In the ongoing effort to reform health care, California is in the midst of an enormous transformation of its Medi-Cal program from a largely fee-for-service program into managed care. Managed care is a health care system where a network of providers is paid a lump sum, “capitated” fee for each patient member, regardless of the services the member uses. The providers thereby have an incentive to reduce the costs of care for its members, hopefully by keeping them healthier so they utilize fewer health care services. California is one of dozens of states working to switch some of its Medicaid recipients into managed care.

The California Coordinated Care Initiative (CCI), passed in 2012, will transform California’s Medi-Cal delivery system for low-income aged and persons with disabilities. There are two major parts to this initiative: Cal MediConnect and the Medi-Cal Long Term Supports and Services (LTSS) program. Persons who are dually eligible, i.e., eligible for both Medicare and Medi-Cal, will be a part of the Cal MediConnect three-year demonstration in eight counties and enrolled in one of the Medi-Cal health plans in that county – Alameda, San Mateo, Santa Clara, San Bernardino, Riverside, Los Angeles, Orange, and San Diego. The transition for duals (Cal MediConnect) is slated to begin on January 1, 2014, although the date could be delayed. Beneficiaries are supposed to receive at least three formal notices of the impending changes 90, 60, and 30 days before the enrollment dates. The notices should have information about all of the available choices and phone numbers to call for help. Duals who are already enrolled in Medicare Advantage do not need to make a change. Duals can exclude their Medicare services from a managed care plan, but Medi-Cal services cannot be excluded. A number of fact sheets and information guides are being prepared by various advocacy stakeholder groups, so ample information should be available by the time the enrollment process starts.

Under the Managed Medi-Cal Long Term Supports and Services (LTSS) program, nearly all Medi-Cal beneficiaries will be required to receive all of their Medi-Cal benefits, including long term supports and services and Medicare wrap-around benefits, through a Medi-Cal health plan. Although most Medi-Cal-only beneficiaries are already enrolled in managed care, they will now have to receive their long-term supports and services through their health plan as well. The Managed Medi-Cal Long Term Supports and Services (LTSS) demonstration will be expanding to the rural counties on September 2013.

Given that there are more than half-a-million Cal MediConnect eligible beneficiaries in the eight affected counties, the transition to managed care promises to be a massive undertaking that may disrupt health care services for thousands of people. Some of these plans will not be prepared to deal with the range of services needed by this vulnerable population. Some beneficiaries may have to find new health care providers if their managed care plan does not include their current providers.

In the long-term care world, the switch to managed care will create some problems. Nursing home residents who are also duals will continue to have a long-term care benefit; however, they may be required to move if their current home is not a participant in the residents’
Changes abound! CANHR is happy to welcome two staff members this summer. First is Kyle Matthews, our new Administrative Assistant. A communications major and former social media consultant, Kyle now brings his skills to CANHR to help keep things organized and running smoothly.

Also joining the staff is attorney Jody Spiegel. Formerly the Director of the Nursing Home Advocacy Project for Bet Tzedek Legal Services in Los Angeles, Jody will bring her talents and extensive experience to CANHR as a staff attorney in our South Pasadena office this coming August.

And finally, while sad for CANHR but exciting for them, Long Term Care Advocates Deborah Espinola and Shawna Reeves have left to pursue other opportunities in advocacy. They are both dedicated and talented advocates and we wish them all the best; they will be missed.

Are you a Social Worker who needs information?

**Just SWAP!**

CANHR would like to invite you to join our Social Worker Advocacy Program (SWAP). Designed specifically for long term care social workers, geriatric case managers, admission and discharge planners, and other community based service providers, this program can connect you with the answers you need.

By joining the SWAP team today, CANHR can help you to stay up to date on changes to Medi-Cal, gain access to a statewide network of social workers and stay up to date on current legislation affecting your clients. In addition to consulting with CANHR’s experienced advocates and receiving our quarterly newsletter, you will receive a discount on any upcoming Social Worker on-line trainings as well as access to our SWAP listserv where you can easily and quickly get your questions answered. Email Pauline Mosher at Pauline@canhr.org.

Send Us Your Feedback and Your Support!

We would like to hear from you. If you have questions you would like answered, comments on our web site or on services you recently received, you can contact CANHR through our new feedback form. Visit our web page at www.cahnr.org, click on “Contact Us” and tell us what you think. You may also make a secure online donation to CANHR through our website by clicking the “Donate Now” button and following the simple instructions.

