The Epidemic in Nursing Home Evictions

As illustrated by a recent New York Times cover story*, nursing homes throughout the country are rapidly adopting a “new” business model: attract lucrative short term patients paying through Medicare, and then throw them out once their Medicare coverage ends.

People are often admitted to nursing homes to recuperate after a hospital stay, and typically have up to 100 days of rehabilitative services covered by Medicare, which pays a generous rate compared to other payment sources. If a person needs to stay in a nursing home for long term care after their rehabilitation days have run out, their Medicare coverage will end and they will need to switch to another payment source, such as Medi-Cal.

Medi-Cal is California’s health insurance program for low-income elderly and disabled individuals, and it is the primary payer for approximately two-thirds of California nursing home residents on any given day. Medi-Cal payment rates for nursing homes, however, are significantly lower than Medicare rates.

As a business practice, nursing home owners will often market their facilities as “short-term stay” or “rehab centers” to attract lucrative Medicare patients. They will spread the fiction that they have limited or no “long term care beds” (i.e. Medi-Cal beds), and then aggressively discharge residents -- denying them care when they have nowhere else to turn -- once their Medicare-funded days are over. Some facilities will even include illegal notices in their admissions agreements requiring residents to acknowledge the limited availability of long term care beds in their facility. These practices are completely illegal, driven by profit at the expense of patient care.

In reality:

- **FACT 1:** There is no such thing as a “short-term” or “rehab” skilled nursing facility. In order to be licensed as a nursing home in California, a facility must provide long term care.

- **FACT 2:** A facility cannot have a limited number of “Medi-Cal beds.” Any nursing home that is Medi-Cal certified must make every single bed in the facility available for patients paying through Medi-Cal. There is no such thing as a distinct part Medi-Cal wing.

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The Epidemic in Nursing Home Evictions (cont. on page 6)
Leave A Legacy

Planned giving leaves a legacy to honor your memory and helps to ensure the future of CANHR. With careful planning, it is possible to reduce or eliminate income and estate taxes while turning appreciated assets into income for yourself or others. Planned giving can include gifts by will, gifts of life insurance or, by a revocable living trust or charitable remainder trust. Call the CANHR office or email robert@canhr.org to get more information and a free booklet on planned giving.

New Publications

CANHR has several new consumer publications now available for free download on www.canhr.org. The new titles include:

Medi-Cal Recovery: What You Need to Know and How to Avoid it.
Elder Financial Abuse Restitution Guide – How to Get Your Money Back

Some of these are also available in Spanish and Chinese. Also available for free download for the first time is CANHR’s popular and highly informative booklet on Medi-Cal: A Consumer’s Guide to Financial Considerations & Medi–Cal Eligibility

Please visit www.canhr.org for more information

In Memorium

CANHR mourns the loss of Betty Perry, a dedicated leader for the Older Women’s League (OWL) locally in Sacramento, the State of California and nationally for over 25 years, who passed away on May 3, 2015. Betty Perry was a tireless advocate for women, the disabled, and low income and long term care consumers. While soft-spoken. Betty’s voice was nevertheless heard round the capitol. All who met and worked with Betty admired her wit, her dedication, her brains and her grace. She will be missed.

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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CANHR’s Executive Director Testifies at Hearing on California Department of Public Health’s Oversight of Nursing Homes

On March 25, 2015, Pat McGinnis, CANHR’s Executive Director, testified at the joint Assembly Committee on Health and Assembly Committee on Aging and Long-Term Care oversight hearing titled California Department of Public Health: What Progress is Being Made to Improve Nursing Home Oversight? Blasting the Department’s incompetent management, failure to investigate thousands of complaints, failure to protect residents from illegal evictions and failure to operate as a consumer protection agency, Ms. McGinnis noted that, if anything, oversight is worse today than it was ten years ago or even one year ago when she testified at another oversight hearing to the same Committees on the same failures of the Department.

She also voiced CANHR’s opposition to the Administration and Department’s budget proposal to provide DPH with millions of dollars to add 250 positions when the Department predicts it will take at least four years to catch up with its current investigative caseload. The California State Auditor, who also testified, called the Department a “high-risk” agency and discussed its rejection of her recommendation to set a timeline for nursing home complaint investigations. In October 2014, the State Auditor issued a report slamming the Department of Public Health for its backlog of 11,000 open nursing home complaints. That backlog has since grown to 12,686 cases.

