Proposed VA Regulations Will Delay and Deny Benefits

The U.S. Department of Veterans Affairs has released proposed regulations that would make it even more difficult for veterans and their spouses to access VA Aid and Attendance benefits. In response to a US Governmental Accountability Office (GAO) report decrying the predators that take advantage of veterans and sell annuities - the VA, instead of proposing any rules to outlaw or punish these predators, chose to punish the veterans.

Lacking any statutory authority, the VA’s package of onerous regulations is basically a mishmash of federal Medicaid and Supplemental Security Income (SSI) statutes. Medicaid is the federal/state health care program for low-income individuals and SSI is an income benefit program for low-income aged, blind and disabled individuals. The VA Aid and Attendance program is an additional pension for wartime veterans and survivors who are eligible for a VA pension and require the aid and attendance of another person, or are housebound. This program helps thousands of veterans remain out of institutionalized care.

The proposed rules, based on SSI and Medicaid federal statutes, include:

1. Establishing a net worth limit of $119,220 (includes annual income and all assets except a home and 2 acres). Note that this limit is the Community Spouse Resource Allowance under Medicaid – but Medicaid does not include annual income.

2. Establishing a 36 month look back period for any transfer of assets; a presumption that any transferred assets were transferred to become eligible for VA pension; a 10 year penalty period and no opportunity to declare a hardship - basically denying benefits for the life of the veteran.

3. Severely narrowing what can be counted as medical expenses - limiting payments to assisted living, which is currently the only option for many veterans except for a nursing home.

4. Placing a cap on what veterans can pay for home care. How these proposed regulations will help expedite claims processing at the Veterans Administration offices – already under fire for thousands of delayed claims- heaven only knows, since it will require three years of documentation and enormous amounts of paper. Unless the goal is to deny claims and ask questions later, hoping that the veteran will die before getting any relief.

The GAO report specifically recommended that the VA obtain clear statutory authority for any transfer of asset regulations and further recommended that Congress consider such legislation. However, no Congressional authority was given, and Senate and House bills ultimately died in committee. Instead of waiting for statutory approval, as recommended by the GAO, the VA decided that they had the ‘authority’ to promulgate regulations. They don’t. These regulations will surely be challenged in federal court and it’s a shameful act on the part of an administration that should be providing services to those who have served our country.

VA must receive comments on or before March 24, 2015. For a copy of the regulations and instructions on where to send comments see: http://www.va.gov/ORPM/docs/20150123_AO73P_NetWorthAssetTransfersandIncomeExclusionsforNeedsBasedBenefits.pdf

Meanwhile, write to your Senator and Congressperson and urge them to pull these poorly drafted rules.

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CANHR News

CANHR Board of Directors

CANHR is pleased to welcome two new members to its Board of Directors. Dr. Harvey “Skip” Davis RN, PhD, CARN, PHN, who is currently Clinical Adjunct Professor at Dominican University, Samuel Merritt University and California State University-East Bay and, Anne Marie Murphy, Esq. who is a principal at Cotchett, Pitre & McCarthy LLP. Welcome Dr. Davis and Anne Marie!

Staff News

CANHR is also pleased to announce the hiring of two new staff members. Kalinda Lisy, Special Project Staff, who is working on Elder Abuse and Elder Financial Abuse issues here at CANHR as well as finishing up her M.A. in Gerontology at San Francisco State University. Daniel Guerrero, Administrative Assistant, formerly an intern with Mission Economic Development Agency, he now brings his considerable administrative skills to CANHR. A very warm welcome to Kalinda and Daniel.

Donate to CANHR When You Shop on Amazon

It’s not just for the holidays! Any time of the year 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 CANHR by shopping at smile.amazon.com. On your first visit to AmazonSmile you will need to select, “California Advocates for Nursing Home Reform” as the charitable organization to receive donations from eligible purchases before you begin shopping. Amazon will remember your selection, and then every eligible purchase you make at smile.amazon.com will result in a donation.

Are you a Social Worker who needs information? Just SWAP!

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

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

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About CANHR

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

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DPH Leaders Take CANHR Advice – To Leave!

In the prior issue of the Advocate, CANHR called on the top two leaders of the California Department of Public Health (DPH) to leave and make room for new leaders who understand DPH’s role as a consumer protection agency for consumers – not providers. And they have done just that. On December 3, 2014, Dr. Ron Chapman announced he was resigning his position as Director of DPH. His second-in-command, Kathleen Billingsley, followed that with her own resignation announcement in February 2015. Ms. Billingsley was most directly responsible for the dysfunction within the licensing and certification division.

Their departure provides an opportunity for reform of the Department’s oversight of nursing homes but is no guarantee that its performance will improve. It is critical that the Governor appoint new leaders who have the qualifications, experience and will to transform the licensing and certification division into a consumer protection agency that is worthy of the public’s trust.

Governor Seeks Hundreds of New Positions for Department of Public Health

In related news, Governor Jerry Brown’s proposed budget for FY 2015-16 would add more than $30 million and about 260 positions for the Licensing & Certification Division of the California Department of Public Health (DPH) and its subcontract with Los Angeles County.

The explanation for the increase is shocking. One would expect that there must have been a huge increase in its workload to justify such an enormous expansion of its workforce, but that is not so. According to the budget proposal, the primary reason for the new positions is that its prior methodology failed to consider that inspectors were needed to investigate its vast backlog of complaints. Even with all of the new positions, DPH estimates it will take approximately four years to complete the current pending investigation workload.

In other words, the Department allowed thousands of complaints involving nursing home abuse and neglect to languish for years because its leaders could not competently perform the most basic assessment of its staffing needs.

Governor Proposes Major Increase in Nursing Home Rates with No Accountability

The Governor proposes to extend the Medi-Cal rate system for skilled nursing facilities – known as AB 1629 – through FY 2019-20 with compounded increases of 3.62 percent each year. Under the proposed five year extension, California’s annual Medi-Cal payments to skilled nursing facilities would grow to more than $5 billion by FY 2019-20, a near doubling of the Medi-Cal rates paid to skilled nursing facilities in 2004 when the AB 1629 rate system was first enacted.

In contrast, the minimum staffing levels for skilled nursing facilities have not been adjusted since 2000 and remain at 3.2 nursing hours per resident per day, a standard that was considered inadequate when it was enacted more than 15 years ago. Today, this standard is dangerously deficient. CANHR opposes extending the AB 1629 rate system unless it is accompanied by annual increases to California’s minimum staffing requirements that raise the minimum staffing requirement to at least 4.1 nursing hours per resident per day, including at least 0.75 RN hours per resident per day, by FY 2019-20.

The Governor’s proposal would continue the so-called Quality/Accountability Supplemental Payment Program, a poorly named program that diverts a tiny fraction of overall Medi-Cal payments to nursing homes that comply with a few suspect quality measures. By all appearances, the program is intended to create an illusion that Medi-Cal payments are tied to quality while doing next to nothing to serve that purpose.

Unmasked: How California’s Largest Nursing Home Chains Perform

The Sacramento Bee published a groundbreaking series of articles in November on who owns California nursing homes and why it matters to people who need nursing home care. The sweeping three-part series by Marjie Lundstrom and Phillip Reese identifies and examines
the performance of California’s 25 largest nursing home chains, exposes some of the people behind them and questions why they are so poorly regulated.

