Medi-Cal: Health Care Benefit or Expensive Health Care Loan?

SB 1124, authored by Senator Ed Hernandez (D-Los Angeles), passed the Senate on May 28 and will now go to the Assembly Health Committee.

Co-sponsored by CANHR and Western Center on Law and Poverty, SB 1124 is a response to consumer concerns and consumer outrage at being forced to obtain coverage via a Medi-Cal managed care program if their income is too low for Covered California; being denied information as to what the monthly capitated managed care rate might be; and then, when they die, having their estates and the estates of their spouses subject to Medi-Cal recovery because they are aged 55 or older, regardless of what health care services they use.

Even more outrageous is the fact that, for the first three years of the Medi-Cal Expansion program, the costs are paid solely by federal funds, with no state funds involved. Thus, by collecting from this population, the state of California is acting as a collection agency for the federal government.

California’s Medi-Cal Recovery 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 to recoup benefits paid, regardless of the type of medical services received. This mandate is somewhat unique to California, since federal law does not require California to collect for optional benefits for those 55 and over, and federal law does not require California to place claims on the estates of surviving spouses.

Most other states, in an effort to encourage health care enrollment, have eliminated recovery for the 55+ population, unless the person is institutionalized. The result of California’s aggressive Medi-Cal recovery program has been an inordinate burden for the families of California’s low-income Medi-Cal beneficiaries. Attention should be paid to the impact of this recovery:

- For most Medi-Cal recipients, the only asset they leave in their estates is a home.
- Under both California and federal laws, the home is generally considered an “exempt” asset and can be transferred at any time to avoid recovery on the home altogether.
- Low income and minority Medi-Cal recipients are disproportionately impacted by Medi-Cal recovery, not only because they are not adequately informed of their rights regarding the transfer of their homes, but also because they can rarely afford the $300+/hour attorney fees required for adequate estate planning.
- This inequitable recovery system results in heirs and family members of deceased Medi-Cal recipients in low-income communities having to sell their homes to pay off the estate recovery claim or sign a “voluntary lien” at 7% interest, so that the state of California can collect on the estate when they die.
- Generations of families lose their family homes, simply because they did not know their rights.

The revenues generated by Medi-Cal Recovery purportedly help fund health care benefits for additional beneficiaries. However, the reality is that the overall recovery amount represents approximately 0.1% of total Medi-Cal expenditures, while the impact of California’s recovery program contributes to creating a new generation of beneficiaries by forcing them to sell the family home or make monthly payments while charging usurious interest rates.

Medi-Cal: Benefit or Loan? ..... (continued on page 10)
**Call to Action!**

In January of this year, in conjunction with a bipartisan group of legislators, California Advocates for Nursing Home Reform introduced the **RCFE Reform Act of 2014**.

This group of 13 bills (11 of which are sponsored by CANHR) provides much needed consumer protections, increased oversight, and staff training. The **RCFE Reform Act of 2014** has been gaining support but we need your help!

**Make a Donation**

- Visit canhr.org and click on the “Donate” button to make a secure online donation.

**Write or call your legislators**

- Visit canhr.org to for sample letters and where to send them.

**Tell your friends and family**

- Share this newsletter to friends and family who are interested in supporting reform.

**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, the Affordable Care Act and legislation affecting your clients. You will also gain access to a statewide network of social workers through our SWAP list serve where you can quickly and easily get your questions answered. With your subscription you will also receive a social worker advocacy tool-kit containing CANHR’s most popular publications, CANHR’s quarterly consumer newsletter, *The Advocate*, plus discounts on upcoming Social Worker trainings. Call or email Pauline Mosher at (415) 974-5171 or Pauline@canhr.org for information on how to join today.

**CANHR Speakers Bureau**

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

---

**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.
Assisted Living Death Tax - No Longer Legal

Most rental agreements require notice to the landlord when you move out. One would think that dying in a residential care facility for the elderly (RCFE) would be notice enough. Apparently not! So last year the State Legislature unanimously passed a law saying “A residential care facility for the elderly shall not require advance notice for terminating an admission agreement upon the death of a resident.” But the practice goes on!

The California Legislature passed the new law, AB 261, in 2013, after negative publicity about RCFEs notifying family members that their relatives had died, then charging them because the deceased resident failed to “give notice” of termination of the admission agreement. In the Bay Area, Channel 7’s, “7 On Your Side” aired several news stories about this reprehensible practice.

After the new law took effect on January 1, 2014, that should have been the end of the story. However, at the urging of the California Assisted Living Association (CALA) – the lobby group for assisted living operators – the California Department of Social Services (DSS) issued a memo on January 8, 2014 advising that the provisions of AB 261 were not “retroactive” and that provisions of admission agreements signed prior to January 1, 2014 would “remain intact.”

The DSS ruling is wrong. The new law does not permit discrimination against the 160,000 RCFE residents who signed admission agreements prior to January 1, 2014. It makes no distinction between residents who were admitted before or after January 1, 2014. The law says “no fees shall accrue once all personal property belong to the deceased resident is removed from the living unit.” It also requires RCFEs to refund fees paid in advance for the time after the resident’s personal property has been removed from the facility.

After learning of the misguided implementation, DSS rescinded the original implementation memo on AB 261 and has posted the new guidance to its website.

Please inform CANHR if you are having problems concerning charges or refunds related to AB 261.

Assisted Living Waiver Expansion

In March 2006, Medi-Cal began paying for assisted living care to select aged and disabled residents of three counties under a pilot program called the Assisted Living Waiver (ALW). The ALW was created to test the effectiveness of assisted living as a Medi-Cal benefit by enabling low-income, Medi-Cal eligible seniors and persons with disabilities, who would otherwise require nursing facility services, to remain in or relocate to the community. In March 2009 and 2014, the Centers for Medicare and Medicaid Services (CMS) approved a waiver renewal for an additional five years and expansion of the program into additional counties. Pending final approval, the waiver program will be renewed through February 28, 2019.

The ALW now serves the counties of Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, San Mateo, Santa Clara and Sonoma. The ALW team is actively working to enroll interested providers in Kern, Orange, San Mateo and Santa Clara Counties, but currently no providers have completed the process. CMS has approved capacity for 3,700 participants, and there are approximately 2,500 currently enrolled in the program.

For more information regarding the ALW, see CANHR’s fact sheet at http://canhr.org/factsheets/rcfe_fs/html/fs_alw.htm, and the DHCS website at http://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx.

CMS Extends Deadline for Long-Term Care Facilities to Install Sprinklers

After nursing homes were given five years to comply with federal rules requiring automatic sprinklers, CMS has extended the deadline for compliance. CMS stated:

“Based on public feedback, we understand that some facilities were not able to meet the 2013 deadline. In order to maintain access to LTC facilities, and in recognition of financing difficulties faced by some providers, we are allowing LTC facilities the opportunity to apply for a deadline extension, not to exceed 2 years, if certain conditions apply. An additional extension may be granted for up to 1 year, depending on the need and particular circumstances.”

The extension underscores the danger posed to nursing home residents who live in facilities that are not fully sprinklered. Although no one needed a reminder, we received one as a fire forced the evacuation of a Davis nursing home in May.

CMS Meets Goal of 15% Antipsychotic Reduction in Nursing Homes

On April 11, 2014, the Center for Medicare and Medicaid Services (CMS) issued a report stating that nursing homes have reduced the use of antipsychotic drugs for “long-stay” residents by 15%. The report shows that nursing homes have made progress in reducing the use of antipsychotics, which have been linked to dehydration, tremors, and other serious side effects.

Long Term Care News .............. (continued on page 6)
May was a very good month for the RCFE Reform Act of 2014. All of the bills have moved onto the next house of the legislature. While the bills are all still alive and moving on, they need consumer and advocacy support more than ever. Reform opponents are doubling their efforts to maintain business-as-usual, meaning poor quality care and weak enforcement. To help support RCFE reform, go to http://canhr.org/legislation/rcfe_reform_act.html

**RCFE Reform Act of 2014**

**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. **Status: Senate Human Services Committee.**

**AB 1554 (Skinner): Responding to Consumer Complaints**

This bill would require the Department of Public Health (DPH) to start and complete complaint investigations in a timely manner, give complainants written notice of findings and provide complainants an opportunity to appeal. **Status: Senate Human Services.**

**AB 1571 (Eggman): Consumer Information System**

This bill would require the Department of Social Services (DSS)/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 would also 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. **Status: Senate Human Services Committee.**

**AB 1572 (Eggman): Resident & Family Councils:**

This bill would amend current laws to enhance the rights of resident councils and family councils in RCFEs. **Status: Senate Human Services Committee.**

**AB 2044 (Rodriguez): RCFE Staffing Requirements**

This bill would require an administrator or facility manager to be on premises 24/7, and for sufficient staff to be on premises 24/7 to carry out required responsibilities. This bill would require at least one staff member with CPR and first aid training to be on premises at all times. This bill would also require staff to be trained on building and fire safety and responding to emergencies. **Status: Senate Human Services.**

**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. **Status: Senate Judiciary & Human Services.**

**SB 894 (Corbett): RCFE Suspension/Revocation of Licenses**

This bill would strengthen and clarify the obligations of the DSS 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. **Status: Senate Human Services Committee.**

**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. **Status: Assembly Human Services Committee.**

**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. **Status: Assembly – to be assigned.**

**SB 1153 (Leno): Ban on Admissions**

This bill would create new penalties for non-compliance, including authorizing the DSS to suspend the admission of new residents in facilities where there is a substantial probability of harm. **Status: Assembly Human Services Committee.**
SB 1382 (Block): Increase in RCFE Fees
This bill increases the initial and annual licensing fees for RCFEs by 30% for every sized facility and makes legislative findings that it is imperative that DSS be given adequate resources to support its mandate to provide consumer protection. Status: Assembly Human Services Committee.