In Los Angeles County, where California subcontracts with the Los Angeles County Department of Public Health, its officials are expecting to be richly rewarded for their incompetent and corrupt oversight of nursing homes. A May 20, 2015 memorandum to the County Board of Supervisors reports that the County is negotiating a contract extension with the State that will increase its staff by 48 percent and decrease its workload by 30 percent. The County’s memo glosses over a tremendous increase in its complaint backlog this year, where the average nursing home complaint now sits nearly a year before an investigation is completed.

California legislators have expressed considerable outrage at the shameful performance, yet it remains to be seen whether they will take any action to hold DPH accountable. They are considering budget proposals and legislation (AB 348) that address this ongoing crisis.

CMS Proposes Rules on Staffing Data Collection for Nursing Homes

On April 20, 2015, the Centers for Medicare & Medicaid Services (CMS) issued proposed rules on several matters (gpo.gov/fdsys/pkg/FR-2015-04-20/pdf/2015-08944.pdf), including updated Medicare payment rates to SNFs for FY 2016, proposed quality measures for SNFs, the SNF Value-Based Purchasing Program, and Staffing Data Collection. The staffing data collection is of particular interest because it is a step toward implementing the long delayed requirement in the Affordable Care Act that nursing homes electronically submit payroll-based staffing information. CMS is proposing to amend the administration requirements for nursing facilities at 42 CFR §483.75 by requiring facilities to electronically submit to CMS complete and accurate direct care staffing and census information in a uniform format specified by CMS on at least a quarterly basis. CMS is accepting comments through June 19, 2015.

LTCCC Issues National Report on State Survey Agency Performance

On April 21, 2015, the Long Term Care Community Coalition (LTCCC), a nursing home resident advocacy organization based in New York, issued a report evaluating state survey agency performance nationwide from an individual resident perspective. The report, Safeguarding NH Residents & Program Integrity: A National Review of State Survey Agency Performance (ltccc.org/publications/documents/LTCCC-Rpt-Safeguarding-ResidentsProgram-Integrity-USA-Nursing-Homes-2015.pdf), compares nursing home citation and fine rates for each state. It finds that there is little or no punishment when nursing homes fail to provide care that meets public standards, even when such failures result in significant suffering. California was called out for dishonorable mention in the report because it is tied for last with Alabama in citing nursing homes for causing harm to residents. Barely one percent of California nursing home violations are classified as harming residents, allowing operators to ignore the law without regulatory consequences.

Feds Strike a Blow for Freedom: $380K Fine for Locking Up Nursing Home Resident

A Maryland nursing home has been fined $380,750 for placing a resident in a locked unit and prohibiting one of her daughters from visiting. The fine, recently upheld by a federal appeals board, is noteworthy for two reasons: one, it involves a large, six-figure fine and two, locking up nursing home residents and restricting their visitation happens all of the time.

The case involved a resident in her 70’s who had lived
CANHR is 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; allow hardship exemptions for homesteads of modest value 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 passed the Senate Health unanimously. **Status:** Passed Senate Appropriations and will go to vote on Senate floor.

**AB 348 (Brown): Nursing Homes: Timelines for Complaint Investigations**

This bill would establish a timeline of 45 days for DPH, Licensing & Certification to complete complaint investigations. **Status:** Passed Assembly. In Senate Committee on Rules for Assignment.

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

AB 601 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:** Passed Assembly Human Services and Assembly Appropriations and will be heard in the Senate Human Services Committee on June 23rd.

**AB 927 (McCarty): The Nursing Home Ownership Disclosure Act**

This bill responds to the November 2014 Sacramento Bee three-part series on nursing home ownership in California that examined the dominant role of nursing home chains in California, the troubled history and poor performance of some of these chains, and the Department of Public Health’s failure to protect the public from operators who put profit before care. AB 927 would revise California laws governing acquisition of nursing homes, strengthen suitability requirements for operators, and improve public disclosure on nursing home ownership. **Status:** AB 927 is now a two-year bill and will not be heard until early 2016.

