Introducing the RCFE Reform Act of 2014

In the last issue of the CANHR Advocate (Winter 2013), we cited the wave of prominent media stories regarding major problems in Residential Care Facilities for the Elderly (RCFEs) in California and CANHR’s own white paper (http://canhr.org/temp/Residential_Care_in_California.pdf) in calling for comprehensive statewide reform. Well, now we have a real chance.

On January 13, a bipartisan group of eight state senators and assembly members appeared together at the Capitol press room to announce the RCFE Reform Act of 2014 sponsored by CANHR and moderated by Executive Director Pat McGinnis. The bill package addresses a number of pressing issues in RCFE care. Currently, the RCFE Reform Act is made up of ten bills (all bills are sponsored by CANHR unless otherwise noted):

1. **AB 1571 (Eggman) Consumer Information System** - requiring CCL to establish an on-line information system to include license, ownership, survey, complaint and enforcement information on every licensed RCFE in California.

2. **SB 895 (Corbett) Inspections/Evaluations of RCFEs** - requiring CCL to conduct unannounced, comprehensive inspections of all RCFEs at least annually.

3. **AB 1554 (Skinner) Responding to Consumer Complaints** - requiring CCL to start and complete complaint investigations in a timely manner, give complainants written notice of findings and provide complainants an opportunity to appeal.

4. **SB 1218 (Yee) Increased Penalties for Violations** - increases civil penalties against RCFEs for violations of laws and regulations.

5. **SB 1153 (Leno) Ban on Admissions** - gives CCL the ability to suspend the admission of new residents in facilities where regulatory violations yield a substantial probability of harm.

6. **AB 2171 (Wieckowski) Statutory Bill of Rights** - creates a statutory, comprehensive, modern bill of rights for residents and gives the right to seek injunctive relief to stop violations of residents’ rights.

7. **SB 911 (Block) Training and Qualifications of RCFE Staff** - increases the training requirements for RCFE administrators and staff and requires facilities that have residents with restricted or prohibited health conditions to employ trained medical personnel.

8. **SB 894 (Corbett) RCFE Suspension/Revocation of Licenses** - strengthens and clarifies the obligations of CCL and the licensee when a license is suspended or revoked and creates timelines for the safe relocation of residents when a facility’s license has been suspended or revoked.

9. **AB 1572 (Eggman) Resident & Family Councils** - amends current laws to enhance the rights of resident councils and family councils.

10. **AB 1523 (Atkins) RCFE Liability Insurance** - requires RCFEs to obtain and maintain liability insurance. (Sponsored by Consumer Advocates for RCFE Reform)

Additional bills have been offered by other legislators, many of which overlap with those listed above. CANHR will be tracking those bills and will provide updates on

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CANHR News

CANHR Board of Directors

CANHR is pleased to welcome two new members to its Board of Directors: Kellie Morgantini,Executive Director(265,544),(329,593) and Directing Attorney for Legal Services for Seniors, and Patrick Nakao, an attorney for Pfeffer and Williams. Welcome Patrick and Kellie!

Giving to CANHR

United Way Campaign Gearing Up

Keep an eye out for this year’s United Way Workplace Giving Campaign for 2014, coming soon to your workplace. As a Certified Community Campaign Agency, California Advocates for Nursing Home Reform (CANHR) is participating in:

- The Bay Area Community Campaign (#151)
- The California State Employees Charitable Giving Campaign (#151)
- The Combined Federal Campaign (#6010)

Consider CANHR when making a charitable contribution through payroll deductions and support CANHR services. A full description of CANHR services is available at www.canhr.org.

Make a donation without writing a check!

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

Simply by clicking on the “Donate” button on CANHR’s website at www.canhr.org, you can help us 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 throughout 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, your next donation of $10 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!
Medicare Denials Because the Resident Fails to “Improve” – No Longer Legal or Viable

How many times have you heard about nursing home residents’ Medicare being terminated because they have “plateaued” or they are not “improving?” Although Medicare theoretically covers the first 100 days in a skilled nursing facility, many nursing home residents are cut off after the first few weeks because, according to the therapist or the nursing staff, their conditions are not improving. These first 100 days of Medicare-covered therapy are crucial to ensuring that the resident gets the therapy and services necessary to eventually return home.

A recent settlement in a case against the Center for Medicare and Medicaid Services (CMS) has clarified once and for all, that Medicare coverage is available for skilled services to maintain an individual’s condition (Jimmo v. Sebelius). Under the maintenance coverage standard articulated in the Jimmo Settlement, the determining issue regarding Medicare coverage is whether the skilled services of a health care professional are needed, not whether the Medicare beneficiary will “improve.” Pursuant to Jimmo, medically necessary nursing and therapy services, provided by or under the supervision of skilled personnel, are coverable by Medicare if the services are needed to maintain the individual’s condition, or prevent or slow their decline.

The standards for Medicare coverage of skilled maintenance services apply now, but many nursing homes are still not aware of them. If you or someone you know is being denied skilled nursing Medicare coverage because they fail to “improve,” make sure to inform the facility of the Jimmo standards.

The Jimmo Settlement Agreement also provides for the re-review of certain Medicare claims under the clarified maintenance coverage standards, applicable when a patient has no restoration or improvement potential, but that patient requires skilled nursing home, home health or occupational therapy services to maintain, or to prevent or slow further deterioration of, his or her clinical condition. Anyone wishing to obtain a re-review request form or to find out more information about this important issue should visit: www.medicareadvocacy.org

Hospitals and Medicare: Outpatient or Inpatient?

Not knowing the difference could cost you. If you go into the hospital and you are on Medicare, you might think you are an inpatient and that Medicare would cover your stay. If you need to go into a nursing home afterwards for some rehabilitation, you might think this, too, would be covered by Medicare, but you could be wrong. In order for the first 100 days of nursing home care to be covered by Medicare, a person must have been an inpatient in a hospital for at least 3 days.

More and more frequently, hospitals are placing older patients on outpatient “observation status,” rather than inpatient status. According to a recent Office of Inspector General Report (OIG), the use of observation status has doubled over the past 6 years. Last year alone, more than 600,000 patients were in the hospital for at least 3 days, and still couldn’t qualify for Medicare coverage of nursing home care. As a consequence, beneficiaries are charged for various services they received in the acute care hospital, including their prescription medications, since Medicare Part A only covers inpatient costs. They are also charged for their entire subsequent nursing home stay, having never satisfied the statutory three-day hospital stay requirement.

Hospitals blame the government auditing system that audits hospital records to see if someone should be an inpatient or an outpatient, and then demands refunds from the hospital if they think these patients are misclassified. To avoid having to pay back any Medicare funds, hospitals error on the side of caution and increasingly use observation status, leaving thousands of elders to face exorbitant hospital and nursing home costs that Medicare refuses to cover.

A class action lawsuit by the Center for Medicare Advocacy and the National Senior Citizens Law Center (Bagnall v. Sebelius) seeks to end observation status. Meanwhile, Medicare beneficiaries who are admitted to a hospital should ask the hospital for written documentation of their status immediately and not wait until after they are discharged. It’s much easier to fight this problem while still in the hospital. Medicare beneficiaries can also file appeals, which take time and effort, but are still winnable. For more information on Observation Status see: www.medicareadvocacy.org

Long Term Care News .......... (continued on page 11)
AB 1554 (Skinner): Responding to Consumer Complaints
This bill would require the Department to start and complete complaint investigations in a timely manner, give complainants written notice of findings and provide complainants an opportunity to appeal.

AB 1571 (Eggman): Consumer Information System
This bill would require the Department of Social Services/Community Care Licensing to establish an on-line RCFE Consumer Information system to include specified updated and accurate license, ownership, survey, complaint and enforcement information on every licensed RCFE in California with components to be phased in over a five (5) year period ending June 30, 2019. This bill also would require complete disclosure of ownership and prior ownership of any type of facility, including nursing facilities, and any similar entity in other states, including history of compliance or non-compliance and require cross check with DPH.

AB 1572 (Eggman): Resident & Family Councils
This bill would amend current laws to enhance the rights of resident councils and family councils in RCFEs.

AB 2171 (Wieckowski): Statutory Residents Bill of Rights
This bill would create a statutory, comprehensive, modern bill of rights for residents of RCFEs and give the Attorney General, residents, or the public the right to seek injunctive relief to stop violations of residents’ rights.

SB 894 (Corbett): RCFE Suspension/Revocation of Licenses
This bill would strengthen and clarify the obligations of the Department of Social Services and the licensee when a license is suspended or revoked and would create timelines for the safe relocation of residents when a facility’s license has been suspended or revoked.

SB 895 (Corbett): Inspections/Evaluations of RCFEs
This bill would require Community Care Licensing to conduct unannounced, comprehensive inspections of all residential care facilities for the elderly at least annually and as often as necessary to ensure the quality of care provided. The inspection must evaluate each facility for compliance with all laws and regulations governing RCFEs.