Using public data, the Sac Bee rated each of the 25 largest chains, giving lowest marks to the following: LifeHouse Health Services, EmpRes Healthcare Management LLC, Genesis HealthCare Corp., Mariner Health Care, and Brius Healthcare Services/Shlomo Rechnitz. The Sac Bee launched a statewide database on California nursing homes that identifies which facilities are owned by chains and the name and rating of the chain for each facility.

The series contains a gold mine of information on California nursing home chains. For example, it reveals that Shlomo Rechnitz, California’s largest nursing home operator, has acquired nearly 75 nursing homes since 2004 – and is connected to 130 businesses tied to his nursing home chain. Although not addressed in the series, two of Mr. Rechnitz’s nursing homes – the Wish-I-Ah Skilled Nursing and Wellness Center in Auberry and the South Pasadena Convalescent Hospital – have been closed or lost Medicare and Medicaid certification since November 2014 due to terrible care that contributed to the deaths of residents.

The series also exposed the Department of Public Health’s total failure to measure quality of care throughout a nursing home chain and to give complete and accurate information on nursing home ownership on its consumer information website. A Sac Bee editorial following the series summed up the situation: People who enforce the rules fail on the most basic level – helping people understand which chains operate safe and humane facilities, and which aren’t acceptable.

CANHR is exploring legislative opportunities to strengthen nursing home ownership disclosure laws, suitability requirements for nursing home operators, scrutiny of ownership transactions and information provided to the public on nursing home ownership.

Administration on Aging Publishes Final Long Term Care Ombudsman Regulations

On February 11, 2015, the Administration on Aging published final regulations for the long term care ombudsman program that take effect on July 1, 2016. The regulations fill a decades-old void for standards to govern ombudsman programs.

The regulations address numerous issues including independence of the program, public policy advocacy, timely response to complaints, the ombudsman’s role as an advocate for residents, confidentiality, the relationship between the state office and local ombudsman programs, conflicts of interest, interference with the ombudsman and many others.

The regulations do not address underfunding of the program, which has always hindered its effectiveness. Nor do they require the state ombudsman office be operated outside of state government. The California office is housed in the California Department of Aging, which has a long history of interfering with its independence.

A link to the regulations is posted on CANHR’s website.

The Consumer Financial Protection Bureau Releases Report of Top Complaints

The Consumer Financial Protection Bureau (CFPB) released a report highlighting the top complaints for reverse mortgages. According to the report, consumers are frustrated with their loan terms, servicer runarounds, and foreclosure problems. To help consumers who already have a reverse mortgage, the CFPB is issuing an advisory with tips on how to plan ahead to protect loved ones from financial hardship brought on by a reverse mortgage.
Canhr will be sponsoring or co-sponsoring several pieces of legislation this session, and will be closely following several other bills, including budget bills.

**Canhr Sponsored**

**SB 33 (Hernandez): Medi-Cal Recovery Reform**

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 require the Department to provide claims detail information free of charge to current or former Medi-Cal beneficiaries and to post how to obtain this information on their website. Co-sponsored with Western Center on Law and Poverty, SB 33 is similar to SB 1124, which had unanimous bipartisan support, passing the Assembly Floor by 78-0 and the Senate Floor by 33-0, but was vetoed by Governor Brown. There is hope that this year his administration can be persuaded that forcing low income citizens to sell their family homes or pay back Medi-Cal claims at 7% interest destabilizes low income communities and is simply poor public policy.

Status: SB 33 will be heard in the Senate Health Committee on March 25.

**Letters of support should be sent to Senator Ed Hernandez, Chair, Senate Health Committee, Room 2191, Sacramento, CA 95814 or via FAX: (916) 266-9438**

**AB 601 (Eggman): Suitability of Ownership/Ownership Disclosure for RCFEs**

Although over 90% of California’s 7,500+ Residential Care Facilities for the Elderly (RCFEs) are owned and operated by for-profit providers, ownership information on RCFE licensees is not made available to the public, and the licensing agency, the Department of Social Services, Community Care Licensing, is often unaware of what other facilities are owned and operated by the same licensee or whether the proposed licensee has a prior record of substandard care. This bill would establish specific suitability of ownership criteria and require applicants for a residential care facility for the elderly license to disclose complete ownership information, including disclosure of any person(s) who holds a 10% or more beneficial interest in the facility and all related entities.

Status: Will be heard in Assembly Human Services in March.

**Budget Issues of Concern in 2015**

**AB 1629 Extension via Budget Trailer Language = $1 Billion in Nursing Home Rate Increases with No Accountability, No Increase in Staffing and No Caps on Spending**

The Governor proposes to extend the Medi-Cal rate system for skilled nursing facilities – known as AB 1629 – through FY 2019-20 with compounded increases of 3.62 percent each year. Under the proposed five year extension, California’s annual Medi-Cal payments to skilled nursing facilities would grow to more than $5 billion by FY 2019-20, a near doubling of the Medi-Cal rates paid to skilled nursing facilities in 2004 when the AB 1629 rate system was first enacted. In contrast, the minimum staffing levels for skilled nursing facilities have not been adjusted since 2000 and remain at 3.2 nursing hours per resident per day, a standard that was considered inadequate when it was enacted more than 15 years ago. Today, this standard is dangerously deficient. CANHR opposes extending the AB 1629 rate system unless it is accompanied by annual increases to California’s minimum staffing requirements that raise the minimum staffing requirement to at least 4.1 nursing hours per resident per day by FY 2019-20. Additionally, the rate system should be amended to cap administrative costs at a maximum of 20 percent (excluding quality assurance and licensing fees).

For details on specific bills, go to: www.leginfo.ca.gov.
Some Power decided that I should be off the planet for a while, so I was afflicted with a severe case of pneumonia and a lung abscess. This put me in the hospital for a couple of weeks, and after figuring out which antibiotic cocktail I needed and draining my lungs, doctors sent me to a nursing home for a month to get antibiotics intravenously. Another health issue was a problem swallowing, a result of long-term heartburn. (GERD)

I was lucky, although quite ill, I was ambulatory and aware, had a loving family and friends, and was covered by Medicare and health insurance.

My health plan offered me a list of nursing home possibilities, and I chose one near my home to be more convenient for visitors and family. The nursing home accommodated two patients to a room, and four to a bathroom. My first two roommates were very nice people and we adjusted to each other successfully. The third week I had my room solo, partly because of the problem with the heating system. My room was cold, and could not be heated because if my room’s temperature was raised, the rest of the patients in the facility complained of it being too warm. I could evade the draft with curtains, but the other bed was right under the vent.

The last week, I had a new roommate. She immediately turned on television to watch “Real Housewives.” I had never watched this before and was horrified. I asked her what time she turned off the TV, and she said 11 PM and would not change her ways. So I went out into the hall, notified the staff that I would be sleeping in the Activity Room. Within 20 minutes, they found me another roommate--she was perfect; she was comatose. I actually found I could be helpful to her at times when she needed repositioning.

