Real RCFE Reform or Window Dressing?

As we go to press, some of the bills in the RCFE Reform Act of 2014 are dead, a couple were signed by the Governor and will become law, and some are still up in the air or, more accurately, on the Governor’s desk. Who knows whether the Governor will sign them? The Governor has given no inclination that he is even aware that there are major problems in California’s assisted living/RCFE facilities. The paltry $7 million+ allocated to the Department of Social Services’ Community Care Licensing in this year’s budget is a mere drop in the bucket given the massive budget cuts to DSS over the last decade and the resulting abuse and neglect of residents and the systemic problems faced by Community Care Licensing. If the Governor really cared about reforming RCFEs in California, he’d make sure to allocate the funds to the Department of Social Services to do the job they are mandated to do.

The thirteen bills that made up the RCFE Reform Act of 2014 were introduced by a bipartisan group of legislators following multiple media reports that revealed widespread abuse and neglect of residents and poor state oversight by the Department of Social Services (DSS). Some of the bills aimed at improving care in facilities: new training requirements for staff, increased penalties for poor care, and creating a resident bill of rights. Other bills moved to enhance RCFE supervision by DSS: mandating annual inspections, enhancing investigations of consumer complaints, and creating an on-line information system so the public could compare facilities. Both approaches were considered necessary to improve the lives of RCFE residents.

When the bills imposing DSS changes (AB 1554 – Skinner), (AB 1571-Eggman) (SB 895-Corbett), failed in their final legislative committee test on August 14, the state message regarding RCFE Reform became clear: there will be no fundamental changes in the Community Care Licensing system. File a complaint? Well, you’ll still have to wait until CCL is good and ready to investigate it – a minimum of 90 days, and sometimes a year or more. Want to select an RCFE from the 7,500 licensed RCFEs in California? Good luck with that, since an RCFE on-line consumer information system is not likely any time soon. Think it’s a good idea for the state to inspect RCFEs once a year rather than once every 5 years? Too costly, so too bad.

Regardless of whether the remaining bills are signed into law, RCFE Reform is notably incomplete without significant changes to DSS oversight. The tragedies widely reported by the media last year were enabled by failures in state supervision that will now go uncorrected by the legislature. As RCFE reform limps to the finish line, 174,000 residents of RCFEs are left wondering when the administration is going to figure out that it is both part of the problem and a critical part of the solution.

For the current status on all of the RCFE Reform bills, see the Legislative Update in this issue and track the bills on CANHR’s web site at www.canhr.org.

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Special Thanks to Summer Interns!

CANHR was fortunate to have great interns this summer to help with research and other special projects that would not have been completed without their help. To Kalinda Lisy and Neal Karkhanis, thank you for your time and talent!

Fall Workplace Giving Through United Way

California Advocates for Nursing Home Reform is participating as a “non-affiliated beneficiary agency” in the United Way Work Place Giving Campaign for 2014. As a Certified Community Campaign Agency we are participating in:

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

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

Stay Informed Between Newsletters

Get updates on long term care issues affecting you and your loved ones by subscribing to CANHR’s electronic newsletter, “CANHR News and Notes.” Visit www.canhr.org and click on “Sign up for our monthly E-Newsletter” right on the front page. Fill in your name and email and begin receiving monthly updates in your email box.

Donate to CANHR When You Shop on Amazon.com

Amazon will donate 0.5% of the price of your eligible Amazon purchases to California Advocates For Nursing Home Reform whenever you shop on AmazonSmile. AmazonSmile is the same Amazon you know - same products, prices, and service. Support us by starting your shopping at smile.amazon.com.

About CANHR

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

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DPH Defeats Legislation Requiring Timely Complaint Investigations

When it comes to obstructing reform legislation, the California Department of Public Health (DPH) is second to none. The DPH’s fingerprints are all over the death of AB 1816 (Yamada), a bill that would have required DPH to complete nursing home complaint investigations in a timely manner. In so doing, DPH has demonstrated once again that it is beyond reform.

When Assembly Member Yamada introduced AB 1816 on February 18, 2014, the bill would have required DPH to complete nursing home complaint investigations within 40 working days, with the opportunity for a 30-day extension when necessary. The original version of the bill had the support of both consumers and the nursing home industry and had no opposition.

The bill sailed along until May when DPH advised the Assembly Appropriations Committee it would cost $18.4 million annually to comply with AB 1816. The outlandish fiscal estimate made no sense, but it served the Department’s purposes in signaling that the Brown Administration would oppose the bill unless it was radically altered.

The Assembly Appropriations Committee promptly complied, amending and gutting the bill on May 23, 2014. The amendments replaced the deadlines for completing complaint investigations with internal benchmarks to be set by DPH and gave DPH unrestricted discretion to exceed whatever benchmark it set. At this point, CANHR withdrew its support for AB 1816 and took an oppose-unless-amended position.

The wounded bill made it out of the Assembly with assurances from Assembly Member Yamada that she would try to restore key provisions. Despite her best efforts to strengthen the bill, the Department continued to stand in her way. On August 1, 2014, DPH took an official position opposing the weakened version of AB 1816, giving the excuse that DPH is in the final stages of a full program assessment. Recognizing the wall in front of her, Assembly Member Yamada withdrew the bill a few days later.

These developments come during a particularly troubled time at DPH where the quality of its nursing home oversight is at an all-time low. State and local auditors are examining its huge backlog of complaints; the Legislature has held oversight hearings criticizing its performance; several DPH district offices appear aimed at protecting nursing home operators rather than residents; it has been the subject of intense federal criticism from CMS; the operations of its subcontractor in Los Angeles County are crumbling; morale of its employees is low; and some of its leaders have fled while others are pretending that nothing is wrong.

In this context, the DPH blockade of AB 1816 is the most recent evidence that DPH remains acutely opposed to any meaningful reforms and that its regulatory culture is rotted to its core. How can DPH expect its surveyors – some of whom are dedicated and capable public servants – to hold nursing home operators responsible for complying with the law when it won’t allow itself to be held accountable for something so basic as investigating complaints involving neglect and abuse in a timely manner?

California nursing home residents deserve far better.

Medi-Cal Recovery Reform – Maybe Now

SB 1124 (Hernandez), co-sponsored by CANHR and Western Center on Law and Poverty, will – if signed by the Governor – institute some positive fundamental changes to California’s Medi-Cal Recovery program.

California’s current 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.

Thus, 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 recovery on surviving spouses and most of the optional recovery provisions not required

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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 tell the Governor to sign SB 1124 into law. For more information about SB 1124, visit http://www.canhr.org/legislation/leg_updateSB1124.html.

**Victory for Ventura County Nursing Home Residents on Informed Consent**

A California nursing home will pay more than half a million dollars in a settlement over the failure to obtain informed consent prior to the administration of antipsychotic drugs. Class counsels Greg Johnson and Jody Moore were joined by AARP in suing Ventura Convalescent Hospital for administering antipsychotic drugs without the informed consent of residents or family members. The class-action lawsuit alleged the nursing facility circumvented California laws regulating the use of antipsychotic drugs. The lead plaintiff, Kathi Levine, whose mother died after being administered numerous such drugs, was joined by 305 residents in her complaint.

The litigation was filed in 2011, when families of residents said medication was being given without informed consent under the care of a skilled nursing facility physician. The lawsuit alleged that Dr. Gary Proffett, a well-known Ventura County physician, regularly relied on California nursing homes to obtain consent from patients rather than doing it himself as the law requires. Dr. Proffett (who is being sued in a separate case) claimed that relying on nursing homes to obtain consent from patients was a routine practice for doctors. That is, until the California Department of Public Health issued guidelines in January 2011 emphasizing the importance of obtaining consent and allegedly changing that standard. However, the law has been the same since 1989, when a lawsuit brought by CANHR (then BANHR) resulted in regulations mandating that doctors must obtain informed consent from patients, barring a medical emergency. While the nursing home denies all wrongdoing in the settlement, the decision of the court made it clear:

“The Court approves Class Counsel’s request for attorney’s fees in the amount of $450,000.00. The Court observes that the magnitude of egregious behavior by Dr. Gary Proffett coupled with the extraordinary failure of supervision by Ventura Convalescent Hospital presented a huge public health risk to Ventura County. But for

Class Counsel’s willingness to confront the defendant it is highly likely that the hundreds of patients in the eight hospital facilities located in Ventura County would still be receiving psychotropic medications without informed consent.”

Congratulations Greg and Jody for persevering in standing up for the rights of residents to be free of chemical restraints!!

BTW: Ventura Convalescent has 71 beds and “above-average” ratings, according to Medicare.gov’s website, Nursing Home Compare.