SB 911 (Block): Training and Qualifications of RCFE Staff
This bill would increase the qualifications and training requirements for RCFE administrators and staff and require facilities who accept and retain residents with restricted or prohibited health conditions to employ trained medical personnel on a full or part-time basis as appropriate.

SB 1153 (Leno): Ban on Admissions
This bill would create new penalties for non-compliance, including authorizing the Department of Social Services to suspend the admission of new residents in facilities where there is a substantial probability of harm.

SB 1218 (Yee): Increased Penalties for Violations
This bill would increase civil penalties against RCFEs for violations of laws and regulations from the current maximum of $150. The fines would vary the minimum and maximum penalties, depending on the seriousness of the violation. SB 1218 would also establish the Emergency Resident Relocation Fund and require 50% of the revenue from the civil penalties to be deposited into the Fund for relocation and care of residents when a facility’s license is revoked or suspended.

CANHR Support

AB 1523 (Atkins): RCFE Liability Insurance
This bill would require Residential Care Facilities for the Elderly, as a condition of licensure, to obtain and maintain liability insurance.

AB 1751 (Bloom): Continuing Care Retirement Communities (CCRCs)
This bill would require CCRCs to provide detailed financial statements to resident associations at least quarterly, expand resident representation on CCRC governing boards, and delete authority allowing CCRCs to exclude resident representatives from governing body executive sessions and from receiving certain information.

AB 1816 (Yamada): Nursing Home Complaint Investigations
This bill would require the California Department of Public Health to complete investigations of nursing home complaints within 40 working days of receipt, with certain exceptions.

Of Interest

AB 1438 (Waldron): Consumer Information
This bill would require DSS to post inspection reports and plans of correction for RCFEs on a consumer website.

AB 2044 (Rodriguez): RCFE Inspections and Fines
This bill would require annual inspections for RCFEs, increase staff training requirements, and provide for timely investigation of complaints, among other provisions.
Feeling Confused by the Affordable Care Act in California?

The Affordable Care Act requires that all individuals and families obtain minimal essential coverage by March 31, 2014, or possibly face a fine. When consumers apply for coverage they will be told if they are eligible for one of two programs: Covered California or the Medi-Cal Expansion Program. Consumers in certain counties who are covered by both Medicare and Medi-Cal may be enrolled in a third program, Cal MediConnect, which has yet to be implemented. While many are able to enroll with little difficulty, others are encountering a new set of confusing, and often frustrating, rules with no clear answers and no guidance on where to turn for help. Below are some of the major concerns CANHR has been hearing about the programs and what agencies you can call for more information.

Covered California is the private insurance marketplace where people can buy coverage for a monthly premium, sometimes at a discounted rate determined by income. Many low income Californians were disappointed to find that filling out an application for Covered California actually enrolled them in Medi-Cal under the new Medi-Cal Expansion Program. Individuals who are currently eligible for Medi-Cal with a share of cost are considered not to have minimal essential coverage and may be eligible for discounts through Covered California.

Where you can get help: The Consumer Healthcare Alliance: www.healthconsumer.org

Medi-Cal Expansion Program: This program offers free medical care to low-income individuals. Free medical care should be good news. However, for people over 55, the cost of the Medi-Cal services they receive may need to be repaid out of their estates after they die. Also known as Medi-Cal recovery, this program requires the state to place a claim on the estates of those who received Medi-Cal benefits when they were 55 years of age or older. Enrollees in Medi-Cal expansion must also abide by reporting requirements to maintain eligibility, and they may face restrictions on what they can do with their assets while they are enrolled in the program. Individuals who are eligible for this program are not eligible for any discounts through Covered California. If consumers choose not to enroll in Medi-Cal and prefer to buy into Covered California, premiums could cost at least $300 a month.

Where you can get help: The Consumer Healthcare Alliance: www.healthconsumer.org
The Medi-Cal Managed Care Ombudsman: 1-888-452-8609
Questions about Medi-Cal recovery: Call CANHR 1-800-474-1116

Cal MediConnect is an experimental project in eight counties aimed at coordination of services for people who are both Medicare and Medi-Cal eligible by using a managed care plan. Managed care is a type of health insurance designed to save money by contracting with a network of providers and medical facilities at a reduced cost. In addition to Medi-Cal and Medicare-covered services, this project will coordinate services categorized as long term care services and supports such as, Nursing Home Care, Adult Day Health Care, In-Home Supportive Services and the Multi Purpose Senior Services Program. The implementation date for this project is April 1, 2014. Advocate groups have voiced their concerns about numerous potential problems to the Centers for Medicare and Medicaid Services and the California Department of Health Care Services and have requested a delay in the implementation of the program. The most important thing consumers can do to make sure this change does not interrupt their services is to review the paperwork about their plan options and make an informed choice. If they do nothing, they may be enrolled in a default plan that may or may not cover the health care services they need.

Where you can get help: Health Insurance Counseling Advocacy Program (HICAP): www.californiahealthadvocates.org

RCFE Reform Act of 2014 ........ (continued from page 1)


The 2014 legislative session provides a once-in-a-generation opportunity to improve the quality of care and the quality of life for over 170,000 assisted living residents in California. In order to ensure the success of such a comprehensive reform package, consumer and organizational support for these bills is absolutely essential. We need your letters of support! For more information about the RCFE Reform Act, the individual bills, and what you can do to help, please go to: http://canhr.org/legislation/rcfe_reform_act.html
The following laws enacted in the 2013 legislative session became effective January 1, 2014. The new laws are briefly summarized and the appropriate sections of the California Codes are cited. Note: Some of these new laws affect not only Residential Care Facilities for the Elderly (RCFEs), but also Adult Residential Facilities (ARFs).

**Assembly Bill 261 (Chesbro):** Prohibits the facility from requiring advance notice to terminate an admission agreement upon the death of a resident and prevents fees from accruing once all personal property belonging to the deceased resident has been removed. This new law also prohibits interference with removal of the resident’s property, and requires the facility to refund any advanced payments within 15 days after the deceased resident’s personal property has been removed. If the facility has a policy to charge a fee while the resident’s belongings remain in their living unit, it must notify in writing within 3 days of the resident’s death the deceased resident’s responsible person or other individual or individuals identified in the admission agreement regarding its contract termination and refund policies. All new and revised admission agreements effective January 1, 2014 must contain these new protections. (Adds Section 1569.652 to and amends Section 1569.884 of the Health and Safety Code.)

**Note:** Special thanks to Randall Yip of Channel 7 ABC Bay Area for highlighting this problem on “7 On Your Side.”

**Assembly Bill 581 (Ammiano):** Prohibits discrimination and retaliation in any manner against residents, including eviction or threat of eviction or against employees for their involvement in the filing of a complaint, grievance or request for inspection with the California Department of Social Services or complaint investigation with the local or state ombudsman. (Amends Health and Safety Code section 1539 related to Community Care Facilities; Health and Safety Code section 1568.07 related to Residential Care Facility for Persons with Chronic Life-Threatening Illness; and Health and Safety Code section 1569.37 related to Residential Care Facility for the Elderly.)

**Assembly Bill 620 (Buchanan):** Requires community care facilities providing adult residential care or offering adult day programs and residential care facilities for the elderly to develop and comply with an absentee notification plan for each client or resident for the purpose of addressing issues that arise when a client or resident is missing from the facility. For Community Care Facilities, this plan is part of the Needs and Services Plan. For Residential Care Facilities for the Elderly, this plan is part of the resident’s written record of care. The plan shall include and be limited to a requirement that the administrator of the facility, or his or her designee, inform the client’s/resident’s authorized representative, if any, when that client/resident is missing from the facility, and the circumstances in which local law enforcement must be notified. (Amends Community Care Facilities Act, Health and Safety Code section 1507.15 and for Residential Care Facilities for the Elderly Act, Health and Safety Code section 1569.317.)

**Assembly Bill 663 (Gomez):** Adds to existing training requirements for administrators of Adult Residential Facilities (ARF) and Residential Care Facilities for the Elderly (RCFE) by requiring instruction and testing on cultural competency and sensitivity relating to aging lesbian, gay, bisexual, and transgender community (LGBT) prior to certification. (Amends Health & Safety Code § 1562.3(c)(1)(J) and § 1569.616(c)(1)(J)).

**Assembly Bill 937 (Wieckowski):** Limits the conservator’s authority to infringe on a conservatee’s personal rights, including, but not limited to, the right to receive visitors, telephone calls, and personal mail, unless specifically limited by a court order. This law only applies to full conservatorships and not to limited conservatorships. The new law affects Residential Care Facilities for the Elderly, Adult Residential Facilities, Adult Residential Facilities for Persons with Special Health Care Needs, Residential Care Facilities for the Chronically Ill and Social Rehabilitation Facilities (Amends Section 2351 of Chapter 1 of Division 4 of the Probate Code.)
Dear Advocate,

Can I be restricted from visiting my brother at the nursing facility?

