or see www.canhr.org
Prison Sentence for Nurse Who Drugged Residents

On January 9, 2013, Gwen D. Hughes, the former Director of Nursing of Kern Valley Healthcare District’s nursing home was sentenced to three years in prison for drugging residents into submission with antipsychotic and anti-seizure drugs. Hughes was the last of four defendants, including the facility’s former pharmacist, acting medical director, and administrator, charged with various crimes related to the systematic forced drugging of residents in 2006. Three of the residents died from being overmedicated.

In 2009, the California Attorney General brought charges against Hughes and her co-workers after an investigation revealed that 23 residents had been regularly drugged with powerful psychotropic drugs for staff convenience, some after being pinned down and given an injection. Many of the residents swiftly deteriorated after being chemically restrained, becoming lethargic, malnourished, and dehydrated.

Hughes ordered the administration of psychotropic medications to the elderly residents of the skilled nursing facility not for therapeutic reasons, but instead to control and quiet them for the convenience of staff. The drugs were given to patients who were noisy, prone to wandering, who complained about conditions or were argumentative. At her command, residents were drugged for actions like refusing to eat in the dining room, throwing milk, and bumping into objects with their wheelchairs. She was initially charged with assault with a deadly weapon, an apt description of what passed as dementia treatment at Kern Valley. The drugs hastened three patients’ deaths, according to the investigation, and all 23 suffered some form of adverse physical reaction as a result. Many of the patients were under care for Alzheimer’s or dementia.

Hughes’ prison sentence sends a long overdue message that drugging residents for staff convenience or without clinical indication is elder abuse and will have criminal consequences. In a state where nearly 60% of all nursing home residents receive at least one psychotropic drug, the message should resonate throughout California’s 1200 nursing homes.

CANHR Files Lawsuit to Close Nursing Home Corporate Loopholes

In an effort to close the loopholes for multi-level corporations who do business in the State of California, CANHR has filed a lawsuit against the California Department of Public Health (DPH) over its failure to enforce state law requiring the Department to examine and approve or disapprove of proposed acquisitions of skilled nursing facilities and intermediate care facilities. Although current law requires that the Department request and review information and give prior written approval to the acquisition of a beneficial interest of 5 percent or more in any entity licensed to operate a skilled nursing facility or intermediate care facility, DPH has refused to fully enforce the law and has instead taken the position that it must only investigate and approve changes in the ownership structure at the nursing home facility level or one ownership level above, thereby creating an enormous loophole for all multi-layer nursing home organizations.

In other words, if a corporation has many levels, the state of California will only scrutinize the lowest levels of the organization and not the top levels, where the decisions are being made and profits are being collected.

Owners and investors in the nursing home industry have purposely and increasingly created more complexity and layers in their corporate and ownership structure so that they can avoid scrutiny and responsibility. The Department’s position permits and even encourages large skilled nursing chains to create multiple levels of ownership and control, allowing them to buy or sell an entire enterprise without reporting the change of beneficial interest. Plaintiffs seek declaratory and injunctive relief and a writ of mandate to compel the Department and other defendants to enforce the provisions of Health and Safety Code section 1267.5(b).
**Focus On**

**CANHR-Sponsored Legislation Impacts Financial Abuse Scams**

On January 1, 2013, two senior financial abuse protection statutes sponsored by CANHR became law. These statutes outlaw certain predatory practices by unscrupulous insurance agents who sell annuities to seniors. The first new law makes it illegal for an insurance agent to use the delivery of legal documents as a pretext for gaining entrance into a senior’s home. The second new law takes away the financial incentive from insurance agents who steer senior veterans into useless financial products in order to qualify them for government benefits. While these changes will not end financial elder abuse completely, they do create bright lines for prosecutors and litigators to use in financial elder abuse cases.

**Breaking up the Discount Legal Document Delivery Scheme**

In the past, certain groups made a business out of connecting seniors to “discount attorneys” who charged low fees for living trusts and durable powers of attorney. These groups also created arrangements with insurance agents who were interested in selling annuities and other financial products to seniors. Before CANHR’s bill became law, the discount attorneys were giving those groups the finished living trusts and durable powers of attorney to deliver to the seniors instead of sending the documents directly to the seniors. The personal and financial information contained in those documents were invaluable to the agents. In them, an agent could learn all about a senior’s estate and inheritance plans. After getting the documents from the discount attorney, the agent would telephone the senior and notify the senior that he or she had been “retained” to deliver the documents. The seniors, who had already prepaid for the documents, would then open their doors to the agent. This delivery scheme was nothing more than a pretext for the insurance agent to get into senior’s home to sell products. Because of CANHR’s efforts, this practice is now illegal and any agent who delivers legal documents to the home of a senior is breaking the law.

**Taking the Financial Incentive Out of Artificially Impoverishing Seniors to Qualify Them for the VA Aid and Attendance Benefit**

The Veterans Administration has a benefit called the Aid and Attendance Pension Program (VA A&A), which is a lifeline for low-wealth veterans and their spouses who cannot afford to pay for medical supplies, assisted living, or in-home care workers. It is a benefit available to those with little or no assets and limited incomes who served in the military during a time of war. The VA will work with seniors to help them with the paperwork needed to qualify for the benefit. Recently, insurance agents discovered that by exploiting this program they could make a fortune in commissions. All they needed to do was talk senior veterans who had excess assets into artificially impoverishing themselves in order to appear qualified “on paper” for the benefit. Their trick was to have the seniors move their money into deferred annuities and place those annuities into irrevocable trusts. The purchase of an annuity is a dangerous and unnecessary move. It is dangerous because the annuity can carry severe surrender penalties. It is unnecessary because it is enough to simply place the money into an irrevocable trust or give it away. For the VA, so long as the senior has no claim to the money, and the asset is no longer in the senior’s name, he or she will qualify for the benefit. There is never a need to lock the senior’s assets up into an annuity.

There are also moral dimensions of this scheme to consider. The VA Aid and Attendance benefit was never intended to be for every senior veteran. It is not an entitlement. This benefit was meant only for those veterans and their spouses who are financially struggling at the end of their lives. Despite this fact, financial predators have been working to manipulate seniors into believing that they are entitled to the benefit and simply have to follow their “estate planning advice” in order to qualify. Ultimately, the seniors who trust these insurance agents end up having their money put out of reach for the rest of their lives. Meanwhile, the insurance agents walk away rich with commissions.

The new law now prohibits an insurance broker or agent from participating in, being associated with, or employing any party that participates in the business of obtaining veterans’ benefits for a senior unless the insurance agent or broker maintains procedural safeguards designed to ensure that the agent or broker has no direct financial incentive to refer the policyholder or prospective policyholder to any government benefits program. This law makes sure insurance agents do not deceptively peddle their products if they are working with other groups or individuals who are assisting veterans with qualifying for benefits. While an insurance agent can still provide information about the program, e.g., make suggestions or drive the senior to the VA or local veterans services organization, he or she may not make any money doing this. This takes into account when a family member or friend, who also happens to be an insurance agent, wants to help a senior veteran qualify for the benefit. The family member or friend may do so as long as he or she doesn’t end up benefiting financially.
**Legislation Update 2013**

Please check the CANHR website for updated details on legislation.

**CANHR Sponsored**

**AB 140 (Dickinson): Undue Influence**
This bill would define undue influence as excessive persuasion that causes another person to act or refrain from acting in a manner that results in an unfair outcome. In determining whether the outcome was produced by undue influence, the vulnerability of the victim, the influencer’s apparent authority, the actions or tactics used by the influencer, and the equity of the result shall be considered. **Status**: double referred to Assembly Judiciary and Aging and Long Term Care.