**Medicare’s Five-Star Rating System Under Fire**

The Center for Medicare and Medicaid Services’ 5-star rating system received a rake over the coals in a scathing New York Times article on Sunday, August 24, 2014. The article by Katie Thomas and a subsequent editorial on August 25 noted that the Medicare nursing home rating system has major flaws, including an overreliance on self-reporting by the nursing homes and failure to include negative information gathered by states. The ratings are based on three criteria. Two of the three — staff levels and quality statistics — are reported by the nursing homes and accepted at face value by Medicare without verification.

Only the other criterion — the results of annual health inspections — relies on independent inspections by state regulators. In addition, the ratings do not take into account other potentially damning information gathered by state authorities. For example, the rating system does not include citations or civil monetary penalties issued by California licensing and certification. CANHR has alleged for a number of years that the CMS rating system is inadequate, subject to manipulation by providers and far too often misrepresents the true quality of care in individual facilities. CANHR has offered numerous recommendations for improvement of the system over the years to no avail.

Clearly a revamping of the CMS rating system for nursing homes is long overdue and consumers should be wary of relying on it to choose a facility for their loved ones. Choosing a nursing home is not like choosing a microwave or a car – you need to visit, to check the state records and rate the facility yourself.
Legislation Update 2014

The following bills include the RCFE Reform Act of 2014, the Medi-Cal Recovery reform bill, and other bills that CANHR supported this legislative session. Two of the bills have been signed into law and two of the bills died in committee. The bills that survived are now on the Governor’s desk for signing or veto. Please write to the Governor and ask him to sign them into law. To check the status of all of the bills, go to [www.canhr.org](http://www.canhr.org).

RCFE Reform Act of 2014

**AB 1523 (Atkins): RCFE Liability Insurance – Signed into law!**

Effective July 1, 2015, each Residential Care Facility for the Elderly, as a condition of licensure, will be required to obtain and maintain liability insurance. Each facility must maintain liability insurance in the amount of $1 million per occurrence and $3 million in the annual aggregate to cover injury to resident or guests caused by the negligent.

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

This bill would require the Department to start and complete complaint investigations in a timely manner, give complainants written notice of findings and provide complainants an opportunity to appeal. Status: Failed in Senate Appropriations. Why? Because the budget analysis included “estimated” and “unknown” ongoing costs of $250,000 to $500,000 to provide consumers with a reliable complaint investigation system. What the analysis failed to take into consideration was the substantial ongoing costs of not responding to complaints in a timely manner: the costs related to serious bodily injury and abuse and neglect that sends residents to acute care hospitals and premature deaths.

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

This bill would require the Department of Social Services/Community Care Licensing to establish an on-line RCFE consumer information system to include specified updated and accurate information on every licensed RCFE in California. This bill would also require complete disclosure of ownership and prior ownership of any type of facility, including nursing facilities, and would have established a rating system by 2019. Status: Failed in Senate Appropriations. Why? Because the Administration did not want to spend the funds necessary to allow consumers to make informed choices about placement in RCFEs.

AB 1572 (Eggman): Resident & Family Councils – Signed into law!

This bill would amend current laws to enhance the rights of resident councils and family councils in RCFEs.

**AB 1899 (Brown): Forfeiture of License – On Governor’s Desk**

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.

**AB 2044 (Rodriguez): RCFE Staffing Requirements – On Governor’s Desk**

This bill would require an administrator or facility manager or designated substitute 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.

**AB 2171 (Wieckowski): Statutory Residents’ Bill of Rights – On Governor’s Desk**

This bill as amended would create a statutory, comprehensive bill of rights for residents of RCFEs. The part of the bill allowing residents to file a lawsuit to obtain an injunction to fight violations of their rights was stripped from the bill in an amendment just prior to its final floor votes. This means the important rights codified in the bill will have to be enforced by DSS, which traditionally has done a poor job of enforcing resident rights.

**AB 2236 (Stone & Mainschein): Increased Penalties – On Governor’s Desk**

This bill would have increased civil penalties against RCFEs for violations of laws and regulations from the

Legislation Update 2014.......... (continued on page 6)
current maximum of $150. Hijacked by the legislature and by the Executive Branch, the bill now includes an enormously complicated civil penalty system for all categories of facilities; imposes a $10,000 fine against RCFEs for physical abuse or serious bodily harm; imposes a $15,000 fine for deaths due to violations; and creates four (4!) levels of appeal for RCFE providers to appeal the fines.

While CANHR supports the increase in penalties for physical abuse, serious bodily injury and deaths for all RCFEs, we have serious reservations about a provider appeal system that is guaranteed to impair the assessment of civil penalties and the collections of such penalties, even if they are assessed. Legislators have committed to work with CANHR in the coming session to address these concerns with the appeal process.

**SB 895 (Corbett): RCFE Suspension/Revocation of Licenses (formerly SB 894) and Inspections/Evaluations of RCFEs (formerly SB 895) – On Governor’s Desk**

These bills have been substantially amended and combined into one bill which variously requires facilities to correct deficiencies within 10 days, unless otherwise specified, and requires the Department to post online instructions on how to obtain inspection reports offline, design an informational poster on reporting complaints and emergencies for display in RCFEs, and notify the State Ombudsman Office when it plans to issue a temporary suspension or revocation of a facility license.

**SB 911 (Block): Training and Qualifications of RCFE Staff – On Governor’s Desk**

This bill would increase the qualifications and training requirements for RCFE administrators from 40 hours to 80 hours and require facilities who accept and retain residents with restricted or prohibited health conditions to employ trained medical personnel as appropriate.

**SB 1153 (Leno): Ban on Admissions – On Governor’s Desk**

This bill would create new penalties for non-compliance, including authorizing the Department of Social Services to suspend the admission of new residents in facilities where there is a substantial probability of harm.

**SB 1382 (Block): Increase in RCFE Fees – On Governor’s Desk**

This bill increases the initial and annual licensing fees for RCFEs 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.

**Other CANHR Sponsored bills:**

**SB 1124 (Hernandez): Medi-Cal Recovery – On Governor’s Desk**

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 requires the Department of provide estate claim itemization to consumers for free upon request. Note: Co-sponsored with Western Center on Law and Poverty, this bill has unanimous bipartisan support, passing the Assembly Floor by 78-0 and the Senate Floor by 33-0.

**CANHR Support**

**AB 2603 (Perez): Access to Medications – On Governor’s Desk**

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.

**AB 1804 (Perea): Consumer Protections from Insurance Lapses – On Governor’s Desk**

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.
Dear Advocate,

Nursing homes and other health facilities can be subject to hefty fines if they disclose your medical information without your permission.

A number of California and federal laws aim to protect the privacy of your medical information. But California Health and Safety Code §1280.15 has special significance because violations carry penalties. The law requires health facilities, hospices, home health agencies and clinics to “prevent unlawful or unauthorized access to, and use or disclosure of, patients’ medical information.”

The Department of Public Health can issue an administrative penalty of up to $25,000 per patient for violations. The law also requires health facilities to self-report any unauthorized disclosures to both the patient and the Department of Public Health within five business days. Facility failure to report unauthorized disclosures is subject to a separate $100 penalty per day.

We hear many complaints that nursing homes release confidential information without a resident’s authorization, such as when a resident is trying to find a better facility. When these violations occur, it is a good idea to remind the Department of Public Health about this law and ask it to impose penalties when you file a complaint.

Did You Know?

Nursing homes and other health facilities can be subject to hefty fines if they disclose your medical information without your permission.

My mother, a Medi-Cal recipient, is being evicted from her nursing home facility unlawfully. She had to be transferred to the emergency room from her facility due to a serious fever. Six days later she was ready for discharge and allowed to return to the nursing home facility. The facility administrator refused to readmit my mother back into the facility, without stating a substantial reason or any violation committed allowing a legal eviction. What can I do to get my mother back into her facility?

Sincerely,

Upset in Upland

Dear Upset,

Nursing home residents have the right to be readmitted after a hospital stay. Whenever a resident is transferred to a hospital, the nursing home must allow the resident or a family member to hold their bed for up to seven days (22 Cal. Code of Regulations §72520). This is called a bed hold. If the resident is on Medi–Cal, the Medi–Cal program will pay for the bed hold for up to seven days (22 Cal. Code of Regulations §51535.1).

Any resident on Medi–Cal has a right to be readmitted to a nursing home even if the resident’s hospital stay exceeds seven days.

The facility’s refusal to honor a bed hold or readmit a resident following a hospital stay will be treated as an involuntary transfer, allowing the resident the right to appeal the transfer (Cal. Health & Safety Code §1599.1(h)). To request an appeal, call the Transfer/Discharge and Refusal to Readmit Unit of the Department of Health Care Services at (916) 445-9775 or (916) 322-5603 and ask for a readmission appeal.