My brother was recently put into a nursing facility. When I went to visit him, the facility told me I could only visit during certain hours because the doctor said he was not in a good condition to receive visitors. My brother’s wife and I have never gotten along well, and it seems like the nursing home is taking her side by giving me restrictions on visiting, but not giving her those same restrictions. My brother tells me he would like me to visit more often, but I do not want to tell him what is going on because he is not feeling well. Can the nursing facility and my brother’s wife restrict me from visiting him?

Sincerely,

Worried in Wilmington

Dear Worried,

As long as your brother has not been conserved, then others, including his wife and the facility, do not have the right to make decisions about who visits him at the nursing home or when those visits occur. While the nursing home may set restricted visiting hours for visitors such as friends and neighbors, a residents’ family members may visit at any time and are not bound by the facility’s visiting hours.

(See federal and state laws at 42 U.S.C. § 1395i-3(c)(3)(B), (42 U.S.C. § 1396r(c)(3)(B)), 22 CCR § 72527(a)(17))

Under California Probate Code §4689, the only person who may override a resident’s visitation preferences is a court-ordered conservator of the person with a special order regarding visitation. A doctor’s opinion regarding your brother’s capacity is not legally binding. Based on the laws governing nursing home residents’ visitation rights you have a right to visit your brother any time he would like.
Past Speaking Engagements, Panel Discussions and Training Sessions

- **December 11:** Staff Attorney Tony Chicotel co-presented on a webinar for CANHR’s Social Worker Advocacy Program (SWAP). The topic was dementia care without psychotropic drugs.

- **December 20:** Jody Spiegel attended a board meeting of the Assisted Living Consumer Alliance.

- **January 6:** Mike Connors presented to the LA County Commission for Older Adults on the RCFE Reform Act of 2014.

- **January 7:** Prescott Cole participated in the TEXCOM Senior Education Advisory Committee meeting – Media and Outreach Strategy Session.

- **January 7:** Program Manager Pauline Mosher presented information about CANHR services and planning for incapacity to a group of 30 seniors at the NorCal Armenian Senior Services in Burlingame.

- **January 7:** Outreach Coordinator Efrain Gutierrez hosted a CANHR information table at the WLCAC Senior Center in Los Angeles.

- **January 10:** Tony Chicotel made a presentation to the Santa Clara County Public Guardian’s office about conservatee rights.

- **January 13:** CANHR hosted a press conference at the State Capitol to introduce the RCFE Reform Act of 2014. Senators Leno, Block, and Corbett, and Assembly Members Skinner, Eggman, Mainschein, Waldron and Yamada attended and addressed their concerns about the RCFE crisis in California.

- **January 14:** Prescott Cole gave a presentation on elder financial abuse awareness at the Stage Bridge Senior Theater Works.

- **January 17:** Jody Spiegel attended a Board meeting of the Assisted Living Consumer Alliance.

- **January 21:** Jody Spiegel attended a Board meeting of the Assisted Living Consumer Alliance.

- **January 21:** Pat McGinnis, CANHR’s Executive Director, testified at an Assembly Joint Oversight hearing regarding the Department of Public Health’s Licensing and Certification Division’s poor oversight and enforcement of nursing homes, including the lack of response to complaints.

- **January 23:** Prescott Cole made a presentation at the Second Annual Fiduciary Attorney Summit in Lake Tahoe.

- **January 25:** Jody Spiegel represented CANHR at the WISE & Healthy Aging Community Advisory Council Quarterly Meeting.

- **February 3-4:** Prescott Cole participated in the Professional Fiduciary Bureau Advisory Committee Quarterly Meeting, Educational Subcommittee Meeting, and Strategic Planning Session.

- **February 6:** Tony Chicotel and Mike Connors participated in the Santa Clara Dementia Care Symposium that was co-sponsored by CANHR and three local ombudsman programs.

- **February 11:** Pat McGinnis, CANHR’s Executive Director, testified at the Senate Human Services and Assembly Human Services Committees joint oversight hearing on Increasing Accountability in Assisted Living Facilities: State Oversight of Care in Residential Care Facilities for the Elderly (RCFEs).

- **February 18:** Prescott Cole participated in the TEXCOM Senior Education Advisory Committee meeting – Media and Outreach Strategy Session.

- **February 21:** Jody Spiegel attended a board meeting of the Assisted Living Consumer Alliance.

- **February 21:** Tony Chicotel made a presentation at the American Health Lawyers Association’s Long-Term Care Conference in Las Vegas. The topic was liability for care providers regarding chemical restraints.

- **February 24:** Prescott Cole participated in the NAPSA Elder Abuse Subcommittee planning session developing bi-laws and strategic planning.

*CANHR on the Move.................(continued on page 11)*
Is Community Care Licensing doing what the 1985 Residential Care Facilities for the Elderly (RCFE) Act intended, or is a new model of care for the elderly urgently needed? One size does not fit all. The current model is a failure, according to a recently released study produced by California Advocates For Nursing Home Reform (CANHR). The study reveals that Residential Care in CCRCs and Assisted Living facilities is “Unsafe, Unregulated and Unaccountable.”

My own personal experiences with two Department of Social Services (DSS) Licensing Program Analysts (LPAs) were shocking and disappointing. One of them had already pledged to take a job after retirement with a provider of care for the elderly at a handsome salary. The other LPA had been swept into the Department of Social Services Licensing Division when the agency that previously employed this person had been closed. That LPA did not know I was entitled to see all that had been written about me and told me the material was confidential. I then contacted the retiring deputy director of the agency and threatened legal action. The entire file was mailed to me by the next day.

My personal experience has been that DSS and the Department of Public Health (DPH), the agencies supposedly protecting the elderly, responded to my formal complaints sluggishly or not at all. Over the past ten years I have devoted several columns to employees of DSS/CCL with a marked bias to providers. When these public servants wish to go to work for providers upon their retirement from public service, what hope is there for the elderly to obtain justice under such circumstances?

Recently (January 21, 2014) the California Assembly Committee called the Department of Public Health to task for its long standing failure to conduct timely and meaningful investigations of nursing home complaints. I waited almost a year and 3 months before I was able to force the DPH to issue a federal deficiency to a Skilled Nursing Facility (SNF) after my dear friend and copy editor’s death in the hospital. His death was due to the negligent behavior of the SNF staff. I devoted two columns to this disgraceful, avoidable occurrence.

Social workers should become aware of and study the California code statutes on what constitutes neglect and when a facility can be fined - California Health and Safety Code Sections 1418.91 and 1424.

In my opinion, the worst fraud being inflicted on seniors is financial. While retaining a religious denominational name and being run by a for-profit management company, a RCFE in Northern California was in such bad shape that the seniors living in the facility had no idea that it was on the verge of closing and that they would lose, not only their large entrance fees, but their homes, even though they were told upon entering after paying most of their life savings, that this facility would be theirs for the rest of their lives.

Sadly, this situation can be prevented. One agency that will respond to financial elder abuse is the Consumer Financial Protection Bureau (CFPB), Office of Older Americans, 1700 G Street, NW, Washington, D.C. 20552. This agency protects consumers from fraud. When various California state agencies supposedly protecting the elderly responded to my formal complaints sluggishly or not at all I contacted the agency mentioned above.

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

Legislation Update ......................... (continued from page 4)

AB 1454 (Calderon): Annual Inspections
This bill would require annual inspections of RCFEs and other community care facilities.

AB 1570 (Chesbro): Residential Care Facilities for the Elderly
This bill would strengthen certification requirements for RCFE administrators and increase training requirements for direct care staff. It would also extend and expand certain dementia care training requirements to all RCFEs rather than just those that advertise or promote special dementia care.

AB 1899 (Brown): Community Care Facilities
This bill would make a person ineligible for licensure to operate a community care facility for a period of ten years if they had a previous license revoked for abandonment of a facility. It also would require the Department of Social Services to establish and maintain a telephone hotline and internet website to take complaints from the public regarding community care facilities.