**AB 462 (Stone): Fire protection in RCFEs/ARFs**
This bill would require a residential care facility for the elderly or adult residential facility, as defined, that has a valid license as of January 1, 2014, to have installed and maintained on and after January 1, 2016, an operable automatic fire sprinkler system approved by the State Fire Marshal. **Status**: doubled referred to Assembly Government and Organizations and Human Services.

**AB 553 (Medina): Reverse Mortgage**
This bill would prohibit a lender from taking a reverse mortgage application unless, at least 7 days prior to receiving counseling, the applicant has received from the lender a specified disclosure notice. **Status**: referred to Assembly Banking and Finance.

**SB 272 (Corbett): Advertising: military endorsements**
This bill would make it illegal for any nongovernmental entity to use a seal or emblem to imply any connection or endorsement of any federal or state military, veteran or Veterans Service Organization (VSO), without approval, for the purpose of financial gain. This would apply to advertising or promotion of events or products, without permission. **Status**: double referred to Senate Business Professions and Economic Development and RLS.

**CANHR Support**

**AB 322 (Yamada): Home Care Services Act of 2013**
This bill would enact the Home Care Services Act of 2013 and would provide for the licensure and regulation of home care organizations, as defined, by the State Department of Social Services. **Status**: referred to Assembly Human Services; hearing 4/2/13.

**AB 364 (Calderon): Community Care Facilities: Unannounced Visits**
This bill would instead require the department to visit a community care facility no less often than once every 2 years. **Status**: referred to Assembly Human Services; hearing 4/2/13.

**AB 471 (Atkins): Medi-Cal: Program of All-Inclusive Care for the Elderly.**
This bill would delete the provision that limits the number of contracts with PACE organizations to 15.

**AB 581 (Ammiano): Residential Care Facilities for the Elderly: Retaliation.**
This bill would prohibit a adult residential facility licensee or a residential facility for the elderly licensee, or officer or employee of the licensee, from discriminating or retaliating in any manner, including, but not limited to, eviction or threat of eviction, against anyone receiving the services of the facility, or against any employee of the licensee’s facility, on the basis, or for the reason that, the person or employee or any other person has initiated or participated in the filing of a complaint, grievance, or a request for inspection with the department or the local or state ombudsman pursuant to prescribed provisions of law. **Status**: double referred to Assembly Human Services and Judiciary.

**AB 663 (Gomez): Residential Care Facilities: Administrators: Training Requirements**
This bill would require the administrator training to be a total of 40 hours and would require that the training include 5 hours of training in cultural competency and sensitivity in aging lesbian, gay, bisexual, and transgender minority issues. **Status**: referred to Assembly Human Services.

**AB 1217 (Lowenthal): Home Care Services Consumer Protection Act of 2013**
This bill would enact the Home Care Services Consumer Protection Act of 2013, which would provide, and after July 1, 2014, for the licensure and regulation of home care organizations, as defined, by the State Department of Social Services, and the certification of home care aides.

**SB 60 (Wright): Victims of Crime Act: Elderly Adults.**
This bill would include financial abuse of an elderly or dependent adult in the definition of crimes eligible for compensation under the California Victim Compensation and Government Claims Restitution Fund. It would also provide legislative findings and declarations regarding financial crimes against elderly or dependent adults. **Status**: referred to Senate Public Safety.

**SB 609 (Wolk): Office of the State Long-Term Care Ombudsman.**
Existing law requires the office to solicit and receive funds, gifts, and contributions to support the operations and program of the office. This bill would require the office to deposit those funds into the Long-Term Care Ombudsman Program Improvement Act Fund, and would continuously appropriate those funds for the purpose of supporting the operations and programs of the office.
Eden Manor, at 3121 Fruitvale Avenue in Oakland, is closing due to foreclosure. WoodPark, LLC (DBA AgeSong at WoodPark) has agreed to take over the lease after Eden Manor closed. However, as we go to print, WoodPark, LLC had yet to receive a license to operate the facility. Eden Manor was an RCFE licensed for 90 residents, but as of 2/22/13, the eviction date, 14 residents still lived in the facility. The administration had not done the appropriate planning to transfer those residents safely to new homes. As a result, 14 residents were left homeless. Residents who had paid Eden Manor for housing and services for the month of February were put out on the sidewalk with their belongings. PG&E came in and turned off the electricity, the water was shut off, and there was not enough food for the residents.

Prior to the eviction date many of the residents had been transferred to another facility also administered by Cristina Musngi: Valley Springs Manor at 17926 Apricot Way in Castro Valley. The health, safety and financial well-being of the residents in Ms. Musngi's facilities are in jeopardy. The following is a short list of laws and regulations that have been violated:

1. H&S 1569.682 (The RCFE Relocation Act of 2008) establishes relocation rights and procedures for residents who are evicted due to the closure of a facility. CANHR is aware of at least three residents illegally transferred from Eden Manor to Valley Springs Manor without proper notice. CANHR sponsored this legislation to minimize transfer trauma, ensure that residents are transferred safely, reduce some of the financial hardships, and provide oversight of the process by the licensing agency. It is clear that this has not happened.

2. According to W&I 9722 (c) and CCR 87468(a) (11), residents have the right to visit privately, without prior notice, with persons of their own choosing, including ombudsmen and other advocacy representatives. On a number of occasions, the facility did not let visitors in, including the Long Term Care Ombudsman of Alameda County.

3. 22 CCR 87555 (a)(1) ensures that “where all food is provided by the facility, arrangements shall be made so that each resident has available at least three meals per day...” CANHR was informed that the facility did not have sufficient food to feed all residents and often had no food at all.

4. According to 22 CCR 87217(c)(1), “Every facility shall account for any cash resources entrusted to the care or control of the licensee or facility staff. Cash resources include, but are not limited to, monetary gifts, tax credits and/or refunds, earnings from employment or workshops, and personal and incidental needs allowance from funding sources such as SSI-SSP.” For at least one resident who was SSI/SSP eligible, the facility became the Representative Payee from the Social Security Administration, and did not give the resident the Personal and Incidental Needs Allowance money for several years. In addition to violating regulations, the licensee committed Elder Financial Abuse (Welfare & Institutions Code Section 15610.30).

5. According to CCR 87217 (b), “Each licensee shall maintain adequate safeguards and accurate records of cash resources and valuables entrusted to his care...” The facility did not keep money in separate accounts for residents who smoked. Instead, the funds were commingled, and the money was used to buy cigarettes for those residents who smoked.

It is evident that the licensee of these facilities does not have the residents’ health, safety or financial interests in mind. This behavior as a licensee has been irresponsible and abusive. Fourteen vulnerable residents’ fate is in Community Care Licensing’s hands. CANHR sponsored SB 897 (Leno), The RCFE Residents Foreclosure Protection Act of 2011 for instances of foreclosures like Eden Manor. Neither CCL nor the licensee complied with the provisions of this law. H&S 1569.686 (c) states “…if a resident is relocated without the notification required by this section, and suffers transfer trauma or other harm to his or her health or safety, the department may also suspend or revoke the licensee’s license and issue a permanent revocation of the licensee’s ability to operate or act as an administrator of a facility anywhere in the state.”

Does Ms. Musngi still have a license to operate a facility? Yes. What has Community Care Licensing done to prevent this? Nothing.

**Update:** The license to the new owners was finally approved on Friday, March 1, but we are continuing with our complaint for inappropriate transfers and failure to follow the applicable law.
My mother owns a mobile home and is on Medi-Cal. The mobile home park is a senior only community, which requires that the owner of the mobile home must be aged 55 or older. I bought the mobile home for her outright but must keep her name on title in order to meet the park’s requirements. Is there anything I can do in this situation to prevent Medi-Cal recovery?