Services offered were physical therapy (PT), occupational therapy (OT), and speech therapy (for my swallowing problem.) What struck me as odd was there seemed to be no routine. At times, an aide would offer me a shower in the morning, other days in the afternoon, other days not at all. Some days they would appear in the morning to offer me towels for washing up, other days not at all. Some days PT might come at 9 AM; other days at 2 PM; sometimes at 5 PM; and sometimes never. OT came some days at various hours and other days not at all. Speech therapy made a point of coming at meal time to gauge my swallowing abilities. I noticed that the cleaning staff did not appear very often, so I obtained some wipes and cleaned the bathroom myself prior to my using it.

My oral medication was supposed to be given to me at 12 midnight, 8 AM and 4 PM. After waking up at 2:30 AM one day, I found I had not been given my antibiotic, and started noticing the time lapses when I should receive them, so I began reminding the staff when to medicate me. A nurse had to link me up to the intravenous antibiotics once a day, usually at 3 PM. This procedure took about an hour, so I could not do PT or OT then, but this was not communicated to these departments.

My problem swallowing made it difficult to take pills, so oral medications had to be in liquid form. Three times during my stay, the home ran out of liquid antibiotics and asked me to get family members to pick them up from Kaiser pharmacy several miles away. I could not believe that I, the patient, should have to demand these services! And figure out how to obtain them! And where was the nursing home in all this.

The quality of the staff varied a great deal. Some staff were wonderful, skilled, caring, and did their jobs well. Others were merely competent, and some were barely with it. One speech therapist helped me a great deal with the swallowing problem, observed me carefully and recommended an endoscopy, which later really helped. Another chatted with me about her grandmother but did not do anything. On occasion, aides would propose working for me after discharge if I needed care. Some PTs were great, giving me exercises and evaluating me, others just took me for a walk and talked. Nurses providing the intravenous medication were highly skilled. In general, my impression was that the home was understaffed. Sometimes it took a long time--an hour--to have a response to my bell if there was a problem or if I needed help.

The head of the kitchen visited early on, and later participated in an early staff meeting held to explain my rights and responsibilities, where I noticed that she yawned a lot. Instructions to the kitchen were ignored much of the time. They gave me food that I was allergic to, (tomatoes) and food that I did not care for (cantaloupe). My printed food list was on my tray, but I am not sure that the kitchen staff were literate or English speaking since it was not followed. Because of the swallowing problem, I could not eat food that was...
Reducing Gross Income for Share of Cost

Many Medi-Cal recipients are shocked to read on their Notices of Action that their Share of Cost is more than the income they actually receive. How is this possible when beneficiaries can’t pay a Share of Cost with money they don’t have. If the beneficiaries only receive Social Security or payments from retirement accounts, this is not usually a problem. The problem arises with pension income where taxes are deducted.

Share of Cost for Medi–Cal is calculated using the gross income – i.e., before taxes are deducted. This is why the Share of Cost can result in being more than your net income, which is the income you actually receive every month. Since this rule is based on federal law, it is impossible to challenge, but you can increase your net income so that they can pay your Medi–Cal Share of Cost.

You can do this by stopping the withholding of taxes from your income. In order to do so, fill out Form W–4P (“Withholding Certificate for Pension or Annuity Payments”) to stop the IRS from withholding federal taxes. You can get this form on line at the IRS web site or from any tax specialist (H&R block, for example). For withholding state taxes, contact your pension plan and request a “California State Income Tax Withholding Election Form.” Once these deductions are stopped, the problem with counting income that you don’t actually receive should be fixed. Most, if not all of what you pay for share of cost for nursing home care can be deducted from your taxes at the end of the year, so it should even out. Ask your tax consultant/expert.

Deducting Medical Assistance Costs

If you are receiving medical assistance in a nursing home, assisted living facility or hire a nurse to receive care at home, there are valuable income tax deductions that you or your loved one will qualify for. Medical expenses that may be incurred for an elderly individual in need of medical and / or maintenance assistance, either in their home, assisted living facility or a medical facility, including medical insurance payments and co-payments, are generally qualifying medical expenses for IRS purposes. For a complete listing of all qualifying medical expenses, please see Publication 502 provided by the Internal Revenue Service which can be found at http://www.irs.gov/pub/irs-pdf/p502.pdf and don’t forget to bring a complete list of these expenses when you do your taxes.

Receipt of Lump Sum Tax Refund

For those fortunate enough to receive an income tax refund, these are considered property in the month of receipt, and, if spent down in that month, will not be considered an asset in the next month. (22 CCR §50454)

Now 50% OFF!

“A Consumer’s Guide to Financial Considerations and Medi-Cal Eligibility”

Outlines requirements for Medi-Cal. Includes discussion of protection of assets, including the home, when a spouse enters a nursing home.

(updated April 2014)

To order online visit:

http://www.canhr.org/publications/Consumer_Pubs.html
Supplemental Security Income/State Supplementary Payment (SSI) is a program funded by the state and federal government that guarantees a minimum monthly income to people who are over 65, blind or disabled, and have limited incomes and resources. If an RCFE resident receives SSI, California law limits the monthly rate that the facility may charge the SSI recipient. As a result, some RCFEs have attempted to limit a resident’s right to receive SSI by including waiver language in their admission agreements, e.g., “You warrant that you (or another person on your behalf) will not apply for SSI benefits while you are a resident of the community.”

**Admission agreement language limiting a resident’s right to apply for SSI is illegal and unenforceable.**

California law provides that an RCFE may not require a resident to sign documents waiving a right to receive benefits as a condition of admission:

“No provision of a contract of admission, including all documents that a resident or his or her representative is required to sign at the time of, or as a condition of, admission to a residential care facility for the elderly, shall require that a resident waive benefits or rights to which he or she is entitled under this chapter or provided by federal or other state law or regulation.”

Health and Safety Code Section 1569.269(c). California law also provides that an RCFE admission agreement shall not include any provision that the facility knows or should know is deceptive or unlawful. Health and Safety Code Section 1569.883(b).

RCFEs cannot prohibit residents from applying for public benefits to which they are entitled and which are necessary for their survival, nor can they require residents to waive their rights to apply for such benefits. Health and Safety Code Sections 1569.269(c), 1569.883(b). Admission agreements or policies purporting to limit a resident’s right to receive such benefits are heinous attempts to undermine, circumvent and violate established laws and protections for our most helpless citizens. A waiver or warranty providing that a resident will not apply for SSI (or eat meals, receive visitors, or seek necessary health care) is deceptive, illegal, and unenforceable.

For more information regarding RCFEs and SSI, including how to apply for SSI, see our fact sheet at [http://canhr.org/factsheets/rcfe_fs/html/rcfe_ssi_fs.htm](http://canhr.org/factsheets/rcfe_fs/html/rcfe_ssi_fs.htm).

My Nursing Home Experience ... (continued from page 6)
Dear Indebted in Indian Wells,

Actually, if your mother owns property, she does have an estate. If the credit card is in her name alone, her estate is responsible for the debt. As the estate goes through probate, the executor or administrator of the estate will make a determination of the assets and debts of the estate and pay off debts in the order that state law requires. If assets remain after that, they will be distributed to heirs according to her will or, if she doesn’t have a will, state law. However, you and your brother are not responsible for her debt. Also, you do not need to use the life insurance to pay debts if your mother names a beneficiary or beneficiaries for the policy and at least one of the people named, outlives her. In that case, the insurance proceeds would go straight to the beneficiaries, avoiding the probate process. Remember - if your mother does not name a beneficiary on the insurance policy, the insurance proceeds may be included in her estate and could be used to pay her bills, including credit card debt.