For details on specific bills, go to: www.leginfo.ca.gov.
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**

Mary W. Ballantyne  
Robert Peterson

Genevieve Ciotti, My Wife - a victim of Haldol  
Tom Ciotti

Beryl Dubois  
Candie Brady

Howard and Marion Dudley  
Howard H. Dudley, Jr. LTC USAR

Vivian C. Elorriaga  
Ronald Lozano

Dorothy Gates  
Cornelia Kelly-Gates

Roy Hale  
Pauline A. Layer

F. X. Kelly  
Colette Kelly

Sheila Lillian Krieger  
Robyn Krieger

In memory of my mother Mrs. Lucille Labat  
Louis Labat

Josephine Luckjohn  
Georgia Riportella

LeRoy McDonald  
David McDonald

Sherry McIlwain  
Joyce McGriff

Sherry McIlwain  
Gloria McIlwain & Sharon Roberts - Cagle

Dr. R. Theodore Muller  
Helen Drachkovitch

W.M. Palmtag  
Mr. & Mrs. James Palmtag

Olga M. Panos deceased 9-17-2012  
Louis W. Panos

**In Honor of**

Tony Chicotel  
Kathy Loo

In honor of Pat McGinnis & Mike Connors  
Terry & Angela Donnelly

In honor of Sabita Goswami  
Subrata Goswami

My Wife Carmen Groves  
Bobby Groves

Lisa Herzog  
Susan Steinberg

Gabriel Hurtado  
Manton Hurd

Lillian Hyatt  
Tedi Dunn

In honor of Marion S. John – Age 102 on 12-6  
George John

Joe Kloberdanz  
Bruce T. Byers

Pat McGinnis  
Donna & Tom Ambrogi

Pat McGinnis  
Geraldine Murphy

Margaret Parker  
Anne Brooks

In honor of the marriage of Steven and Robin Peck.Congratulations!! Best for a blessed life together!  
Mazel Tov!  
Tricia West

Betty R. Shelley  
Douglas & Diane Shelley

Tess Weiner  
Karen Horowitz-Weiner
**DPH Taken to Task for Neglecting Nursing Home Complaints**

It is said that things change with time, but that does not seem to be true of the Department of Public Health’s failures to investigate nursing home complaints in a timely and effective manner. These longstanding failures were the subject of two recent legislative hearings.

The first hearing was held on January 21st by the Assembly Committees on Health and Aging and Long-Term Care. The second hearing, on February 11th, was held by the Senate Committees on Health and Business, Professions and Economic Development. Both of the hearings can be viewed online on the Cal Channel.

The hearings focused on a backlog of nearly 10,000 nursing home complaints and the Center for Investigative Reporting’s report that DPH’s Professional Certification Branch routinely conducts cursory and indifferent investigations of misconduct by certified nursing assistants and in-home health aides.

Testifying for CANHR at the January 21st hearing, Pat McGinnis called for leadership change at the DPH, legislative reforms and an audit. Immediate action has been taken on two of these recommendations. Assembly Member Mariko Yamada introduced AB 1816, an updated version of a CANHR sponsored bill in 2007 (AB 399) to set deadlines for completing investigations. Although the Legislature passed AB 399 by a near unanimous vote in 2007, former Governor Schwarzenegger vetoed it.

Assembly Member Yamada followed up this action by requesting an audit of the DPH Licensing and Certification Division. The Legislature’s Joint Legislative Audit Committee will hear this request on March 4th.

**CANHR Up Coming Events**

- **May 19:** CANHR staff member Armando Rafailan will be attending the 3rd Annual Dementia Resource Awareness Event at Kaiser Permanente 2238 Geary Street in San Francisco.

- **February 27:** Tony Chicotel led a discussion about unrepresented nursing home residents at the quarterly meeting of the San Francisco Bioethics Forum.

- **March 4:** Prescott Cole taught a class on Medi-Cal Long Term Care at the University of California Hastings College of the Law.

- **March 5:** Prescott Cole made a presentation on the Resident Rights Protection Act of 2014 at the Family Law/Self-Help Conference in San Francisco.

- **March 7:** CANHR staff gave a presentation on Medi-Cal Recovery and the new Medi-Cal expansion program to a community forum in Pacoima.

- **March 7:** Administrative Assistant Kyle Matthews hosted a CANHR information table at the Napa Senior Activity Center Health and Wellness Fair at the Napa Senior Activity Center.

- **March 8:** CANHR staff gave a presentation on Medi-Cal Recovery and the new Medi-Cal expansion program to a community forum in Chinatown in Los Angeles.

- **March 8:** City of Newark Senior Center 14th Annual Healthy Lifestyle & Fitness Fair 9am-12pm at the Newark Community Center 35501 Cedar Blvd., Newark. For more information call 510-578-4845.
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Alameda County

Alameda Hospital D/P SNF
2070 Clinton Ave, Alameda
A $16000 Medication 10/21/2013
A female resident who was admitted on 8/15/12 was on Coumadin, a blood thinning medication requiring close monitoring to prevent severe bleeding episodes. On 9/26/12, the resident was found unresponsive and was transferred to a hospital where she died the next day of brain hemorrhaging. A lab report showed the resident had blood clotting time six times the normal range. The facility had failed to perform basic blood tests to ensure the resident's blood was not too thin. A number of nurses failed to properly monitor the resident's blood. The facility was cited for failing to ensure the resident was spared unnecessary drugs. Citation # 020010227.

Amador County

Kit Carson Nursing & Rehabilitation Center
811 Court Street, Jackson
B $1000 Decubiti (Bedsores) Patient Care 9/26/2013
A care plan entry dated 7/16/10, indicated that a resident was at risk for skin breakdown. On 8/1/10, a stage III pressure sore was found on the resident's right heel. On 8/11/10, the resident was admitted to the acute care hospital for wound care related to the pressure sore. The facility was cited for failure to provide skin assessments as ordered and provide treatment as ordered when the pressure sore developed. Citation # 030010156.

Calaveras County

Mark Twain Convalescent Hospital
900 Mountain Ranch Road, San Andreas
B $1000 Patient Care 10/4/2013
The facility failed to ensure that the resident's environment remain free from accident hazards when a resident suffered a fall while being transported in the facility's van while in his wheelchair. While the van was transporting the resident, the driver accelerated abruptly while on a hill. The resident's wheelchair was not properly tied down, causing the wheelchair to tip backwards and the resident to hit his head on the floor of the van. The resident was hospitalized for two days after suffering a laceration to the back of his head. Citation # 030010160.

Contra Costa County

San Miguel Villa
1050 San Miguel Road, Concord
B $1200 Patient Care 12/6/2013
On 9/14/13, a 72 year-old resident, who was totally dependent on staff for all activies of daily living, was found unresponsive and transferred to the hospital. At the ER, it was noted that he was significantly constipated and had Urosepsis and Encephalopathy (a brain disorder secondary to sepsis and dehydration). It was also noted that his catheter was full of pus and not draining. When questioned by Department investigators about the catheter, the facility's Director of Nurses said there was no documentation showing that the catheter had been taken out or replaced during August or September of 2013, nor were there any records showing that the catheter was draining. It was determined that the clogged catheter contributed to the spread of a urinary tract infection into the resident's entire blood stream. The facility was cited for failure to properly maintain the resident's catheter and for failing to respond to his progressively worsening condition until he became unresponsive and needed to be sent to the hospital. Citation # 020010295.

Shields Nursing Center
3230 Carlson Blvd., El Cerrito
B $2000 11/20/2013
Between 4/17/13 and 8/27/13, three of seven sampled residents were transferred involuntarily from one facility to another in a town far away from their homes, social supports and familiar neighborhoods for the facility's convenience. The admissions coordinator stated, "I don't know anything about 30 day notices." The facility was cited for failure to give written notice of the impending transfers with a chance to appeal. Citation # 020010274.

El Dorado County

Gold Country Health Center
4301 Golden Center Drive, Placerville
B $2000 Fall Patient Care Supervision 11/14/2013
On 9/16/11 a female resident with dementia fell in her room after getting out of bed undetected by staff. A physician ordered xray revealed a fracture to her leg. The bed alarms were supposed to be checked weekly and the CNA on duty did not have a record of the alarm status for this resident's alarm. The CNA indicated that she was aware that her alarm may not have been working. The facility failed to ensure her bed alarm was in place and working properly to alert staff when she got out of bed without assistance. Citation # 030010251.

Lassen County

Country Villa Riverview Rehabilitation and Healthcare Center
2005 River Street, Susanville
B $1000 Bed Hold 12/31/2013
In March of 2012, a resident was transferred to a mental health facility for temporary care. When the social services worker attempted to place the resident back into the original facility, the resident was denied re-admittance on several occasions. The Director of Nursing stated they had a "verbal agreement" that the mental health facility would find alternate placement for the

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resident. When it was explained that without a written agreement the facility would have to take him back, the resident was readmitted on 6/8/12. The facility was cited for failure to readmit the resident. Citation # 230009387.