**In Memory – Nicholas Petris**

Senator Nicholas (Nick) Petris, who represented the East Bay in the California Legislature for 37 years, both as an Assembly member and as a Senator, passed away on March 20, 2013. Mr. Petris championed the causes of the poor, the elderly and the disabled, along with multiple other progressive issues. His many legislative achievements included the Lanterman-Petris-Short Act, passed in 1967, which barred the involuntary commitment of most people with mental health problems; and the Right of Private Action for nursing home residents, Health & Safety Code §1430, which allowed nursing home residents to personally bring suit against a facility that violated the resident’s rights. He also authored laws that increased environmental protections and expanded the rights of farmworkers and tenants. Known for his eloquence, passion and compassion, Mr. Petris has left a legacy for all California citizens.

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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.

**CANHR**

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CA Coordinated Care Initiative.. (continued from page 1)

managed care plan. Obviously, forcing a resident to move from a nursing home may be traumatic, particularly if the resident has been in the home for years. Advocates have raised this issue with the government and been told that nursing home residents may be given a one-year grace period before they are forced to move. Still, we expect that hundreds of residents will eventually be forced to move from their nursing homes due to the managed care shift.

For long-term care consumers who are in a home or community-based setting, major changes may be in store. The various managed care plans have discretion on whether to offer home and community-based services. On the other hand, dental, vision, and even some transportation services must be covered.

Another major change that managed care promises for long-term care recipients is in estate recovery. As a fee-for-service program, Medi-Cal estate recovery has been limited to the cost of services that a beneficiary has received. Under a managed care program, payments are made regularly on the beneficiaries’ behalf, whether they use services or not. Therefore, beneficiaries who have used Medi-Cal as a safety net for health care, rarely using their benefits, nonetheless face a potentially enormous estate recovery at the time of their death. In other words, estate recovery will no longer necessarily be proportional to the benefits received, but will consist of the total payments made to the managed care plan.

With the huge number of affected beneficiaries and the patchwork of service provision in California, the transition will likely be problematic.

Some organizations that can assist beneficiaries with questions are:

HICAP 800-434-0222
Health Consumer Alliance www.healthconsumer.org
Disability Rights California www.disabilityrightsca.org
Medi-Cal Managed Care Office of the Ombudsman 888-452-8609
Department of Managed Health Care 888-466-2219.

For updates on implementation of the Coordinated Care Initiative, see www.calduals.org.

Stay tuned at www.canhr.org for news about the managed care migration and what it means for long-term care.

Covered California: Affordable Coverage for the Uninsured

Following the passage of the federal Affordable Care Act (ACA), California was the first state in the country to create a health benefit exchange to offer health insurance options to the uninsured. “Covered California” will be the primary health insurance marketplace in California. Low-income individuals and families can qualify for free health coverage under Medi-Cal, and moderate-income families will qualify for premium subsidies to help make private health coverage affordable.

All of the health plans approved for Covered California must meet certain standards required by the ACA, including:

- Insurers cannot deny coverage based on pre-existing condition
- No annual limits on essential health benefits
- Prohibits discrimination based on health status
- Health care premiums can only be based on geography, age and family size
- Inclusion of preventive care mandatory for all plans—e.g. mammograms, vaccinations, well-child care, contraception, colonoscopies and many health screenings

Individuals and businesses will be able to shop for health care insurance and compare prices and, depending on family income, there will be subsidies for some families that buy into the Exchange.

A tiered system will set “metallic” rates, e.g., platinum, gold, silver, bronze. The higher the metal, the higher the premiums will be and the greater the coverage.

On May 23, 2013, Covered California announced 13 diverse health insurance plans that were selected to be a part of the Exchange. Although the tentative selection of health plans is subject to a rate review by state regulators, most will likely be approved. In the most populated areas of the state, consumers will be able to choose from among six health plans and, on average, consumers will have four health plans to choose among. Even in most rural areas consumers can choose between two or three health plans. Coverage from Covered California is statewide, with every part of that state covered. In a small number of counties, there will be areas covered by only one plan - but the program estimates those areas represent a small percentage of those eligible for subsidies (meaning 99.5% of Californians will have choice of quality plans).

Meanwhile, state health officials are gearing up for full implementation. Open enrollment begins October 2014 for coverage starting January 1, 2014. For details on Covered California see www.coveredca.com.
Nursing Home Drugging Going Down

Since the beginning of 2012, the use of antipsychotics in California nursing homes has gone down nearly seven percent, reflecting a national trend. In early 2012, the Center for Medicare and Medicaid Services (CMS), spurred in part by CANHR and other advocacy organizations, announced a national initiative to end the misuse of antipsychotic drugs in nursing homes and improve dementia care. CMS set a goal of reducing antipsychotic use by 15% by the end of 2012. Although the goal has not been met, the downward trends in antipsychotic use throughout the nation shows that providers are beginning to accept that antipsychotics are an ineffective and dangerous “treatment” for dementia. Perhaps even more remarkable, the use of other classes of psychotropic drugs, including anti-anxiety and anti-depressant medications, has gone down in California and nationwide as well. To track the latest efforts being made to reduce nursing home drugging, check www.canhr.org/stop-drugging.