**Support:**

**SB 475 (Monning): Return of CCRC Resale Payments**

This bill would require the continuing care retirement facility to pay the full lump-sum payment that is conditioned upon resale of a unit to the resident within 14 days after resale of the unit and would require the CCRC, for contracts signed after January 1, 2016, to pay at least 20% of the full lump-sum payment to the resident within 90 days after a formerly occupied unit has been vacated. The bill would also require any payment balance not paid to the resident within 90 days to accrue interest at a rate not lower than 2% plus the United States prime lending rate until the full lump-sum payment is made. The bill would require any payment balance not paid to the resident within 180 days to accrue interest at a rate not lower than 5% plus the United States prime lending rate until the full lump-sum payment is made. The bill would require the facility to make the lump-sum payment to the resident’s estate if the resident is deceased. **Status:** Passed Senate floor. Now in Assembly Human Services Committee.

**AB 474 (Brown): Increase in SSI/SSP Payments**

This bill, for the 2015–16 fiscal year, and annually thereafter, would require the state maximum SSP grant for individuals to be readjusted and increased so that the state SSP payment and federal SSI payment, when combined, equal 112% of the federal poverty level. **Status:** Assembly Budget.

**AB 763 (Burke & Bonilla): Aged and Disabled FPL Income Disregard Increase**

Increases the amount of income that is disregarded.

*Legislation Update 2015*............. (continued on page 5)*

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**Please check the CANHR website for updated details on legislation.**
in calculating eligibility for purposes of the Medi-Cal Aged and Disabled (A&D) program which effectively increases the upper limit of financial eligibility to 138% of the federal poverty level (FPL). Status: Assembly Appropriations.

**AB 1085 (Gatto): Visitation and Personal Contact Rights**

Declares that every adult in this state has the right to visit with, and receive mail and telephone or electronic communication from whomever he or she so chooses, unless a court has specifically ordered otherwise. **Status:** Hearing June 16 in Senate Judiciary Committee.

**AB 1235 (Gipson): Long Term Care Medi-Cal - Home Upkeep Allowance**

This bill would increase the current home upkeep allowance for those who intend to leave the long term care facility within six months to return to an existing home and extends it for those who wish to leave a facility and establish a home. The current home upkeep allowance is $208.33, which can be deducted from the share of cost to “maintain” a current home. This bill expands the upkeep to the actual minimum cost of maintaining the home, such as mortgage or rent, property taxes, and required insurance: sets a limit of $7,500 on the total allowance; and establishes other eligibility criteria. In the end, this bill will actually enable residents to return home! **Status:** Passed Assembly. In Senate Committee on Rules for Assignment.

**AB 1319 (Dababneh): Medi-Cal Share of Cost**

Increases the “any income deduction” from $20 to $50 for Medi-Cal beneficiaries in assisted living facilities. Dependent on federal approval. **Status:** Passed Assembly. In Senate Committee on Rules for Assignment.

**AB 1387 (Chu): RCFE Fines and Penalties Appeals System**

Provides a system of appeal for those who file complaints against RCFEs and would also amend the RCFE citation appeals system, which currently offers four (4) levels of appeals for RCFE violations, essentially guaranteeing that fines, even if they are assessed, will never be collected. **Status:** Passed Assembly Appropriations, to the Senate Committee on Rules for Assignment.

**AB 1518 (Committee on Aging & Long Term Care): Expansion of NF/AH Waivers**

Expands the Nursing Facility/Acute Hospital (NF/AH) waiver program by 5,000 slots, and stabilizes service for younger, disabled Californians participating in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. **Status:** Passed Assembly. In Senate Committee on Rules for Assignment.

**Oppose**

**AB 139 (Gatto): Transfer Upon Death Deeds**

This bill would, until January 1, 2021, create the revocable transfer on death deed (revocable TOD deed), as defined, which would transfer real property on the death of its owner without a probate proceeding. The bill would also provide that the deed, during the owner’s life, does not affect his or her ownership rights and, specifically, is part of the owner’s estate for the purpose of Medi-Cal eligibility and recovery. CANHR’s concern is that even more low-income beneficiaries will be subject to Medi-Cal recovery. **Status:** Passed the Assembly and is now in Senate Judiciary.