Placer County
Auburn Oaks Care Center
3400 Bell Road, Auburn
A $20000 Injury Patient Care 08/01/2013
An 84 year old female resident had cerebral vascular disease that had led to a loss of functioning in her left arm and leg. On 1/16/10, the resident began to complain of pain in her legs which intensified over two days. On 1/18/10, the resident was hospitalized and her right leg required amputation due to loss of blood flow and subsequent gangrene. The facility nurses had failed to properly evaluate the possible causes of the resident’s leg pain and had failed to update the physician about her condition. Citation # 030010045.
B $800 Dignity Physical Abuse 8/13/2013
The facility was cited for failing to protect a 69 year old female’s rights by not subjecting her to abuse when a male CNA purposefully sprayed the resident with cold water during a shower. The resident stated she told the CNA to stop because of the cold water. She then told the CNA the cold water spray was “on purpose” and he replied, “Maybe.” As a result, the CNA was terminated for abuse. Citation # 030010068.
B $500 Mandated Reporting 8/29/2013
On 3/21/11, a resident complained to a nurse about neglect by a CNA. The nurse notified the Ombudsman, but failed to notify the Department because she was unaware that the Department was supposed to be notified. The nurse stated that the DON does that part and we didn’t have [a DON]. The facility was cited for failing to report the alleged abuse of a resident by a CNA to the Department within 24 hours as required by law. Citation # 030010113.
B $800 Neglect Physical Abuse 8/29/2013
On 3/20/11, a CNA made the resident wait an extended period of time to change her absorbent underwear, and then threw the bed control and call light at the resident after the resident kept calling for assistance. The facility was cited for failing to protect a resident from neglect and abuse by a CNA. Citation # 030010115.

Lincoln Meadows Care Center
1550 Third Street, Lincoln
B $800 Physical Abuse 7/19/2013
On 5/24/10, a licensed nurse administered a rectal suppository to a resident after the resident stated that she did not want the suppository. The Director of Nursing stated that the staff made a mistake, and that it was abuse. The facility was cited for violating the residents rights by failing to protect her from physical abuse. Citation # 030009989.

Pine Creek Care Center
1139 Cirby Way, Roseville
B $1000 Mandated Reporting Physical Abuse Verbal Abuse 9/17/2013
On 10/13/10, a CNA physically abused an 81 year old resident, yanking him roughly around in his bed, and spoke to him in a very loud, harsh manner. The abuse is the subject of a separate citation. In this citation, the facility was cited for failing to report the abuse to the Department of Public Health (DPH) in a timely manner. It did not report the abuse to DPH until five days after it was observed. Citation # 030010123.
B $1000 Physical Abuse Verbal Abuse 9/17/2013
On 10/13/2010, a CNA verbally and physically abused an 81 year old resident. Two other CNAs witnessed the abuse. One reported the CNA was yanking the resident around in bed, causing him pain, and speaking to him in a very harsh, loud manner. The resident was screaming, “Don’t let her touch me,” “You’re hurting me,” and “Stop hurting me.” The facility was cited for failing to prevent abuse of the resident. Citation # 030010122.

Roseville Care Center
1161 Cirby Way, Roseville
B $1000 Medication Patient Care 10/2/2013
A resident was admitted to the facility for comfort (end of life) care on 11/25/11, with medical orders for intravenous (IV) morphine for end-stage respiratory failure with pneumonia. The family elected to admit him to the facility because they were told it was the only skilled nursing facility in the area with the ability to administer IV fluids and medications. The DON indicated in an interview that there was a facility policy they could not give morphine intravenously but there was no written documentation of the policy. The resident received no medication for his persistent coughing and died at 3:40 am on 1/26/11. The facility was cited for accepting a resident for whom it could not provide adequate care. Citation # 030010172.

Sacramento County
Asian Community Nursing Home
7801 Rush River Drive, Sacramento
B $1000 Fall Injury Patient Care 1/29/2014
On 2/16/12, a female resident, who was at risk for falls, fell and bumped her head and complained of right hip pain. Later that evening she was admitted to the acute care hospital with a fracture to her right hip. The CNA who was assisting the resident did not have her gait belt to prevent the fall from happening. The resident required the gait belt around her wrist when being transferred or when she was being assisted with walking. The facility failed to follow its policy which required the use of a gait belt while walking the resident, who subsequently fractured her hip, requiring surgery. Citation # 030010383.
Carmichael Care & Rehabilitation Center
8336 Fair Oaks Blvd., Carmichael
A $20000 Fall 10/30/2013
A male resident, admitted on 12/28/10 with a history of falls, fell from the toilet on 1/11/11. His physician ordered a bed and wheelchair alarm be used to prevent falls. On 1/12/11, the resident fell and broke his upper arm. His alarm was not in use. The broken arm may have caused a pulmonary emboli which led to the resident's death on 1/14/11. The facility was cited for failing to implement the resident's plan of care for a personal alarm and failing to provide adequate supervision to prevent a fall. Citation # 030010237.
Casa Coloma Health Care Center
10410 Coloma Road, Rancho Cordova
B $500 Mandated Reporting 11/14/2013
The facility failed to report an allegation of abuse toward a resident to the Department of Public Health within 24 hours of the allegation, as required by the facility's policy. On 9/30/2013, a resident complained that a "black" staff member threw pillows at her. On 10/2/2013, the resident complained that five personal items were missing, including $580. The Director of Nurses said that she did not believe the resident at first because she found no "black" staff members on duty during the incident, but made the report on 10/7/2013 because the resident kept complaining. Citation # 030010252.
Double Tree Post-Acute Care Center
7400 24th Street, Sacramento
B $1000 Mandated Reporting 10/22/2013
The facility failed to report an allegation of suspected abuse to the Department of Public Health (DPH) within 24 hours of being notified of the allegation, as required by law. On 6/7/2011, a resident entered another resident's room uninvited and sexually assaulted her. The facility was able to provide any documentation that they had reported the incident/allegation to the DPH. Citation # 030010222.
Eskaton Care Center Manzanita
5318 Manzanita Avenue, Carmichael
B $1000 Medication 11/14/2013
From 4/4/11 through 4/13/11, a resident received 18 doses of
Bactrim (an antibiotic) despite the facility’s knowledge that she was allergic to it. She suffered serious side effects including drowsiness, nausea, fever, pain, and rash. On 4/13/11 she was sent to the hospital emergency room after her doctor became aware of the allergic reaction. The resident reported she expressed concern to facility nurses on multiple occasions that she might be allergic to the antibiotic, but they continued to give her the drug. The facility was cited for failing to prevent a serious medication error. Citation # 030010243.

**Gramercy Court**
2200 Gramercy Drive, Sacramento

**B $500 Notification Patient Care 7/8/2013**
A resident with severe mobility limitations due to a stroke, in need of regular repositioning in her bed, was not repositioned for a total of 6 hours on 5/5/13. After 4 hours without being repositioned, the resident put on her call light for assistance from facility staff. Staff did not respond to her call light until 2 hours later, causing the resident to experience pain and discomfort. The facility failed to report the resident’s allegation of abuse to the Department of Public Health within the 24 hour period required by law. Citation # 030009993.

**Manorcare Health Services (Citrus Heights)**
7807 Uplands Way, Citrus Heights

**B $1000 Injury 8/14/2013**
On 7/23/10, a 62 year old male resident was admitted to the facility for rehabilitation following a foot surgery. During a walk with the physical therapist, the resident attempted to sit down is his wheelchair while assisted by the physical therapist. The resident fell face forward and hit his face against the hallway rails. As a result, the resident sustained multiple facial fractures and soft tissue swelling around both eyes and his sinuses. The facility was cited for failing to follow the gait belt policy to use the assistive device during therapy services. Citation # 030010044.

**Rosewood Post Acute Rehabilitation**
6041 Fair Oaks Blvd., Carmichael

**B $1000 Eloement 10/23/2013**
On 10/23/10, the Sheriffs’ Department returned an elderly man with cognitive impairment to the facility after finding him attempting to cross a street in his wheelchair. Facility staff did not see the resident leave the building and were unaware that he was missing until he was brought back to the facility. The resident was admitted with a diagnosis of altered mental status, and his continued repositioned facility staff to OBE Alert regarding resident’s whereabouts. The facility was cited for failing to ensure that the resident received adequate supervision to prevent him from leaving the facility. Citation # 030010206.

**Windsor El Camino Care Center**
2540 Carmichael Way, Carmichael

**B $1000 Mandated Reporting Patient Rights Sexual Abuse 10/11/2013**
The facility was cited for failure to thoroughly investigate a resident’s allegation made on 5/4/10. The resident claimed a CNA was too “touchy-feely” and requested that the CNA no longer give her the drug. The facility was cited for failing to counteract the effects were administered. The patient, who under doctor’s orders was not to receive any sedative medications, was given 90 milligrams of Aviszna, an extended release Morphine Sulfate Bead. The facility was cited for failure to properly administer prescribed medication. Citation # 030009986.