Waiting for VA Benefits

A recent report by the Center for Investigative Reporting revealed astonishing delays in the processing of VA benefit applications. While the VA acknowledges that there are slightly more than 800,000 pending claims clogging its 58 regional offices with an average wait time of 273 days before a claim is processed, the Center for Investigative Reporting, citing internal VA documents, found that those veterans face wait times that can be twice as long. The Oakland office, which serves Northern California veterans and has more than 30,000 claims pending, was singled out as being among the nation’s worst with a wait period of 618 days for initial claims. VA Secretary Eric Shinseki told the U.S. Senate Committee on Veterans’ Affairs that his agency will fix the backlog by 2015. That pronouncement was met with skepticism.

The documents obtained by the Center for Investigative Reporting shed light on why the agency is failing to make headway despite public and political pressure and its own promises. They show that while the agency has spent four years and $537 million on a new computer system, 97 percent of all veterans’ claims remain on paper. Since those numbers were tallied by the agency in January, the VA’s two top technology officers have announced their resignations, saying they had accomplished their goals. On Feb. 27, the agency’s principal deputy undersecretary for benefits also announced he was quitting.

In interviews, workers at five VA offices said they were exhausted by the ever-growing piles of paperwork, with files becoming so thick that employees frequently have asked veterans to resend medical records or military service documents simply because the claims workers could not locate them. Delays in processing VA disability benefits and VA Aid and Attendance are becoming the norm. And the problem could get worse: An estimated 1 million service members are expected to become veterans in the next five years.

Elder Justice Advocates

CANHR is excited to announce the launch of the CANHR Elder Justice Advocate™ program (EJA). Participants in the EJA are attorneys and their clients who are committed to protecting and safeguarding elders in California through advocacy and elder abuse litigation. EJA participating attorneys and their clients pledge to donate a nominal amount of any recovery to CANHR. The donations CANHR receives enables CANHR to continue working for the improvement of the lives of residents in California’s long-term care facilities and advocating for the prevention of abuse and neglect of elders and persons with disabilities. Participation in the EJA is strictly voluntary and there is absolutely no obligation for any client to make any donation to CANHR.

Clients can go to the civil courts to seek justice and redress for wrongs committed against them or their loved ones. Advocates agree that the only way to change the culture of those facilities whose primary concern is return on investment rather than quality care, is to hit them where it hurts, i.e., in the pocket book. The fear of future lawsuits can change the way a business conducts itself. Whenever a facility puts profits ahead of the safety and well being of residents, that facility needs to be held liable.

If someone has been neglected or injured in a facility, it is important to consult with an experienced civil litigator about suing the facility. CANHR Elder Justice Advocates™ effectively use the civil courts to bring dignity and justice to those who have been neglected and abused in long-term care facilities. CANHR Elder Justice Advocates™ are committed to improving the quality of care in nursing homes and other long-term care facilities and have our full appreciation. For more information about CANHR’s advocacy, see www.canhr.org.
A number of bills have been held in the Senate or Assembly Appropriations suspense files. This means that fiscal issues ($$) will likely keep the bills from moving forward. We at CANHR are particularly disappointed at the failure of AB 462 (Stone), which would have provided much greater protection to elder and disabled residents of small (6 beds or less) residential care facilities.

**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:** Passed Assembly and now in the Senate.

**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:** Bill was pulled due to opposition.

**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:** Passed Assembly, now in Senate.

**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:** Assembly Appropriations – suspense file, which means it most likely won’t move forward.

**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 two years. **Status:** Appropriations Suspense file.

**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. **Status:** Passed the Assembly, now in the Senate.

**AB 581 (Ammiano): Residential Care Facilities for the Elderly: Retaliation.**

This bill would prohibit an 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 any person 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:** Passed the Assembly, now in the Senate.

**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:** On Assembly Floor.

**AB 1217 (Lowenthal): Home Care Services Consumer Protection Act of 2013**

This bill would enact the Home Care Services Consumer Protection Act of 2013. **Status:** Passed the Assembly, now in the Senate.