Did You Know?

New Toll-Free Hotline for RCFE Complaints

On January 20, 2015, the Department of Social Services’ Community Care Licensing Division (CCL) launched a statewide toll-free public complaint hotline. To file a complaint about an RCFE, community care or child care facility, call 1-844-LET-US-NO [1-844-538-8766]. The complaint hotline will be managed and staffed by the newly created Centralized Complaint and Information Bureau (CCIB) who are available to take calls between 8am-5pm. Consumers should also send a written statement of their concerns to the CCIB by email, fax or mail:

California Department of Social Services
Community Care Licensing Division
Centralized Complaint and Information Bureau
744 P Street
Sacramento, CA 95814
Fax: (916) 651-6668
Email: letusno@dss.ca.gov

The CCIB is responsible for complaint intake only. Investigation and enforcement activities will continue to be handled locally. Complaints received by the CCIB will be sent to regional offices for investigation and follow-up. Questions and concerns regarding a complaint should be directed to the local Adult and Senior Care Regional Office - http://ccld.ca.gov/PG408.htm.

While CANHR recognizes that the current decentralized approach may be inefficient and ineffective, the same could be true of a centralized hotline, especially if it is understaffed or the staff lacks the qualifications, training and experience to process complaints for all of the facility types licensed by CCL. For more information about the complaint hotline, see http://ccld.ca.gov/PG408.htm.

For more information on filing complaints about RCFEs, see http://canhr.org/factsheets/rcfe_fs/html/rcfe_complaints_fs.htm.

Dear Advocate,

Who Pays Mom’s Debts After She Passes Away?

Dear Advocate,

My mother has credit card debt. She is a widow. She has no estate, but there is a small amount of life insurance that we’re planning to use for funeral expenses and to do repairs to the house so we can put it up for sale. When she passes, are my brother and I responsible for her debt?

Best,

Indebted in Indian Wells
CANHR on the Move...

Past Speaking Engagements, Panel Discussions and Training Sessions

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

• **October 31:** Staff Attorney Prescott Cole presented at the National Adult Protective Services Association’s 5th Annual Summit on Elder Financial Exploitation in Portland, Oregon.

• **December 18:** Staff Attorney Jody Spiegel gave a presentation on CANHR services for the Center for Health Care Rights’ HICAP Volunteer Counselor holiday meeting in Burbank.

• **January 13:** Outreach Coordinator Efrain Gutierrez hosted a CANHR information table at Alice Manor in Los Angeles.

• **January 28:** Staff Attorney Tony Chicotel spoke to the fine staff of Hayward Hills Healthcare Center and provided an in-service training on capacity and resident rights.

• **February 17:** Staff Attorney Jody Spiegel presented to the Alzheimer’s Association and discussed CANHR services, trainings and collaboration.

• **February 10:** Outreach Coordinator Efrain Gutierrez spoke to Kaiser social workers in Gardena.

• **February 23:** Tony Chicotel with Dr. Al Power and the management team of Hayward Hills Health Care Center at the February 23rd Sustaining Momentum and Success in Dementia Care conference in Sacramento.

• **February 25:** Long Term Care Advocate Julie Pollock spoke at the Coast side Adult Day Health Center in Half Moon Bay.

• **February 25:** Long Term Care Advocate Mike Connors hosted a CANHR information table at the Dementia Care Partnership Event in Pasadena.

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*Efrain Gutierrez representing CANHR at Alice Manor in Los Angeles*

*Tony Chicotel with Dr. Al Power and the management team of Hayward Hills Health Care Center at the Sustaining Momentum and Success in Dementia Care conference in Sacramento.*

CANHR welcomes memorial and honorary gifts. This is a great way to honor a special person or a loved one who has been a nursing home resident, while helping those who are nursing home residents. Recent gifts have been made in the names of the following persons:

**MEMORIALS**

- **My Husband Robert C. Bennett**
  Robert & Jane Bennett
- **My Mom - Carrie J. Brown**
  Art Brown
- **Isabel Brown**
  Bobbi Johnson
- **Herman Chetlen**
  Martin Chetlen
- **Ethel Christensen**
  Ron Christensen
- **My husband Joseph “Joe” V Joyce, Jr (Navy veteran) and my mother**
  Jeannette T. Chumbler
  Nina Joyce
- **Donna Smith and Luther B. Denson**
  Ruth Holland
- **Professor Milorad M. Drachkovitch**
  Helen Drachkovitch
- **Charles Etherington**
  Mary Etherington
- **Maxine and Ernie Gallo**
  La Vonne Gallo
- **Faith Geer**
  Martin Schiffenbauer
- **My husband, Robert Haake**
  Susana Haake
- **Annie Ruth Hammontree**
  Jack & Annie Murphy
- **Edward A. Jaworski**
  Joanne Jaworski
- **Sanford Kadish**
  Ada Burko
- **Jean Kards**
  Aliki Hill
- **Sheila Lillian Krieger**
  Robyn Krieger
- **Israel Kunofsky**
  Judith Kunofsky
- **Mrs. Lucille Labat**
  Louis Labat
- **Esther Lindberg**
  Lorenzo & Patricia Sandoval
- **Josephine Luckjohn**
  Georgia Riportella
- **Lily Mason**
  Ron Wing
- **LeRoy McDonald**
  David McDonald
- **Joseph W. McDonough**
  Gwen McDonough
- **Charles ‘Chuck’ McLuen**
  Jeannette Santine
- **Helen Vail Muller**
  Helen Drachkovitch
- **Dr. R. Theodore Muller**
  Helen Drachkovitch
- **Mary Nagel**
  Ann & Franz Tittiger
- **Patrick Nobis**
  Carole Nobis
- **Rosalie Ortega**
  Shirley Ortega
- **Thelma Ousborn**
  Mary Woolfolk
- **Maud Pamphile**
  Jane Pamphile
- **Martha Pauly**
  John Pauly
- **Franklin & Rosita Pennill**
  Lee Pennil
- **My beloved husband Jerry Lamont Rogers**
  Gerri Rogers
- **Larry Roth**
  Penny Deleray Taylor
- **Lynne Cowden Sanders**
  Gail Bean
- **Julius Schnall**
  Jean Schnall
- **LaVerne Schwacher**
  Debra Vogler
- **Richard Bauman and Celia Sebastian**
  Maxine Barton
- **Lottie Shamis**
  Judith Betts
- **Evelyn D. Smith**
  Tonya Smith
- **Beatrice Smythe**
  Susan Nissen
- **Karen Spishak**
  Martin Raymon
- **Esme Springer**
  Alan Springer
- **Burton Sukhov**
  Amy Sukhov
- **Don & Eunice Stuart**
  Kathleen Stuart
- **William F. Taylor**
  Martha Taylor
- **Pasty Tremewan**
  Marianne Meredith
- **My beloved mother, Rita Twomey**
  Denise Twomey
- **Bruno and Evelyn Wartman**
  Mr. & Mrs. John & Paddy Moran
- **Patricia Isabel Wright**
  Alice Jones
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 HONOR OF**