Sincerely,

Overwhelmed in Oroville

Dear Overwhelmed,

To prevent Medi-Cal recovery, the title of the mobile home cannot be in your mother’s name at the time of her death. It can be registered to her, if that satisfies the mobile home park’s requirements, but if her name remains on title, it is recoverable. In order to transfer the title, contact your local Department of Housing & Community Development. As an alternative to transferring the title yourself, contact an escrow company to help you transfer the title. If your mother does pass away with her name still on title, you can apply for a hardship waiver once you receive the recovery claim if you feel you meet the hardship criteria. For example, if you can prove: a) you paid for the mobile home outright and with your own funds, and b) your mother owned the home without paying any consideration. For more information contact: The Department of Housing and Community Development Registration and Titling (916) 323-9224 or toll free (800) 952-8356 or go online to http://www.hcd.ca.gov/codes/rt/
Psychosocial and emotional abuse is a subject that is rarely, if ever, addressed regarding treatment of residents by staff in various types of facilities, particularly Continuing Care Retirement Communities (CCRCs). This column will discuss why this lack of attention exists, why CCRC corporations are never called to account for this behavior, and how this type of abuse is used against the residents in their care.

“Psychosocial and Emotional Abuse” is defined in a medical dictionary as a form of mistreatment in which there is intent to cause mental or emotional pain or injury, together with infantilization, insults, threats of institutionalization. This behavior can result in stress, anxiety, social withdrawal, and depression. A flagrant, personal example of this behavior follows. My legitimate food needs, due to a condition called Cricopharangeal Spasms, had been ignored by staff. I was told that I could not receive the pureed foods I required in my apartment and must move into the Skilled Nursing Facility in order to have this request honored. In essence, I was being threatened with institutionalization because I had a swallowing disorder. At the time I was still driving a car, involved in complex community work, and managing all the activities of my daily living on my own.

It should be noted that a move to the Skilled Nursing Facility would have resulted in a financial windfall for the corporation, since I had spent a substantial sum of money to considerably improve my apartment to accommodate a severely disabled person, should I have the future need. This was done when I initially moved into the CCRC. The management threat to move me to the SNF was designed to discourage me from asking for a service, which was my right under state law, as well as the provisions in my contract. My crime was my attempt to reach the Board of Directors of the corporation that owns my CCRC facility. In my opinion, any complaint that reports staff abuse of residents will never reach the Board of Directors because the only resident allowed to speak to the Board is the president of the Residents’ Council. This person (with few exceptions) often acts as an arm of the administration, rather than a representative of residents’ concerns or rights. (See LLH California News column of November/December, 2011).

The term, “Psychosocial Abuse” is used to describe the bullying behavior staff feels free to impose on residents. One resident of a CCRC told me of a housekeeper who bullied him into leaving his apartment while she cleaned when he wished to stay there. Since the facility he lived in had no social worker available to intervene or to train that staff person not to exhibit such behavior, there was no help for that resident. Another observed common practice of department heads in CCRCs is to routinely tell residents that they will not perform a requested and needed service. If the resident protests, the routine answer is often, “if you are so unhappy in this facility, why don’t you leave?” Of course, there is no offer to return the resident’s money to help that resident relocate and pay another hefty entrance fee for another facility.

There is a simple, inexpensive solution. A resident can obtain a Court Restraining Order. Elders should obtain the assistance of an ombudsman and submit a formal report to that person. They can then explore representing themselves and if possible, also have a social worker assist in the process. This procedure does cover institutions like CCRCs, in addition to private home settings. See the definition of Mental Suffering, California Welfare and Institutions Code Section 15610.53:

“Mental suffering” means fear, agitation, confusion, severe depression, or other forms of serious emotional distress that is brought about by forms of intimidating behavior, threats, harassment, or by deceptive acts performed or false or misleading statements made with malicious intent to agitate, confuse, frighten, or cause severe depression or serious emotional distress of the elder or dependent adult.

Hardly any attention is paid or any attempt is made to address the issue of emotional abuse by staff at institutions like CCRCs. It would benefit all social workers to study the laws governing this type of mental abuse. Serious attempts should be made to design training programs to encourage staff in all departments to be more aware of the arrogance and lack of empathy they display for elders in their care. Staffing in institutions such as CCRCs is often inadequate and should allow sufficient time for employees to complete their assigned tasks, but with consideration for the residents.

(Ms. Hyatt is a resident of a CCRC and an AARP Policy Specialist on CCRCs)
Past Speaking Engagements, Panel Discussions and Training Sessions

• January 9: Shawna Reeves gave an overview of CANHR's services and presented on elder financial abuse to social workers and nurses at Kaiser Santa Clara.

• January 9: Terry Donnelly attended the TOPS’ monthly meeting in Los Angeles.

• January 14: Prescott Cole made an evening presentation to the Bay View Community Seniors about reverse mortgages and financial elder abuse.

• January 14: Prescott Cole and Shawna Reeves gave a presentation on Medi-Cal, financial abuse and reverse mortgages to members of Our Lady of Lourdes Parish in the Bayview neighborhood of San Francisco.

• January 25: Prescott Cole, with consultant Neil Granger, gave a presentation on elder financial abuse at the Redding Senior Center.

• January 29: Pat McGinnis represented CANHR at the Nursing Home Quality Assurance & Performance Improvement (QAPI) stakeholders meeting in South San Francisco.

• February 7: Shawna Reeves gave a presentation on scams targeting elder veterans at a meeting of the San Francisco Elder Forensic Center and Multidisciplinary Team.

• February 9: Pat McGinnis was the luncheon keynote speaker at the California Federation of Business and Professional Women’s Public Policy conference in Ontario.

• February 18: Prescott Cole was a guest on the TRadio Program “Friends Without Benefits”.

• February 20: Terry Donnelly presented at the End of Life Issues Forum on Legal and Financial Considerations, Pilgrim Place CCRC.

• February 20: Pat McGinnis was guest speaker at a U.C. Hastings class on Elder Law.

• February 21: Prescott Cole attended the California Collaborative for Long Term Services and Supports Community of Constituents Conference in Sacramento.

• February 21: Terry Donnelly made a presentation on CCRC Rights at Villa Gardens, CCRC in Pasadena.

• February 22: Terry Donnelly represented CANHR at UCLA’s MSW Intern Fair.

• February 26: Terry Donnelly attended a meeting of the West San Gabriel Valley Elder Abuse Coalition promoting CANHR services and upcoming training programs.

• March 1: Long Term Care Advocate Pauline Mosher hosted a CANHR information table at the Napa Senior Activity Center Health and Wellness Fair.

Upcoming Events

April 2, 2013, Los Angeles: CANHR presents Free Consumer Workshop on Elder Financial Abuse

• Learn how to avoid dangerous reverse mortgages, dangerous annuities, bad long-term care insurance policies, dangerous notaries, and about nursing home and veteran benefit lies. CANHR's senior staff attorney, Prescott Cole will be the presenter at 11:30am at the Magnolia Place Family Center, 1910 Magnolia Ave., Los Angeles, CA 90007. To attend please contact Efrain Gutierrez at 800.474.1116 or efrain@canhr.org or see Upcoming Events at www.canhr.org

April 11 and April 12, 2013, Pasadena and Los Angeles: CANHR Social Worker Long Term Care Medi-Cal Trainings

• For social workers and discharge planners, these trainings will review the eligibility requirements for Long Term Care Medi-Cal and help ensure that your clients are accurately informed about Medi-Cal Recovery issues.

• 1:00pm-4:00pm; Participants are eligible for 3.0 hours of CEU credits—Board of Behavioral Sciences. Fee: $30/session.