See the “Transfer and Discharge Rights” section below for more information regarding appeals: www.canhr.org/factsheets/nh_fs/html/fs_transfer.htm
### CANHR on the Move...

#### Past Speaking Engagements, Panel Discussions and Training Sessions

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

- **June 2:** Staff Attorney Tony Chicotel presented a webinar on the RCFE Reform Act of 2014 for the Stanislaus County Council on Aging.

- **June 4:** Tony Chicotel participated in the POLST Task Force meeting hosted by the California Coalition for Compassionate Care.

- **June 4:** Tony Chicotel co-presented a webinar on communicating with people with disabilities, hosted by the Legal Aid Association of California.

- **June 11:** Outreach Coordinator Efrain Gutierrez visited State Senator Kevin de Leon’s district office to support SB 1124.

- **June 11:** Efrain Gutierrez visited State Senator Ricardo Lara’s district office to support SB 1124.

- **June 25:** Prescott Cole made a presentation about RCFE laws to the Area Agency on Aging meeting in Vallejo.

- **July 1:** Prescott Cole participated on the State Bar Legal Services Coordination Meeting.

- **July 9:** Prescott Cole made a presentation to the San Mateo Ombudsmen about Medi-Cal and Skilled Nursing Facility issues.

- **July 11:** Tony Chicotel attended the Legal Aid Association of California’s (LAAC) statewide meeting in San Francisco.

- **July 15:** Tony Chicotel participated in the board meeting of the California Culture Change Coalition.

- **July 24:** Long Term Care Advocate Mike Connors participated in a training session for the Comfort Care as the New Medicine in San Diego. This event was co-sponsored by CANHR, Elder Law & Advocacy and the Southern Caregiver Resource Center.

- **July 25:** Tony Chicotel presented at a Share the Care meeting in Napa. The topic was avoiding antipsychotics and improving dementia care.

- **July 30:** Tony Chicotel presented a webinar, hosted by the Family Caregiver Alliance, on improving dementia care by focusing on comfort instead of sedation.

- **July 31:** Tony Chicotel co-presented a webinar on the state of assisted living hosted by the Assisted Living Consumer Alliance.

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*From Left to Right: Roger Bastien, Sue Stuchlik, Marion Williams, and Armando Rafailan.*

- **August 6:** Office Manager Armando Rafailan attended the 13th Annual Healthy Aging Fair in Hayward, CA.

- **August 7:** Prescott Cole made a Medi-Cal recovery presentation at the San Francisco Forensic Center Multi-Disciplinary Team Meeting.

- **August 8:** Prescott Cole represented CANHR at the San Francisco premier showing of the documentary “Alive Inside”.

- **August 13:** Efrain Gutierrez visited California State Assemblymember Sebastian Ridley-Thomas to support SB 1124.

- **August 15:** Staff Attorney Jody Spiegel attended a board meeting of the Assisted Living Consumer Alliance.

- **August 18:** Tony Chicotel was part of a panel discussing abuse and neglect of people with disabilities hosted by the People With Disabilities Foundation.

- **August 19:** Tony Chicotel and Mike Connors participated in a meeting of the Statewide Partnership to Reduce Antipsychotic Drug Use and Improve Dementia Care in Nursing Homes.
For years and years, skilled nursing facilities have been illegally evicting residents from their homes with no regard to due process or the rule of law. The reason? Because they can!

Illegal nursing home evictions work one of two ways. The first way is facilities tell residents they have to leave, typically because their Medicare-covered days are ending and “all of the long term care beds are full.” We hear about these cases frequently but we suspect that most go unreported, and residents or their responsible parties – not knowing their rights – comply with the facility’s demand. These types of evictions are illegal for many reasons: advance 30-day written notice is required in most cases, a change in payment source is not justification for an eviction, and the residents are not informed of their right to appeal. But they are also based on a lie: every bed in a nursing home is a long term care bed. Long term care is what nursing homes do. The notion that some beds are for short term or rehabilitation care and other beds are for long term care is a fraud to support nursing home profitability.

The second way illegal nursing home evictions work is even more insidious. In these cases, facilities use a resident hospitalization to affect a permanent eviction – a hospital dump. Once the resident is at the hospital, the facility all too often refuses to readmit her, claiming it can no longer provide needed care or that the resident is a health or safety risk.

There are federal and state laws that are supposed to prevent hospital dumping from nursing homes. Residents of California nursing homes are required to have their bed held for up to seven days during a hospitalization, to ensure they don’t lose their homes because of a brief illness. For residents whose care is paid by Medi-Cal (virtually all of the residents in the hospital dump scenario), if the hospitalization exceeds seven days, the resident still retains the right to return to the first available bed.

When a facility wrongfully refuses to readmit a resident, the resident may request a readmission hearing with the state Department of Health Care Services (DHCS). Most residents never learn this or are unable to request a hearing, so the facility’s flouting of the bed-hold laws is a success. The few residents who do request a hearing invariably win the appeal, but some facilities become still more truculent and ignore the state’s order to readmit.

When a nursing home refuses to readmit a hospitalized resident – even after a state order to do so – usually nothing happens. DHCS claims it has no authority to compel compliance with its orders. The Department of Public Health (DPH), which enforces federal and state laws in nursing homes, will sometimes conduct its own investigation and maybe even fine a facility a small bit. But facilities are happy to pay a few hundred dollars to get rid of a problem resident on Medi-Cal and replace her with a much more lucrative new resident with eligible Medicare days.

The only real way for an illegally evicted resident to get readmitted is to file a petition in court. But obtaining an order for readmission in a short time frame is very difficult. Often, the resident is left with only an action for damages. But these cases should be pursued. There are potential causes of action for breach of contract, financial elder abuse, and resident rights violations. Until facilities are held accountable for illegal evictions, we can only expect the problem to continue.

For more information about this issue, see:

Over the past twenty years, the RCFE industry has become the fastest growing component of long term care. In addition to assisting residents with activities of daily living, RCFEs are now serving residents with serious health problems and increasing levels of dementia. Despite this growth and the fact that RCFE staff provide care to residents who just 4 or 5 years ago would have been treated in nursing homes, RCFE staff remain among the lowest paid workers in the service industry. The lack of adequate pay increases turnover, destabilizes the work force, and puts RCFE residents at risk.

RCFE employees are guaranteed minimum wage and overtime pay by the Fair Labor Standards Act (FLSA). The U.S. Department of Labor’s Wage and Hour Division (WHD) is responsible for enforcing the FLSA, and ensuring that RCFE staff are paid properly for all the hours they work. The FLSA applies to residential care facilities, whether the institution is public or private or is operated for profit or not-for-profit.

Although the RCFE industry is a multi-million dollar industry with enormous profit margins, its success is not being shared with direct care staff. Within the past year, the WHD has taken action against the a number of RCFE operators for failing to pay proper wages, including the following:

**Anne's Guest Home of Livermore and Pleasanton**
- Agreed to pay $447,689.53 in minimum and overtime back wages to 17 employees.
- In addition to minimum wage and overtime pay violations, WHD found employees sleeping on the floor.

**Damenik’s Home, San Francisco Bay Area**
- Paid $125,000 in minimum wage and overtime back wages to 32 employees working at three different San Francisco Bay Area locations.
- WHD found employees worked 60 hours per week on average, but were paid rates as low as $5.77 per hour and no overtime.

**Cristina’s Care Home, San Bruno Company**
- WHD recovered $62,215 in minimum wage and overtime back wages due to 15 employees.
- Cristina’s Care Home will also pay $4,620 in civil penalties for the willful and repeated nature of the violations.

**Farol’s Residential Care Home, San Francisco**
- Agreed to pay $33,779 to six employees, plus an equal amount in damages.

**B & B Residential Facilities, San Mateo**
- Paid $79,382 in back wages and an equal amount in damages to 16 employees.

Many elderly people and people with illnesses, injuries and disabilities rely on the vital services provided by RCFE staff. Because of their hard work, over 170,000 Californians are able to live more independently in community settings. The FLSA guarantees that these professionals receive the wage protections they deserve while protecting the rights of individuals to live in the community. Fair wages are critical in stabilizing one of California’s fastest-growing workforces, and one made up predominantly of women, minorities and immigrants.

If you work in an RCFE or suspect that RCFE staff are not being paid proper wages, contact the WHD at 866-487-9243 or visit [www.wagehour.dol.gov](http://www.wagehour.dol.gov). For more information, see U.S. Department of Labor Fact Sheet #33: Residential Care Facilities (Group Homes) Under the Fair Labor Standards Act - [http://www.dol.gov/whd/regs/compliance/whdfs33.pdf](http://www.dol.gov/whd/regs/compliance/whdfs33.pdf).