Please check the CANHR website for updated details on legislation.
Imagine having a closet full of clothing in your home that you can’t access. Imagine being visually singled out from your peers by being forced to wear a hospital gown in your home. Residents at a skilled nursing facility (SNF) in San Diego County expressed their feelings of being punished and that their fellow residents knew they were being punished when they were forced to wear hospital gowns as an elopement deterrent. In March 2012, the Jewish Family Service of San Diego Patient Advocacy Program (JFS) began an investigation of a potential violation of residents’ right to wear their own clothing at a local SNF that specializes in mental health services. According to the SNF’s policies and procedures, if a resident was perceived by staff to be an elopement risk, they would be placed in a hospital gown instead of their own clothing for 72 hours (and sometimes longer), and this appeared to be punitive.

During this investigation, JFS used a clinical consultant (psychiatrist) to review records of residents who had been placed in hospital gowns due to their perceived elopement risk. The clinical consultant found that there was no documentation indicating that the denial of wearing one’s own clothes was implemented to protect the residents from self harm, such as suicide, or harm to others, and that denial of clothing is not considered a standard and/or globally accepted implementation as an AWOL precaution. JFS also reviewed policies and procedures from other SNFs and long-term care facilities throughout California, and found that none of these facilities placed residents in gowns in order to prevent elopement. JFS interviewed patient rights advocates throughout the state of California and found that every advocate interviewed agreed that placing residents in gowns to prevent elopement is not appropriate, stating that potential elopement does not meet the criteria for good cause for a rights denial, and that rights cannot be denied as a blanket policy. Additionally, advocates expressed concern that this policy was being used for staff convenience and the denial is not clearly related to the right being denied [California Code of Regulations, Title 9, section 865.2 (b)]. Lastly, advocates reported that, in their experience, wearing a gown does not prevent elopement, and that there are lesser restrictive alternatives that can be used [9 CCR § 865.1].

Several other local sources were consulted, such as the Public Conservator, the Ombudsman, and San Diego County Behavioral Health Services, and concerns were expressed that the use of hospital gowns to deter elopement is not appropriate, and is a violation of the residents’ right to dignity and humane care.

JFS concluded that denying residents their right to clothing is not justified for the prevention of elopement. JFS met with staff from the SNF to discuss these findings, and were faced with resistance. However, on May 31, 2012, the SNF finally agreed to change their policies and procedures and have to date stopped utilizing clothing restrictions to hinder elopement risks.

If you, your loved one, or your client is experiencing a similar situation, don’t be afraid to speak up and ask questions. Contact your local Ombudsman (posters with contact information should be displayed at your SNF), your local patient rights advocacy office, or CANHR for further assistance.

(Melissa Hall is an advocate with the Patient Rights Advocacy Program of Jewish Family Services in San Diego.)

Legislative Update..........................(continued from page 5)

Protection Act of 2013, which would provide, on 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. Status: Assembly Appropriations Suspense file.

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: Senate Appropriations Suspense file.

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. Status: Passed the Senate, now in Assembly.
As Margaret Reeves remembers the beginnings of The Next Generation Family Council, it started over ten years ago when residents were upset about the firing of a popular social worker, and called in family members to support residents in finding a resolution. Ten years later, the family council is ironically focused on urging the facility to hire a social worker.

Like the foundation of many family councils, The Next Generation was formed in response to a crisis. It has been sustained, however, by finding ways to improve the care and quality of life of residents, or as Margaret puts it, “to make this a better place for everyone.”

Some of the effective actions taken by The Next Generation have been inviting the administrator and key managers to meetings to share mutual concerns and find solutions. This has helped change somewhat the unfortunate perception by administration that the family council is an adversarial organization. To counter this perception, and to affirm the many positive aspects of the care, one past project had residents filling out cards recognizing excellence in service by staff, and then the cards were posted in a prominent place on a main bulletin board.

One of the biggest concerns for residents is transferring from independent living to a higher level of care, e.g. assisted living. The Family Council developed an information packet on assisted living as one way to address the fears and anxieties of residents facing transfer. More recently, the Council has produced and distributed refrigerator magnets indicating how and where residents can go to resolve complaints.

Although The Next Generation has by-laws, their way of operating is informal and highly flexible. The agenda is developed by a steering committee with significant input from residents, a real resident-centered approach. The Next Generation maintains a close and cooperative relationship with the Resident Council. Family Council members step up to take on different responsibilities.

The frequency of the meetings varies from monthly to quarterly, depending on the composition of the group and the urgency of the issues that residents are facing. As Margaret recognizes, this organizational approach sometimes lacks focus but she knows that it has created a very positive and supportive environment for both residents and family members. This mutual support, Margaret states, “has provided the organizational continuity over these past ten years.” In some instances, family members remain part of the group, even after their loved ones have died.