Raymond M. Biederman  
Sharyl Shanen-Raya  
Ciara Isabella Gibney Gutierrez  
Marian Rubin  
Laura R Mitchell  
Neil & Laura Mitchell  
Malcolm Osoff  
Carol Osoff  
David Parker  
Anne Brooks  
Marilyn Rowland  
Trevor & Marilyn Rowland  
Josephine Roy  
Steven Roy  
CANHR Staff  
Virginia & Robert Barker  
Malcolm Osoff  
Carol Osoff  
Pat McGinnis for many years of service  
Geraldine Murphy  
Social Services Designees trying their best!  
Tracy Greene Mintz, LCSW  
My homies at CANHR  
Kyle Matthews  
In appreciation of Mike Connors  
Nancy Biederman  
Sabita Goswani  
Subrata Goswami  
Laura R Mitchell  
Neil & Laura Mitchell  
Marilyn Rowland  
Trevor & Marilyn Rowland  
Josephine Roy  
Steven Roy  
Ciara and her family  
Donna & Tom Ambrogi  
Annie Ruth Hammontree  
Jack & Annie Murphy  
David Parker  
Anne Brooks  
My mom Alice M. Scobey and all vulnerable seniors.  
Mary Webster  
CANHR Staff  
Terry Donnelly  
Toby Edelman  
Pat McGinnis & Staff  
George & Rovena Tacusis  
CANHR Staff  
Terry Donnelly  
Toby Edelman  
Pat McGinnis & Staff  
George & Rovena Tacusis  

**IN CELEBRATION OF**

Evelyn D. Smith  
Teri Smith  
Tracy Greene Mintz, LCSW  
Mary Webster

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**CANHR Up Coming Events**

- **April 10:** Los Angeles Social Worker Training- Medi-Cal and Medi-Cal Recovery Frequently Asked Questions- 10am-1pm, Magnolia Place Family Center, 1910 Magnolia Avenue, Los Angeles, CA 90007
- **April 17:** San Francisco Social Worker Training- Medi-Cal and Medi-Cal Recovery Frequently Asked Questions- 10am-1pm, St. Mary’s Cathedral, 1111 Gough St., San Francisco, CA 94109

To register for the trainings, please visit:  
http://www.canhr.org/trainings/SWTrainings.html
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CANHR, 650 Harrison Street, 2nd Floor, San Francisco, CA 94107.

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

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

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Address: _________________________________________________________________________
City/State: _________________________ Zip: ________________________
Telephone: ________________________ E-mail: ________________________________
Facility Name: ________________________________

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### Alameda County

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

B $1500 Fall Injury Patient Care 07/14/2014
On 8/6/13, a 71 year old female resident fell and fractured her ankle while being transferred from the toilet to her wheelchair. The CNA failed to follow the resident's care plan, which required a two-person assist for transfers. The facility was cited for failure to provide adequate supervision and assistance devices to prevent accidents. Citation # 020010855.

**Elmwood Care Center**
2829 Shattuck Ave., Berkeley

B $1000 Fall Patient Care 7/14/2014
On 4/18/14 a resident who had an order for a bed alarm fell from bed trying to use the bed pan on his own. There was no bed alarm, and a nurse said there were no bed alarms available. As a result of the fall, the resident suffered a dislocation of the right hip. The facility failed to prevent the resident from getting out of bed on his own. The facility also failed to follow their own Fall Prevention policy to create individual care plans for residents determined to be at risk for falls in order to prevent accidents. Citation # 020010860.

**Pleasanton Nursing And Rehabilitation Center**
300 Neal Street, Pleasanton

B $1350 Patient Care 7/09/2014
On 5/8/14 a resident fell trying to go to the bathroom by herself. When the CNA found her, she noted a baseball sized bump on the back of the resident's head. Apparently the resident forgot to use her call light to ask for help going to the bathroom. The facility failed to provide a bed alarm. The facility also failed to ensure the necessary staff to prevent her fall, or implement a care plan to prevent falls. Citation # 020010913.

**Windsor Healthcare Center of Oakland**
2919 Fruitvale Ave., Oakland

B $1500 Patient Care 9/3/2014
On 3/6/14, a resident's primary care physician requested a wound consultant. The resident had three pressure ulcers with dead tissue and two with deep tissue injury indicating tissue death beneath the intact skin. A wound care physician was retained, but the facility failed to communicate with the physician that the resident was taking anticoagulant blood thinning medications prior to the physician performing surgical wound debridement (removal of tissue by surgical instruments). As a result, the resident developed uncontrolled bleeding after the procedure, and had to be sent to the ER for evaluation and treatment. The facility was cited for failing to communicate that the resident had been taking anticoagulant medications. Citation # 020010969.

### Butte County

**Gridley Healthcare & Wellness Centre, LLC**
246 Spruce Street, Gridley

B $1000 Mandated Reporting Physical Abuse 11/17/2014
Gridley Healthcare & Wellness Centre failed to report an incident of alleged resident-to-resident physical abuse. On 5/13/14, an 86 year old female resident told a licensed nurse that her roommate struck her in the face. The nurse informed the Administrator that day; however, no staff member reported the incident to the Department of Public Health until 7/11/14, when the incident was discovered during a medical record audit. Citation # 230010990.

### Contra Costa County

**Lone Tree Convalescent Hospital**
4001 Lone Tree Way, Antioch

B $1500 Fall Patient Care 8/6/2014
On 5/8/14 a resident fell trying to go to the bathroom by herself. When the CNA found her, she noted a baseball sized bump on the back of the resident's head. Apparently the resident forgot to use her call light to ask for help going to the bathroom. The facility failed to provide a bed alarm. The facility also failed to ensure the necessary staff to prevent her fall, or implement a care plan to prevent falls. Citation # 020010913.

### San Pablo County

**San Pablo Healthcare & Wellness Center**
13328 San Pablo Ave., San Pablo

B $2000 Physical Environment 06/04/2014
On May 20, 2014 the California Office of Statewide Health Planning and Development (OSHPD) found that the facility was out of compliance with state regulations for hot water heating, and that in the inspector's opinion, "all residents of the facility were at serious risk for hot water injury." The facility was cited for failing to ensure the safety of resident from burns due to overheated water. Citation # 020010744.

**Shields/Richmond Nursing Center**
1919 Cutting Blvd, Richmond

B $1500 Patient Care 7/17/2014
On 4/26/14, a resident's roommate heard the resident, who was behind a curtain, cry out in pain while being attended to by facility staff. The roommate said that neither the staff nor the resident, who had dementia and cognitive impairment, would say what happened. After the incident the resident's eye turned purple. When interviewed by the state inspector, the director of nurses stated that the bed railings were padded after the incident, so the resident must have hit the railing. The facility was cited for failing to protect a resident from accidental injury. Citation # 020010865.