See also Department of Labor newsletters at [http://www.dol.gov/_sec/newsletter/](http://www.dol.gov/_sec/newsletter/).
RCFE Reform Fiction and Facts: A Response to “6beds.org”

A group of operators of small residential care facilities for the elderly (RCFEs) are opposing the RCFE Reform Act of 2014. A centerpiece of the opposition is a website - 6beds.org - that includes a number of cursory attacks on the Reform Act that are inaccurate, misleading, or misunderstand of the proposed policy.

The RCFE Reform Act was undertaken by bipartisan legislative leaders to address an elder care crisis revealed in a number of media reports about systemic abuse and neglect and poor state oversight. (To read these media reports, please go to http://canhr.org/newsroom/rcfe_crisis/news_coverage.html) The crisis was analyzed in our white paper: Residential Care in California: Unsafe, Unregulated, & Unaccountable.

California’s standards for RCFEs were established three decades ago. The standards and state oversight system no longer fit the needs of today’s RCFE residents, who require much greater nursing and personal care. The RCFE Reform Act is designed to modernize California standards and apply them to 21st century realities.

**FICTION** If the RCFE Reform Act bills pass, they will eliminate most small RCFEs.

**FACT** The Reform Act will strengthen RCFEs, not eliminate them. Most of the bills in the RCFE Reform Act have no direct costs for RCFE operators. A few bills, like AB 1570 (Chesbro) and SB 911 (Block), increase training requirements for new direct care staff from only ten hours to forty. In California, manicurists must have 400 hours of training and hairdressers must have 1600. Yet manicures and haircuts are still affordable. The training requirements ensure new staff members are better trained to meet the increased needs of the average resident.

**FICTION** AB 2236 (Maienschein and Stone) raises most civil penalties by 667%.

**FACT** This long overdue increase from $150 to $250 will not raise costs to RCFEs that comply with the law and do not harm residents. RCFEs that abuse or kill a resident are currently subject to a maximum $150 fine. AB 2236 raises civil penalties for most violations from $150 to $250 but in extreme cases of abuse or death, the penalties range from $500 to $15,000.

**FICTION** AB 2044 (Rodriguez) requires 24/7 administrator/facility managers, costing small facilities $8,000/month.

**FACT** AB 2044 does not require a 24/7 administrator or facility manager.

The bill permits a designated substitute who is at least 21 years old to be on-site to handle emergencies. The bill’s author is working to confirm that the designated substitute can be a current employee such as a direct care worker.

**FICTION** SB 1382 (Block) increases licensing fee 30%.

**FACT** SB 1382 will cost a 6-bed RCFE an additional $83 per year and is just the third increase since 1985. This 20% increase comes out to less than four cents per day per resident.

**FICTION** AB 1572 (Eggman) allows families to dictate 24/7 visitation.

**FACT** AB 1572 has nothing to do with visitation. The bill promotes the development of Resident and Family Councils, which positively influence the quality of care in RCFEs, enhance communications with facility staff, and offer peer support.

The RCFE Reform Act of 2014 is tailored to address the myriad problems in RCFE care while avoiding unnecessary additional costs to providers. While the bills are aimed at protecting residents, they will also strengthen care in large and small RCFEs. California has set standards for care to protect the health and safety of its elderly and disabled residents, and the RCFE Reform Act ensures these standards are meaningful. The care residents receive should not be dependent on the square footage of the building.
IN MEMORIAL

Lowell H. Aiken
Gloria M. Aiken
Lula C.T. Bishop, My Mother
Gwendolyn Bishop
My Mother - Carrie Brown
Art Brown
Pat and Chet Brown
Linda Johnson
Genevieve Ciotti, My Wife
Tom Ciotti
Faith Geer
Martin Schiffenbauer
Helen M. Henderson
Jerry Henderson
Shirley Hutt
Diane Anderson
Wayola B. Larson
Paul Larson
Jean Levine
Zita Bar
Lydia Manuel
Jim Manuel
Sherry McIlwain
Joyce McGriff
Rosalie Ortega
Ms. Shirley A. Ortega
Lynne Cowden Sanders
Gail L Bean
LaVerne Schwacher
Debra Vogler
Lottie Shamis
Judith Betts
My Beloved Mother, Rita Twomey
Ms. Denise Twomey
Thomas Spear Walther
Anthony Moy
Evelyn Wartman
Mr. & Mrs. John & Paddy Moran

IN HONOR OF

Carmen
John G. McDonald
Anna Renteria Estrada
Peggy Estrada
Eva Fleischner
Donna & Tom Ambrogi
Your Good Work
James D Opp

IN CELEBRATION OF

CANHR
Mary Gerber

CANHR Up Coming Events

• **October 3:** CANHR will be attending The City of Cerritos Senior Center’s “Mind, Body and Spirit: A Wholeness Approach to Aging.” CANHR will have an information booth available at this event from 9:00 AM to 12:00 PM. 12340 South St., Cerritos, CA 90701.

• **October 7:** CANHR will attend the 15th Annual Senior Resource Faire. CANHR’s information booth will be from 9:00 AM to 12:00 PM. Newark Senior Center, 6800 Mowry Ave., Newark, CA 94560.
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CANHR, 650 Harrison Street, 2nd Floor, San Francisco, CA 94107.

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This gift is in memory of: ______________________________________________________
(or in honor of: ____________________________________________________________

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☐ 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.
Citation Watch - Consumer Report

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Alameda County

Crestwood Manor - Fremont
4303 Stevenson Blvd., Fremont
A $15000 Patient Care Supervision 6/6/2014
On 11/23/13, a resident was found unresponsive and bluish in color during mealtime. Physician's orders were to have all her foods pureed. A resident stated he saw another resident give her part of a sandwich while she was unsupervised. This resulted in the resident choking and sustaining a cardiac arrest. She remained in intensive care on life support for 20 days before life support was discontinued and the resident died. The facility was cited for failure to maintain supervision and provide a safe environment. Citation # 020010747.

Oakhill Springs Care Center
3145 High Street, Oakland
AN $15000 Staffing 10/10/2013
The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 7 days out of 24 randomly selected days. Citation # 020010175.

Amador County

Kit Carson Nursing & Rehabilitation Center
811 Court Street, Jackson
AN $30000 Staffing 11/19/2013
The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 12 days out of 24 randomly selected days. Citation # 030010257.

Butte County

Country Crest Post Acute
50 Concordia Lane, Oroville
B $2000 12/17/2013
CitationWatch description will be published once citation is received. Citation # 230009704.

Calaveras County

Mark Twain Convalescent Hospital
900 Mountain Ranch Road, San Andreas
B $1000 Injury 1/16/2014
On 2/26/12, a resident who was in the facility following a hip fracture sustained a fracture to her right ring finger when it became caught in the wheel of the wheelchair as it was being pushed by a CNA. The facility was cited for failure to ensure that the resident was protected from injury. Citation # 030010381.

Marin County

Pine Ridge Care Center
45 Professional Center Parkway, San Rafael
A $20000 Careplan Patient Care Security Supervision 12/30/2013
The facility failed to provide a resident adequate supervision to prevent elopement from the facility after the resident was able to leave undetected and drive away in his own car. The resident was later found after a car accident in which the car went down a steep ravine and the resident was ejected from the car and had to be rescued by the fire department. The resident had a long history of noncompliance and elopement from previous facilities, and on several occasions had failed to sign in and out of the facility or turn over his car keys. The resident was able to leave the facility despite care plan instructions which included 15 minute visual checks on his whereabouts and loss of his "pass privileges" for leaving without signing out. The resident's elopement was not discovered until an hour and 15 minutes after he left the facility. Citation # 110009715.

B $2000 Injury Physical Abuse Supervision 03/27/2014

Fall 2014 CANHR Advocate NC-1
On 1/5/12, a resident picked up a book and threw it hitting another resident in the nose. The offending resident had a history of aggressive behavior and the care plan called for “one to one” monitoring meaning a CNA was always supposed to be within arms reach of the resident. The CNA assigned to monitor the resident at the time was across the room when the incident occurred. The facility was cited for failure to provide adequate supervision. Citation # 110010572.

Mariposa County
Avalon Care Center-Sonora
19929 Greenley Road, Sonora
AN $15000 Staffing 12/11/2013
The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 3 days out of 24 randomly selected days. Citation # 030010317.