Other CANHR Sponsored bills:
SB 1124 (Hernandez): Medi-Cal Recovery
This bill would limit Medi-Cal recovery for those who are 55+ years of age to only what is required by federal law, and eliminate optional recovery for other services; eliminate recovery on surviving spouses’ estates; and restrict recovery amounts to benefits paid for services actually received or the capitated monthly rate, whichever is less. Status: Assembly Health Committee.

CANHR Support
AB 1700 (Medina): Elder Financial Abuse:
This bill would prohibit a lender from taking a reverse mortgage application or assessing any fees until the suitability counseling is provided. Status: Senate Banking & Finance.

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. Status: Senate – to be assigned.

AB 1804 (Perea): Consumer Protections from Insurance Lapses:
This bill would expand the ability of consumers to designate additional persons to receive notices of lapse or termination of insurance policies due to non-payment of the premium. Status: Assembly Floor.

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

AB 1899 (Brown): RCFE’s Quality of Care
This bill would prohibit a person whose license has been revoked or forfeited for abandonment of the facility permanently ineligible for reinstatement of a license. Status: Senate – to be assigned.

AB 2025 (Dickinson): Increasing the Income Level for Aged and Disabled Medi-Cal
This bill would raise the income level of the Aged and Disabled Medi-Cal program (A&D program) to 138% of the Federal Poverty Level, currently set at 124%. Many low-income beneficiaries are currently required to spend all of their monthly income, minus $600, on healthcare before Medi-Cal coverage kicks in. Status: Assembly Appropriations - suspense.

AB 2603 (Perez): Access to Medications
This bill would clarify current law so that those trying to help an infirm family member or friend will not inadvertently break the law by picking up or transporting a prescription that is not in their name. Status: Senate Health Committee.

AB 2606 (Dababneh): Long Term Care Tax Credit
This bill would allow eligible caregivers to claim a $500 tax credit annually to help offset the financial and personal cost of being a caregiver. Status: Assembly Appropriations Committee.

AB 2623 (Pan): Elder Abuse
This bill would require that elder abuse training provided to local law enforcement include additional subjects relating to legal rights and remedies available to victims of elder abuse; require elder abuse training to be updated every two years; and require first responder police officers to be provided with a card containing, among other information, the local number of Adult Protective Services. Status: Assembly Floor.

Of Interest
AB 1436 (Waldron): Consumer Information
This bill would require DSS to post inspection reports and plans of correction for RCFEs on a consumer website. Status: Assembly Appropriations Committee - suspense.

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

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. Status: Senate Human Services Committee.

AB 1974 (Quirk): Therapy Services in Nursing Homes
This bill would amend California law to exclude therapy services from the definition of “special services.” This change may undermine the authority of longstanding California regulations governing therapy services in nursing homes. Status: Senate Health Committee.
nursing home residents by 15.1% since 2011. The CMS report, *Interim Report on the CMS National Partnership to Improve Dementia Care in Nursing Homes*, describes activities and outcomes of the campaign it initiated in March 2012 to reduce antipsychotic use and improve dementia care in nursing homes. CMS originally set a goal to reduce antipsychotic use by 15% by the end of 2012, but when that goal was not met, CMS moved the target date to the end of 2013.

While CMS’s modest initial goal has been met, misuse of antipsychotic drugs as chemical restraints for residents with dementia is far from finished. Over 300,000 residents nationwide continue to get antipsychotics. Most of these residents have dementia, most receive them inappropriately, and most will suffer unnecessary harm and a higher risk of death.

It is encouraging that antipsychotic use is declining and more residents may be receiving better dementia care. However, our campaign to end antipsychotic misuse continues with renewed vigor on behalf of over 20,000 Californians in nursing homes who are drugged with antipsychotics. Visit CANHR’s Stop Drugging website to learn more about our campaign.

**OIG Finds One-in-Three Nursing Home Residents Suffer Adverse Events**

A February 27, 2014 report by the Health and Human Services Office of Inspector General (OIG) concluded that 32 percent of Medicare beneficiaries who went to skilled nursing facilities in August 2011 suffered adverse events or other harm. The report, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*, attributes “much of the preventable harm to substandard treatment, inadequate monitoring, and failure or delay of necessary care.”

Physician reviewers working with OIG found that 59 percent of the adverse events and incidents of harm, including falls, pressure ulcers and medication errors, were preventable. The Inspector General calculated that 1,538 residents died, 10,742 residents experienced harm and Medicare paid $208 million for hospitalizations of nursing home residents, just in the month of August 2011.

The terribly high occurrence of neglect, harm and death are remarkable because the OIG study examined records of Medicare beneficiaries whose stays averaged 15.5 days; the residents of nursing homes who usually get the very best of care. Had the OIG performed the same review for long stay residents on Medicaid, there is no doubt that the findings would have been even more alarming.

The OIG investigation confirmed what has long been known about nursing homes. Too many of them are extremely dangerous places for the highly vulnerable persons who turn to them for care. But its findings also reveal that much of the neglect that occurs is not recognized by nursing homes or regulatory agencies, so nothing is done to prevent reoccurrence.

**Los Angeles County Auditor Finds Nursing Home Complaints Not Investigated**

Los Angeles County, which is home to nearly 400 nursing homes, has long given nursing home regulators a bad name. Under a contract with the California Department of Public Health, the Los Angeles County Department of Public Health is charged with inspecting nursing homes and protecting the rights of nursing home residents. Yet it has little evident concern for nursing home residents.

Its malfeasance is finally attracting public attention after a series of articles by Kaiser Health News reporter Anna Gorman on its “clean up” project to clear out a huge backlog of nursing home complaints without any investigation. The articles led to reassignment of Ernest Poolean, the supervisor in charge of nursing home inspections, and to a probe by the Los Angeles County Auditor-Controller.

The first phase of the Auditor’s investigation found that the department had nearly 1,000 complaints that had been open for more than two years. According to the Auditor, the department had no central management of complaint investigations and no deadlines for completing cases.

An April 12, 2014 article by Ms. Gorman illustrates the dire impact of this neglect. It reported an 85-year old resident died after developing multiple bed sores, including one on her backside that was so deep it exposed the bone. Her daughter filed a 7-page complaint against the Arcadia Health Care Center with the Los Angeles County Department of Public Health in September 2011 and asked it to investigate. Subsequently, she sued the nursing home and won an award of more than a half a million dollars for elder abuse, negligence and wrongful death. Although the lawsuit concluded months ago, the Los Angeles County DPH still has not finished its investigation or taken action against the nursing home. Even when faced with evidence that nursing home residents are dying due to reckless care, DPH may take years to act.
Dear Advocate,

I’m 56 years old and I recently enrolled in the Medi-Cal Expansion Program, which provides medical care to me at no cost. While I’m grateful to have coverage, I also heard that the state could put a claim against my house after I die. Is that true?

Sincerely,

Worried Sick in Worswick

Dear Worried Sick,

Yes. State and Federal laws allow the state to seek repayment for services received upon your death. However, there may be some good news. CANHR is proud to be a co-sponsor of SB 1124, which would eliminate estate recovery for Medi-Cal costs incurred on behalf of beneficiaries 55 years of age and over, unless they are institutionalized. Please show your support by calling or writing to the Senator and Assemblymember in your district and ask them to vote “Yes” on SB 1124.

At this time, the best way to avoid recovery is to have nothing in the Medi-Cal beneficiary’s name at the time of death. Since an outright transfer can have tax and other consequences, this is not generally recommended. However, there are several alternatives, such as grant deeds with occupancy agreements or irrevocable life estates, that can avoid recovery, avoid probate, avoid tax consequences and still leave the beneficiary with the right to live in the home. Any such transactions should always be discussed with a qualified estate planning attorney.

If you need an attorney, CANHR has a statewide, state bar-certified referral service for attorneys specializing in estate planning for long term care. For more information, call CANHR at 800-474-1116.
**Past Speaking Engagements, Panel Discussions and Training Sessions**

- **March 7th:** Administrative Assistant Kyle Matthews hosted a table at the Napa Senior Activity Center’s Health & Wellness Fair, passing out literature on the 2014 RCFE Reform Act and CANHR’s various services.

- **March 7:** Outreach Coordinator Efrain Gutierrez participated in a consumer workshop at the Mary Immaculate Church in Pacoima.

- **March 12:** Staff Attorney Tony Chicotel provided a webinar for legal services programs on civil rights for seniors.

- **March 14:** Staff Attorney Jody Spiegel attended a board meeting of the Assisted Living Consumer Alliance.

- **March 19:** Senior Staff Attorney Prescott Cole presented a legal services webinar, “Why Do We Worry About Elder Abuse Scams?”

- **March 19:** Executive Director Pat McGinnis participated in a panel presentation on Protecting Our Adult Children from Physical, Sexual, Financial and Emotional Abuse, in Palo Alto, sponsored by the Bay Area Autism Society.

- **March 25:** Prescott Cole attended a NAPSA Elder Abuse Subcommittee planning session.

- **March 26:** Pat McGinnis presented a CANHR-sponsored webinar, “Medi-Cal Recovery and the Affordable Care Act,” for legal services program staff.

- **March 27:** Tony Chicotel presented a CANHR-hosted webinar on dementia care and physical and chemical restraints for Doctors Medical Center in Modesto.

- **April 4:** Jody Spiegel attended the 2014 Support Center Meeting of the Legal Aid Association of California at Public Counsel’s offices in Los Angeles.

- **April 16:** Pat McGinnis presented a session on Medi-Cal Recovery and the Coordinated Care Initiative at a health care community forum at the Santa Clara Convention Center, sponsored by the Sourcewise HICAP Program.

- **April 18:** Tony Chicotel traveled to Clearlake to talk about civil rights for seniors at the Lake and Mendocino County Area Agency on Aging’s Elder and Dependent Adult Abuse Prevention Conference.