### Humboldt County

**Eureka Rehabilitation & Wellness Center, LP**
2353 Twenty-Third St, Eureka

A $20000 Medication 7/30/2014

The facility was cited for continually giving a resident doses of Risperdal and Ativan, even though the resident was exhibiting symptoms of adverse reactions to those antipsychotic medications. The resident was a 70 year-old with dementia, anxiety, and depression. The nurses’ notes indicate that she was able to ambulate independently on 12/8/12, but progressively became unsteady, weak, and then unable to stand. By 1/28/13 she was noted to be pale, cold to the touch and shivering in blankets, and had to be sent to an acute care hospital. At the hospital she was described as almost catatonic. It was determined that her conditions was “likely due to psychiatric medications.” Once the antipsychotic medications cleared from her body the resident became more alert. She able to get out of bed, walk, and talk. Citation # 110010516.

Mendocino County

**Redwood Cove Healthcare Center**

1162 S. Dora Street, Ukiah

B $2000 Verbal Abuse 10/2/2014

On 5/21/14 a resident who had suffered from a stroke and who was wheelchair bound yelled for a nurse. When the nurse arrived, the nurse yelled at the resident and told him to shut up. The facility was cited for failing to ensure that the resident was free from verbal abuse and for failing to prevent the nurse from yelling at the resident during an investigation of the allegations. Citation # 110010869.

A $20000 Deterioration Neglect Notification 10/24/2014

On 2/3/14, a diabetic resident was hospitalized with diabetic ketoacidosis – a life threatening complication of diabetes – resulting from neglect at the facility. Prior to hospitalization, the resident vomited several times and became increasingly confused and ill throughout the day while his blood sugar levels soared. He did not receive sufficient insulin because the licensed nursing staff did not recognize the significance of a “HI” result on the facility glucometer and the facility did not have a care plan to assist him when he became confused and unable to manage his insulin pump. The facility also failed to notify his attending physician of a nearly 3 hour delay in reaching a consulting physician for treatment orders, adding to other long delays in responding to the life threatening emergency. Citation # 110010719.

**Ukiah Post Acute**

1349 S. Dora St, Ukiah

A $20000 Fall Injury Supervision 10/01/2014

On 6/9/14, a resident fell and fractured her right hip while attempting to walk unassisted. She was hospitalized for surgery on her hip. The facility was cited because it did not provide her adequate supervision to keep her safe and failed to appropriately modify her care plan after earlier falls. During the six-month period prior to her hip injury, the resident suffered seven earlier falls while getting out of her bed or her wheelchair unassisted. Citation # 110010928.

Napa County

**Napa Valley Care Center**

3275 Villa Lane, Napa

A $20000 Careplan Patient Care 10/09/2014

The facility was cited for failure to develop an effective fall prevention plan for a resident who was determined to be high risk for falls and who was known to get up unassisted. The resident, diagnosed with muscle weakness, was assessed as having cognitive deficits and poor safety awareness. A prevention plan included the use of bed and chair alarms; however, staff reported they were aware of the resident's history of removing the alarms and getting up without supervision. The lack of an effective fall prevention plan resulted in the resident walking out of the facility unsupervised to the outdoor patio, falling, and receiving multiple facial fractures and lacerations. Citation # 11001054.

**Piner's Nursing Home**

1800 Pueblo Avenue, Napa

A $18000 Careplan Patient Care Supervision Staffing 10/15/2014

The facility failed to develop a nursing plan of care to provide adequate supervision for a 73 year old resident who had previously been determined to be at risk for falls. During a bedside ultrasound, the resident was moved to the edge of the bed without a staff member present to ensure she would not fall. This resulted in the resident falling out of bed onto the floor and sustaining a fracture to her left elbow. Citation # 110011062.

Sacramento County

**Asbury Park Nursing And Rehabilitation Center**

2257 Fair Oaks Blvd., Sacramento

B $2000 Mandated Reporting Physical Abuse 09/17/2014

On July 19, 2014, an allegation of abuse was reported to the Ombudsman that a resident was fighting off a worker and sustained discoloration to her left forearm. On July 24, 2014, an allegation of abuse of another resident was reported to the Ombudsman. The resident stated that someone had twisted her hand causing a bluish discoloration and swelling, and her clinical record revealed that she had a broken bone in the palm of her hand. The Ombudsman reported both incidents to the Department, but the Department did not receive any information from the facility regarding the abuse allegations. The facility was cited for failing to report the two allegations of abuse to the Department within 24 hours. Citation # 030010989.

B $2000 Mandated Reporting Verbal Abuse 09/17/2014

On June 25, 2014, it was reported to the Ombudsman that a CNA made inappropriate comments to one resident, and repeatedly yelled and scolded another resident until she was so upset she was shaking. On June 26, 2014, it was reported to the Ombudsman that the CNA yelled multiple abusive statements to a third resident. The Ombudsman reported these allegations to the Administrator, who was unable to provide evidence that he reported them to the Department. The facility was cited for failing to report the three allegations of abuse to the Department within 24 hours. Citation # 030010988.

**San Francisco County**

**Central Gardens**

1355 Ellis Street, San Francisco

B $2000 8/13/2014

CitationWatch description will be published once citation is received. Citation # 220010921.

**San Joaquin County**

**Wagner Heights Nursing And Rehabilitation Center**

9289 Branstetter Place, Stockton

B $1000 Mandated Reporting Physical Abuse 07/10/2014

On March 19, 2014, a resident reported that a CNA choked him. Neither the CNA, nor other facility staff, completed an abuse report. According to the Administrator, the resident had been the one to report the abuse to him on March 24, 2014. The facility was cited for failing to report an allegation of abuse to the Department within 24 hours. Citation # 030010840.

**San Mateo County**

**Nazareth Vista**

1041 Hill St., Belmont

A $20000 Fall Patient Care 11/14/2014

In 2014, a female resident fell and fractured her left hip in the bathroom. The resident was a fall risk, and the staff failed to assist her to the bathroom every two to three hours as indicated in her care plan. According to staff interviews, the resident was taken to the bathroom at 8:00 a.m. on the morning of the fall, and was not taken again before she fell at 1:15 p.m. The facility also did not put a bed pad on the floor as directed by the resident's care plan. The facility was cited for failure to implement the resident's plan of care. Citation # 220011126.
Santa Clara County

Pacific Hills Manor

370 Noble Court, Morgan Hill
B $1000 Mandated Reporting Mental Abuse Patient Care Physical Abuse 09/04/2014
A female resident was being turned by a CNA on 8/18/14, when she told the CNA her neck was sore. The CNA responded by stating, "You are ok," and then calling the resident a baby when she began to cry due to the pain. The facility failed to report the incident within 24 hours. Furthermore, records indicate that the CNA worked with an expired certification for 10 days in May of 2014. The facility was cited for failure to develop and implement policies to prevent resident abuse and neglect. Citation # 070010981.

Skyline Healthcare Center - San Jose

2065 Forest Avenue, San Jose
B $1000 Patient Care Transfer 08/28/2014
On 8/1/14, a 77 year-old female resident was improperly transferred from her bed to her shower chair, resulting in a left shoulder fracture and contusion. The CNA transferred the resident by himself, even though the resident's assessment stated that she required a "two or more person transfer." The facility was cited for failure to ensure that each resident receives adequate supervision and assistance devices to prevent accidents, and failure to ensure the resident environment remains free of accident hazards. Citation # 070010942.