Whether you or your loved one lives is in a Continuing Care Community (CCRC) or not, there are many lessons to learn from The Next Generation. CCRCs have a unique opportunity because the independent living units where the vast majority of residents live are regulated as residential care/assisted living, thus extending the rights to form a family council to all residents regardless of their living situation.

Please tell us your story so we can share both the successes and challenges of Family Councils with consumers throughout the state.

Contact CANHR to obtain a free DVD on organizing Family Councils and download or order an Organizing Guide to Family Councils in Long Term Care Facilities at http://www.canhr.org/familycouncils/.
My father is an undocumented immigrant. He has lived in this country for years and has recently been admitted to a nursing home. I am starting to fill out the application for Long-Term Care Medi-Cal and when I asked the Social Worker at the facility for help she told me that he will not be eligible for Medi-Cal because he is not a legal citizen. Is this true?

Sincerely,
Lost in Los Angeles

Dear Advocate,

If your father is otherwise eligible, he should be able to get Medi-Cal coverage for long-term care. California Welfare & Institutions Code § 14007.65 provides that as long as funding is available, immigrants who are not lawfully present in the United States who meet the program’s requirements shall be eligible to receive long-term care Medi-Cal services. In Crespin v. Belshe, Alameda County Superior Court, No. 636714-5, the Court confirmed that the state cannot deny long-term care services under Medi-Cal to undocumented immigrants who are otherwise eligible for those services.

Dear Lost,

Did You Know?

Medi-Cal Recovery: Satisfying Legal Notification Requirements

You can notify the Department of Healthcare Services, Estate Recovery Unit of a Medi-Cal beneficiary’s death online. California law, under Probate Code §215, requires that, when a deceased person has received or may have received health care benefits or was the surviving spouse of a person who received such benefits, the estate attorney, the beneficiary of the estate, the personal representative or the person in possession of the property is required to notify the Director of the Department (at the Sacramento office of DHS) no later than 90 days after the person’s death. A copy of the death certificate is required to be sent. (See www.canhr.org for our FAQ on Medi-Cal Recovery)

The Medi-Cal estate recovery program maintains an on-line forms page where notification can be submitted online with an electronic attachment of the death certificate. Submitting the form with the attached certificate will satisfy reporting requirements by state law. The form will also ask additional questions to find out what property, if any, is left in the deceased beneficiary’s estate. If there was no property left in the deceased’s name, then completion of the form should be an easy matter. If the estate is more complicated, then consumers should seek advice from their attorney, legal services or CANHR before completing the online form.

Estate Recovery Program web site: http://www.dhcs.ca.gov/services/Pages/TPLRD_ER_cont.aspx
CCRC Corner

Dress Rehearsal For Disaster

By Lillian L. Hyatt, M.S.W.

I personally observed an elevator outage in a 26 story CCRC in Northern California with a Skilled Nursing Facility, Assisted Living Facility and about 300 so-called Independent Living units. I sat for three hours in the main floor lobby and could not return to my apartment to eat the food prepared earlier, or to get my medication. I was not alone, since all four elevators were inoperable even manually. Many people have disabilities and are legally blind as am I. They were all trapped as well. Since it was dinner hour and many had not yet come down to the dining room they were trapped on the higher floors with no food.

Security and food staff were busy running up and down 25 flights of stairs trying to get some food to people trapped on all floors. The repair crew did not come for an hour and a half and were not successful in fixing the problem. A total of three hours elapsed when, at 9 p.m., one elevator was possible to operate manually. The elevators are currently breaking down regularly.

The problem, as I discovered from the state agency responsible for oversight, was that the system installed 30 years earlier was left in place and was incompatible with new, very high tech systems installed in 2012. The State of California agency elevator unit finally got the repair call back records on April 25th, 20 days after the incident. The company that was unable to fix the regular elevator breakdowns was being asked for the records for the entire year. This occurred when the CCRC needed their elevator permit renewed. There were 58 repair calls from 2012 to 2013.

There is a solution: Get in touch with the Principal Safety Engineer of the Department of Industrial Relations Elevator Unit in your area, then file a complaint. This may require some courage because the CCRC industry does not like to disclose that elevator inspections are performed by the same companies responsible for repairing the elevators. In addition, in-house CCRC staff are also doing the monthly inspections required by law. The “pass” is then logged. No inspections will be made by the state unless a complaint is made.

The Department of Industrial Relations Elevator Unit Principle Safety Engineer was extremely helpful. I was provided with the following information that should help any CCRC resident to report any elevator problems to the appropriate area office. There are eight such offices in California. The website is http://www.dir.ca.gov/dosh/Elevator.html. All eight offices are listed on the website.