- **April 22:** Prescott Cole taught a class on elder law to graduate students at San Francisco State University.

- **April 25:** Prescott Cole attended a press conference hosted by Senator Ellen Corbett on the RCFE Reform Act of 2014.

- **April 29:** Tony Chicotel attended the Board meeting of the California Culture Change Coalition.

- **April 30:** Tony Chicotel gave a presentation on civil rights for seniors to the Fresno and Madera County Long Term Care Ombudsman Program.

- **May 5:** Jody Spiegel coordinated a meeting of the RCFE Advocacy Coalition.

- **May 9:** Pat McGinnis presented a session on Medi-Cal Recovery and Cal MediConnect at the CANHR-sponsored social Worker Advocacy Program (SWAP) training in Los Angeles.

- **May 9:** Efrain Gutierrez participated in the SWAP at the Magnolia Place Family Center in Los Angeles.

- **May 10:** Over 100 private bar and legal services attorneys attended a one-day CANHR attorney training at the Pickwick Gardens in Burbank.

- **May 12:** Long Term Care Advocate, Mike Connors, gave a presentation on residents’ rights to the residents of Rosewood Court in Pasadena.

- **May 14:** Operations Manager, Robert Martien, hosted a...
May 12: Long Term Care Advocate Mike Connors gave a presentation on residents’ rights to the residents of Rosewood Court in Pasadena.

May 14: Operations Manager Robert Martien hosted a CANHR information table at the Richmond Civic Center for the 32nd annual Richmond Commission on Aging Senior Health and Information Fair.

May 16: Jody Spiegel attended a board meeting of the Assisted Living Consumer Alliance.

May 19: Office Manager Armando Rafailan attended the 3rd annual Dementia Resource Awareness Event in San Francisco.

May 20: Prescott Cole and Tony Chicotel presented at the Legal Assistance for Seniors’ 9th annual Elder Abuse Conference at UC Hastings in San Francisco. Their presentation was entitled, “Nothing Happens by Accident: How the Law Shapes Elder Abuse and How Elder Abuse Shapes the Law.”

May 21: Program Manager Pauline Mosher spoke about Medi-Cal recovery on a Vietnamese radio show called Program to Learn About the Law 1290 AM, KAZA.

May 22: Tony Chicotel attended the San Francisco Bioethics forum meeting.

May 22: Efrain Gutierrez hosted a CANHR information table at the South Pasadena Senior Center Health Fair.

May 28: Tony Chicotel co-hosted a webinar with Tena Alonzo on dementia care and a comfort-centered approach to the staff of the Department of Social Services’ Community Care Licensing Division.

May 29: Prescott Cole as Governor’s Appointee, attended a meeting of the Professional Fiduciary Advisory Committee in Sacramento.

Prescott Cole Honored

Prescott Cole, CANHR’s Senior Staff Attorney, was presented with the 2014 Legal Assistance for Seniors (LAS) Outstanding Service Award for his work on elder abuse issues over the years. The award was presented at LAS’s annual Elder Abuse Forum held at Hastings College of Law in San Francisco.

CANHR Upcoming Events

July 24: “Comfort as the New Medicine” Comes to San Diego: CANHR is bringing its comfort-focused dementia care training back to San Diego to focus on implementation of comfort care principles in lieu of chemical restraints. The trainers are Tena Alonzo, the fantastic comfort care teacher from the Beatitudes Campus in Phoenix, AZ, and Martha Ranon from the Southern Caregiver Resource Center (an event co-sponsor). Other co-sponsors include Elder Law & Advocacy, and the State Office of the Long-Term Care Ombudsman. Lunch and CEUs will be provided. The cost of the event is $25. To register, call (858) 565-1392.
Demonstrating the urgent need for improvements in assisted living, the dedication of resident advocates, and the statewide support for reform, the twelve bills comprising the RCFE Reform Act of 2014 are all alive and moving through the legislative process. Each of the bills has been vetted through multiple committees and largely improved by amendments and stand a very good chance of being presented to the governor for his consideration by the end of the summer.

The bills enhancing Community Care Licensing’s (CCL’s) enforcement authority to punish bad operators have had tremendous success and support so far. SB 1153 (Leno), permitting CCL to ban the acceptance of new residents at troubled facilities, is already out of the Senate and onto the Assembly while AB 2236 (Maienschein and Stone), raising the fines for facilities that break the rules, is awaiting a floor vote.

Other RCFE Reform Act bills that have moved onto the second house from the Senate or Assembly include AB 1523 (Atkins), requiring RCFEs to have liability insurance; AB 1572 (Eggman), enhancing resident and family councils; and SB 1382 (Block), increasing licensing fees so CCL has more resources to protect residents.

The bills addressing CCL’s role in overseeing the care provided in RCFEs faced hurdles in the legislative appropriations committees due to potential increased costs. Despite a proposed CCL budget increase of $7.5 million dollars, the costs of moving to annual comprehensive regulatory inspections from drive-by inspections every five years (SB 895 (Corbett)) and requiring complaint investigations be completed within 90 days (AB 1554 (Skinner)) proved too much and the bills had to be amended. However, the bills remain strong and would significantly improve oversight of RCFEs.

Other important RCFE Reform Act bills that recently passed through appropriations committees include AB 1571 (Eggman), establishing an on-line consumer information system about all RCFEs; AB 2171 (Wieckowski), creating a statutory bill of rights for residents; SB 894 (Corbett), regarding relocation protection to residents in facilities that have lost their license; and SB 911 (Block), augmenting the training and qualifications of RCFE staff and administrators. AB 2171 in particular has proven controversial, primarily because it empowers residents to go to court if their rights are violated. Without a private right of action, resident rights would mean very little.

For a complete list of the bills comprising the RCFE Reform Act of 2014 and updates regarding their status, please go to http://canhr.org/legislation/index.html.

While all of the bills are still alive and moving forward, they need your support more than ever. If you haven’t already done so, contact your state Senator and Assembly Member and tell them they need to vote yes for RCFE reform. We are closer than ever to realizing this once-in-a-generation to comprehensively address assisted living quality for older and disabled adults. To learn more about what you can do to support RCFE reform, please go to http://www.canhr.org/

The federal Centers for Medicare & Medicaid Services (CMS) also took notice. In an April 21, 2014 letter to the California Department of Public Health, CMS stated it would withhold over $500,000 unless it took several actions to bring the Los Angeles County Department of Public Health into compliance with federal standards. Along with other actions, the CMS letter directed the California Department of Public Health to install a temporary management monitoring team to oversee implementation of a compliance plan.

The California Department of Public Health is also under investigation for similar failures and is failing its mission to protect nursing home residents from mistreatment. CANHR is calling for leadership change at both agencies, the California and Los Angeles County Departments of Public Health.

Under the current system in California, Medi-Cal is hardly a benefit for anyone over 55 years of age. It is a very expensive health care loan. We need to invest in the future for low-income Californians, and not continue to deny them the right to inherit the family home simply because their parents were not aware of their rights and were too poor to afford health care.

SB 1124 would eliminate most of the optional recovery provisions not required by federal law and allow thousands of older, low-income Medi-Cal recipients to be relieved of the worry about losing their family homes. We need to support SB 1124 and see it signed into law. For more information about SB 1124, please go to www.canhr.org.
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:

**In Memory of John Vasconcellos**
*His Friends at CANHR*

John Vasconcellos, a former Senator and Assembly Member and California's longest continuously serving legislator until 2004, died in his home in Santa Clara on Saturday, May 24. Mr. Vasconcellos was more than a visionary – he was a bold, forceful advocate for what he believed in – always for the betterment of his fellow humans. Sometimes irascible, often impatient to “move the bill” and to cease the aimless discussions, he was usually the keenest mind in the room.

As an Assembly Member, he became chair of the powerful Ways and Means Committee. In the State Senate, he chaired the Public Safety, Education, and Economic Development committees, as well as the Senate Subcommittee on Aging, where he authored SB 1061, the nursing home standardized admission agreement bill. He authored numerous bills to improve education and assistance to seniors and persons with disabilities.

Many of us would like to think we’ve left the world a better place than we found it. John Vasconcellos actually did. There was nobody like him and the void in the universe is large without him.

*We must become both hospice workers to support the peaceful dying and letting go of our traditional culture of fear and cynicism, and midwives to gently usher in our emerging culture of trust and mutual regard - and with it a more hopeful human future.* – John Vasconcellos

**In Memorial**

Paul & Gladys Weber, Shelby & Selma Allen  
Mary & Friel Allen

Mary W. Ballantyne  
Robert Peterson

Joan B. Barriga  
Jorge Barriga

Jim Brown  
Isabel Lakretz Brown

Ed Del Carlo  
Larry & Bobbie Ross

Cele Charnow  
James Branson

My granddaughter, Donna Smith and my brother, Luther B. Denson, Jr.  
Ruth Holland

Charles (Chuck) Etherington  
Mary Etherington

Carmen M. Garcia  
John Garcia

Margaret Mizner Glidden  
Nancie Glidden

Bernard Greer  
Sharon Greer

Ross & Olive Kerr  
Bill & Janette Kassis

Mrs. Lucille Labat  
Louis Labat

Margie  
Joanne Williams

Roxie Marsh  
Elgian Hurley

Fran Michael  
Patricia Mullet
IN MEMORIAL CONTINUED

Deborah Mizrahi
Mike Manesh
My dear Mom
Susan Walsh
Mary Nagel
Ann Tittiger
Dorothy Opp
James Opp
Rosalie Ortega
Shirley Ortega
Thelma Ousborn
Mary Woolfolk
Our Parents
Mr. & Mrs. KC. Burchill
Our Parents
Martha Frenzel-Smith

Robert D. Barker
Virginia Barker
Elizabeth Bell
Victoria Bell
Ruth Brenizer
Anita Fazio