**San Francisco County**
Sequoias San Francisco Convalescent Hospital
1400 Geary Blvd., San Francisco

**A $20000 Patient Care 9/17/2013**
On 3/7/12 a resident, who had a high risk for falls, was found lying on the floor and sustained lacerations from broken glass. He was taken to the acute care hospital where he was treated for lacerations and blood loss. On 3/22/12, he was found on the floor again and had removed his alarm device and his Continuous Positive Air Pressure breathing device. He was taken to the acute care hospital to be treated for a laceration to his head. It was discovered that he had a subdural hematoma that needed to be drained under the site of the laceration. The family opted to have the resident treated. The resident died on 4/8/12 due to head trauma with subdural hemorrhage in a fall. Never was a physician notified of the falls or the increase in agitation. The facility failed to provide proper supervision through appropriate care planning and implementation, as well as to provide a safe environment. Citation # 220010147.

**San Joaquin County**
Bethany Home Society San Joaquin Co.
930 West Main Street, Ripon

**A $20000 Fall 08/08/2013**
On 6/14/10, a 73 year-old resident was being transferred from her wheelchair to her bed and a front clip on one corner of the transfer sling became dislodged, causing the resident to fall face first to the floor. The resident was sent to the ER where it was determined that she had fractured her spine at the second cervical vertebra (neck). She had also fractured her right femur, which required surgery. On 6/16/10, the lift was examined and it was determined that the sling was very worn, in poor condition, and had stitching coming out. The facility was cited for failure to ensure that the lift’s sling was in good condition. Citation # 030010063.

**Delta Rehabilitation & Care Center**
1334 South Ham Lane, Lodi

**B $10000 Eloement Supervision 7/19/2013**
A resident at risk for elopement wore an armband to alert staff in the event she left the facility. A family member who was not the responsible party for the resident removed his mother from the facility on 10/22/10, without setting off any alarms. Investigation revealed two exit doors were not equipped with alarms. The facility was cited for failure to provide adequate supervision. Citation # 030010006.

**Golden Living Center - Hy-Pana**
4545 Shelley Court, Stockton

**B $1000 Hydration Medication Patient Care 11/27/2013**
On 11/29/10, a resident developed diarrhea related to a Clostridium difficile, or C-diff, infection resulting in unrelenting diarrhea for 18 days and episodes of nausea and vomiting, all of which resulted in the resident being unable to retain food and fluids in her system to maintain fluid and electrolyte balance. The situation was also aggravated by the continuation of a diuretic medication, further reducing her fluid volume. The resident was transferred to the Acute Care Hospital on 12/17/10, where she was treated for kidney failure related to severe dehydration and dangerously low sodium levels. The facility was cited for failure to provide necessary care to ensure adequate hydration. Citation # 030010281.
On 7/7/2011, a surgeon observed gangrene in the wound and determined that an amputation above the knee would be necessary for healing. Citation # 030010244.

**Wagner Heights Nursing And Rehabilitation Center**
9289 Branstetter Place, Stockton
A $16000 Deterioration 8/20/2013
On 4/11/10, an 81 year-old resident, who was dependent on staff for eating and drinking, went to the ER in an altered mental state. It was determined that she was profoundly dehydrated and had acute renal failure due to the lack of hydration. The resident remained hospitalized for seven days. The facility was cited for failure to ensure that the resident was being given sufficient fluids to maintain hydration. Citation # 030010094.

**Windsor Elmhaven Care Center**
6940 Pacific Avenue, Stockton
A $20000 Fall Injury Notification 1/24/2014
On 4/307, at 3 am, a resident was attempting to get out of bed and fell sustaining a cut to his left elbow and a small cut on his left eyebrow. The resident's daughter was not notified until she arrived at the facility at 7:15 am, and the resident's physician was notified at 7:30 am. At the daughter's insistence, the resident was transferred to the Acute Care Hospital where he was found to have an area of pooled blood on his brain large enough to shift the brain structure such that the structure of the brain was compromised. The resident underwent surgery to relieve the bleeding but never regained consciousness and subsequently died on 4/10/07. The facility was cited for failure to immediately consult with the physician and notify the resident's family member regarding the fall. Citation # 0300010380.

**Windsor Hampton Care Center**
442 Hampton Street, Stockton
B $1000 Patient Rights 8/1/2013
On 1/12/12, the Department made an unannounced visit to the facility following up on a complaint that the facility had illegally transferred a number of residents who had failed to adhere to the facility's cigarette smoking policy. The County Ombudsmen told investigators that residents were being discharged for breaking the rules, and the facility was just "trying to push the smokers out," and that the facility's Administrator personally drove residents away in his own car. The Administrator stated that those residents left "voluntarily." When the department interviewed 14 residents who were smokers they said that they lived in fear of being sent away if they broke the facility rules. The facility was cited for transferring residents out of the facility for reasons other than those regulated by law. Citation # 0300010024.

B $1000 Decubiti (Bedsores) Patient Care 7/25/2013
On 3/23/10, a physician ordered a male resident was to be monitored for changes to a pressure sore on his left heel for 14 days and then re-evaluated. The resident developed pressure sores on his left and right heels that were described by the doctor as unstageable and gangrenous and a Stage III pressure sore on his buttocks. On 5/3/10, the resident's left heel was described as Stage IV. On 5/22/10 he had both legs amputated. The facility failed to ensure that the resident received necessary care and treatment to promote the healing of an existing pressure sore and to ensure that the resident did not develop additional pressure sores. Citation # 030010007.

**Santa Clara County**

**Los Altos Sub-Acute And Rehabilitation Center**
809 Fremont Avenue, Los Altos
A $20000 Careplan Patient Care 10/18/2013
A female resident was to receive moist heat packs wrapped in two towels applied to her right shoulder. On 11/29/12, the resident fell again, while transferring out of her bed with the aid of a CNA. The CNA had helped the resident to her bedside and then turned away to retrieve a lift and the resident fell from the bed. Facility policy required two staff people when using the lift. The resident fractured her hip, requiring surgery, and she died the next day. The facility was cited for failing to prevent the resident's fall. Citation # 03001012.
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Kern County

Corinthian Gardens Health Care Center
1611 Height Street, Bakersfield

B $2000 Mandated Reporting 10/23/2013
The facility failed to report an allegation of resident to resident abuse within 24 hours to the Department of Public Health, as required by the facility's policy. On 10/23/2013, a resident grabbed another resident's wrist. The abused resident said the grab was so hard that she thought her wrist would be fractured. The two staff members who broke up the incident did not document or report it. Citation # 120010212.

Delano District Skilled Nursing Facility
1509 Tokay Street, Delano

B $2000 Mandated Reporting 10/23/2013
The facility failed to report to the California Department of Public Health (DPH) an allegation of fiduciary abuse towards a resident within 24 hours of the allegation, as required by the facility's policy. On 6/12/2012, a resident reported a loss of $200. The facility ran an investigation, but did not report the incident to the DPH because it did not appear to be an abuse case. Citation # 120010176.

B $2000 Medication 1/29/2014
On 7/10/12, a resident suffered severe pain without adequate response from the facility. Tylenol was given but did not help. Through much of the day and night she suffered unduly. Ultimately she was transferred to the emergency room. The facility was cited for failing to ensure adequate pain relief for the resident. Citation # 120010169.

Evergreen Arvin Healthcare
323 Campus Drive, Arvin

B $2000 Mandated Reporting Physical Abuse 1/29/2014
On 9/18/11, a resident punched another resident in the face during a dining room altercation observed by staff. The facility did not report the incident to the Department of Public Health until 9/21/11. It was cited for failing to report an allegation of abuse within 24 hours. Citation # 120010413.

B $2000 Physical Abuse 2/6/2014
On 6/27/2013, there was an altercation between a CNA and a resident with multiple medical issues including dementia, and the CNA hit the resident's leg with a closed fist. The facility was cited for failing to protect the resident from physical abuse, and possibly creating distrust between the resident and caregivers leading to needs not being met and emotional trauma. Citation # 120010424.

Evergreen Bakersfield Post Acute Care
6212 Tudor Way, Bakersfield

B $2000 Mandated Reporting Physical Abuse 1/23/2014
On 4/25/12, a former staff member gave a written statement to the Admission Coordinator (AC) alleging that a CNA had abused three residents. The AC told the staff member not to report the incident to the Department because the Director of Nursing (DON) would do it. Both the DON and the Administrator denied receiving a report. The facility was cited for failure to report an allegation of abuse to the Department within 24 hours. Citation # 120010393.

Parkview Healthcare Center
329 North Real Road, Bakersfield

B $2000 Mandated Reporting Sexual Abuse 9/16/2013
Nurses' notes dated 1/23/12 indicated that at 2:30 pm the resident had been observed touching a female resident's thigh. There was no information indicating that the Department had been notified of the incident. The facility was cited for failing to report an allegation of abuse to the Department with 24 hours. Citation # 120009509.

B $1000 Physical Abuse Retaliation Against Resident Verbal Abuse 9/16/2013
On 09/06/09, following a complaint made by a female resident to the nurse supervisor about the call light not being answered at night, a CNA came into the resident's room and yelled at her in a very threatening manner, "You quit accusing me of things, I'm sick and tired of it, and you better shut up." As a result, the facility was cited for failing to protect a resident from verbal and physical abuse from a CNA. Citation # 120007933.