• April 11th: Western Justice Center Foundation, 55 South Grand Avenue, Pasadena, CA 91105, 1pm-4pm.

• April 12th: Los Angeles: Magnolia Place Family Center, 1920 Magnolia Ave., Los Angeles, CA 90007, 1pm-4pm

• For more information contact Deborah Espinola at deborah@canhr.org

• To register see Upcoming Events at www.canhr.org

June 7, 2013: Four Seasons of Health Expo:

• CANHR will be hosting an information booth at the Four Seasons of Health Expo from 9:30am to 1:30pm, at the Fremont Multi-Service Senior Center in Central Park (Lake Elizabeth) 40086 Paseo Padre Parkway, Fremont.
CANHR welcomes memorial and honorary gifts. This is a great way to honor a special person, or a loved one who has been a nursing home resident, while helping those who are nursing home residents. Recent gifts have been made in the names of the following persons:

**Memorials**

Estelle Adams
Geraldine Murphy
Estelle Adams
Elizabeth Massie
Mary Ballantyne
Bob Peterson
George Bower and Evelyn G. Bower
S. Avenal Fehder
Jim Brown
Isabel Lakretz Brown
Cele Charnow
James & Linda Branson
Josephine Comando
Angela McCarron
Rosamond Edeline
Gail & Vern Bean
Vivian C. Eloriaga
Ronald Lozano
Bob Floden
Laural Reid
Margie B. and Don G.
Joanne Williams
Maxine & Ernie Gallo
La Vonne Gallo
Flo Gilbo
Gwendolyn Gilbo
Viola Goldan
Devane Goldan
Eva W. Goldschmidt
George & Rovenia Tacasis
Mr. George Homan
Jeanie Kayser-Jones
Dorwin Jones
Mary Gerber
Lucille Labat
Louis Labat
Lyle and Wayola Larson
Paul & Samara Larson
Helen C. Logan
Mary Davis
Josephine Luckjohn
Georgia Riportella
Our Parents
Michelle Noble McCain
LeRoy “MAC” McDonald
Janice McDonald
Leroy McDonald
David McDonald
Joseph M. McDonough
Gwen McDonough
Myrtle Georgina McDowell, and her so sweet and giving nature.
Sheila Simas
Myrtle McDowell
Elizabeth Gay
Myrtle McDowell
San Diego Unified School District
Sherry McIwain
Gloria McIwain & Sharon Roberts - Cagle
Mollie E. Mitchell
Neil & Laura Mitchell
Deborah Mizrahi
Mike Manesh
Helen Vail Muller
Helen Drachkovitch
Kenneth Lee Napier
Diane Dell'Arno
Patrick Nobis
Carole Nobis
Bill and Mary Ellen O'Brien
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Rosalie Ortega
Shirley Ortega
Olga Panos
Louis Panos
Reverend Dr. Joseph N. Patterson
Erica Patterson
Denis J. Powell
Argene Powell
Alice and Tom Riley
Barbara Riley
Jerry Lamonte Rogers
Gerri Rogers
Miriam & Herman Samon
Felice Urban
Lottie Shamis
Judith Betts
Luther B Denson and Donna Smith
Ruth Holland
Mary Stellar
Richard Stellar
William F. Taylor
Martha Taylor
Barbara Tremewan
Marianne Meredith
Rita Twomey
Denise Twomey
Bruno and Evelyn Wartman
Mr. & Mrs. John & Paddy Moran
Mac and Gwen Winters
Barbara Winters

**In Honor Of**

A great annual conference!!!
Linda Durston
Aline Bau
Katharine Hsiao
Jean Bjorkman
Debra Halvarson Groh
California
Lawrence Solorio
FDS-Financial Security Designs
Tony Bevin
Faith Geer
Martin Schiffenbauer
Sabita Goswami
Subrata Goswami
Allen and Gail Hinand
Donna & Tom Ambrogi
Helen Hughes
Bonnie Linden
Lillian Hyatt
Tedi Dunn
Pat McGinnis
Geraldine Murphy
Pat McGinnis
David Ishida
J. Douglas Merritt
J Douglas Merritt
The development of better public policy
Anonymous Donor
The development of better public policy
Anonymous Donor
Therese Serezlis
Nola Serezlis-Slattery & Carl Slattery
Noel Taylor
Bill Taylor
Your Good Work!
James & Dorothy Opp
Your Excellent Work
Arthur Halenbeck
What You Need to Know About Elder Financial Abuse

A Free Consumer Education Presentation

Learn How to Avoid:

Dangerous Reverse Mortgages
Dangerous Annuities
Bad Long-Term Care Insurance Policies
Dangerous Notaries
Lies about Nursing Home and Veterans Benefits

Presented by Prescott Cole, Esq., Senior Staff Attorney
California Advocates for Nursing Home Reform, a non-profit organization

TUESDAY, APRIL 2, 2013
10:00A.M. - 11:30A.M.

Magnolia Place Family Center
1910 Magnolia Ave., Los Angeles, CA 90007

Refreshments Provided

Space is limited. Free parking in the parking lot across the street.
To attend, please contact Efrain Gutierrez at (800) 474-1116 or e-mail at efrain@canhr.org

See back of flyer for directions to the presentation.
Directions To Magnolia Place

Directions from San Fernando Valley
1. Take the 101 South toward Los Angeles.
2. Take the Vermont Avenue Exit.
3. Take Vermont Avenue and go South on Vermont Avenue to Washington Blvd. (approximately 3 miles, just before you come to the Santa Monica Freeway).
4. Turn left onto Washington Blvd. and drive 5 blocks to Magnolia Avenue.
5. Turn right onto Magnolia Avenue. Magnolia Place Family Center is on your left, on the corner of Washington and Magnolia.
6. Park in the parking lot on the right side.

Directions from Downtown Los Angeles
1. Take I-10 west toward Santa Monica.
2. Take the Hoover Street exit.
3. At bottom of ramp, turn left onto 20th Street.
4. Turn right on Magnolia Avenue. Magnolia Place Family Center is on your right, on the corner of Washington and Magnolia.
5. Park in the parking lot on the left side.

Directions from Glendale/Pasadena
1. Take the I-110 South toward Los Angeles.
2. Transition onto I-10 west, stay to the right.
3. Take the Hoover Street exit.
4. At bottom of ramp, turn left onto 20th Street.
5. Turn right on Magnolia Avenue. Magnolia Place Family Center is on your right, on the corner of Washington and Magnolia.
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Directions from the Westside
1. Take I-10 East toward Los Angeles.
2. Take the Vermont Avenue Exit.
3. Turn left (North) onto Vermont Avenue.
4. Take Vermont Avenue and drive 2 blocks to Washington Blvd.
5. Turn right on Washington Blvd. and drive 5 blocks to Magnolia Avenue.
6. Turn right on Magnolia Avenue. Magnolia Place Family Center is on your left, on the corner of Washington and Magnolia.
7. Park in parking lot on the right side.
Support CANHR...
If you appreciate our services and the information we bring to you, please help us by making a donation.
Make a secure donation online at www.canhr.org or fill out this section and return it with your donation to:

CANHR, 650 Harrison Street, 2nd Floor, San Francisco, CA 94107.

Enclosed is my check for:  $500  $100  $50  $30  Other _______________________

This gift is in memory of: ____________________________________________
(or) in honor of: ____________________________________________________

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Facility Name: _______________________________________________________

CANHR prohibits the use of its name for the purpose of advertisement by attorneys, financial planners or any other organization or entity.
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Citations without summaries will be reprinted with summaries once received by the CANHR office. Citations from earlier months are included if a description was not printed in a previous Advocate. Appeals of citations and collection of fines can take up to three years. For up-to-date information on any citation or facility, visit the Nursing Home Guide through CANHR's web site: www.canhr.org or call the CANHR office.