Beloved Husband Jerry Lamonte Rogers
Gerri Rogers

Lottie Shamis
Judith Betts
Donald Stuart
Kathleen Stuart
LaVerne Schwacher
Debra Vogler
Lottie Shamis
Judith Betts
Esme Springer
Alan Springer
Donald Stuart
Kathleen Stuart
Noel Taylor
Bill Taylor

William F. Taylor
Martha Taylor
My Beloved Wife, Rita Twomey
Joseph Twomey
Newton Young
Evelyn Young
In Memory of Evelyn Wartman
From Mr. & Mrs. John and Paddy Moran
Howard Westaby
Elaine Nelsen
Frances Williams
Jackie Johnson
Shiaw Wong
Michael Roan

IN HONOR OF

Robert D. Barker
Virginia Barker
Elizabeth Bell
Victoria Bell
Ruth Brenizer
Anita Fazio

CANHR.org
George & Rovena Tacusic
Patients/People with Dementia and Their Families
Elizabeth Santos
Eva Fleischer
Donna & Tom Ambrogi

Pauline Mosher
Nina & Jim Galloway
M. O’Malley
Suzanne Reed
Evelyn Daniels Smith
Linda Stanley

IN CELEBRATION OF

Donna Calame
Dr. Darlene Yee-Melichar

A SPECIAL MEMORY

In memory of Ben Yerger and in honor of Charlene Harrington from the faculty of the UCSF John A. Hartford Center of Gerontological Nursing and Friends of Charlene:

Glenna Dowling
Heather Leutwyler
Lynda Mackin

Caroline Stephens
Laura Wagner
Margaret Wallhagen
Support CANHR...
If you appreciate our services and the information we bring to you, please help us by making a donation.
Make a secure donation online at www.canhr.org or fill out this section and return it with your donation to:

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

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

This gift is in memory of: __________________________________________
(or) in honor of: ________________________________________________

☐ Contact me about legislation and other advocacy opportunities.
☐ Save paper, send me The Advocate via e-mail. E-mail: ______________________

Name: _____________________________________________________________
Address: __________________________________________________________
City/State: __________________________ Zip: _________________________
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 insure 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

**Baywood Court Health Center**
21966 Dolores Street, Castro Valley

**A** $20000 Medication Neglect 1/17/2014

Four licensed nurses continued to give Coumadin every day for four days after a resident's lab results on 9/23/13 indicated she was at high risk for bleeding. On 9/27/13, the resident experienced black tarry stools that contained blood and vomited brownish liquid on multiple occasions. She was admitted to the local hospital's critical care unit for blood transfusions; her diagnoses included gastrointestinal bleeding and anemia. The resident died on 10/16/13 after being discharged to a different nursing home and readmission to the hospital. The facility was cited for failing to protect the resident from a significant medication error. Citation # 020010385.

### Butte County

**Country Crest Post Acute**
50 Concordia Lane, Oroville

**B** $2000 Patient Rights Physical Abuse Sexual Abuse Verbal Abuse 2/19/2014

The facility failed to protect two female residents from sexual and verbal abuse by a male resident who required continuous one to one visual checks as part of his care plan to prevent inappropriate behavior. The three residents were all housed in a specialized unit for patients with dementia. The male resident inappropriately touched and attempted sexual acts upon female residents in the Memory Unit on several occasions. On 5/10/12, the male resident was seen grabbing a female resident by her hair and forcing her head down to attempt forced oral sex. A CNA intervened and was able to separate the residents. The facility was cited because they only provided sporadic visual checks of the male resident instead of the continuous supervision he required. Citation # 230009327.

### Lassen County

**Country Villa Riverview Rehabilitation and Healthcare Center**
2005 River Street, Susanville

**A** $10000 Elopement Injury 2/13/2014

On 10/30/2012, a male resident with dementia walked out of the facility unnoticed. He was eventually found four miles away lying on a highway with facial lacerations and a compression fracture in her spine. The 100-pound resident was totally dependent on staff for dressing, bathing, and personal hygiene. A staff member witnessed the CNA grab the resident by the arm and push her, causing her to fall on the floor. The CNA then yelled obscenities at her, and after helping her back up into bed, threw her bedcover at her. The resident was witnessed crying after being assisted by other staff. Citation # 230010118.

**Olive Ridge Post Acute Care**
1000 Exec. Parkway, Oroville

**AA** $50000 Medication 3/5/2014

The facility failed to give a resident daily injections of an antibiotic ordered by her physician on 3/9/2012, leading to her death on 3/11/2012. The facility did not record the physician's faxed order or administer the antibiotic. The resident's infection became more serious, she developed septic shock and died due to urosepsis two days later. Her physician stated, "We might have been able to prevent it (urosepsis) if she had gotten the first shot." The facility was cited for failing to protect residents from serious medication errors. Citation # 230009465.

**Twin Oaks Post Acute Rehab**
1200 Springfield Dr, Chico

**B** $2000 Mental Abuse Verbal Abuse 3/28/2014

On 12/30/2012, the facility failed to protect a resident from verbal abuse from a staff member. On the last day of his employment, a CNA came into the resident's room, stood next to his bed, pointed his finger at him and called him a profane term. The resident later said in an interview that he was nearly asleep when the CNA walked in, and that he had rudely woken him up several times before. Citation # 230009692.

**Glenn County**

**Willows Care Center**
320 North Crawford St., Willows

**B** $2000 Patient Rights Physical Abuse Verbal Abuse 1/28/2014

The facility was cited after a CNA verbally and physically abused a 95 year old resident diagnosed with dementia and a compression fracture in her spine. The 100-pound resident was totally dependent on staff for dressing, bathing, and personal hygiene. A staff member witnessed the CNA grab the resident by the arm and push her, causing her to fall on the floor. The CNA then yelled obscenities at her, and after helping her back up into bed, threw her bedcover at her. The resident was witnessed crying after being assisted by other staff. Citation # 230010118.
ity faxed the lab report to the resident’s physician and documented “waiting for response.” On 1/30/13, four days after the specimen of a resident with dementia was submitted to a laboratory, the lab reported to the facility that the resident had C. diff, a highly contagious infection. On 1/28/13, the facility was cited for failing to provide adequate supervision and an environment free from accident hazards, and failing to have an effective alarm system that ensured alarms were regularly checked for proper functioning. Citation # 230010540.

Merced County
Hy-Lond Health Care Center-Merced
3170 M Street, Merced
B $1000 5/5/2014
CitationWatch description will be published once citation is received. Citation # 040010702.

Monterey County
Kindred Nursing and Transitional Care-Pacific Coast
720 East Romie Lane, Salinas
B $1400 Fall Injury Neglect Physical Restraints
Staff (Inservice) Training 4/30/2014
On March 18, 2014, a resident in a wheelchair was transported to a hospital via a facility van driven by a facility employee. While the driver was assisting the resident out of the van, the lift was in the down position and the driver failed to properly operate safety features on lift that caused the resident to fall to the ground. As a result the resident sustained a head injury on the back of the head. In an interview with the facility administrator he stated “If the lift gate was up, this would not have happened. It was caused by human error.” The facility was cited for failing to ensure the resident free from an avoidable accident. Citation # 070010621.

Nevada County
Crystal Ridge Care Center
396 Dorsey Drive, Grass Valley
A $10000 Patient Care 1/17/2014
On 2/7/12, a resident was discharged to her home where she died on 2/8/12 from congestive heart failure (CHF). The resident had been admitted into the facility on 1/22/12 following an acute care hospitalization for respiratory and CHF. Her care plan was to have her on medication that eliminates excess fluid buildup and she was to be assessed for fluid excess, shortness of breath, edema, and weight gain. The records showed that she had gained 15 pounds in three weeks. On the day she was discharged, the Social Service Director was told by a family member that the resident said that she was anxious, not feeling well, not breathing well, and should not be sent home. The records did not show any documentation that the facility Medical Director had been notified about her weight gain or her symptoms of worsening CHF. The facility was cited for failure to recognize the decline in the resident's clinical status. Citation # 070010621.

Sacramento County
Gramercy Court
2200 Gramercy Drive, Sacramento
B $2000 Fall Medication 11/19/2013
During the evening on 1/21/12, a resident fell twice from her wheelchair, with the second fall causing head and facial injuries that required treatment in the emergency room. In the days prior to the falls, the resident had experienced increased confusion. Although her doctor had ordered an antibiotic to treat a urinary tract infection, the facility did not notify the
doctor that the resident had been refusing her medications for several days prior to the fall. The facility was cited for failing to notify the doctor and for failing to ensure that her doctor's order for a wheelchair alarm was implemented. Citation # 030010254.

**Norwood Pines Alzheimers Center**
500 Jessie Avenue, Sacramento
A $5000 Patient Care 1/29/2014
Due to falls on 12/14/09 and 1/22/10, a resident of the facility fractured both of his hips, resulting in right hip replacement surgery after the first fall. He lost the ability to walk and reported he had sharp pain from the fractures. The resident had suffered 14 earlier falls in the facility between 8/12/09 and 12/15/09. The director of nurses acknowledged that the facility did not initiate new interventions to help prevent more falls after the earlier falls. The facility was cited for failing to provide adequate supervision to prevent the resident from falling. Citation # 030010372.

**Rosewood Post Acute Rehabilitation**
6041 Fair Oaks Blvd., Carmichael
AA $100000 Medication 11/13/2013
A female patient with amyotrophic lateral sclerosis requiring a ventilator to breathe was admitted to the facility on 12/15/06 for rehabilitation following femur fracture surgery. She was prescribed Warfarin, a blood thinning medication, and ordered to receive periodic blood tests to ensure her blood to clot ratio was therapeutic. On 12/18/06, the resident's applicable blood test was 2.09, within the reference range of 2-3. By 12/26/06, the measure had jumped to 5.48, which is a "high panic" result. There was no evidence the facility staff informed the resident's physician. On 1/1/07, the resident became non-responsive and was rushed to the hospital. Her blood test measure was over 13. She was diagnosed with bleeding in the brain and died that day. Facility records showed that the resident's Warfarin had not been given from 12/26 to 12/30 but no reason was given. Nurses interviewed shortly after the resident died stated they had given Warfarin to the resident in those days. The records may have been altered. The facility was cited for failing to develop a care plan, failing to notify the doctor of the dangerous blood levels, and maintaining records to professional standards. Citation # 030010256.