The Rehabilitation Center Of Bakersfield
2211 Mount Vernon Avenue, Bakersfield

B $1000 Patient Care 1/16/2014
On 8/31/10, a resident who had partial loss of voluntary movements of her legs and feet was being transported in her wheelchair. The wheelchair only had one footrest and the resident tried to balance both feet on it. Her right foot slipped off, dragged beneath the wheelchair, and got caught in the carpet. This caused her foot to be fractured. The facility was cited for failure to ensure that the wheelchair was equipped with two footrests. Citation # 120010345.
Valley Convalescent Hospital
1205 Eighth Street, Bakersfield
B $2000 Injury Patient Care Supervision 1/28/2014
On 6/22/13, a resident whose careplan required one-on-one monitoring to ensure he would not harm himself or others was left unsupervised and attempted suicide by cutting his own throat. The facility was cited for failure to provide adequate supervision and assistance to prevent accidents. Citation # 120010409.

$14000 Fall 8/15/2013
On 1/12/13, a 63 year old stroke resident who had a history of falls was found on the floor. The facility's records indicated that this was the third time that resident had been found on the floor. On 1/14/13, the resident was again found on the floor, this time with head injuries and a laceration on her forehead. The facility was cited for failing to adequately supervise and address the needs of a resident who was at high risk for falling. Citation # 910010093.

B $2000 Physical Abuse 1/28/2014
On 6/11/13, a female resident who was in the dining room yelling uncontrollably made a remark about a male resident's mother. The male resident grabbed her and put her in a choke hold. After staff separated them, the male resident said that he was trying to kill her for making a bad remark about his mother. He had an extensive history of assaulting others, such as striking facility staff and residents, shouting verbal threats, and kicking and punching windows, doors, and walls. The facility was cited for failure to remove the female resident from the dining room once she became agitated because her behavior was likely to cause significant humiliation, indignity, anxiety, or other emotional trauma to patients. Citation # 120010405.

Los Angeles County
Bel Tooren Villa Convalescent Hospital
16910 Woodruff Ave., Bellflower
B $2000 Physical Abuse 09/12/2013
The facility failed to protect a resident's right to be free from abuse and also failed to investigate an alleged instance of abuse immediately. In June of 2013, a resident reported that he was punched in the face by another resident in the facility. The resident reported the alleged abuse to staff members but an investigation was not conducted immediately in accordance with facility abuse reporting procedures. Citation # 940010146.

B $2000 Physical Abuse 09/16/2013
The facility failed to report within 24 hours an incident of alleged abuse against a resident as required by law. In June of 2013, a resident reported that another resident punched him in the face in the facility. The resident reported the alleged abuse to staff members, but staff failed to report to the Department State Survey and Certification Agency as required by law. Citation # 940010149.

Centinela Skilled Nursing & Wellness Centre West
950 Flower Street, Inglewood
WMF $2000 Patient Records 8/19/2013
Two licensed nurses in the facility fraudulently noted they had provided an 86 year old male resident's physician-ordered potassium sodium phosphate on 4/11/13 and 4/12/13 when they had not. An investigation revealed the facility had not had any potassium sodium phosphate on hand during that time. The facility was cited for making a willful material false entry in the resident's records. Citation # 910010102.

Country Villa Mar Vista Nursing Center
3966 Marcasel Ave, Los Angeles
A $14000 Fall 8/15/2013
On 1/12/13, a 63 year old stroke resident who had a history of falls was found on the floor. The facility's records indicated that this was the third time that resident had been found on the floor. On 1/14/13, the resident was again found on the floor, this time with head injuries and a laceration on her forehead. The facility was cited for failing to adequately supervise and address the needs of a resident who was at high risk for falling. Citation # 910010093.

Country Villa Pavilion Nursing Center
5916 West Pico Blvd, Los Angeles
B $1800 Fall 8/16/2013
On 6/8/09, a 90 year old resident, totally dependent others, fell off of a Hoyer lift and sustained a head injury and was sent to the ER. Upon investigation into the incident, it was determined that the staff person operating the lift was using an improper sling. The sling that was being used was designed for a different machine. The facility was cited for the employee's incorrect use of equipment. Citation # 910010101.

Country Villa Rehabilitation Center
340 S. Alvarado St., Los Angeles
B $2000 Patient Care 08/16/2013
On 10/3/12 a female resident reported that a CNA had threatened to choke her with the call light cord if she called for help again. On 9/10/12, the CNA was disciplined for refusing to care for the resident. However, the CNA stated she was not allowed to care for the resident because the family filed a complaint against her for being too rough. However, there was no documentation of a complaint by the family. The facility failed to ensure an abuse allegation was thoroughly investigated, and failed to prevent further abuse from occurring by continuously assigning the CNA for 19 days after the resident complained and family members requested not to assign the CNA to the resident. Citation # 910010098.

Emeritus at San Dimas
1740 San Dimas Avenue, San Dimas
B $2000 Careplan Medication 07/03/2013
A female resident was experiencing elevated potassium levels in the blood, which can lead to irregular heartbeat or cardiac arrest. The facility failed to notify the physician promptly, thus the resident received three unnecessary doses of potassium chloride, likely worsening the resident's high potassium levels. The facility failed to develop a care plan to monitor for an increase in the resident's potassium blood levels. The facility also failed to notify the physician promptly, when the situation required prompt medical intervention and could lead to serious harm. Citation # 950009849.

Gardena Convalescent Center
14819 S Vermont, Gardena
B $2000 Physical Environment 10/17/2013
The facility was cited for failing to maintain a comfortable hot water temperature range for its residents. A facility maintenance report documented that there was no hot water in facility for three days, and housekeeping staff said that the hot water and the water heater was “off and on, not working” when he was working during the week. Citation # 910010214.

Goldstar Rehabilitation and Nursing Center of Santa Monica
1340 15th Street, Santa Monica
B $2000 Physical Abuse 8/22/2013
A resident's family member noticed the resident's eye was red and swollen on 8/28/10. The resident was able to identify a staff member as the person who had hit him. The police were called and determined the resident had suffered physical trauma. The facility was cited for failing to protect the resident from physical abuse by the staff. Citation # 910010100.

Greenfield Care Center Of Gardena
16530 S Broadway, Gardena
B $2000 Patient Care 10/17/2013
On 11/9/11, the facility failed to investigate a bruise of unknown origin in the middle of a resident's forehead, which is required by the facility's own policy on Care of Accident and Incident. The facility also failed to report the injury to the Department of Public Health. Citation # 910010197.
Los Palos Convalescent Hospital
1430 W 6th Street, San Pedro

B $2000 Injury Patient Care 9/13/2013
On 6/11/2009, a facility CNA failed to ask for assistance, as instructed by her superior, and failed to use a transfer assistance device to transfer a resident from the shower chair to her bed. This resulted in the resident twisting her ankle and fracturing two bones in her lower left leg. Citation # 91000141.

Palos Verdes Health Care Center
26303 S. Western Ave, Lomita

A $20000 Sexual Abuse 10/03/2013
On 10/30/09, a licensed nurse sexually abused a 55 year old female resident. The male nurse entered the resident's room and put his hand down her stomach, grabbing her "crotch." The resident screamed and a CNA entered the room. The CNA reported the resident was furious and complained that the nurse had twice before abused her during care by kissing her and fondling her breasts. The CNA also reported the nurse "looked guilty and his body language said it more." However, the facility did not initially suspend the nurse and he remained on duty for weeks after the abuse. The resident felt unsafe and she was hospitalized for psychiatric care about a month after the abuse, stating at the time: "I reported the assault to the facility, but nothing was done and I'm angry he still works there." Citation # 910007237.

B $2000 Mandated Reporting Sexual Abuse 10/03/2013
On 10/30/09, a licensed nurse sexually abused a 55 year old female resident. The male nurse entered the resident's room and put his hand down her stomach, grabbing her "crotch." The resident reported the same nurse had twice before sexually abused her during care by kissing her and fondling her breasts. The facility allowed the nurse to continue working for 19 days after the abuse occurred. The facility was cited separately for abuse and in this citation for failing to report the abuse to the Department of Public Health and the ombudsman in a timely manner and for failing to immediately remove the nurse during the investigation to keep the resident safe. Citation # 910007238.

Rosecrans Care Center
1140 West Rosecrans, Gardena

B $1500 Physical Abuse 9/6/2013
A resident with Parkinson's disease was hit on the head by another resident with a hard plastic coffee cup on 1/30/11. The resident who did the hitting had had recent incidents of hitting but his careplan had not been updated. The victim was sent to the hospital with a forehead contusion. The facility was cited for failing to keep the resident free from physical abuse. Citation # 91000128.