Merced County
Hy-Lond Health Care Center-Merced
3170 M Street, Merced
B $1000 Patient Care Patient Rights 5/5/2014
The facility failed to ensure that a resident's personal belongings were safe and available for his personal use after the resident's personal cell phone went missing from his bedside. A few days later, a fellow staff member reported to the administration that the CNA had posted a photo advertising the cell phone for sale on a social media website. Police were called to investigate and eventually the phone was recovered and returned to the resident. Citation # 040010702.

Napa County
Napa Valley Care Center
3275 Villa Lane, Napa
A $20000 Notification Patient Care 7/3/2014
The resident was admitted on 4/11/13, with a diagnosis of a urinary obstruction with an indwelling catheter. On 7/21/13, licensed staff failed to notify the physician of a cut on the head of the penis. By 7/27/13, the resident's penis started to split. The facility was cited for failure to ensure that staff provided continued nursing assessment, develop the plan of care for treatment of a penile cut, notify the physician of changes to the skin, and document changes to the cut on the head of his penis. This resulted in a full erosion of the penile shaft down to the scrotal sack. Citation # 110010226.

Placer County
Oak Ridge Healthcare Center
310 Oak Ridge Drive, Roseville
B $800 Physical Abuse 2/6/2014
On November 26, 2010, a resident was taken to the bathroom at the facility and the resident's wedding band was forcefully removed from her finger. The resident's finger was bruised. A family member reported the theft to the facility. The Administrator said that he did not believe that the ring was stolen, so he did not report it. The facility was cited for failing to report the alleged abuse to the Department within 24 hours. Citation # 030010437.

Sacramento County
Carmichael Care & Rehabilitation Center
8336 Fair Oaks Blvd., Carmichael
B $1000 Fiduciary Patient Rights Theft & Loss 1/23/2014
On 1/26/11, a resident was unable to locate his prepaid credit card. The credit card company confirmed that unauthorized charges were made and the police confirmed that a staff member had withdrawn cash without the resident's consent. The staff member had previously been convicted of a financial crime. The facility was cited for failure to protect the resident from financial abuse and thoroughly screen a staff member with a criminal conviction of a financial crime. Citation # 030010397.

Eskaton Care Center Manzanita
5318 Manzanita Avenue, Carmichael
B $1000 Patient Rights 1/23/2014
On April 20, 2011, a CNA screamed at a resident while giving her a shower, and she used very hot and very cold water. After the incident, the Unit Manager requested anti-anxiety medication for the resident because the resident was not able to relax. Two other residents indicated they had experienced rough care from the same CNA. The facility was cited for failing to ensure that residents were free from mental and physical abuse, and for failing to implement its abuse policy requiring interviews with other residents who received care from the CNA and notifying the CNA licensing board of the abuse allegations. Citation # 030010396.

McKinley Park Care Center
3700 H Street, Sacramento
FB $1200 Mandated Reporting Patient Records 10/30/2013
The facility failed to report unauthorized access of Resident 1's medical information to the Department of Public Health (DPH) within five business days after becoming aware of the issue. The facility accidentally sent a letter to the family member of Resident 2 that included some of Resident 1's medical documents. The family member hand delivered the documents to the facility on 7/19/2013, but the facility did not report their mistake to DPH until 8/7/2013. Citation # 030010188.

FP $1100 Mandated Reporting Patient Records 10/30/2013
On 7/9/2013, the facility failed to notify Resident 1's responsible party (RP) when Resident 1's personal health information was accidentally given to Resident 2. The facility did not notify Resident 1 or their RP within five business days as required by law. In Resident 2's discharge packet, Resident 2's family member found Resident 1's observation report, which included diagnoses and a note of "difficult adjustment" to the facility. Resident 1's RP was not notified until 8/6/2013. Citation # 030010189.

Norwood Pines Alzheimers Center
500 Jessie Avenue, Sacramento
A $18000 Careplan Patient Care 2/12/2014
A female resident began treatment for reddened areas on her buttocks on 9/7/11. A cream has been prescribed for her perineum area on 8/25/11. On 9/16/11 a report indicated she tested positive for a bacterial infection. This lead to her having diarrhea. Eventually she developed pressure sores
which required surgery. The facility failed to identify a bacterial infection and notify the resident's physician when she started having frequent loose stools. The facility failed to monitor her for risks of pressure ulcers and implement preventative measures to relieve pressure from vulnerable areas as well as ensure a plan of care to monitor skin condition following diarrhea. Citation # 030010456.

San Joaquin County
La Salette Health And Rehabilitation Center
537 E. Fulton Street, Stockton
A $20000 Patient Care  2/12/2014
On 10/1/11 a female resident was given an anti-anxiety medication which can suppress breathing function. She was placed on a breather mask to ensure she was getting enough oxygen. That afternoon she was sitting on the edge of her bed, trying to take her mask off. A CNA found that she was desperate to breathe and called the nurse. However there was no call to the physician and therefore no physician order to increase the oxygen. Additionally, the nurse's notes did not indicate any assessment of her respiratory status. Eventually the resident stopped breathing, went into cardiac arrest and died. The facility failed to conduct a thorough assessment of her respiratory condition, notify the physician promptly of changes to her condition, or obtain a physician's order before putting the breather mask on her. This inappropriate action contributed to the resident's worsening condition and death. Citation # 030010445.

Santa Clara County
San Jose Healthcare Center
180 North Jackson Avenue, San Jose
AN $30000 Staffing  10/10/2013
The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 14 days out of 24 randomly selected days. Citation # 070010174.

Skyline Healthcare Center - San Jose
2065 Forest Avenue, San Jose
B $800 Administration Careplan Patient Care Security Supervision  11/15/2013
A facility was cited after it failed to adequately supervise and prevent a resident from leaving the facility without staff knowledge. Although the resident's written care plan included the use of a WanderGuard system (door alarms activated by bracelets worn by a resident) the facility had not yet purchased or installed such a system. The resident was able to leave unobserved by staff from one of six unlocked exit doors. The resident, diagnosed with diabetes and dementia, was later found 2.7 miles from the facility, 25 hours after leaving the facility. During the time period the resident was missing from the facility the outside temperature dropped to a low of 40 degrees. Citation # 070010263.

Santa Cruz County
Cresthaven Skilled Nursing Facility, Inc.
740 17th Avenue, Santa Cruz
A $12000 Patient Care  05/28/2014
On 4/2/2014, the facility was cited for failing to ensure a male patient was provided necessary medical care and services for his change in condition. The resident developed a soft and limp right arm and increased difficulty swallowing. The facility was unable to reach the physician for any medical interventions and on 4/5/2014 the resident was sent to the acute care hospital where he was admitted with renal failure, hyperglycemia and a suspected stroke. Citation # 070010740.

Solano County
Fairfield Post-Acute Rehab
1255 Travis Blvd., Fairfield
B $1000 Administration Patient Care  10/10/2013
After an observation at the facility in July of 2013, a citation was issued for failure to post a recently-issued "A" citation. Health and Safety Code regulations state that such a level of citation should be prominently posted in plain view of residents and visitors for up to 120 days. Failure to post a copy of the citation had the potential for residents, visitors, employees, and the public to not be aware of facility practices that could impact patient care. Citation # 110010028.

Orchard Post Acute Care
101 S. Orchard Street, Vacaville
A $20000 Patient Care Supervision  12/12/2013
The facility was cited for failure to keep the resident environment free of accident hazards after a 79 year old resident fell from her wheelchair on two separate occasions while unsupervised. The resident had previously been identified at risk for falling due to poor balance and limited mobility. These falls resulted in the resident suffering a Hematoma to the forehead and a probably brain bleed. Citation # 110009258.

Sutter County
Yuba Skilled Nursing Center
521 Lorel Way, Yuba City
B $2000 Hydration Patient Care  2/7/2014
The facility was cited when it failed to properly provide a resident with sufficient fluids to prevent dehydration and failed to properly monitor the resident's fluid intake and output. These failures resulted in the resident requiring treatment at an acute care hospital for symptoms related to dehydration including an altered mental state and deterioration of kidney function. Citation # 230010435.
B $2000 Hydration  2/7/2014
On 1/11/2012, a resident was admitted to a hospital for a Norovirus outbreak. An emergency room physician's order showed that the resident would be admitted to the hospital's intensive care unit for further treatment on dehydration and required extensive intravenous fluid replacement. On 8/21/2012 a licensed nurse was interviewed at the facility and she confirmed that the facility failed to implement the facility's Resident Hydration and Prevention of Dehydration policy. The DON at the facility also confirmed that the resident's Intake and Output Records were not completed and left blank. The facility was cited for failure to implement its Hydration/Dehydration assessment and care policies. Citation # 230010434.
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Fresno County

Twilight Haven
1717 S. Winery Ave., Fresno
B $2000 Patient Care 5/8/2014
The facility was cited after a CNA failed to properly implement the physician's order regarding lifts for transfer, when she used a standing lift to transfer a resident with osteoporosis recovering from hip surgery. The resident was unable to support her own weight and per the doctor's instructions, was to be transferred only using a two person lift which would not force the resident to bear weight in her legs. As a result, the resident slipped during a transfer from her bed to her wheelchair and fractured her left kneecap, resulting in a surgery to repair her knee. Citation # 040010716.