**Woodside Healthcare Center**
2240 Northrop Avenue, Sacramento
B $10000 Careplan Patient Records 12/03/2013
On 7/24/2010, the facility failed to assess and provide timely pain management for a resident, follow the resident's careplan as prescribed. The resident was a ventilator patient with amyotrophic lateral sclerosis requiring a ventilator to breathe and was admitted to the facility on 9/29/11. A female resident was admitted to the facility on 12/15/06 for rehabilitation following femur fracture surgery. She was prescribed Warfarin, a blood thinning medication, and ordered to receive periodic blood tests to ensure her blood to clot ratio was therapeutic. On 12/18/06, the resident's applicable blood test was 2.09, within the reference range of 2-3. By 12/26/06, the measure had jumped to 5.48, which is a "high panic" result. There was no evidence the facility staff informed the resident's physician. On 1/1/07, the resident became non-responsive and was rushed to the hospital. Her blood test measure was over 13. She was diagnosed with bleeding in the brain and died that day. Facility records showed that the resident's Warfarin had not been given from 12/26 to 12/30 but no reason was given. Nurses interviewed shortly after the resident died stated they had given Warfarin to the resident in those days. The records may have been altered. The facility was cited for failing to develop a care plan, failing to notify the doctor of the dangerous blood levels, and maintaining records to professional standards. Citation # 030010256.

**San Joaquin County**
**Windsor Elmhaven Care Center**
6940 Pacific Avenue, Stockton
A $20000 Patient Care 1/29/2014
A female patient with amyotrophic lateral sclerosis requiring a ventilator to breathe was admitted to the facility on 9/29/11. On 12/3/11, the resident was given a suction treatment. An hour later, the resident was discovered disconnected from the ventilator and not breathing and had no pulse. The ventilator disconnection alarm had not activated, probably because it had not been set. The resident was sent to the hospital where she died four days later after suffering seizures while in a comatose state. The facility was cited for failing to ensure the ventilator alarm was set and functioning. Citation # 030010401.

**Shasta County**
**Golden Living Center - Redding**
1836 Gold Street, Redding
B $2000 Fall 1/27/2014
On the morning of 11/9/11, a resident got up from her bed to go to the bathroom. She slipped on a puddle that was on the floor and fell, sustaining a large bruise on her abdomen, left hand, lower left arm, and a broken left wrist. The resident had a history of falls, bladder incontinence, and was assessed as requiring staff assistance for transfers and toilet needs. The facility was cited for failing to develop a care plan for the resident that addressed her conditions. Citation # 230009272.

**Mayers Memorial Hospital D/P SNF**
43563 Hwy 299 E, P.O. Box 459, Fall River Mills
B $2000 Physical Abuse 3/5/2014
On 11/12/13, a CNA witnessed another CNA place his hands on a resident's chest and forcefully push the resident down onto his bed. The facility was cited for failure to ensure the resident was free from physical abuse. Citation # 230010288.

**Sutter County**
**Yuba Skilled Nursing Center**
521 Lorel Way, Yuba City
B $2000 Careplan Infection Patient Care 1/24/2014
On 11/29/11, a male resident was admitted to the facility following surgical repair of a fractured left leg. The physician's orders were to monitor and clean the incision site. By 1/5/12, the resident's left leg surgery incision had become infected. The facility failed to provide wound assessment and treatment from December 2011 to March 2012 as ordered by a physician and indicated in the care plan. Citation # 230009466.

**Trinity County**
**Trinity Hospital D/P SNF**
60 Easter Avenue, Weaverville
B $2000 Dignity Verbal Abuse 2/20/2014
On 10/7/13, when changing a resident's brief, a CNA told two CNA students who were also in the room that the resident had sexually relieved himself (the CNA used crude terminology) the day before. While the CNA was face to face with the resident, she admonished, "It was f**king disgusting!" The student recounting the event stated, "My heart hurt" because what the CNA said to the resident was humiliating and she was embarrassed for him. The facility was cited for failure to protect the resident from verbal abuse. Citation # 230010245.
notify him of the results as soon as they arrived. The facility's physician ordered the tests on 4/17/13 and directed the facility to report critical laboratory results to his physician. The physician's critical laboratory results were received, to advise them and other nurses at the facility on 4/18/13, before the resident had been notified. During the investigation, the resident's physician reported he had a meeting with the DON and other nurses at the facility on 4/18/13, before the resident's critical laboratory results were received, to advise them to call him for all laboratory results because he had been having problems getting notified. The physician stated, “I told them you guys are going to kill somebody.” After the warning from the resident's physician, the facility staff did not change their practice. Citation # 120010453.

Golden Living Center - Bakersfield
3601 San Dimas St., Bakersfield
B $2000 Injury Mandated Reporting 2/25/2014
On 12/4/13, the facility discovered a resident had suffered a large bruise to her left arm and her whole arm was filled with fluid. The resident was hospitalized the next day when an X-ray showed there was a fracture. The facility reported the injury on 12/9/13 to the Department of Public Health. The facility was cited because it did not report an injury of unknown source to the Department of Public Health within 24 hours. Citation # 120010491.

Kern County
Bakersfield Healthcare Center
730 34th Street, Bakersfield
A $20000 Hydration 3/24/2014
A male resident with paraplegia was to be carefully monitored for fluid intake and output, especially due to his urinary catheter. The facility's records were missing important fluid intake and output forms and had documentation of inadequate fluid intake. On 2/3/13, the resident was hospitalized due to dehydration. The resident died two weeks later on 2/17/13. Citation # 120010546.

Corinthian Gardens Health Care Center
1611 Height Street, Bakersfield
A $10000 4/1/2014
CitationWatch description will be published once citation is received. Citation # 120010559.

Evergreen Arvin Healthcare
323 Campus Drive, Arvin
A $20000 Injury Sexual Abuse 3/12/2014
On 5/21/13, a resident's family member reported that the resident had been sexually abused by a CNA. The facility administrator claimed he had notified the Department that day but the Department disputed the claim. The facility policies required notification to law enforcement and suspension of the employee pending an investigation but that was not done. On 5/26/13, a different resident suffered a deep vaginal tear that required surgery. The facility was cited for failing to protect its residents from sexual assault. The administrator's inaction had allowed the abusive CNA to continue working with residents at great risk of sexual assault. Citation # 120010512.

Glenwood Gardens SNF
350 Calloway Drive, Bakersfield
A $20000 Medication Neglect Notification 2/19/2014
On 4/19/13, a 75 year old resident died after the facility failed to report critical laboratory results to his physician. The physician ordered the tests on 4/17/13 and directed the facility to notify him of the results as soon as they arrived. The facility received the results the next day, which showed critical problems requiring immediate attention, but did not review them or notify the physician. On 4/19/13, the resident was found unresponsive and was transferred to the hospital where he was diagnosed with septic shock, renal insufficiency and anemia. He died within a few hours. After he died, his physician wanted to see the facility and found the critical laboratory results that had not been relayed to him. During the investigation, the resident's physician reported he had a meeting with the DON and other nurses at the facility on 4/18/13, before the resident's critical laboratory results were received, to advise them to call him for all laboratory results because he had been having problems getting notified. The physician stated, “I told them you guys are going to kill somebody.” After the warning from the resident's physician, the facility staff did not change their practice. Citation # 120010453.

Kern Valley Healthcare District D/P SNF
6412 Laurel Ave., Lake Isabella
B $2000 Fiduciary 3/26/2014
On 8/16/12, a family was reviewing the file of the family's resident, an 85 year old female with Alzheimer's, and discovered a notarized document from April of 2012 where the resident's responsible party was confessing to financially abusing the resident. The statement read in part, “To whom it may concern, I acknowledge I had complete control of all assets and properties ... as well as ... bank account... I acknowledge there may have been mismanagement of that bank account and properties while in my control ...” The facility was cited for failure to report an allegation of financial abuse to the Department within 24 hours. Citation # 120010562.

Parkview Healthcare Center
329 North Real Road, Bakersfield
A $5000 Injury Patient Care 2/11/2014
On 3/18/11, a female resident received a third degree burn when an OT applied moist heat to her right shoulder. On 4/5/11 a note indicated the burn on her shoulder was worse
and had very thick necrosis (death of tissue) and would require surgery. The facility failed to take appropriate precautions to prevent injury to her shoulder when moist heat therapy was applied, which resulted in a third-degree burn to her shoulder. Citation # 120010167.

A $10000 Fall Injury Patient Care Supervision 3/26/2014
On 9/24/12, a 91 year old resident at risk for falls was found lying on her bathroom floor. She was sent to the emergency room where an X-Ray showed a fractured left hip. She underwent a left hip replacement surgery the following day. A review of the resident's care plan showed a total of five falls between 8/15/2012, and 9/24/12. During an interview with the DON, she stated the nursing assistant could not remember if she had turned on the pad alarm on the resident's wheelchair or the pad alarm on the bed to notify staff in the event the resident attempted to ambulate without assistance. The facility was cited for not implementing the resident care plan. These failures caused resident to fall repeatedly and sustained a hip fracture. Citation # 120010482.

Parkview Julian Convalescent
1801 Julian Avenue, Bakersfield

B $2000 Mandated Reporting 2/11/2014
On 5/13/12, A 79 year old male resident with Alzheimer's disease was seen arguing and throwing water on another resident. The facility failed to report an allegation of abuse to the California Department of Public Health within 24 hours of the abusive altercation. The nurse who broke up the residents indicated she called the Administrator within 30 minutes of the incident occurring. The facility policy and procedure states all cases of alleged or suspected resident abuse shall be investigated and reported. Citation # 120010422.