Sharon Care Center
8167 W 3rd Street, Los Angeles

A $16000 Careplan Patient Care 08/20/2013
Physician's orders and a resident's plan of care called for an abduction pillow (used to immobilize a person's legs after hip surgery) and left leg immobilizer to be in place for several days following his surgery. There was no documented evidence that the devices were used as ordered from 3/24/11 to 3/26/11. The resident was transferred to the acute care hospital on 3/26/13, due to being in great pain where he required surgery again to correct a malalignment of the joint and a dislocated hip. The facility was cited for failure to follow physician's orders and the resident's plan of care. Citation # 910010099.

South Pasadena Convalescent Hospital
904 Mission Street, South Pasadena

B $2000 Patient Rights 4/22/2013
The facility was cited for failure to follow written policy requiring that residents are readmitted immediately upon availability of a semi-private room. A resident was transferred to an acute hospital for head and back pain. After being discharged from the acute hospital, the facility refused to readmit the resident even though beds were available and the resident was eligible for Medicaid services. Citation # 950009850.

B $1000 Administration 7/1/2013
The facility failed to comply with California Health and Safety Code by not posting complete information regarding their current overall facility rating information. During an annual rectification visit, an evaluator noticed the facility had posted their rating as determined by the Centers for Medicare and Medicaid Services (CMS), but did not include additional required information that provides consumers with available information in making informed choices about facilities. Citation # 950009988.

B $2000 Medication 7/24/2013
A 42 year old resident became unable to stand and speak clearly to such an extent that he required evaluation and treatment at a hospital for six days where he was identified with medication toxicity. The facility was cited for failing to ensure that the resident's medication use was monitored, including consulting with the attending physician regarding dosage, developing a care plan for use of the medication, and immediately notifying the attending physician when the resident reported to staff that he was experiencing symptoms consistent with possible overdose. Citation # 950010023.

Sunnyview Care Center
2000 West Washington Blvd., Los Angeles

A $16000 Injury 10/21/2013
On 5/26/13, a resident's hip was broken while she was being transferred from her bed into a wheelchair using a lift. The lift sling broke and she was dropped into the wheelchair, and required seven days of hospitalization. The medical team of consultants determined that she was not an operative candidate and recommended hospice care. The facility was cited for failing to prevent an accident by ensuring that the lift sling was inspected prior to use for wear or frayed areas as indicated in the facility's policy and procedures. Citation # 91001201.

Westlake Convalescent Hospital
316 S Westlake Ave., Los Angeles

B $2000 Theft & Loss 9/16/2013
The facility failed to ensure a resident's wallet was safe from theft from his room. On 3/29/2013, a CNA stole the resident's wallet and used his debit card to withdraw $1,000 from his bank account. Not until after the incident did the facility install locks in the resident's drawer and closet. Citation # 910010148.

Whittier Hills Health Care Center
10426 Bogardus, Whittier

B $2000 Verbal Abuse 08/07/2013
On 5/18/2013, the facility failed to ensure an intellectually disabled resident was not verbally abused by a CNA. The CNA swore down the hallway at the resident and yelled "shut up" after the resident repeatedly said, "It's a Saturday morning," while moving down the hallway. Another resident witnessed the incident, which made her feel unsafe and insecure. Citation # 940010090.

Riverside County

AFVV Health Center
17050 Arnold Drive, Riverside

A $5000 Careplan Fall Injury Patient Care 11/14/2013
On 6/26/08, an 85 year old female resident was admitted to the facility for physical therapy rehabilitation after fracturing her hip at home. The resident fell in the bathroom four days later. On 7/16/08, the resident was receiving toileting assistance by a CNA. The CNA told the resident to use her call light when she was finished and then left the resident alone to assist another resident. When the CNA returned, she found the resident on the floor. The resident was found to have a fracture around her right hip replacement at the acute care hospital requiring additional surgery. There were no indications in the resident's care plan that it was safe to leave the resident alone. The facility failed to develop a comprehensive plan of care based on the continual assessment of care needs for the resident. This failure resulted in the resident falling and fracturing her hip. Citation # 090010258.

Emeritus At Rancho Mirage
72-201 Country Club Drive, Rancho Mirage

B $1000 Careplan Fall Staff (Inservice) Training 10/15/2013
The facility failed to follow a resident's careplan for safety from falls, and failed to ensure the staff had the necessary training to operate the patient's HI/LO bed to keep it in the low position as ordered by his careplan. On 11/5/2010, the resident accidentally raised his bed and fell on the floor, fracturing his neck. Upon investigation, it was discovered that the bed's on/off switch had been left switched on. Had it been switched off, the resident would not have been able to raise his bed. Staff members responsible for the resident's care did not know about the on/off switch. Citation # 250010204.

San Diego County

Escondido Post Acute Rehab
421 E. Mission Ave., Escondido

B $2000 Patient Care 11/26/2013
On 10/14/13, A 75 year old male resident fell on the floor. When the nurse discovered him unresponsive, she failed to check his pulse as required per facility policy. Therefore, no one initiated CPR in accordance with the resident's wishes. When paramedics arrived they administered CPR, but the resident was pronounced dead at the scene. The facility failed to ensure that a resident be immediately assessed when found on the floor. In addition, the facility failed to ensure the emergency cart had an Ambu bag, or device used to assist with breathing in an emergency, was available for CPR. Citation # 080010278.

Point Loma Convalescent Hospital
3202 Duke Street, San Diego

B $1500 Medication 1/31/2014
An 89 year old female resident with a number of health conditions was receiving Coumadin, a blood thinning medication. On 1/16/13, she received a prescription for Bactrim, an antibiotic. The pharmacist sent the facility a warning about risk of bleeding from drug interaction and recommended close monitoring. The facility failed to monitor the resident and failed to inform the resident's physician of the drug interaction warning. On 1/26/13, the resident's health declined and she was noted to have black tarry stool, an indication of the drug interaction warning. On 1/26/13, the resident's health declined and she was noted to have black tarry stool, an indication of internal bleeding. She was transferred to the hospital. The facility was cited for failing to notify the resident's physician of the dangerous drug interaction. Citation # 090010181.

Poway Healthcare Center
15632 Pomerado Road, Poway

B $2000 Decubiti (Bedsores) Patient Care 12/2/2013
A resident at risk for skin breakdown on his heels was not given heel protectors by the facility as required by his care plan, dated 3/16/13, and developed stage III pressure sores on both heels. He was transferred to a different facility on 4/17/13 for treatment of the sores and was not released until 5/18/13. The facility was cited for failure to provide heel protectors per the care plan. Citation # 080010173.

Vista Healthcare Center
247 E. Bobier Drive, Vista

B $2000 Evictions 12/19/2013
On 7/21/2013, the facility failed to allow a resident to return to the facility after she left for a routine outing with her family. When she returned from the outing, her belongings were packed and she was discharged from the facility against medical advice. With nowhere to go, the resident developed chest pain, called 911, and was admitted to a hospital. The hospital physician noted that the eviction could have caused the resident emotional or psychological trauma, which could have caused her chest pain. Citation # 080010344.

Santa Barbara County

Lompoc Valley Medical Center Comprehensive Care Center D/P SNF
216 North Third Street, Lompoc

B $1000 Medication 11/21/2013
On 1/14/13, a resident became unresponsive after being transferred to the hospital for tests. The resident was found to have three Fentanyl patches affixed to his body. Fentanyl is a narcotic used to control pain and carries a "Black Box Warning" (indicating significant risk of serious or life threatening adverse effects) indicating that the prior patch must be removed before placing a new patch. The facility was cited for failure to administer and monitor the patches according to the manufacturer's recommendations. Citation # 050009766.

Tulare County

Kaweah Manor Convalescent Hospital
5710 West Tulare Ave, Visalia

B $2000 Administration Notification Other 2/5/2014
The facility failed to report an incident of alleged financial abuse of a resident within the 24 hour period required by law. The facility administrator alleges that the daughter of a resident failed to pay her mother's share of cost during her stay at the facility. The administrator notified the Department of Justice but did not report the alleged abuse to the Department of Public Health. Citation # 120010404.

Sierra Valley Rehabilitation Center
301 West Putnam, Porterville

B $2000 Physical Abuse 2/5/2014
On 9/28/12, a family member of a 74 year old resident with dementia notified staff of bruising to the resident’s chest. Staff noted several fingertip size bruises close to both of the resident’s nipples. The Director of Nurses reported the bruising to the Department of Public Health, but did not initiate an investigation. The facility was cited for failing to follow their abuse policy and procedure to ensure that all injuries of unknown source were thoroughly investigated and documented. Citation # 120010416.

B $2000 Notification Physical Abuse 2/5/2014
The facility was cited when a staff member failed to report an alleged incident of abuse within a 24 hour period as required by law. A CNA reported that another CNA was rough with a resident and twisted the resident’s arm. The reporting CNA waited approximately one month before reporting alleged abuse. Citation # 120010412.