Kern County

Corinthian Gardens Health Care Center
1611 Height Street, Bakersfield
A $10000 Patient Care 4/1/2014
A 54 year old ventilator-dependent resident who was receiving fluids through a G-tube began to swell due to overload of fluids. By 5am the CNA found her with her eyes swollen shut, tongue swollen, and she was not breathing. The CNA told the RN that she was suffocating. While being transferred to the gurney, her breathing tube came out. The facility failed to accurately assess the severity of the resident's change in condition when she was noted to have increased swelling to her entire body and failed to notify the attending physician of the change in condition for the patient. CPR was done when the ambulance arrived. However, the resident subsequently died. Citation # 120010559.

Glenwood Gardens SNF
350 Calloway Drive, Bakersfield
A $20000 Careplan Fall Supervision 5/8/2014
The facility failed to supervise a resident with dementia and a history of falls and place a pressure alarm pad on her wheelchair as ordered by her physician. She also had a personal tab alarm, but she removed it as she had in the past. This resulted in her un-witnessed fall on 12/3/2013, where she sustained cuts and internal bleeding to the head. She was transferred to a hospital, but died from her injuries two days later. Citation # 120010617.

Ridgecrest Healthcare Center
1131 North China Lake Blvd., Ridgecrest
B $2000 Mandated Reporting Physical Abuse 5/6/2014
On 11/16/13, a 56-year old resident of the facility struck a 92-year old resident in the face with his fist, cutting and bruising her face and spraining her neck. The facility reported the abuse to the Department of Public Health 27 hours later, rather than within 2 hours as required by the Elder Justice Act when serious bodily injury is involved. In a separate incident on 11/29/13, the same resident threw an 86-year old resident from her wheelchair to the floor. The facility reported the abuse to the Department about 76 hours later, rather than within 24 hours as required. The facility was cited for not reporting the two instances of abuse in a timely manner. Citation # 120010682.

A $20000 Injury Physical Abuse 5/6/2014
On 11/16/13, a 56-year old resident of the facility struck a 92-year old resident in the face with his fist, cutting and bruising her face and spraining her neck. She was taken to the hospital for treatment. Thirteen days later, on 11/29/13, the same resident threw an 86-year old resident from her wheelchair to the floor. The facility was aware that the resident posed a danger to other residents but did not take any actions to ensure their safety. The facility was cited because two residents were victims of its inaction. Citation # 120010681.

A $10000 Infection Neglect Notification 5/6/2014
On 11/17/13, a 93-year old resident was hospitalized with pneumonia, where records show he was admitted unkempt, with copious amounts of pus draining from his ear and large amounts of green sputum were suctioned from his throat. The facility was cited because it failed to notify his physician during the week prior to hospitalization that he was suffering from fever and cough, contributing to the worsening of his condition. Citation # 120010662.

Los Angeles County

Avalon Villa Care Center
12029 S Avalon Blvd., Los Angeles
AN $15000 Staffing 1/24/2014
The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs.
Through an audit of the facility's records, they were found to be out of compliance with this requirement for 3 days out of 24 randomly selected days. Citation # 940010329.

**Bellflower Convalescent Hospital**

9710 E. Artesia Ave., Bellflower

AN $30000 Staffing 2/28/2014

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 24 days out of 24 randomly selected days. Citation # 940010351.

**California Convalescent Center 1**

909 S Lake Street, Los Angeles

AN $15000 Staffing 12/30/2013

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 10 days out of 24 randomly selected days. Citation # 910010327.

**Country Villa Glendale Healthcare Center**

1208 S. Central Ave., Glendale

B $1800 Careplan Notification Patient Records Physical Abuse 10/10/2013

The facility failed to monitor a resident for symptoms of complications, pain and discomfort after a fall on 9/5/2011, as required by his careplan. When he complained of hip pain that increased over time after the fall, the nursing staff failed to stop his physical therapy exercises and failed to evaluate if his hip pain was related to the preceding fall. The resident was also administered pain medication without documentation of pain assessment, medication administration or tolerance for physical therapy; and his physician was not notified of changes in his pain intensity. Citation # 920010179.

**Country Villa Rehabilitation Center**

340 S. Alvarado St., Los Angeles

A $20000 Fall 11/13/2013

On 6/20/13, a resident fell when a CNA improperly transferred the resident without assistance of another staff member while using a mechanical lift. The resident sustained a gash to the left side of the forehead, had pinpoint pupils, vomited, required CPR, and was transferred by paramedics to the general acute care hospital where she subsequently expired due to heart disease. The facility was cited for not adequately supervising and assisting devices to prevent accidents and ensuring that the resident environment remains as free from accident hazards as possible. Citation # 910010192.

**El Rancho Vista Health Care Center**

8925 Mines Avenue, Pico Rivera

B $2000 Patient Care 11/19/2013

On 9/5/13, a resident was readmitted to the facility with skin itching and rashes. The resident was not seen by a dermatologist until 9/30/13. As a result, 13 other residents and 6 staff members contracted scabies. The facility failed to implement established infection control policies and procedures by failing to consult the dermatologist promptly, place the resident in isolation to protect the other residents, and develop a tracking record of patients with onset of signs and symptoms and exposures. Citation # 940010271.

**Glendora Grand, Inc.**

805 West Arrow Highway, Glendora

B $2000 Supervision 8/22/2013

The facility was cited for failing to provide adequate supervision for a resident who was assessed as an unsafe smoker. As a result the resident accidentally started a fire in the facility bathroom caused by a cigarette in the trash can. Citation # 950010116.

**Harbor Care Center**

21521 S. Vermont Ave, Torrance


CitationWatch description will be published once citation is received. Citation # 910010582.

**Hyde Park Convalescent Hospital**

6520 West Blvd, Los Angeles

AN $15000 Staffing 12/30/2013

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 2 days out of 24 randomly selected days. Citation # 910010303.

**Imperial Convalescent Hospital**

11926 La Mirada Blvd, La Mirada

AN $15000 Staffing 2/28/2014

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 2 days out of 24 randomly selected days. Citation # 940010304.

**Ivy Creek Healthcare & Wellness Centre**

115 Bridge Street, San Gabriel

AN $15000 Staffing 2/4/2014

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 5 days out of 24 randomly selected days. Citation # 950010375.

**La Paz Geropsychiatric Center**

8835 Vans Avenue, Paramount

B $1500 Patient Care 12/23/2013

On 11/6/13 a 49 year old female resident complained about not getting treatment for a back rash. She told the staff she was diagnosed at another facility for having a bug under her skin and was being treated with hydrocortisone. Consequently, the rash spread to other residents. On 11/13 she was diagnosed with scabies. The supervisor at the CDPH/Communicable Disease stated she did not know why the staff were not following the policy that was given to them as they had recently been trained by her staff. The facility failed to maintain an Infection Control Program to identify or track rashes and prevent the spread of scabies. The facility also failed to treat a reddened rash with itching for over 40 days, or provide surveillance to prevent the spread of scabies. Citation # 940010297.
On 11/6/2013, a resident complained that the nurses had been neglecting her and had not provided the necessary care in treating her rashes. It was observed that the resident had various rashes and multiple sores in various degrees throughout her back, buttocks, arms, breasts, stomach, lower legs, and under arm area. The resident was not being adequately treated for the rash for over 40 days, which caused mental anguish, severe itching and inability to sleep at night. On 11/11/2013, the resident's dermatologist diagnosed the resident with scabies. The facility was cited for not implementing its policy related to abuse and neglect, by not providing the care necessary to prevent neglect. Citation # 940010357.

Las Flores Convalescent Hospital
14165 Purche Avenue, Gardena
AN $15000 Staffing 1/2/2014
The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 5 days out of 24 randomly selected days. Citation # 910010305.

Lighthouse Healthcare Center
2222 Santa Ana Blvd, Los Angeles
AN $15000 Staffing 9/4/2013
The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 6 days out of 24 randomly selected days. Citation # 940010110.

Long Beach Care Center
2615 Grand Avenue, Long Beach
AN $15000 Staffing 1/24/2014
The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 2 days out of 24 randomly selected days. Citation # 940010310.

Marycrest Manor
10664 St. James Drive, Culver City
A $20000 3/4/2014
CitationWatch description will be published once citation is received. Citation # 910010490.