Ridgecrest Healthcare Center
1131 North China Lake Blvd., Ridgecrest

A $20000 5/6/2014
CitationWatch description will be published once citation is received. Citation # 120010681.
A $10000 5/6/2014
CitationWatch description will be published once citation is received. Citation # 120010662.
B $20000 5/6/2014
CitationWatch description will be published once citation is received. Citation # 120010682.

Ridgecrest Regional Transitional Care and Rehabilitation Unit
1081 N China Lake Blvd, Ridgecrest

A $20000 Patient Care 12/10/2014
The facility was cited for failure to provide skin assessments, nutrition and assisted devices necessary to prevent deep tissue injuries to a resident's tailbone, heel and calf, resulting in actual physical harm to the resident. A bedridden resident diagnosed with end-stage dementia was admitted to the facility for a short term "respite" stay with clear skin and no pressure sores. After 5 days in the facility the resident returned home with two black bedsores and one pressure sore. The facility did not provide resident with a specialized mattress to reduce pressure sores because they stated it needed to be supplied by the Hospice agency, although records indicated that four such mattresses were available in the facility during the resident's stay. Facility staff told the resident's visiting Home Hospice Nurse that the resident could not swallow, although prior to her admission the resident was capable of eating by spoon and straw. The resident died within 45 days after leaving the facility. Citation # 120010430.

The Rehabilitation Center Of Bakersfield
2211 Mount Vernon Avenue, Bakersfield

B $2000 Careplan Notification Patient Care Verbal Abuse 2/12/2014
A facility was cited for failure to report an incident of alleged abuse within the 24 hour period as required by law. A 72 year old resident reported to staff that a CNA did not provide her with assistance to the bathroom as required by her care plan when requested, and also reported that the staff member yelled at her. The facility reported the incident after the 24 hour required reporting period lapsed. Citation # 120010407.

A $10000 Dignity Sexual Abuse 2/26/2014
On 5/17/13, a CNA witnessed a resident sexually assault another resident. The resident was known to exhibit sexually inappropriate behavior but no care plan was developed to address the issue. The facility was cited for failure to protect the resident from sexual abuse and failure to develop a care plan to prevent incidents of abuse. Citation # 120010486.

Los Angeles County

Ararat Nursing Facility
15099 Mission Hills Road, Mission Hills

B $1000 Physical Abuse 2/13/2014
On 10/30/12, a CNA came into a resident's room and woke her up, telling her to open her legs so she could put on two disposable diapers. The resident protested that she didn't want two diapers because having two hurts her. The CNA told the resident to be quiet, then slapped her face. During the Department's investigation noted that prior to this incident that same CNA had been reprimanded for being rude and rough with an another resident. The facility was cited for failing to ensure that a resident was free from physical abuse. Citation # 920010473.

Bonnie Brae Convalescent Hospital
420 Bonnie Brae, Los Angeles

A $20000 Fall Injury Supervision 1/14/2014
On 12/1/11, a resident at risk for falls and wandering exited the facility unsupervised and wandered into an unsafe storage area. He was found on the ground at 5:20am with swelling to his right eye and multiple contusions and abrasions. The resident was transferred to the Acute Care Hospital where the report stated, "it looked as though the resident had been dragged across the floor." The facility was cited for failure to provide adequate supervision. Citation # 910010325.

Country Villa Broadway Healthcare Center
112 E. Broadway, San Gabriel

A $20000 Notification Patient Care 12/10/2013
According to a complaint on 2/12/12, a resident was having phlegm and a cough that required suctioning. A family member made several requests for the resident to be suctioned and the physician to be notified. Facility policy indicated that the physician be notified of a change in condition. The resident had been complaining of headache and dizziness. Facility staff failed to suction the resident and the physician was never contacted. Six hours later the resident was found unresponsive and expired shortly thereafter. The facility was cited for failure to notify the physician of a change of condition and failure to provide suctioning. Citation # 950010234.

Canyon Oaks Nursing and Rehabilitation Center
22029 Saticoy St., Canoga Park

A $17500 Careplan Injury Physical Environment Supervision 02/11/2014
On 11/18/12, a 90 year old female resident was preparing for a shower with the assistance of a CNA. When the CNA was
removing the bed sheets she turned her back to the resident and the resident fell from her bed on to the floor and sustained a broken neck and back. The facility was cited for failing to maintain a hazard free environment, by supervising the resident during morning care, maintaining side rails in the upright position, and maintaining the floor mats and bed in lowest position as stipulated in the care plan. Citation # 920010415.

Chatsworth Park Care Center
10610 Owensmouth Ave., Chatsworth
B $1500 Careplan 01/29/2014
On 9/13/2011, the facility failed to honor a resident’s wishes by not notifying paramedics about his physician ordered “do not attempt resuscitation” status. When the resident experienced shortness of breath, he received an unnecessary insertion of a breathing tube, mechanical ventilation and extubation. Due to the resident’s fragile skin, the intubation caused bruising and bleeding in his arms, mouth and throat. Citation # 920010440.

Country Villa South Convalescent Center
3515 Overland Ave., Los Angeles
B $2000 Careplan Hydration Supervision 2/6/2014
On 2/5/2013, the facility failed to ensure a resident with a history of dehydration, and an order to not receive anything by mouth, was monitored for signs of dehydration as ordered by her careplan. The facility also failed to provide other means of hydration when the nasogastric tube was changed and awaited X-ray confirmation of proper placement. As a result, the resident was admitted to the general acute care hospital and diagnosed with dehydration. Citation # 910010440.

Culver West Convalescent Hospital
4035 Grandview Blvd., Los Angeles
B $2000 Fiduciary 2/20/2014
On 7/3/12, an investigation was initiated on a complaint of financial abuse of a former resident. It was alleged that money was withdrawn from the resident’s bank account during his stay at the facility. Several checks were made payable to the facility’s social service designee (SSD). The investigation found five checks totally an amount of $4,100 were made payable to, and cashed by the SSD. The facility was cited for failing to ensure that the resident was free from misappropriation of his property. Citation # 910010487.

Emerald Terrace Convalescent Hospital
1154 S. Alvarado St., Los Angeles
A $15000 Patient Care 2/6/2014
On 8/30/2011, the facility failed to respond in a timely manner when a resident was found pale with shallow breathing, low blood oxygen saturation, slow heart rate and low blood pressure. The staff nurses waited 15 minutes before calling 911 and did not administer enough oxygen for the resident’s blood oxygen saturation to prevent respiratory distress. The resident was pronounced dead 20 minutes after 911 was called. Citation # 910010414.

Garbera Convalescent Center
14819 S Vermont, Gardena
A $20000 Fall Injury Supervision 11/26/2013
On 4/8/13, a resident at risk for falls and wandering was found on the ground outside the facility with a right arm fracture. The facility was cited for failure to develop a plan of care to prevent wandering. Citation # 910010261.
B $20000 Fall Mandated Reporting 11/26/2013
On April 1, 2013, facility front office staff heard a loud bang and found a 91 year old resident with dementia lying at the bottom of a ramp outside of the building. The resident was transferred to the emergency room and found to have a broken arm. The facility did not report the fall to the Department, and was cited for failing to report an unusual occurrence to the Department within 24 hours that resulted in the resident’s unwitnessed fall and injury. Citation # 910010259.
voluntary movement to her legs and feet was being wheeled into the facility by the van driver. Her feet had not been properly positioned on the wheelchair footrests, and as a result, her left foot slid off of the footrest, went under the wheelchair, and dragged on the ground. This caused abrasions and bleeding to her left 3rd, 4th, and 5th toes. The facility was cited for failing to properly position the resident’s foot on the wheelchair footrest before wheeling the resident into the facility. Citation # 910010499.

Lakeview Terrace Special Care Center
9601 Foothill Blvd, Lakeview Terrace

B $2000 Careplan Deterioration Medication Patient Care 2/27/2014
On 10/23/2013, the facility failed to ensure that a resident received pain medication one hour before treatment for pressure ulcers as ordered by the physician. The facility also failed to assess and monitor the effectiveness of the pain medication before and during the pressure ulcer treatment. As a result, the resident expressed pain and fear during the treatment, but the LVN did not stop to assess the need to relieve the resident’s pain. Citation # 910010467.

B $2000 Careplan Security Supervision 10/17/2013
The facility failed to prevent a resident from leaving the locked perimeter four times without permission between 5/16/2011 and 9/17/2011, twice while under one to one (1:1) monitoring, and failed to follow the resident’s careplan for 1:1 monitoring. The resident had been assigned 1:1 monitoring after the first incident, but the Interdisciplinary Team (IDT) later recommended reducing the resident’s 24-hour 1:1 monitoring to 3 pm to 7 am, with only hourly checks from 7 am to 3 pm. While the resident was under 24-hour supervision after the second incident, he managed to leave the facility unsupervised because his assigned monitor wanted to give him a moment of privacy in his room. Citation # 920009102.

Leisure Glen Post Acute Care Center
330 Mission Rd, Glendale

A $15000 Hydration Infection Patient Care 02/10/2014
On 2/27/2014, a resident was admitted to the Acute Care Hospital from the facility with urinary tract infection (UTI) that progressed to a systemic infection or, urosepsis. The resident was diagnosed with altered mental status, UTI, dehydration and urosepsis. The facility was cited for failure to provide adequate fluids, monitor the resident’s hydration status and provide care to prevent UTI. Citation # 920010260.

Maple Healthcare Center
2625 S. Maple Avenue, Los Angeles

On 10/16/13, a resident was transferred to the acute care hospital for psychiatric evaluation and treatment. When the resident was returned by ambulance the facility refused readmittance. The facility was cited for failure to provide written information to the resident regarding a bed hold which allows the resident to return to the facility. Citation # 920010260.