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Alameda County

Kindred Transitional Care and Rehabilitation - Bay View
516 Willow St., Alameda

AA $75000 Patient Care 03/05/2012
On 11/7/10, a RN recorded that a CNA reported to her that a resident had blood on his chest, abdomen and AVF (a shunt installed in an artery in the arm to allow for dialysis.) The RN called 911, gave breathing treatment and recorded his blood pressure. The RN did not record any information as to the cause of the blood, nor was there any information recorded as to any attempt to stop the bleeding. The resident was transferred to the emergency department and pronounced dead. The coroner’s preliminary report indicated cause of death as “shock due to hemorrhaging.” The coroner also found a hole in the resident’s AVF. The CNA who reported the bleeding stated that she observed the RN walking back and forth in front of the resident’s room and returning to the nurses station to check the chart or use the phone at least three times while the CNA cleaned the resident of blood. The facility staff did not assess the resident for bleeding from his AVF or apply pressure to stop the bleeding. The facility was cited for allowing the resident to bleed to death. Citation # 020009078.

Morton Bakar Center
494 Blossom Way, Hayward

AA $60000 Feeding Nutrition 03/12/2012
On 9/6/11, a resident who had no teeth and a history of choking on food was given a cheese sandwich that was not suitable for her therapeutic diet. As a result, the resident choked on the sandwich, was unable to breathe, and her heart stopped. The resident did not recover from the incident and died. The facility was cited for failure to provide the resident with the therapeutic diet ordered by the physician. Citation # 020009084.

Butte County

Olive Ridge Post Acute Care
1000 Exec. Parkway, Oroville

B $2000 Sexual Abuse 11/20/2012
A female resident reported to the facility’s Dietary Department Supervisor on 4/24/12 that a male resident had grabbed her crotch and, during a prior incident, her breast. The facility did not report the allegation to the Department of Public Health as required by law. Because the male resident’s behavior was neither investigated nor addressed by the facility, he went on to sexually abuse another female resident. The facility was cited for failure to implement its abuse prevention policy, which had a direct relationship to the health, safety and security of residents. Citation # 230009595.

B $2000 Neglect 11/20/2012
A resident died on 9/14/11, three days after he developed pneumonia. His doctor ordered antibiotics and he was put on “alert charting,” which called for more intensive assessment and monitoring, plus notification of the resident’s representative. The investigator was unable to review the 24-hour report that documented the facility’s response because a staff member shredded it, in violation of the facility’s policy. Nonetheless, it was determined that the facility failed to provide the necessary care and services after the resident developed pneumonia, that it failed to inform his responsible party of the significant deterioration in his condition, and that the facility’s actions may have contributed to his death. Citation # 230009391.

B $2000 Dignity 11/20/2012
On 4/22/12, a large male nurse yelled at an 81 year old female resident in an angry manner, telling her she needed to wait for help. The nurse was on his knees and nose-to-nose with the resident, scaring and humiliating her. The facility was cited because it failed to treat the resident with dignity and respect. Citation # 230009275.

B $2000 Sexual Abuse 11/20/2012
The facility was cited for failing to protect two female residents from sexual abuse by a male resident who fondled their breasts and genital areas. This violation was found to have occurred under circumstances likely to cause significant humiliation, anxiety or other emotional trauma to the residents. Citation # 230009340.

B $2000 Chemical Restraints 11/20/2012
On 8/1/11 a resident with dementia was transferred to an acute care hospital where he died on 9/12/11 from complications of a urinary tract infection (UTI), pneumonia, malnutrition, and sepsis. It was determined that the facility had been giving him multiple psychotherapeutic drugs and that the facility had failed to recognize, address or report the adverse side effects caused by the drugs. The resident had repeated falls, recurrent UTIs, increased agitation and aggression, confusion, wandering and increased sedation from the use of the multiple psychotherapeutic medications being given to him. The facility was cited for failure to keep the resident free from unnecessary drugs. Citation # 230008706.

B $2000 Dignity 11/20/2012
On 2/24/12, a CNA approached a resident and asked him if he wanted a hot shower. The resident responded, “Absolutely
A male resident, admitted to the facility on 6/27/10, needed assistance with toileting but was given protective briefs instead. The resident also required assistance with bathing and cleaning but his medical chart revealed that little assistance was provided. On 8/15/10, the resident required an 11-day hospitalization for uremic burns and a MRSA skin infection on his sacrum. His skin was red and inflamed and causing stinging pain. The facility was cited for failing to assist the resident to the toilet and with bathing and for forcing the resident to wear urine soaked protective briefs for staff convenience. Citation # 110007586.

Nevada County

Wolf Creek Care Center

107 Catherine Lane, Grass Valley

B $1000 Patient Care 10/15/2012

The facility was cited for failing to ensure that a nurse examined the resident after a fall on 3/9/2012. The licensed nurses caring for the resident failed to provide ongoing assessments and failed to monitor the resident’s condition. As a result, the resident’s fractured hip was not identified and treated for three days. Citation # 230009305.

Sacramento County

American River Care Center

3900 Garfield Avenue, Carmichael

B $1000 Fall Supervision 11/15/2013

A 95 year old resident fell from his wheelchair on 3/24/09 after a CNA left him unattended without his physician-ordered restraint and clip alarm. The resident suffered cuts and bruises. The facility was cited for failing to provide adequate supervision to prevent accidents. Citation # 030009588.

Ashbury Park Nursing And Rehabilitation Center

2257 Fair Oaks Blvd., Sacramento

B $500 Patient Rights 08/16/2012

On 3/14/09, a resident requested to leave against medical advice, but was not allowed to go home. Despite his continuing requests to go home, the facility refused to let him leave. It took 4 days to complete a mental status examination ordered by his doctor, which found that he was able to make safe decisions. The facility was cited because it failed to honor the resident’s right to refuse treatment when he expressed a desire to leave the facility against medical advice on 3/14/09. Citation # 030009433.

B $1000 Staffing 10/23/2012

The facility was cited for employing unlicensed CNAs and not doing background and certification checks on their CNAs. One CNA was never certified and “had a conviction,” which would make it illegal for the facility to employ the person. There was also no documentation of another CNA’s certification prior to employment. Citation # 030009564.

Eskaton Care Center Manzanita

5318 Manzanita Avenue, Carmichael

B $1000 Neglect 09/04/2012

A resident with diabetes, admitted on 8/10/10, was hospitalized on 9/20/10 for extremely elevated blood sugar, altered level of consciousness, and diabetic ketoacidosis. The resident was supposed to have two blood sugar checks each day but those were discontinued. The facility also discontinued his diabetic medications. On 9/20/10, the resident’s case manager found him nearly unconscious and he was rushed to the hospital. The facility was cited for failing to recognize the signs of hyperglycemia and failing to follow the resident’s care plan. Citation # 110007663.

A $20000 Neglect 10/19/2012

A male resident, admitted to the facility on 6/27/10, needed assistance with toileting but was given protective briefs instead. The resident also required assistance with bathing and cleaning but his medical chart revealed that little assistance was provided. On 8/15/10, the resident required an 11-day hospitalization for uremic burns and a MRSA skin infection on his sacrum. His skin was red and inflamed and causing stinging pain. The facility was cited for failing to assist the resident to the toilet and with bathing and for forcing the resident to wear urine soaked protective briefs for staff convenience. Citation # 110007586.
abuse. A CNA was accused of alleged abuse on the following four occasions: 1) On 3/3/09, the CNA was given a warning for scolding a resident with an episode of incontinence, 2) On 4/30/09, the CNA was accused of throwing a call cord at the resident, 3) On 6/17/09, the CNA was accused of raising her voice in a rude manner, and 4) On 8/4/09, the CNA threw toilet paper and a small carrying case at the resident. Following these events the CNA was terminated on 08/07/09. The facility was also cited for failure to report the alleged abuse to the Department of Public Health. Citation # 030009697.