Pacific Care Nursing Center
3355 Pacific Place, Long Beach
B $2000 Physical Environment 9/26/2013
The facility was cited for failure to ensure residents were provided safe hot water temperature below 120 degrees Fahrenheit in 39 of 40 resident's bedrooms and in 4 out of 4 shower rooms. The unsafe hot water placed all 86 residents in the facility at risk for burn, scalding and tissue damage. Citation # 940010164.

Rehabilitation Center of Santa Monica, The
1338 20th Street, Santa Monica
A $20000 4/22/2014
CitationWatch description will be published once citation is received. Citation # 910010581.

Royal Care Skilled Nursing Center
2725 Pacific Avenue, Long Beach
AN $15000 Staffing 1/24/2014
The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 2 days out of 24 randomly selected days. Citation # 940010315.

Saint Vincent Healthcare
1810 N. Fair Oaks, Pasadena
B $2000 Mandated Reporting 8/20/2013
On 1/31/13, the facility reported to the Department of Public Health (DPH) that a resident hit another resident on the arm, causing bruising, in an altercation over a bag of chips. The incident occurred on 1/25/13. The facility was cited for failing to report the incident to DPH within 24 hours as required. Citation # 950010103.

The Earlwood
20820 Earl Street, Torrance
B $2000 Theft & Loss 5/13/2014
On 12/11/12, a complaint investigation revealed that an employee of the facility stole a resident's check book and forged and cashed two checks for $200.00. The facility was cited for failure to ensure the resident's property was not misappropriated. Citation # 910010728.

Valley Palms Care Center
13400 Sherman Way, North Hollywood
B $500 Administration 10/17/2013
On 2/1/2013, the facility failed to post its overall five-star quality rating determined by the Centers for Medicare and Medicaid Services in the required areas for review by the residents, staff and visiting public. The facility's rating information was not posted in two dining rooms and in the employee lounge. Citation # 920010199.

Vermon Care Center
22035 S Vermont Ave, Torrance
B $2000 Mandated Reporting 8/20/2013
On 1/22/13, the facility reported to the Department of Public Health (DPH) that a resident hit another resident on the arm, causing bruising, in an altercation over a bag of chips. The incident occurred on 1/25/13. The facility was cited for failing to report the incident to DPH within 24 hours as required. Citation # 950010103.

Western Convalescent Hospital
2190 W Adams Blvd, Los Angeles
B $2000 Transfer 4/10/2014
Western Convalescent received 55 Class B citations for unlawfully transferring 55 residents from the facility without proper notice in April 2014.

The facility failed to comply with a federal regulation requiring it to be equipped with a supervised automatic sprinkler system by 8/13/13. In April 2014, it planned to remove all of the residents from its second floor to enable a construction project to install sprinklers. The facility was cited because it failed to comply with a California law requiring it to give residents at least 30 day advance notice of the change in facility environment.
written notice prior to the transfer out of the facility. Its written notice also failed to give an expected date for the residents' return to the facility. These failures violated the rights of each resident who was transferred. Citation # 910010813.

B $2000  
6/10/2014
Citation # 910010832.

B $2000  
6/16/2014
Citation # 910010786.

B $2000  
6/19/2014
910010757, 910010759, 910010763, 910010777, 91-0010779-910010785, 910010787-910010793, 910010795-910010809, 910010811, 910010812, 910010814-910010816, 910010833

Westside Health Care
1020 S Fairfax Ave, Los Angeles
A $20000  
Careplan Injury Patient Records
12/10/2013
The facility failed to develop a comprehensive nursing assessment and plan of care to address a resident's right arm contractures (permanent tightening or shortening of a body part, such as muscle, tendon or skin), and failed to develop approaches to providing daily care, especially when dressing the resident. This resulted in a CNA lifting the resident's arm while dressing her on 4/17/2012, causing a distal humerus fracture in her elbow. The facility had no documentation of contraction in the resident's arm between her admission on 3/30/2012 and the incident date. Citation # 910010265.

Orange County
Fullerton Post Acute Care
2222 N. Harbor Blvd., Fullerton
B $2000  
Administration Neglect Physical Abuse Sexual Abuse
12/19/2013
Two female residents reported separate incidents of a male CNA inappropriately touching them on various occasions to facility staff and administrators. The facility was cited for failure to investigate these accusations properly, allowing the CNA to continue working with vulnerable female residents, including an additional female resident who also eventually reported unwanted sexual touching by the male CNA. Citation # 060010335.

B $2000  
Patient Care
12/19/2013
A female resident who suffered from glaucoma, had not seen an eye doctor in 16 months. Eventually she lost her sight. Another resident was not assisted with financial matters until her home was in danger of being auctioned off. Another resident's hearing aids broke, but the facility failed to make arrangements to have them repaired. She cannot hear what people are saying to her and she cannot read lips. Another resident was scheduled for cataract surgery on her left eye in February 2012. The surgery did not take place and there was no documentation of a follow up. This resident states she is now blind in her left eye. The facility failed to provide medically related social services for residents needing eye appointments, hearing aids, and financial assistance. Because of this, the residents' quality of life have been greatly diminished. Citation # 060010334.

Country Villa Seal Beach
3000 N Gate Road, Seal Beach
B $1000  
Administration Privacy
08/26/2013

The facility failed to secure the personal and confidential medical privacy of 56 residents when documents identifying names, health conditions and treatments were found in a trash can in a public area by an unauthorized person. Citation # 060010117.

Riverside County
AFVW Health Center
17050 Arnold Drive, Riverside
A $5000  
Fall Injury Patient Care
11/14/2013
On 6/26/08, an 85 year old female resident was admitted to the facility for physical therapy rehabilitation after fracturing her hip at home. The resident fell in the bathroom four days later. On 7/16/08, the resident was receiving toileting assistance by a CNA. The CNA told the resident to use her call light when she was finished and then left the resident alone to assist another resident. When the CNA returned, she found the resident on the floor. The resident was found to have a fracture around her right hip replacement at the acute care hospital requiring additional surgery. There were no indications in the resident's care plan that it was safe to leave the resident alone. The facility failed to develop a comprehensive plan of care based on the continual assessment of care needs for the resident. This failure resulted in the resident falling and re-fracturing her hip. Citation # 250010258.

B $2000  
Dignity Physical Abuse Sexual Abuse
4/10/2014
On 4/17/2014, the facility was cited for failing to ensure a 91-year-old female resident was treated with dignity and not subjected to verbal and physical abuse. Two students and a CNA witnessed another CNA slap the resident on her buttock and say "She has a nice butt," and "Don't you baby." Citation # 250010610.

Blythe Nursing Care Center
285 W. Chanslor Way, PO. Box 850, Blythe
AN $15000  
Staffing
12/16/2013
The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 2 days out of 24 randomly selected days. Citation # 250010300.

California Nursing & Rehabilitation Center
2299 North Indian Canyon Drive, Palm Springs
B $1000  
Fiduciary Theft & Loss
7/10/2014
The facility failed to protect a resident from theft of personal property and financial abuse when a CNA stole checks from a residents purse and cashed them without the resident's permission. Three checks dated 7/11, 7/15 and 7/18/2013, totaling $1,300, were written to the CNA's mother. Upon investigation by the police, three other residents reported thefts. The CNA was arrested on 7/19/2013 for elderly financial abuse and forgery against a resident. Citation # 250010858.

Manorcare Health Services-Hemet
1717 West Stetson Avenue, Hemet
FB $4700  
Mandated Reporting
10/14/2013
The facility was cited for failure to report an unlawful or unauthorized access to, or use or disclosure of a patient's medical information within five business days of the date the unlawful or unauthorized access, use or disclosure
On 3/9/2013, the facility failed to ensure two residents were free from financial abuse. The facility's business office manager (BOM) stole a total of $771.75 from the residents' trust funds by illegally using the facility administrator's signature stamp on company checks that the BOM wrote to herself. This could have been prevented if the facility had conducted monthly reviews of the residents' trust accounts as required by facility policy. Citation # 250010683.

On 3/9/2013, the facility failed to ensure two residents were free from financial abuse. The facility's business office manager (BOM) stole a total of $1,069.12 from the residents' trust funds by illegally using the facility administrator's signature stamp on company checks that the BOM wrote to herself. This could have been prevented if the facility had conducted monthly reviews of the residents' trust accounts as required by facility policy. Citation # 250010684.

On 3/9/2013, the facility failed to ensure two residents were free from financial abuse. The facility's business office manager (BOM) stole a total of $1,076.60 from the residents' trust funds by illegally using the facility administrator's signature stamp on company checks that the BOM wrote to herself. This could have been prevented if the facility had conducted monthly reviews of the residents' trust accounts as required by facility policy. Citation # 250010688.