Oakpark Healthcare Center
9166 Tujunga Canyon, Tujunga

B $2000 Administration Physical Environment 02/12/2014
Upon investigation on 1/24/2014, the facility was found to have failed to obtain required approval from the Office of Statewide Health Planning and Development (OSHPD) to perform construction on the building. Without the required permits, several rooms were under renovation and recessed lighting fixtures were being installed. A review from the OSHPD reported the construction had also prevented use of the main entrance and lobby, created several fire hazards, and decreased an exit corridor below its required minimal width. Citation # 920010469.

Pasadena Meadows Nursing Center
1361 Bellefontaine, Pasadena

B $1000 Administration 2/20/2014
On 9/24/2013, a Centers for Medicare and Medicaid Services evaluator observed that the facility did not have the current overall facility rating information posted in the facility. During an interview with the facility administrator on 9/30/14, he stated, “it was an oversight that the information was not posted.” The facility was cited for failing to comply and post the most current overall facility rating information determined by the Centers for Medicare and Medicaid Services. Citation # 950010488.

Sierra View Care Center
14318 Ohio Street, Baldwin Park

A $20000 Fall Injury 3/13/2014
On 11/15/10, a resident at risk for falls and unable to maintain balance while standing unassisted, fell during a transfer from a shower chair back to bed. An employee left the resident standing alone on a wet shower blanket when the resident fell sustaining a fracture to her hip that required surgery. The facility was cited for failure to implement safety precautions and facility policy for resident safety. Citation # 950010484.

St. John Of God Retirement And Care Center
2468 S. St. Andrews Place, Los Angeles

A $20000 Medication 11/07/2013
A 99 year old female resident was given Glipizide, a medication to lower blood sugar levels for diabetics, by mistake and became non-responsive. She was transported to the hospital on 8/30/2012 with dangerously low blood sugar levels. She stayed in the hospital for five days. The facility was cited for failing to ensure the resident was free from medications that were not ordered by a physician. Citation # 910010242.

Torrance Care Center East - CLOSED
4315 Torrance Blvd., Torrance

On 11/20/13, a 51 year-old resident was being transferred back to the facility after being sent to a general hospital after attacking a facility staff person. When his transport van arrived at the facility he was taken out and placed into another van, then sent to another facility. This happened without the resident or any of his family members being notified in advance and without sufficient preparation being made before he was transferred to another facility. The citation was for failure to provide a written notice and for insufficient preparation before transferring the resident to the second facility. Citation # 910010666.

Torrance Care Center West, Inc.
4333 Torrance Blvd., Torrance

A $20000 Patient Care Physical Abuse Verbal Abuse 2/7/2014
On 10/28/10, a male resident was discovered to have bruises all over his body. The family of the resident placed a hidden camera in his room. The CNA was seen hitting and slapping the resident. The family took the video straight to the police. The facility failed to ensure the resident was free from abuse by allowing the CNA to continue to provide care to the resident after being suspended in 2006 for verbally abusing the same resident. This failure resulted in the resident being verbally and physically abused and required a transfer to a general acute care hospital for a physical abuse evaluation. The CNA was arrested for physically abusing the resident. Citation # 910010439.
View Park Convalescent Center
3737 Don Felipe Dr, Los Angeles
B $2000 Patient Rights Privacy 3/22/2014
A male resident who was newly admitted to the facility was confronted by another resident about his personal health history. Apparently on 1/7/14 a CNA had told the other resident about his personal health history. This made her not want to be friends with him. The facility failed to ensure the CNA did not disclose the resident's private health history to another resident. This resulted in the resident feeling violated, angry, humiliated, frustrated and embarrassed. This caused the resident to isolate himself. Citation # 910010563.

Merced County
Hy-Lond Health Care Center-Merced
3170 M Street, Merced
B $1000 5/5/2014
CitationWatch description will be published once citation is received. Citation # 040010702.

Orange County
Fairview Developmental Center D/P SNF
2501 Harbor Blvd., Costa Mesa
B $2000 Careplan Fall 4/7/2014
On 8/16/2013, while being transported from his room to the bathroom by a staff member using a mechanized lift with a sling, a resident fell from the lift, hitting his head on the lift's metal chassis. The resident sustained a small cut on his forehead, bruising on his shoulder, and redness on his collarbone and neck. The lift was only designed for transfers between a bed and wheelchair, not for translocation. The resident's careplan required a two-person assist for transfers, but the staff member stated he was unsure whether he should have had another staff member assisting him with the lift. According to facility policy, the resident should have been transferred by wheelchair rather than the lift. Citation # 170010359.

Riverside County
Alta Vista Healthcare & Wellness Centre
9020 Garfield Ave., Riverside
B $750 Mandated Reporting Sexual Abuse 1/30/2014
On August 6, 2010, several facility staff members saw a resident touch two other residents in their crotch areas on separate occasions. Staff reported the inappropriate touching to the facility's Abuse Coordinator, Administrator and Director of Nursing, and the Administrator reported the incidents to the Department on August 13, 2010. The facility was cited for failing to report the incidents to the Department within 24 hours, and failing to protect the residents from the reported inappropriate touching. Citation # 170010391.

Arlington Gardens Care Center
3688 Nye Ave, Riverside
B $1000 Careplan Fall Injury 4/10/2014
On 4/25/2011, an 89 year old resident suffered neck fractures when he fell after getting up from bed. The resident had sought help from his CNA, but she told him to wait. He then got up by himself, fell, and was found with blood all over his face. A bed alarm used to alert staff he was getting out of bed did not sound. When asked about getting out of bed, the resident stated, "There is nobody here at night." The fractures made the resident more dependent and increased his pain and weakness. The facility was cited because it failed to help the resident get out of bed as called for in his care plan. Citation # 250010606.

Beaumont Care Center
1441 North Michigan Avenue, Beaumont
B $1000 Injury Physical Abuse 1/24/2014
An 86 year old female resident with dementia was hit on the head on 5/15/2011 by another resident who accused her of stealing her belongings. The resident had to be transferred to the hospital two days later when she developed bruising, swelling, headaches, and vomited. She was diagnosed with a skull fracture. The abusive resident had a history of being aggressive with other residents. The facility was cited for failing to protect the victimized resident. Citation # 250010394.

B $1000 Injury Mandated Reporting Physical Abuse 1/30/2014
On 5/15/2011, a resident struck another resident with an unknown object. The injured resident was transferred to the Acute Care Hospital with a skull fracture. The facility stated that their investigation of the incident was not completed in time to report to the Department. The facility was cited for failure to report the allegation of abuse within 24 hours as required. Citation # 250010410.

California Nursing & Rehabilitation Center
2299 North Indian Canyon Drive, Palm Springs
B $2000 Fiduciary Theft & Loss 3/6/2014
The facility failed to protect a resident's rights when a CNA stole the resident's checkbook and debit card and wrote several checks without the resident's permission. The fraudulent transactions between 4/26/2012 and 7/12/2013 totaled $14,919.58. The CNA was reported by facility staff on 7/19/2013 and arrested the same day. Citation # 250010518.

Desert Regional Medical Center D/P Snf
1150 N. Indian Canyon Drive, Palm Springs
A $17000 Careplan Fall 2/13/2014
On June 14, 2011, an 83 year old resident admitted for rehabilitation following a total right hip replacement fell and broke her right femur requiring a second surgery four days after her admission. Prior to the fall, the facility gave the resident a narcotic pain medication and sleeping medication at the same time, did not perform a comprehensive pain assessment before and after giving her the medication, and failed to ensure that her bed alarm was activated. The facility also failed to promptly notify the resident's physician about the fall, and did not perform a post fall assessment. The facility was cited for failing to ensure the resident's care needs were identified and assessed with appropriate interventions. Citation # 250010458.

Emeritus At Rancho Mirage
72-201 Country Club Drive, Rancho Mirage
A $10000 Careplan Fall Security Supervision 4/10/2014
The facility failed to develop a careplan that ordered consistent supervision of a resident, despite his history of falls and attempts to leave the facility unattended. On 9/26/2010, the resident wandered into the facility parking lot, fell from his wheelchair and hit his head on the driveway, causing three brain hemorrhages. The resident was admitted to a nearby hospital for his injuries where he remained until his death. Citation # 250010604.

Extended Care Hospital of Riverside
8171 Magnolia Street, Riverside
B $1000 Sexual Abuse 2/27/2014
On 8/18/10, a CNA observed an 87 year-old male resident sexually molesting a blind 32 year-old female resident in her room. The male resident had a history of inappropriate sexual advances towards other patients and suffered from organic...
On 8/20/13, a CNA observed another CNA having a problem
B   $1000   Physical Abuse   3/6/2014
2990 East Ramon Road, Palm Springs
Premier Care Center For Palm Springs

On 11/10/2010, 32 year old female resident with quadriplegia
complained of being cold so a CNA warmed a blanket in
a microwave and placed it over the resident's shoulders. A
few minutes later, staff smelled smoke and found the blanket
smoldering on the resident, burning her chest. The blanket
had 16 holes with burnt edges. The facility was cited for failing
to protect the resident from abuse. Citation # 250010457.

Lifehouse of Riverside Healthcare Center
8781 Lakeview Avenue, Riverside
B   $2000   Injury   Physical Abuse   1/23/2014
On 9/24/13, a female resident complained that a CNA had
hurt her and later showed bruising on her arm. The facility
failed to ensure the resident was treated with dignity and respect,
and free from physical abuse while getting assistance from the staff. Citation # 250010389.