**AB 722 (Parea): Securities Transactions Waivers**

This bill would exempt certain investments from the Department of Business Oversight’s (DBO) current stringent qualification and filing requirements if investors were limited to putting no more than $5,000 per year into the venture. AB 722 will open the way for unscrupulous promoters who target seniors who are interested in improving their financial situation or suffer cognitive impairments. **Status:** Assembly Appropriations.

**SB 19 (Wolk): Statewide POLST Registry**

This bill would require the California Health and Human Services Agency (CHHS) to operate a statewide registry system for the purpose of collecting (Physician’s Orders for Life Sustaining Treatment) POLST forms from health care providers and disseminating that information to authorized users. In addition to the fact that AHCDs are generally superior to POLSTs for advance care planning, under SB 19 (Advanced Health Care Directives) AHCDs will continue to languish in a registry system that is ancient, unused, and virtually

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*Legislative Update 2015 ............ (continued on page 6)*
worthless. If the state is going to create a state of the
art registry for POLST, it ought to include AHCDs.
**Status:** Passed Senate and ordered to the Assembly.

**SB 196 (Hancock): Elder Abuse – Protective Orders**

This bill would, commencing July 1, 2016, authorize
a county adult protective services agency and a public
conservator to file a petition for a protective order on
behalf of an elder or dependent adult if the elder or
dependent adult has been identified as lacking capacity
and a conservatorship is being sought. **Status:** Passed
Senate and ordered to the Assembly.

**SB 269 (Vidak): Conservatorship Fees**

Expands fees payable by conservatees to include time
and reimbursement of conservatorship petitioners who
seek appointment of a third party as conservator.
Creates incentives for people to petition for conserva-
torships in which they will not be a part of and
increases costs to conservatees. **Status:** Passed Senate,
now in Assembly Judiciary.

**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 increas-
es 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 require-
ment to at least 4.1 nursing hours per resident per day
by FY 2019-20. **Status:** The Governor’s May Budget
Revisions did not address CANHR’s recommendations.
The Governor’s proposal is awaiting action by the
Senate and Assembly Budget Committees.

Please check [www.canhr.org](http://www.canhr.org) for updated details on
legislation, and [www.leginfo.ca.gov](http://www.leginfo.ca.gov) for information of
specific bills.

**The Epidemic in Nursing Home Evictions (cont from page 1)**

- **FACT 3:** You do not have to leave a nursing
  facility just because your Medicare days are over!
  In fact, the facility must allow you to stay so long
  as you need skilled nursing care and those services
  are paid for.

- **FACT 4:** In Medi-Cal certified facilities, residents
  on Medicare have a right to transition to Medi-
  Cal if they are eligible. If you apply to Medi-Cal,
  you cannot be evicted for nonpayment while your
  application is pending. If you are in a shared
  room, you even have the right to remain in the
  same bed and not be moved to another room. It is
  illegal to discriminate against residents who are on
  Medi-Cal.

So, if a nursing home is pressuring you to leave volun-
tarily when your Medicare days are up, simply don’t go.
Tell them that no discharge can be performed without
following all of the notice and other legal requirements
and that changing payment source is not a sufficient legal
reason for discharge. See CANHR’s fact sheet on Transfer
and Discharge Rights - [www.canhr.org/factsheets/](http://www.canhr.org/factsheets/).
It’s also important to report any illegal discharge (or illegal
notice in the admissions agreement that is not part of the
California standard admissions agreement - [www.canhr.
org/factsheets/](http://www.canhr.org/factsheets/) to the Department of Public Health, the
agency responsible for licensure and regulation of nursing
homes. File a complaint with DPH Licensing and Certi-
fication - [www.canhr.org/factsheets/](http://www.canhr.org/factsheets/). And please contact
CANHR at (800) 474-1116 if you have any questions or
need help.

Don’t let the nursing homes endanger your loved one
because they’ve decided that compassion is just not
profitable.

*www.nytimes.com/2015/04/15/business/as-nursing-homes-
chase-lucrative-patients-quality-of-care-is-said-to-lag.html*
Dear Friend:

When you, a family member or a friend has a question about Medi-Cal, Medi-Cal Recovery, or resident rights in nursing homes or residential care facilities - where do you turn? If you are like the 10,000+ consumers, advocates and attorneys who contacted CANHR last year, or the 40,000+ people who access our website each month, you turn to California Advocates for Nursing Home Reform.