Santa Cruz County

Kindred Nursing and Transitional Care-Santa Cruz

1115 Capitola Road, Santa Cruz
A $15000 Fall Patient Care Transfer 05/12/2014
On 2/16/14, a female resident was improperly transferred from her bed to an electric wheelchair. Two CNAs did not turn the wheelchair off prior to the transfer, and the resident's arm hit the control joystick, causing the wheelchair to spin around. The resident fell to the floor and hit her head, resulting in a fracture to her right eye socket and significant bleeding. The facility was cited for failure to provide an environment free from accident hazards, and failure to provide each resident with adequate supervision and assistance devices to prevent accidents. Citation # 070010708.

Solano County

Greenfield Care Center of Fairfield

1260 Travis Blvd., Fairfield
B $1000 Mandated Reporting Physical Abuse 9/26/2014
After a staff member was observed dragging a resident from the dining room by their walker, the facility failed to report the instance of alleged resident abuse within the 24 hours required by law. Citation # 110010906.

Sonoma County

Sonoma Healthcare Center

1250 Broadway, Sonoma
A $20000 Fall Injury 03/4/2014
A male resident with a high fall risk and several documented attempts to stand and walk without assistance suffered six falls in a 20-day period from 8/26/11 to 9/16/11. The facility did not intervene to prevent further falls. On 9/16/11, the resident fell while getting up unassisted from his wheelchair and broke his femur. The facility was cited for failing to provide adequate supervision and prevent accidents. Citation # 110010198.

EmpRes Post Acute Rehabilitation

300 Douglas Street, Petaluma
A $20000 Chemical Restraints 9/16/2014
A male resident with dementia was drugged with three antipsychotic drugs to restrain him from alleged physical aggression. Within days, he suffered a rapid decline, was no longer able to walk or talk, and required a mechanical lift to transfer from his bed to a wheelchair. The resident was drugged with Seroquel (the dosage increased over time), Risperdal (the dosage increased over time), and Zyprexa. The resident's physician rebuffed a nurse practitioner's recommendation to discontinue Zyprexa and another recommendation to reduce the Seroquel. Multiple symptoms were noted including tremors and immobile facial expressions but the drugging continued. A consultant pharmacist report recommended the physician justify the extreme drugging. The physician responded "no changes" to current plan. The facility's staff asked the physician to approve a gradual reduction in the drugs to which the physician responded "no" without including a justification. Upon interview, the physician said he prescribed all three drugs to control the resident's behaviors. The facility was cited for failure to implement its policies for decreasing or discontinuing antipsychotic drug usage in the presence of severe side effects. Citation # 110010655.

A $18000 Fall Injury 11/18/2014
On 5/3/11, a resident with amputations below both knees fell from a special toilet for people with limited mobility. He sustained a severe head wound and a cervical spine fracture. The facility failed to properly account for the resident's fall risk and did not use the resident's leg prosthesis to decrease that risk. The facility was cited for failing to use preventative measures to reasonably reduce his fall risk. Citation # 110011120.

Friends House

684 Benicia Drive, Santa Rosa
B $2000 Physical Environment 09/19/2014
On 5/27/2014, the facility failed to maintain an environment free of fire hazards when a foam board was used to insulate a gas dryer. The foam board was leaning against a ceiling light fixture because the board was held up by glue and masking tape, which easily broke. The foam board could have combusted, causing immediate danger to all of the residents. According to the manufacturer, the foam board should have been installed behind the wall. Citation # 110010984.

Golden Living Center- Santa Rosa

4650 Hoen Avenue, Santa Rosa
B $2000 Medication 10/13/2014
On 9/21/12, a resident was admitted to the ER with an altered mental state, a heart rate of 52 beats per minute, acute kidney failure and abnormal brain function due to the adverse side effects of medication (lithium and digoxin). The facility was cited for failing to properly monitor the resident for side effects and to contact the physician if the medication caused drowsiness or urinary retention. Citation # 11001047.

Stanislaus County

Evergreen Nursing & Rehabilitation Care Center

2030 Evergreen Avenue, Modesto
B $1500 Bed Hold 1/12/2015
On 10/1/14, Evergreen Nursing and Rehabilitation refused to readmit a 68 year old male resident, after his six-day hospitalization at a Behavioral Health Center. Instead, police transported the resident to crisis housing, which can only keep residents for 24 to 48 hours, against the resident's will and without any of his medications, clothing, or belongings. On 10/3/14, the resident was taken to a Board and Care facility, where he continued to express his desire to go home, to Evergreen Nursing, where he had lived for three years prior to the hospitalization. Citation # 04001219.

Riverbank Nursing Center

2649 Topeka Street, Riverbank
B $1500 Mental Abuse Physical Abuse Verbal Abuse 11/24/2014
On October 1, 2014, a 27 year old resident who was paralyzed and dependent on staff for his total care and well-being, was verbally, emotionally and physically abused by a CNA. The resident told the CNA that he did not want her to provide him with care when she responded to his call light, and she deliberately returned to his room against an LN's instructions. The CNA then engaged in a verbal altercation with the resident and slapped him on the cheek. The resident stated: "I was defenseless and felt so helpless, I could not bend my elbows or raise my arms to protect myself." Citation # 04001133.
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Fresno County

Wish-I-Ah Healthcare & Wellness Center
35680 N. Wish-I-Ah Road, Auberry

A $20000 Careplan Infection Neglect Patient Care 11/26/2014

A 75 year old female resident was sent to the ER for septic shock on 9/21/14, due to improper wound care. The resident had undergone a right breast mastectomy on 6/3/14, and returned to Wish-I-Ah on 7/3/14. The nursing staff failed to change her wound dressing for 25 days, even though the doctor’s orders required a change two to three times per week. A nurse also put porous foam directly on the wound, against treatment protocol. At no point did staff at Wish-I-Ah document the size, shape, appearance, drainage, or progress of the wound. When the resident was sent to the ER on 9/21/14, hospital staff found pieces of foam embedded in the wound and overgrown by tissue, no longer removable without surgical intervention. The facility was cited for failure to provide care and services to ensure resident well-being. Citation # 040011141.

A $20000 Dietary Services Infection Physical Environment 11/26/2014

In September and October 2014, 12 facility residents suffered a severe outbreak of stomach flu, at least some of which was caused by Salmonella infection. The facility was found to have multiple serious food-handling, laundry, sanitation, sewage, and infection control problems. Standing water and fecal matter from toilet overflow were observed in one resident room. One resident with Salmonella developed sepsis and died in the hospital. Multiple staff members were infected as well. The outbreak may have started when a kitchen worker left work with severe nausea but returned the next day. The facility was cited for multiple failures that significantly harmed the residents' health and quality of life. Citation # 040011140.

Kern County

Golden Living Center - Bakersfield
3601 San Dimas St., Bakersfield

A $20000 Administration Careplan Infection Patient Care Staff (Inservice) Training 2/3/2015

During an inspection on 12/16/2014, four randomly selected residents were found to have scabies with no documented care plan to address the condition. The facility failed to administer a proper Infectious Control Program, failed to follow proper policy and procedures for Scabies and to report the outbreak to the County Department of Public Health. This resulted in infecting at least nine residents and three health care workers and placing all 92 residents at risk. Suspected scabies rashes were first reported on 6/2014 to DON and Administrator. Citation # 120011240.