In Southern California, another CCRC had elevator outages in a four-story building that lasted four months. Residents were told that they were to hire help (at their own expense) to get down the stairs to the dining room if they were disabled. A resident reported this elevator outage to me. I was sent messages reporting other elevator problems in all parts of California, which I cannot report in a short column. This leads me to believe this is a very wide spread, but underreported, problem throughout the state.

I spent a full week researching how and who to contact. The CCRC industry is very obstructive and secretive. They deliberately withhold such information which could save lives in the event of a fire or an earthquake. There may be no elevators available when an elevator failure occurs and disabled people would be trapped. Although these elevator systems pass the code for safe evacuation, in reality, disabled people in such circumstances would be at risk.

Ms. Hyatt is a resident of a CCRC and an AARP Policy Specialist on CCRCs.

A Consumer's Guide
Continuing Care Retirement Communities in California
Is One Right for You?

This consumer's guide provides essential information to make an informed decision regarding whether a Continuing Care Retirement Community (CCRC) is right for you.

To order, visit www.CANHR.org or call (415) 974-5171

A Consumer's Guide

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This consumer's guide provides essential information to make an informed decision regarding whether a Continuing Care Retirement Community (CCRC) is right for you.
Past Speaking Engagements, Panel Discussions and Training Sessions

March 4: Prescott Cole gave a presentation on Medi-Cal and Financial Abuse at the Catholic Charities Oceanside, Merced, and Ingleside Senior Center.

March 5: Prescott Cole taught a law class on Medi-Cal and Health care issues at the University of California, Hastings College of the Law.

March 7: Terry Donnell gave a presentation to Ombudsman from Los Angeles County on CANHR services and Family Council organizing.

March 15: Prescott Cole gave a presentation on financial scams at the Sacramento Financial Abuse Specialization Team’s monthly meeting.

March 20: Prescott Cole gave a presentation at the California Senior Legislature about CANHR’s legislative priorities in Sacramento.

March 29: Tony Chicotel presented a webinar for long-term care Ombudsman programs on the history and problems of misusing antipsychotic drugs as chemical restraints in nursing homes.

April 11: Prescott Cole gave a presentation about elder law issues to geriatric majors at San Francisco State University.

April 11: Pat McGinnis presented a workshop on Long Term Care Medi-Cal to social workers, discharge planners and other elder advocates at the Western Justice Center Foundation in Pasadena.

April 12: Pat McGinnis presented a workshop on Long Term Care Medi-Cal at the Magnolia Place Family Center in Los Angeles.

April 18: Tony Chicotel provided a one hour webinar on advanced conservatorship defense for the Legal Aid Association of California’s Spring Armchair Training series.

April 19: Tony Chicotel provided training for Legal Services of Northern California on CANHR services and various elder law topics.

April 21: Pat McGinnis attended an Invitational Conference on Residential Long Term Services and Supports and the Role of Public Reporting in Washington, D.C. The conference was sponsored by the Agency for Healthcare Research and Quality.

May 2: Tony Chicotel gave the keynote speech at the Alzheimer’s Association of Northern California’s Annual Elder Education Conference.

May 7: Tony Chicotel presented at the spring Ombudsman Coordinators’ conference. He addressed the misuse of antipsychotic drugs in long-term care settings and other “hot topics” in long-term care.

May 8: Prescott Cole presented a lecture on long-term care and financial scams at the Fresno Elder Abuse Prevention Roundtable.

May 15: Tony Chicotel hosted a webinar on capacity and decision-making for legal services organizations.

May 15: CANHR volunteer Claire Lomax attended the 31st Annual Senior Information and Health Fair at the Richmond Memorial Auditorium. Claire headed an information table and distributed CANHR factsheets about Medi-Cal, Veteran Affairs Aid and Attendance, and planning for incapacity.

May 15: Prescott Cole made a presentation on financial scams at the Sacramento Financial Abuse Specialization Team’s monthly meeting.

May 20: Armando Rafailan, CANHR Office Manager, hosted an information table at the Dementia Resource Fair held at Kaiser Hospital in San Francisco.

May 21: Prescott Cole and Tony Chicotel presented a training session titled “Society’s Struggle with Cognitive Decline and the Rise of Financial Elder Abuse” for the Legal Assistance for Seniors’ annual Elder Abuse Conference in San Francisco.

Prescott Cole & Tony Chicotel presenting at the 8th Annual LAS Conference on Elder Abuse on May 21st.

May 22: Tony Chicotel spoke about the legal perspective of using psychotropic drugs for dementia patients at the Alzheimer’s Association of Northern California’s Circle of Care Conference.

May 23: CANHR volunteer Claire Lomax represented CANHR at the City of Oakland Mayor’s Commission on Aging to discuss the issues and opportunities confronting seniors in 2013 and beyond.