Golden Living Center - Galt
144 F Street, Galt
B $1000 Hydration 09/20/2012
On 4/20/10, a 96 year old resident was hospitalized due to dehydration, sepsis and a urinary tract infection. During the 19 days prior to hospitalization, his records showed that he consumed only a fraction of the fluids he was supposed to receive. The facility was cited for failing to provide the resident with the necessary fluids for hydration and for failing to notify the resident’s physician in a timely manner of this concern. Citation # 030009507.

Rosewood Post Acute Rehabilitation
6041 Fair Oaks Blvd., Carmichael
B $1000 Fall Injury Patient Care 12/20/2012
On 10/27/09, a resident suffered a broken tibia when a CNA attempted to transfer her from the wheelchair to the bed without assistance from another staff member or a lifting device. The facility was cited for failure to provide adequate assistance during a transfer. Citation # 030009612.

University Post-Acute Rehab
2120 Stockton Blvd., Sacramento
B $1000 Mandated Reporting Physical Abuse 12/27/2012
The facility was cited for failing to report alleged physical abuse within 24 hours. On 3/2/12, a staff person reported that a resident complained that a CNA was rough when she helped him. After visually examining the resident and finding no sign of abuse or fear, the incident was recorded in a notebook, but not reported to the Department of Public Health. The notebook was reviewed on 10/31/2012 by the Department of Public Health. Citation # 030009682.

Whitney Oaks Care Center
3529 Walnut Avenue, Carmichael
B $1000 Careplan Fall Injury 12/07/2012
A single CNA was attempting to transfer a resident whose care plan required a two person transfer. The resident slid to the floor and sustained a fractured left femur. The facility was cited for failure to follow the care plan. Citation # 030009629.

Windsor Care Center of Sacramento
501 Jessie Avenue, Sacramento
B $1000 Mandated Reporting Physical Abuse 09/12/2012
A resident with psychosis and dementia physically abused three other residents on 7/17/08 and 7/19/08. The incidents were not reported to the Department of Public Health until 7/21/08. The facility was cited for failing to report alleged abuse within 24 hours and for failing to ensure residents are free from abuse. Citation # 030009480.

San Joaquin County

Crescent Court Nursing Home
610 So. Fairmont Avenue, Lodi
B $800 Dignity Mandated Reporting Physical Abuse 11/08/2012
The facility was cited for failing to prevent abuse, implement its abuse prevention policies, report the abuse, and ensure that employees have a criminal background check. In July of 2009, a resident complained that a CNA was rough when she helped him. He stated she was like “the military police, barking orders,” and once while turning him did it so hard that he hit the wall. Three other CNAs gave written declarations about the CNA’s history of being abrupt. When asked, the facility was unable to produce any evidence of the CNA’s background screening and abuse training. The CNA was terminated on 7/29/09. Citation # 030009571.

St. Jude Care Center
469 East North Street, Manteca
B $1000 Fall Injury Mandated Reporting Patient Care 1/15/2013
The facility was cited for failing to ensure that a staff person reported an incident to supervisory staff when a resident fell while being assisted. The resident complained of severe pain and was not assessed for eleven hours before being transferred to the emergency room for evaluation and treatment. The resident sustained a fractured ankle. Citation # 030009691.

Wagner Heights Nursing And Rehabilitation Center
9289 Branstetter Place, Stockton
B $1000 Physical Abuse 07/25/2012
On 1/7/09, an 85 year old resident suffered bruising to her right arm when a nursing assistant grabbed her arms and roughly forced her down onto a toilet. The resident had been requesting to use a toilet in a different room that had suitable grab bars so that she could help herself. According to facility records, the abuse left the resident very shaken and teary. The facility was cited because it failed to prevent physical abuse to the resident. Citation # 030009409.

Whispering Hope Care Center
5320 Carrington Circle, Stockton
A $18000 Physical Abuse 11/28/2013
On 10/14/09, a resident with a history of violence toward others punched his 83 year old roommate in the face, causing the roommate to fall to the ground and sustain critical injuries. The victim was blind and confused and weighed 141 pounds. The aggressor was 260 pounds and known to intimidate other residents by throwing things and, on one occasion, choking another resident. Before the attack the roommate was able to walk, was continent, and was able to dress himself. After the attack the victim lost his ability to walk and stayed in bed all day. On 10/20/09 the roommate was found unconscious and taken to the hospital, where he was pronounced dead. Citation # 030009216.

Shasta County

Marquis Care at Shasta
3550 Churn Creek Road, Redding
B $2000 (x 4) Patient Rights 10/23/2012
In April 2011, the facility announced it was prohibiting smoking but that current residents would be “grandfathered” in and could continue to smoke. In December 2011, the facility abruptly shifted course and prohibited smoking for all residents, telling smokers their choices were to stop smoking or move. A resident with multiple psychiatric problems was forced to stop smok-
ing and could no longer socialize with some of her friends who smoked. 2) A resident with dementia was forced to quit smoking and was angry. 3) One resident, who had lived in the facility for two years, was forced to move. 4) A resident with dementia who wished to smoke was therefore moved to another nursing home. The facility was cited for failing to ensure the right to choose activities when the facility chose to be non-smoking. The citations did not include a reference to 22 Calif. Admin. Code Sec. 72507, which requires smoking be accommodated in nursing homes. Citations # 230008862, 230009130, 230009132, 230009131.

**Mayers Memorial Hospital D/P SNF**

43563 Hwy 299 E, P.O. Bx 459, Fall River Mills

**B $1000 Patient Care Physical Abuse Verbal Abuse 10/16/2012**
The facility was cited for failing to ensure that a resident was not physically or mentally abused when two CNAs used profane language, pulled the resident’s arm, and spoke to the resident in a demeaning manner. The CNAs then proceeded to pull the call light cord from the wall so that the resident could not call for help. Citation # 230009377.

**Solano County**

**Vacaville Convalescent And Rehabilitation Center**

585 Nut Tree Court, Vacaville

**B $1000 Administration 10/22/2012**

During a tour of the facility on 10/11/12, the Department of Public Health investigator noted that the facility’s overall rating was not posted in the employee’s break room. A member of the facility’s management staff stated that he did not know that the ratings needed to be posted in the break room. This resulted in the potential for staff not being informed of the facility’s overall rating. Citation # 110009561.

**Windsor Vallejo Nursing & Rehabilitation Center**

2200 Tuolumne, Vallejo

**B $1000 Infection 07/13/2012**

An 87 year old man with advanced dementia and Parkinson’s disease developed a pressure ulcer on his penis due to his Foley catheter not being changed regularly. The facility was cited for failure to administer care on a prompt and timely basis as prescribed by the physician and for failure to follow correct pressure ulcer prevention measures. This was found to have a direct relationship to the failure of the health, safety and security of the resident. Citation # 110009395.

**Sonoma County**

**Sonoma Healthcare Center**

1250 Broadway, Sonoma

**B $2000 Sexual Abuse 09/19/2012**

On 3/9/12, a resident came to the facility’s administrator to report that she was a witness to a rape and wanted to be transferred to another nursing facility. The administrator failed to report the allegation to the Department of Public Health within 24 hours as required by law. The Department became aware of the allegation when it received an anonymous complaint on 3/15/12. The facility was cited for its failure to report the allegation. Citation # 110000066.