Magnolia Rehabilitation & Nursing Center
8133 Magnolia Avenue, Riverside
A   $10000   Patient Care   4/10/2014
The facility failed to use equipment safely in order to prevent
the injury of a resident, resulting in the resident's death. The resident
had a history of falls from his bed, so his physician ordered guard rails and a soft roll waist restraint to prevent further falls. The unsupervised resident fell out of bed on 5/28/2010 while in the restraint and (possibly) strangled to death. Upon issue of the citation, autopsy results were inconclusive, but doctors noted symptoms of asphyxia. The staff also did not follow the facility's policy of checking the resident's restraint every two hours. Citation # 250010605.

Manorcare Health Services-Hemet
1717 West Stetson Avenue, Hemet
B   $2000   Mandated Reporting   Mental Abuse
CitationWatch description will be published once citation is received. Citation # 250010574.

B   $1000 Medication   3/27/2014
On 08/23/2010 at 3:00pm the RN mistook a 94 year old female resident with diabetes for another resident and administered the wrong morning medications which included insulin. At 5:30pm the resident had low blood sugar and was sent to the acute hospital for 5 days, 3 of which were spent in the ICU. Citation # 250010576.

Orange Tree Nursing Center
4000 Harrison Street, Riverside
B   $2000   Deterioration   Dietary Services   3/14/2014
The facility failed to identify a resident's poor eating habits, which led to continued weight loss and a decline in nutritional status. A quarterly health assessment on 6/14/2012 indicated the resident needed "Supervision-oversight, encouragement or cueing" while eating. However, the facility staff failed to properly follow this order, and the resident lost 28 pounds in seven months. The resident had to be transferred to a hospital for severe weight loss and was also diagnosed with dysphagia (difficulty swallowing). Citation # 250010528.

Premier Care Center For Palm Springs
2990 East Ramon Road, Palm Springs
B   $1000   Physical Abuse   3/6/2014
On 8/20/13, a CNA observed another CNA having a problem with a mentally incapacitated resident while the CNA was changing his brief. The resident was being uncooperative and said, in Tagalog, that the CNA's mother was a whore. The CNA slapped the resident's hand and used Tagalog curse words while putting her fingers on the resident's mouth. The facility was cited for failure to ensure that the resident was free from verbal and physical abuse. Citation # 250010514.

Ramona Manor Convalescent Hospital
485 W. Johnston Ave., Hemet
A   $10000   Patient Care   2/21/2014
On 7/17/2010, the facility failed to safely transfer a resident from a gurney to her bed. The resident was not transferred with her Hoyer lift, which is required by policy, but was instead transferred by a sling lift with the assistance of two CNAs and two paramedics. Her foot was caught between the mattress and the frame of the gurney during the transfer and she sustained a hip fracture. She was admitted to the hospital for hip surgery. Citation # 250010470.

San Jacinto Healthcare
275 North San Jacinto St., Hemet
A   $10000   Injury   Patient Care   2/20/2014
On 3/23/2013, a resident diagnosed with dementia and psychosis was allegedly raped in her bathroom by a CNA. According to the DON, she stated that the police were called but no police report was generated, as the resident is known to fabricate stories. An RN was assigned to investigate the incident, but failed to substantiate any abuse and failed to report the incident to the department. The facility was cited for failing to report to the alleged rape to the Department. Citation # 250010547.

The Bradley Gardens
980 West Seventh Street, San Jacinto
B   $2000   Sexual Abuse   3/18/2014
On 3/24/2012, a LVN wrote a progress note for a resident, indicating he had struck another resident twice in the back of the head. In response, the other resident turned around and struck the first resident in the forehead, leaving a six inch scratch. The same form indicated The Department of Public Health (DPH) was notified on 3/27/2012. The facility failed to report an allegation of resident to resident abuse to the DPH within 24 hours, which is required by the facility's policy. Citation # 250010560.

Vista Pacifica Center
3674 Pacific Avenue, Riverside
B   $1000   Mandated Reporting   3/20/2014
On 3/24/2012, a LVN wrote a progress note for a resident, indicating he had struck another resident twice in the back of the head. In response, the other resident turned around and struck the first resident in the forehead, leaving a six inch scratch. The same form indicated The Department of Public Health (DPH) was notified on 3/27/2012. The facility failed to report an allegation of resident to resident abuse to the DPH within 24 hours, which is required by the facility's policy. Citation # 250010560.

Vista Pacifica Convalescent Hospital
3662 Pacific Avenue, Riverside
B   $1000   Mandated Reporting   Mental Abuse
2/28/2014
In September 2011, a CNA overheard another CNA say to a resident with Alzheimer's disease: "You f...ing crazy old man. I'm going to take you back to your room and tell your roommate to abuse you sexually. "The CNA then heard the resident tell another CNA that he did not want to go to bed because he did not want his roommate to rape him. The CNA did not report the verbal abuse and threat to the Charge Nurse for over one week, and the Charge Nurse did not report the incident to the Director of Nursing until the following day. The facility was cited for failing to report the allega-
A facility was cited when a staff member verbally abused an elderly male resident diagnosed with Alzheimer's disease and psychosis. Several staff members witnessed a CNA verbally abuse the resident on multiple occasions, telling him, "You f...ing crazy old man. I'm going to take you back to your room and tell your roommate to abuse you sexually." On another occasion a staff overheard the CNA threatening that a second resident would "rape" him if he did not stay in bed. The facility was also cited for failure to report the abuse within the required time frame of 24 hours. Citation # 250010506.

**San Bernardino County**

**Shandin Hills Behavior Therapy Center**

**4164 North 4th Avenue, San Bernardino**

**A $18000 Elopement Injury Supervision 2/5/2014**

On 10/9/11, a resident left the facility unsupervised, climbed to the roof of a maintenance shed and then fell approximately 12 feet to the ground. The resident sustained pelvic and right femur fractures requiring surgery. The facility was cited for failure to provide a safe environment and supervision. Citation # 240010442.

**San Diego County**

**Escondido Post Acute Rehab**

421 E. Mission Ave., Escondido

**A $20000 Neglect Patient Care 2/13/2014**

A male resident broke his hip and was transported to the hospital for surgery on 8/22/13. On 9/3/13, the resident's physician ordered the post-surgical staples removed but the facility nurse interpreted the order as the staples had already been removed. The nurse did not assess the surgical site as she should have done regardless. Though subsequent nursing notes indicated there was no infection at the site, the nurses never actually looked at it. Weekly skin assessments were completed without looking at the resident's skin. The 31 staples were not discovered until 11/26/13 at which point the wound had split open and was badly infected requiring a second surgery. The facility was cited for failing to monitor the resident's wound. Citation # 080010451.

**B $2000 Physical Abuse 5/1/2014**

In March 2014, a 62 year old resident reported that CNA 1 hit her several times with an open hand. The facility failed to investigate and assess the resident after she made the report. An 84 year old resident reported that CNA 2 damaged and twisted a towel in the shower room, and hit him across his eyes and almost blinded him. The facility failed to conduct a thorough investigation, and failed to suspend CNA 2 pending the investigation allowing the alleged abuser to continue providing care for nine residents. The facility was cited for failing to follow its policies and procedures for investigating, assessing, and protecting residents from abuse. Citation # 080010694.

**B $1200 Mandated Reporting 5/01/2014**

On 12/7/13, a resident reported that someone bit her and put a blanket over her head. The facility Social Worker stated that she discussed the incident with the Administrator who was the Abuse Coordinator, and was told that she did not need to report the allegation to the Department. Facility staff did not report the incident to the Department until 12/9/13. The facility was cited for failing to report an allegation of abuse to the Department within 24 hours. Citation # 080010680.

**Santa Barbara County**

**Santa Maria Care Center**

820 W Cook Street, Santa Maria

**A $4000 2/20/2014**

CitationWatch description will be published once citation is received. Citation # 050010171.

**Tulare County**

**Porterville Developmental Center D/P SNF**

26501 Avenue 140, Porterville

**WMF $2500 Administration Medication Patient Records 4/2/2014**

In February 2012, a resident did not receive 13 doses of a medication ordered to treat nausea and vomiting after the drug was inadvertently discontinued. When the error was discovered, a nurse back-dated the order. Three staff then charted that all of the doses ordered had been given at the correct times, even though the staff had been off duty during some of those dosage times. The facility was cited for willful falsification of the resident's medical records. Citation # 170009453.

**Sierra Valley Rehabilitation Center**

301 West Putnam, Porterville

**B $2000 Patient Care 3/20/2014**

On 4/18/2012 a male resident's hair was lit on fire by another resident who lit his cigarette for him. The injury left the resident's left side of his face with a blister and singed hair. During an observation interview with the resident on 9/25/2012 a lighter was found by his table side. The clinical record did not include a care plan for smoking, a smoking assessment, or a smoking indication on his chart. The facility failed to implement their smoking policies and procedures by failing to, secure smoking supplies properly, assess residents to determine the required level of supervision during smoking and post the smoking designation of the resident on the front cover of medical chart. Citation # 120010542.

**Tulare Nursing & Rehabilitation Center**

680 East Merritt Avenue, Tulare

**B $2000 Other Security 2/26/2014**

On 5/9/2013, during a survey at the facility an unreported allegation of abuse was discovered. The administrator of the facility showed the surveyor evidence of past allegations of abuse by the resident's daughter and stated, "We didn't report to the Department because the family was outside the facility". A Social Service Director became aware of the allegations on 1/22/2013 when the resident's family member failed to meet deadlines on seriously delinquent share of cost payments. The facility was cited for failing to report an allegation of abuse of a resident with 24 hours. Citation # 120010479.

**Twin Oaks Rehabilitation & Nursing Center**

897 North M Street, Tulare

**B $2000 Verbal Abuse 3/6/2014**

On 7/2/2012, a CNA was verbally abusive while cleaning a resident after she soiled herself. A facility investigator investigated the incident and post the smoking designation of the resident on the front cover of medical chart. Citation # 120010542.

**Westgate Gardens Care Center**

4525 W. Tulare Avenue, Visalia

**A $5000 4/8/2014**

CitationWatch description will be published once citation is received. Citation # 120010455.