Efrain Gutierrez, Outreach Coordinator at the Pasadena Senior Center Fair on May 23rd.
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**

- **Hennilue Albury**
  - Barbara Jones
- **Mary Ballantyne**
  - Bob Peterson
- **Robert D. Cole**
  - Barbara Lieberman
- **Rosamond Edeline**
  - Gail & Vern Bean
- **Gilbert V. Fernandez**
  - Pauline Fernandez
- **Jewel Fisher**
  - William Earl Fisher
- **Bob Folden**
  - Laural Reid
- **Maxine & Ernie Gallo**
  - La Vonne Gallo
- **Dorothy Godfrey**
  - Susan Walsh
- **Ross L. Kerr**
  - Bill & Janette Kassis
- **Robert D. Cole**
  - Barbara Lieberman
- **Briana Ortega**
  - Shirley Ortega
- **Our Parents**
  - Mr. & Mrs. Kenneth Burchill
- **Martha Pauly**
  - John Pauly
- **James Van Ry**
  - Diana Van Ry
- **Joyce Simon**
  - Irma Kalish
- **Luther B. Denson & Dona Smith**
  - Ruth Holland
- **Virginia Stott**
  - Selma Hemiu
- **William F. Taylor**
  - Martha Taylor
- **Martin Titcomb**
  - Lydia Titcomb
- **Rolf Westphal**
  - Golshan Westphal
- **Gertrude Young**
  - Barry & Norma Green

**In Honor Of**

- **Collette Robin Brown**
  - Colleen Adams
- **Carmen**
  - John McDonald
- **Mike Connors**
  - Irma Kalish
- **Patricia L. Cooper**
  - Lynn Cooper
- **Elaine Lerner**
  - Karen Kleiner
- **Pat McGinnis**
  - Bob Peterson
- **Clyde & Lois Ritchie**
  - Judy Morrison
- **Iris T. Sims aka Mom**
  - Lydia Sims
- **Yvonne Troya, UCSF Lakeside Medi**
  - Eileen Downey
- **The development of better public policy**
  - Anonymous
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Enclosed is my check for: ☐ $500 ☐ $100 ☐ $50 ☐ $30 ☐ Other  _________________________

This gift is in memory of: ________________________________________________________________
(or) in honor of: _______________________________________________________________________

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Telephone: _______________________ E-mail: ________________________
Facility Name: ________________________________________________________________

CANHR prohibits the use of its name for the purpose of advertisement by attorneys, financial planners or any other organization or entity.
The following citation summaries are compiled from the citations issued by the California Department of Public Health to Northern California skilled nursing facilities and received by CANHR as of the publication of this Advocate. CANHR makes every effort to ensure that consumers are provided with accurate information. CANHR welcomes comments and suggestions or notice of errors. Please direct such comments to mis@canhr.org or by calling the CANHR office at (800) 474-1116.

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.

Explanation of citation classifications: “AA” citations are issued when a resident death has occurred due to nursing home regulation violations, and carry fines of up to $100,000. A class “A” citation is issued when violations present imminent danger to resident or the substantial probability of death or serious harm, and carry a fine of up to $20,000. Class “B” citations are fined up to $2,000 and are issued for violations which have a direct or immediate relationship to health, safety, or security, but do not qualify as “A” or “AA” citations. “Willful material falsification” (WMF) violations also result in a fine. Fines are not always required to be paid. Citations can be appealed, requiring the Department of Health Services to substantiate the violation. Violations repeated within twelve months may be issued “trebled fines”— triple the normal amount.

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 # 230009391.

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 shred 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
not! Last time they dragged me in there!” After the refusal, a Licensed Nurse (LN) told two CNAs to put the resident in a shower chair and give him a shower. One of the CNAs told the LN, “We do not want to do this!” and suggested other forms of care such as a bed bath. Ignoring that suggestion, the LN wheeled the resident to the shower room and the resident yelled all the way down the hallway. The two CNAs then proceeded to shower the resident as directed by the LN while the LN held the upset and agitated resident’s shower chair from behind. The facility was cited for failing to protect the resident’s dignity when he was forced to take a shower against his will. Citation # 230009587.

**B $2000 Supervision 11/20/2012**

The facility was cited for failing to provide adequate supervision to a resident who was to be checked on every 15 minutes. A resident eloped from the facility on 4/12/12. He went through the main lobby, past the front desk, out the front door, through the parking lot, down two steep driveways and walked half a mile to a gas station where local law enforcement found him at 4:15 pm. The CNA responsible for checking on him last saw the resident at 3:45 pm, but initially that she had seen him at 4:15 pm. She had gone on break for 30 minutes and didn’t let anyone else know that they had to check on the resident in 15 minute intervals. Citation # 230009274.