**Stanislaus County**

**Acacia Park Nursing & Rehabilitation Center**

1611 Scenic Drive, Modesto

**B $600 Careplan Sexual Abuse 11/08/2012**

The facility was cited for failing to keep two residents free from sexual abuse and develop a care plan so that the sexual abuse did not continue to happen. A resident was found touching a female resident’s breasts on 9/11/09 and 10/5/09, and her groin and legs, in addition to her breasts, on 11/21/09. The resident was also found touching another resident between her thighs on 10/19/09 and grabbing her crotch area on 1/24/10. Citation # 030009574.

**B $1000 Fall Injury Staffing 12/14/2012**

While a CNA was changing a resident on 3/26/09, the resident’s leg got stuck in a side rail. When the CNA turned the resident she heard a pop and noticed that her leg was stuck. The resident suffered a fractured femur as a result. The investigation report stated that “...Although the injury appeared to be a result of the resident resisting care, CNA should have asked for assistance...” The CNA stated she waited half an hour for help and then decided to attempt the care on her own. Facility records show that staffing levels were at 2.3-2.88 from 3/8/09 through 3/28/09, well below the mandated 3.2 minimum nursing hours per resident per day. The facility was cited for failure to ensure adequate staffing levels were maintained to provide appropriate care and services. Citation # 030009674.

**Crestwood Manor**

1400 Celeste Drive, Modesto

**B $800 Hydration 11/08/2012**

The facility was cited for failing to ensure that a resident received the recommended amounts of fluids daily. The resident’s records from 12/14/09-12/24/09 indicate that the resident was deficient in fluids and received less than half of the fluids needed. On 12/24/09, he was found unresponsive and sent to the emergency room, where he was diagnosed as “markedly dehydrated.” Citation # 030009568.

**Hy-Lond Health Care Center - Modesto**

1900 Coffee Road, Modesto

**B $1000 Transfer 11/19/2012**

On 1/10/09, a 64 year old resident with memory impairment who required extensive assistance for bed mobility, transfers, walking, dressing, toileting, and personal hygiene, was put in a taxi and discharged to an unsafe environment without the benefit of the assistance she required or physician-ordered home health services. The facility was cited for failure to implement a discharge plan for the resident that ensured she would be discharged to a safe environment with needed equipment and services in place. Citation # 030009602.

**Yolo County**

**Courtyard Health Care Center**

1850 East 8th Street, Davis

**B $1000 Patient Care 11/28/2012**

On 7/17/09, an 83 year old was admitted to the facility following hospitalization for placement of a heart stent. Prior to being transferred from the hospital the resident had an intravenous line (IV) in his right arm. The facility was to discontinue the resident’s IV line. Between 7/17 and 7/21 there were no records to indicate the presence or removal of the IV and no documentation of any body checks or skin inspections. Six days after admission a licensed nurse at the facility telephoned a request for a dressing change for the IV. A physician then ordered the facility to change the IV, even though there was no evidence the resident was receiving any IV medication. The resident contracted MRSA and on 7/25/09 was sent to the ER with a 105.5 F temperature. The facility was cited for failure to properly assess the presence of an IV. Citation # 030009613.
Citation Watch - Consumer Report

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Kern County

Delano District Skilled Nursing Facility
1509 Tokay Street, Delano
A $20000 Injury Physical Environment Supervision 10/03/2012
On 7/18/10, a resident who had a history of wandering, removed her body alarm and eloped from the facility without any shoes. It was about 105 degrees Fahrenheit outside, and the resident suffered second degree burns on her feet and a burn to her left knee. The facility was cited for failing to protect the resident from eloping. Citation # 120009285.

Los Angeles County

Bel Tooren Villa Convalescent Hospital
16910 Woodruff Ave., Bellflower
B $2000 Evictions 08/20/2012
A 99 year old female resident was falsely told that she had to move to another skilled nursing facility because she had completed her rehabilitation therapy and Medicare coverage. The facility did not offer to continue to provide custodial care. The resident was not given a written discharge notice. She transferred to a new facility despite her desire to stay. The facility was cited for failing to protect the resident from eloping. Citation # 940009447.

Country Villa South Convalescent Center
3515 Overland Ave., Los Angeles
A $12000 Fall 07/11/2012
On 3/2/10, an 89 year old resident needed to be transferred from her wheelchair to her bed. The staff had been instructed to use a Hoyer lift to transfer the resident. The CNA called for assistance to help with the transfer, but didn’t wait for help to arrive. The CNA attempted a solo transfer and the resident’s right knee “popped” and the resident screamed that her knee was broken. An x-ray revealed that the resident had a right tibia fracture just below the knee joint. The facility was cited for failing to ensure that a Hoyer lift was used to transfer this resident. Citation # 910009388.

Fidelity Health Care
11210 Lower Azusa Road, El Monte
AA $80000 Neglect 07/03/2012
A 76 year old male resident with senile dementia wandered out of the facility and was struck and killed by a car on the freeway on 2/17/11. It was the second time in five days that the resident had wandered from the facility, and he had been a resident of the facility for less than a week. Even though a WanderGuard bracelet had been placed on the resident’s wrist after the first incident, this did not prevent the second incident from occurring because the WanderGuard alarm system had not been fully installed on all exit doors at the facility. The facility was cited for failure to provide adequate supervision and assistive devices as well as for failure to maintain a safe and secure environment for the resident, which was determined to be a direct cause of the resident’s death. Citation # 950009371.

Goldstar Healthcare Center Of Chatsworth
21820 Craggy View St., Chatsworth
A $190000 Careplan Physical Abuse Supervision 08/10/2012
On 8/8/10, a resident assaulted another resident when he wandered into his room. The resident suffered a laceration on his eyebrow, nasal bone fracture, fractured ribs and collapsed lung. He required a seven day hospitalization. The facility was cited for failing to monitor the wandering resident and for failing to develop an effective plan of care for the other resident’s behavior. Citation # 920009224.

Hollywood Presbyterian Medical Center D/P Snf
4636 Fountain Avenue, Los Angeles
B $1000 Patient Care Verbal Abuse 07/17/2012
The facility was cited for failing to ensure that a resident was treated with dignity and respect by a CNA who screamed at the resident, rushed her to get up from bed, and pushed her when she was on her way to the bathroom. Citation # 930008863.
Huntington Healthcare Center
4515 Huntington Drive South, Los Angeles

**B $2000 Physical Environment 07/18/2012**
The facility was cited for failing to provide safe hot water temperatures at 120 degrees Fahrenheit or below. Hot water temperatures above 120 degrees were measured in one shower room and in the hand washing sinks in three restrooms. The unsafe water temperature placed the residents at risk of burning and scalding. Citation # 940009400.

Lighthouse Healthcare Center
2222 Santa Ana Blvd, Los Angeles

**B $2000 Physical Abuse 08/20/2012**
On 4/2/11, a resident hit another resident on the head with a chair. The victim suffered a scalp laceration. At the time of the incident the residents had been left unattended in the lobby. Their care plans indicated that both were irritable and exhibited verbally and physically aggressive behaviors. The facility was cited for failing to properly monitor the residents and alert their environments during periods of behavioral problems. Citation # 940009449.

Marlora Post Acute Rehabilitation Hospital
3801 E Anaheim St, Long Beach

**B $2000 Neglect Patient Care 09/12/2012**
The facility was cited for failing to follow physician’s orders for pain control of a resident who was admitted to the facility three days after back surgery. The resident was admitted to the facility on 03/09/12 at 5 p.m. The physician's orders for medications were not faxed to the pharmacy until 10:30 p.m. This resulted in the resident missing his daily dosage of his required medications. The facility was cited for failure to ensure that the resident had an orderly discharge. Citation # 940009446.