On 3/9/2013, the facility failed to ensure two residents were free from financial abuse. The facility's business office manager (BOM) stole a total of $1,210.71 from the resident's trust fund by illegally using the facility administrator's signature stamp on company checks that the BOM wrote to herself. This could have been prevented if the facility had conducted monthly reviews of the residents' trust accounts as required by facility policy. Citation # 250010690.

On 3/9/2013, the facility failed to ensure a resident was free from financial abuse. The facility's business office manager (BOM) stole $1,344.66 from the resident's trust fund by illegally using the facility administrator's signature stamp on company checks that the BOM wrote to herself. The money was supposed to be refunded to the resident's family within 30 days of the resident's death on 5/30/2013, but they never received it. This could have been prevented if the facility had conducted monthly reviews of the residents' trust accounts as required by facility policy. Citation # 250010678.

On 3/9/2013, the facility failed to ensure a resident was free from financial abuse. The facility's business office manager (BOM) stole $1,963.34 from the resident's trust fund by illegally using the facility administrator's signature stamp on company checks that the BOM wrote to herself. This could have been prevented if the facility had conducted monthly reviews of the residents' trust accounts as required by facility policy. Citation # 250010675.

On 3/9/2013, the facility failed to ensure a resident was free from financial abuse. The facility's business office manager (BOM) stole $1,859.33 from the resident's trust fund by illegally using the facility administrator's signature stamp on company checks that the BOM wrote to herself. This could have been prevented if the facility had conducted monthly reviews of the residents' trust accounts as required by facility policy. Citation # 250010685.

On 3/9/2013, the facility failed to ensure a resident was free from financial abuse. The facility's business office manager (BOM) stole $3,628.99 from the resident's trust fund by illegally using the facility administrator's signature stamp on company checks that the BOM wrote to herself. This could have been prevented if the facility had conducted monthly reviews of the residents' trust accounts as required by facility policy. Citation # 250010692.

On 3/9/2013, the facility failed to ensure 14 residents were free from financial abuse. The facility's business office manager (BOM) stole $3,100.92 from the resident's trust fund by illegally using the facility administrator's signature stamp on company checks that the BOM wrote to herself. This could have been prevented if the facility had conducted monthly reviews of the residents' trust accounts as required by facility policy. Citation # 250010686.
were free from financial abuse. The facility's business office manager (BOM) stole a total of $515.89 from the residents' trust funds by illegally using the facility administrator's signature stamp on company checks that the BOM wrote to herself. Three of the residents died in the facility and their families or responsible parties were never refunded by the respective trust funds as required by facility policy. This could have been prevented if the facility had conducted monthly reviews of the residents' trust accounts as required by facility policy. Citation # 250010678.

B $2000 Fiduciary 05/13/2014
On 3/9/2013, the facility failed to ensure a resident was free from financial abuse. The facility's business office manager (BOM) stole $3,316.13 from the resident's trust fund by illegally using the facility administrator's signature stamp on company checks that the BOM wrote to herself. This could have been prevented if the facility had conducted monthly reviews of the residents' trust accounts as required by facility policy. Citation # 250010667.

B $2000 Fiduciary 05/13/2014
On 3/9/2013, the facility failed to ensure a resident was free from financial abuse. The facility's business office manager (BOM) stole $1,643.64 from the resident's trust fund by illegally using the facility administrator's signature stamp on company checks that the BOM wrote to herself. This could have been prevented if the facility had conducted monthly reviews of the residents' trust accounts as required by facility policy. Citation # 250010672.

San Jacinto Healthcare
275 North San Jacinto St., Hemet
B $2000 07/24/2014
CitationWatch description will be published once citation is received. Citation # 250010881.

The Springs At The Carlotta
41-505 Carlotta Drive, Palm Desert
B $1000 Physical Abuse Verbal Abuse 9/04/2013
The facility failed to protect a resident from physical and verbal abuse from a staff member. On 9/10/2008, an occupational therapist (OT) gave unwanted treatment to the resident who said she had chest pain. During a meeting between the resident's daughter and the discharge planner, the OT interrupted and contradicted everything the discharge planner had said and told her what was going to happen. The OT also threatened to take away the resident's oxygen because he was tired of carrying it behind her, and insisted she use a walker she didn't like because he "[knew] best." Citation # 250010072.

B $1000 Mental Abuse Verbal Abuse 9/4/2013
The facility failed to protect a resident from verbal and mental abuse from a staff member. On 9/10/2008, an occupational therapist told a resident to go somewhere else if she didn't like the treatment she was receiving, and that she needed to respect him and not treat him like a puppet. He also took her personal sling, dangling it in her face before returning it to her, because they had disagreements on treatment for her broken shoulder. Citation # 250010083.

Vista Pacifica Center
3674 Pacific Avenue, Riverside
B $2000 Fiduciary 05/13/2014
On 3/9/2013, the facility failed to ensure a resident was free from financial abuse. The facility's business office manager (BOM) stole $999.90 from the resident's trust fund by illegally using the facility administrator's signature stamp on company checks that the BOM wrote to herself. The money was supposed to be refunded to the resident's family within 30 days of the resident's death in the facility on 7/21/2012, but they never received it. This could have been prevented if the facility had conducted monthly reviews of the residents' trust accounts as required by facility policy. Citation # 250010673.
On 12/28/2013, the facility failed to ensure a resident was treated with dignity and protected from any verbal or mental abuse. When the resident called two CNAs a derogatory, belittling term, they responded by calling him a derogatory, sexual term. Later, when the resident confronted one of the CNAs, the CNA challenged the resident to a fight. This caused the resident to feel agitated. The CNA was fired after this incident, but blamed the resident for everything. Citation # 250010421.

San Bernardino County

Hillcrest Nursing Home
4280 Cypress Drive, San Bernardino
AN $15000 Staffing 9/4/2013

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 4 days out of 24 randomly selected days. Citation # 240010111.

Redlands Healthcare Center
1620 West Fern Avenue, Redlands
AN $15000 Staffing 1/9/2014

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 2 days out of 24 randomly selected days. Citation # 240010350.

Sky Harbor Care Center
57333 Joshua Lane, Yucca Valley
AN $15000 Staffing 2/20/2014

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 9 days out of 24 randomly selected days. Citation # 240010326.

San Diego County

Life Care Center of Escondido
1980 Felicita Road, Escondido
AN $15000 Staffing 1/9/2014

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 3 days out of 24 randomly selected days. Citation # 080010306.

Shea Family Care South Bay
553 F Street, Chula Vista
B $1600 Bed Hold 11/07/2013

On 1/4/13, a resident was sent to a general acute care hospital for evaluation. On 1/9/13, the resident was refused readmission by the DON. During the time of the admission refusal the resident become very anxious, had complaints of chest pain, and was sent back to the general acute care hospital. The DON denied being contacted by the hospital and receiving information and paperwork to readmit the resident. The facility administrator stated that the bed hold should have been honored upon return to the facility and acknowledged that the miscommunication on the facility's part lead to the denial of the readmission. The facility was cited for failure to honor their bed-hold policy. Citation # 090010183.

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.

Valle Verde Health Facility
900 Calle De Los Amigos, Santa Barbara
A $4000 Careplan Patient Care 7/1/2014

A 96 year old female resident, with dementia and osteoarthritis, was considered a high risk for falls and needed extensive assistance of one staff member for transfers. On 10/27/13, she fell while walking with her walker, switched to a wheelchair and the CNAs flow sheet indicated, "I need to have supervision when I am up in my wheelchair." She fell two more times in December 2013. On 2/17/14, she was found lying on the floor by her bed. Apparently she had tried to get out of bed and slipped. She sustained a fracture to her right upper arm as a result. The facility failed to provide the necessary supervision as well as consistently evaluating the effectiveness of current interventions and revision the care plan as needed. Citation # 050010827.

Tulare County

Westgate Gardens Care Center
4525 W. Tulare Avenue, Visalia
A $5000 Patient Care 4/8/2014

On 12/8/12, a female resident fell to the floor during a lift transfer because the lift legs were not open all the way. She was lying on the floor with the lift tipped over on top of her, complaining of severe nausea, headache and pain. The facility failed to protect the resident from injury when she fell from a mechanical lift onto the floor. Her injuries included a small compression fracture of her spine, a bruise and swelling to her head, bruises to her body, and increased pain throughout her body that persisted for several days. Citation # 120010455.

Ventura County

Ojai Gardens Nursing Center
601 N Montgomery Avenue, Ojai
AN $15000 Staffing 1/2/2014

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 4 days out of 24 randomly selected days. Citation # 050010311.