**El Dorado County**

**Barton Memorial Hospital D/P SNF**

2170 South Avenue, So. Lake Tahoe

**B $1000 Fall 09/28/2012**

On 9/24/09, a resident with a high risk of falls fell and broke her hip. Her personal alarm to monitor her movement had not been activated. The facility was cited for failing to ensure the patient’s electronic fall monitoring system was working. Citation # 030009530.

**Humboldt County**

**Eureka Rehabilitation & Wellness Center, LP**

2353 Twenty-Third St, Eureka

**B $1000 Patient Rights 08/16/2012**

On 7/16/12, it was observed that the facility had failed to post the facility rating information in an area used by residents for communal functions, (such as dining, resident council meetings or activities). This failure to post the facility’s rating prevents residents from having access to the information. The facility was cited for its failure to post. Citation # 110009412.

**Fortuna Rehabilitation & Wellness Center, LP**

2321 Newburg Road, Fortuna

**B $1000 Infection 10/15/2012**

The facility experienced an outbreak of gastrointestinal infections on 11/25/2011, and by 11/30/11, 15 residents had contracted the illness. The outbreak was not reported to the Department of Public Health until 12/1/11, six days after the initial outbreak. The facility was cited for failing to report the outbreak to the Department of Health within 24 hours, which threatened the welfare, safety, and health of the residents. Citation # 110008824.

**Marin County**

**Pine Ridge Care Center**

45 Professional Center Parkway, San Rafael

**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.

**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.

**Asbury 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 Mental Abuse Patient Care Patient Rights Physical Abuse 01/11/2013**

The facility failed to ensure that two residents were free from 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 Rehabilitation
2720 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 reported to her that she had been slapped. 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 on 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 Verbal 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.

Meadowood A Health & Rehabilitation Center
3110 Wagner Heights Road, Stockton
B $1000 12/27/2012
CitationWatch description will be published once citation is received. Citation # 030009681.

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 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 smoking and could no longer socialize with some of her friends who smoked. The facility was cited for
failing to ensure the right to choose activities when the facility chose to be non-smoking. The citation did not include a reference to 22 Calif. Admin. Code Sec. 72507, which requires smoking be accommodated in nursing homes. Citation # 230008862.

In the same facility, a resident with dementia was forced to quit smoking and was angry. Citation # 230009130.

In the same facility, one resident, who had lived in the facility for two years, was forced to move. Citation # 230009132.

In the same facility, a resident with dementia who wished to smoke was therefore moved to another nursing home. Citation # 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 cited for failure to ensure the right to choose activities when the facility chose to be non-smoking. The citation did not include a reference to 22 Calif. Admin. Code Sec. 72507, which requires smoking be accommodated in nursing homes. Citation # 230008862.

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Citation Watch - Consumer Report

The following citation summaries are compiled from the citations issued by the California Department of Public Health to Southern California skilled nursing facilities and received by CANHR as of the publication of this Advocate. CANHR makes every effort to ensure that consumers are provided with accurate information. CANHR welcomes comments and suggestions or notice of errors. Please direct such comments to mis@canhr.org or by calling the CANHR office at (800) 474-1116.

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.

Explanation of citation classifications: “AA” citations are issued when a resident death has occurred due to nursing home regulation violations, and carry fines of up to $100,000. A class “A” citation is issued when violations present imminent danger to resident or the substantial probability of death or serious harm, and carry a fine of up to $20,000. Class “B” citations are fined up to $2,000 and are issued for violations which have a direct or immediate relationship to health, safety, or security, but do not qualify as “A” or “AA” citations. “Willful material falsification” (WMF) violations also result in a fine. Fines are not always required to be paid. Citations can be appealed, requiring the Department of Health Services to substantiate the violation. Violations repeated within twelve months may be issued “trebled fines”—triple the normal amount.

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 illegally discharging the resident. 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 $19000 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 # 940009499.

**Mirada Hills Rehabilitation And Convalescent Hospital**

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.

**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 and faxed to the pharmacy until 10:30 p.m. This resulted in the resident calling 911 at 11:30 pm due to uncontrolled back pain. Citation # 940009485.

**Maywood Skilled Nursing & Wellness Centre**

6025 Pine Avenue, Maywood

**A $20000 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.

**Marlora Post Acute Rehabilitation Hospital**

3801 E Anaheim St, Long Beach

**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 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 failure 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 had to 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.

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.

CANHR’s Medi-Cal Eligibility Booklet
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The layperson’s guide to Medi-Cal Eligibility

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