Maywood Skilled Nursing & Wellness Centre
6025 Pine Avenue, Maywood

**A $2000 Fall Neglect 08/07/2012**
A 61 year old male resident with bipolar disorder and end stage renal disease was found unresponsive outside of a convenience store located .37 miles from the facility on 11/8/12 at 4:02 am. The resident was pronounced dead shortly after. Footage from the store's surveillance camera showed the resident pushing his wheelchair toward the direction of a phone booth outside of the store at around 1:30 am, falling forward, and then hitting his forehead on the ground. The facility was cited for failure to monitor the resident’s whereabouts according to the care plan and failure to ensure that the alarm system alerting staff when someone exited the front door was turned on. Citation # 940009065.

Mirada Hills Rehabilitation And Convalescent Hosp
12200 La Mirada Blvd, La Mirada

**A $18000 Careplan 09/11/2012**
A 76 year old female resident with risk of dehydration was noted to have declining health. Her physician ordered IV fluids at noon on 3/9/11. The IV was not placed until 5:20 pm. The resident was rushed to the hospital a few hours later, where she was found to have severe dehydration and acute renal failure. The facility was cited for failing to adequately address the resident’s risk for dehydration, failing to administer IV fluids as ordered by a physician, and failing to notify the physician when it was unable to initiate the IV hydration. Citation # 940009471.

Pacifica Hospital Of The Valley D/P SNF
9449 San Fernando Rd, Sun Valley

**WMF $900 Patient Records 08/23/2012**
The facility was cited for failing to ensure that a resident’s treatment record pertaining to the services for the treatment of decubitus ulcers reflected the care and services provided by a licensed vocational nurse (LVN). On 04/2/2012, an LVN made an entry in the resident’s record that falsely reflected the care and services provided. Citation # 930009452.

Santa Anita Convalescent Hospital
5522 Gracewood Avenue, Temple City

**B $2000 Injury Neglect 06/27/2012**
A 91 year old female resident who was unable to speak due to cerebrovascular disease suffered burns to her scalp, ears and neck on 10/16/2008 when her hair was placed under an electric hooded hair dryer by the facility’s beautician. The facility was cited for failure to follow and apply the hooded dryer safety instructions and failure to ensure that each resident received adequate supervision to prevent accidents. Citation # 950009379.

Sunrise Convalescent Hospital
1640 N. Fair Oaks, Pasadena

**B $2000 Sexual Abuse 08/23/2012**
The facility was cited for failing to keep a resident free from sexual abuse, failing to perform a criminal background check on the alleged abusers, and failing to report the abuse immediately. On 7/14/11, a staff member observed another staff member insert his fingers into a resident’s vagina, touch her breast and make her give him oral sex. The alleged abuser did not know that the other staff member was there, as she was there attending to the resident in the next bed. The staff member did not report the abuse for four days because she was afraid of what would happen to her. The alleged abuser was terminated and when his employee records were reviewed, they showed the facility did not perform a background check. Citation # 950009456.

Tarzana Health And Rehabilitation Center
5650 RESEDA BOULEVARD, Tarzana

**B $2000 Bed Hold Evictions 10/03/2012**
A resident with diagnoses of bipolar disorder and anorexia was sent to the hospital emergency room on 8/22/12 after exhibiting extreme agitation and physically aggressive behavior toward staff and other residents. She
was then transferred to an acute care hospital. The facility physician’s order stated that the resident was “not to return to the facility under any circumstances.” On 8/24/12 the social worker from the acute care hospital informed the Department of Public Health that the facility refused to readmit the resident. The facility was cited for failing to provide the resident with a written 7 day bed hold notice and for failure to readmit the resident during the seven-day hold period. Citation # 920009538.

The Rowland
330 W. Rowland Ave., Covina
B $2000 Patient Care 09/11/2012
The facility was cited for failing to ensure that two residents’ social service needs were met. The facility failed to provide an appropriate wheelchair to support proper body alignment of a resident. The facility also failed to provide the necessary dental care for another resident. This resulted in one resident using a wheelchair that did not support her head and neck for five months. The other resident experienced a delay in receiving dental services. Citation # 950009483.

Verdugo Valley Skilled Nursing & Wellness Centre
2635 Honolulu Avenue, Montrose
B $2000 Careplan Injury Patient Care Supervision 12/10/2012
The facility was cited for failing to develop a plan of care for a resident who had a history of hearing voices that were telling him to cut his wrists or overdose on medication. The resident cut his left forearm with a razor and to had be transferred to an acute care hospital via 911. Citation # 920009667.

Whittier Hills Health Care Center
10426 Bogardus, Whittier
A $12000 Feeding Hydration 09/11/2012
An 86 year old male resident with Alzheimer’s disease lost 35 pounds (22% of his total body weight) in 32 days between February and March 2012. On 3/27/12, the resident was rushed to the hospital for dehydration, renal failure, and hypernatremia. The facility was cited for failing to address and revise the resident’s care plan for weight loss. Citation # 940009481.

B $1500 Evictions 09/11/2012
An 86 year old male resident with significant care needs was discharged to a residential care facility that was unable to take care of him. The resident was hospitalized less than eight hours after the discharge for altered levels of consciousness. Just prior to the discharge, the resident had been declining and had abnormal blood test results. The facility was cited for failing to ensure a safe and appropriate discharge. Citation # 940009482.

Riverside County

Chapman Convalescent Hospital
4301 Caroline Court, Riverside
B $500 Injury 12/06/2012
A 100 year old resident with dementia and diabetes suffered a bruise to the top of her left hand on 9/13/07 when a CNA attempted to transfer her from a bedside commode to her wheelchair. The facility was cited for failure to ensure that a two person transfer was followed by all staff for the resident, per policy and procedure, causing the resident to sustain pain and injury to her left hand. Citation # 250009662.

Country Villa Murrieta Healthcare Center
24100 Monroe Avenue, Murrieta
B $1000 Physical Restraints 11/14/2012
The facility was cited for failing to keep a resident free from physical restraints. An RN, LVN and CNA tied a resident’s wheelchair to the handrails with a bed sheet from 4:30 am to 6:20 am on 9/22/09 to prevent her from wandering the facility. There was no physician’s order for restraints. Citation # 250009585.

Desert Regional Medical Center D/P Snf
1150 N. Indian Canyon Drive, Palm Springs
B $1000 Careplan Fall 11/19/2012
The facility was cited for failing to follow a resident’s care plan that called for assisting the resident with transfers. On 8/26/11, a CNA helped a resident to the bathroom, left her on the toilet and walked out of the room. When the CNA returned to the room, the resident was on the floor. The resident sustained a fractured ankle. Citation # 250009425.

Palm Springs Healthcare & Rehabilitation Center
277 S. Sunrise Way, Palm Springs
B $1000 Fiduciary 11/16/2012
A CNA from the facility was arrested on 6/30/08 for attempting to cash a check given to her by a 93 year old resident with Alzheimer’s. The resident had given the CNA a signed blank check, onto which the CNA had written the dollar amount of $700. The facility was cited for failure to ensure the resident was free from financial abuse and for failure to provide interventions after identifying the resident’s previous behavior of writing personal checks to staff. Citation # 250009589.

Tulare County

Tulare Nursing & Rehabilitation Center
680 East Merritt Avenue, Tulare
B $1000 Mandated Reporting Verbal Abuse 10/03/2012
On 1/22/11, a resident and her responsible party reported to a LVN that a CNA was “very mean to her.” The resident said that when she called for someone to change her undergarments, the CNA told her to quit bugging her and “shut up.” The abuse was not reported to the Department of Public Health until 1/24/11. The facility was cited for failing to report the abuse within 24 hours. Citation # 120009537.