Golden Living Center - Shafter
140 E. Tulare Ave, Shafter

A $20000 Fall Injury 10/8/2014

A 60 year old female resident with dementia and vision impairment was admitted to the facility on 11/12/13 with noted fall risk. She often walked and bumped into objects or tripped due to her vision problems. On 7/14/14, she suffered a fall while walking, breaking her finger and bruising her hip. The facility was cited for failing to provide adequate supervision to the resident while she was walking, and for failing to refer her to rehabilitation for therapy to improve her functioning. Citation # 120011044.

Parkview Healthcare Center
320 North Real Road, Bakersfield

A $10000 Careplan Injury Patient Care Supervision 2/4/2015

On 9/5/14, a 90 year old resident suffered injuries to the right side of his face and bleeding to his upper lip, due to an altercation with another 58 year old resident that had a history of violent outbursts. Staff failed to follow the 58 year old resident's care plan, which was to pro-
The Parkview Healthcare Center was fined for failing to ensure the 90 year old patient was free from physical and verbal abuse. Citation # 120011224.

Los Angeles County

Leisure Glen Post Acute Care Center
330 Mission Rd., Glendale
WMF $2000 Medication Patient Care Patient Records 1/13/2015
A Registered Nurse at Leisure Glen Post Acute Care Center falsified a 69 year old woman's medical records, by signing that he administered a medication which he did not administer. The medication was actually given to the patient by a nursing assistant, who was not authorized to administer any medications. The facility was cited for the nurse's willful falsification of the health records of a patient. Citation # 920011215.

Maclay Healthcare Center
12831 Maclay Street, Sylmar
B $1000 Bed Hold Evictions Patient Rights Transfer 8/15/2014
On 10/4/14, a male resident was pending evaluation and transfer to the acute psychiatric unit at an acute hospital for aggressive behavior. Nurse's notes revealed no documentation had been given to the resident or the responsible party, and neither were notified of the bed hold requirements during and after the transfer of the resident to the acute hospital. The hospital told the facility that he was evaluated and able to go back to the facility. The facility failed to inform the resident or his representative, in writing, of the right to exercise the seven day bed hold provision, and failed to readmit him within the seven day bed hold period. Citation # 920010936.

AA $75000 Hydration 12/29/2014
A resident admitted on 6/9/14 with risk of dehydration was hospitalized for severe dehydration on 6/18/14. The facility records of liquid intake and output demonstrated the resident was getting barely over half of the liquids she needed. The monitoring of the resident's hydration was haphazard and her hydration status was poorly monitored. She was found unresponsive on 6/18/14 and rushed to the hospital. The facility was cited for failing to provide sufficient hydration and for failing to monitor and communicate the resident's hydration status. Citation # 920010936.

Paramount Meadows Nursing Center
7039 Alondra Blvd, Paramount
A $20000 Medication 12/23/2014
A 59 year old resident with severe gastro-intestinal problems, received an order increasing his acid reflux medication on 3/7/2014. On 3/8/14 and 3/10/14, the resident's family member called the facility to confirm receipt of the order but the medication was not increased. On 3/11/14, the resident was hospitalized for nausea and vomiting and returned to the facility on 3/17/14, with discharge instructions for increased medication, which was never given. After a second hospitalization, the resident finally began receiving his medication as prescribed. The facility was cited for failing to implement and follow up on the physician's order for increased medication. Citation # 940010999.

Panorama Meadows Nursing Center, LP
14857 Roscoe Blvd., Panorama City
B $2000 Physical Environment 11/10/2014
During an observation of the kitchen on March 11, 2014, approximately 30 cockroaches were found crawling under the dishwasher. Others were observed in the janitor closet, sink, and next to the refrigerator. Dust, dirt, grease and food debris were found in various areas of the kitchen. The facility was cited for failing to take effective measures to eliminate cockroaches and to subsequently maintain the kitchen and equipment free from such infestations and in a clean and sanitary manner. Citation # 920011103.

B $2000 Physical Environment 11/10/2014
On 3/11/14, the Department of Public Health came to investigate a complaint about a construction project in the facility that was creating a large amount of dust and affecting the residents. The investigator found most of the staff, but no residents, wearing masks covering their noses and mouths. The investigator heard residents coughing and sneezing and was told that the construction had been going on for three days. The investigator noted dust in the physical therapy room on the microwave table, a storage shelf, and an oxygen concentrator. On 3/12/14, the administrator promised to protect the residents from dust and was given a "Notice of intent to issue a Citation". On 3/13/14, the investigator returned and found construction going on outside of a resident's room which wasn't being protected from the dust and debris. The facility was cited for failure to provide a safe environment. Citation # 920011102.

AA $75000 Infection 12/23/2014
A 66 year old resident with a urinary catheter developed an infection of the urinary tract, was hospitalized, and died in March 2014. The resident was documented as having a high risk for UTI. Early in her stay, she was identified as having a UTI and was prescribed an antibiotic, but the infection proved resistant and the facility did not adequately review the effectiveness of the resident's treatment. The resident's family member and facility CNAs reported the resident was in excruciating pain in February and March and often had dark, foul-smelling urine. Hospice notes documented the same problems, yet the facility's records showed clear urine with no smell. Direct observations of other residents with catheters revealed a great deal of poor and deficient catheter care. The facility was cited for providing poor urinary incontinence care and inadequate infection control. Citation # 940010998.
A female resident at Sherman Village Healthcare Center gave a staff member her EBT Card on 11/3/14, in order to purchase items at the 99 cent store. In addition to buying the resident's requested items, the staff member used the card to buy food for her personal use. The staff member then accepted a one dollar tip from the resident for running the errand. The facility's Employee Handbook states that employees may not borrow, solicit, or accept gifts of any type from residents. The facility was cited for failure to prevent financial abuse. Citation # 920011186.

A resident admitted on 1/23/13, with chronic airway obstruction and difficulty swallowing, was nonetheless given medications mixed into her applesauce and choked on them on 1/26/13. She quickly declined and had to be hospitalized. The airway obstruction led to an acute shortage of oxygen and aspiration pneumonia. The resident died two days later, due to acute respiratory failure. The facility was cited for giving the resident medications in a manner that likely lead to choking. Citation # 920011186.

CitationWatch description will be published once citation is received. Citation # 060011127.

The facility was cited for failure to provide necessary care and services in accordance with the resident's plan of care. Facility staff failed to accurately assess and manage a resident's neuropathic pain resulting in the resident suffering for seven days of uncontrolled, excruciating pain. Facility staff repeatedly failed to report the resident's complaints of severe pain and the facility did not administer the resident's prescribed pain medication as outlined in his care plan, offering him only Tylenol. Citation # 080010839.

The facility was cited for failure to provide adequate supervision to prevent accidents. Citation # 050011030.

The facility was cited for failure to ensure a resident's environment remained free from accident hazards when an 86 year old resident diagnosed with muscle weakness and Alzheimer's disease fell out of her wheelchair and broke her nose. The resident's fall was found to have been caused by the facility staff's failure to properly use posterior support straps to secure the resident in her wheelchair. Citation # 120011078.