Why?

Because you know you’ll get accurate, up-to-date information and the help you need from knowledgeable, compassionate and caring professionals.

Whether it’s helping Mr. Williams through the complexities of a Medi-Cal application; helping Leslie figure out the hardship criteria so she can keep the family home safe from Medi-Cal Recovery; or simply providing you with the correct legal cite to assist a client with a nursing home eviction appeal or a residents’ rights violation, CANHR is here to help.

Your contributions have helped CANHR grow and thrive, so we can extend our services and support to ever more long term care consumers and their family members. Thanks to you, our services have helped thousands of California consumers, and we want to continue to grow and serve.

Please consider making as generous a gift as you can. Your donation will make an impact. I promise you.

Thank you for whatever you can give. If you have recently donated, please disregard this message and thank you for your donation!

**Click here to make a secure online donation**

Sincerely,

Patricia L. McGinnis
Executive Director, CANHR
What is a Residential Care for the Elderly?

Residential Care Facilities for the Elderly (RCFEs) — sometimes called “Assisted Living” (e.g., 16+ beds) or “Board and Care” (e.g., 4 to 6 beds) — are non–medical facilities that provide room, meals, housekeeping, supervision, storage and distribution of medication, and personal care assistance with basic activities like hygiene, dressing, eating, bathing and transferring. RCFEs are for people who are unable to live by themselves, but do not need 24 hour nursing care. RCFEs serve persons 60 years of age and older.

As of June 30, 2014, there were 7,570 RCFEs licensed in California with a total bed capacity of 176,579, ranging in size from two-bed facilities to 200+ bed facilities. Although the majority of licensed RCFEs house six or fewer residents, the majority of residents live in larger RCFEs.

Are RCFEs Regulated?

Yes. RCFEs must meet care and safety standards set by the State, and are licensed and inspected by the Department of Social Services, Community Care Licensing Division (CCLD). Senior housing complexes, retirement villages and retirement hotels that provide only housing, housekeeping and meals are not required to be licensed as RCFEs.

How Much Do RCFEs Cost?

The cost depends on a variety of factors such as the type of accommodations (e.g., apartment, private room, shared room), the range of services needed, and the geographic area. The median monthly cost in California is $3,750, with costs ranging from a low of around $1,000 a month for a resident on Supplemental Security Income (SSI) to a high of $9,000 a month. Specialized services like dementia or hospice care are more costly.

Who Pays for Care in RCFEs?

Most people must pay privately for care in RCFEs. Long-term care insurance only covers a very small percentage of people. There is very limited public funding through Supplemental Security Income (SSI) for RCFE residents who qualify for this program (see CANHR’s fact sheet on SSI in a RCFE - www.canhr.org/factsheets/). Unfortunately, the SSI rate is so low that fewer and fewer facilities will accept persons on SSI. Aid and Attendance is a benefit paid by Veterans Affairs (VA) to veterans, veteran spouses or surviving spouses that may help pay for residential care (see CANHR’s Fact sheet on Aid and Attendance - www.canhr.org/factsheets/).

Will Medicare or Medi–Cal Pay?

No. Because RCFEs are not medical facilities, neither Medicare nor Medi–Cal pays directly for residential care/assisted living. There is a special program in 14 counties (Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, San Mateo, Santa Clara and Sonoma) — the Assisted Living Waiver (ALW) — in which Medi-Cal pays for eligible residents assessed to need nursing home level care to live in an RCFE or public housing. (For more information, see CANHR’s fact sheet on ALW - www.canhr.org/factsheets/).

Will an RCFE Accept or Retain Someone Who Needs Medical Care?

It will depend on the type and severity of the medical condition(s). Some medical conditions are not allowed in RCFEs (e.g., tube feeding, or treatment of open bedsores). Other medical conditions are allowable if the resident is capable of caring for the condition, or the resident receives necessary health care from an “appropriate skilled professional” (e.g., colostomy/ileostomy care, injections, diabetes). The facility must inform residents in writing at or before the time of admission of any resident retention limitations set by the state or facility such as whether the facility can serve persons who need help in leaving the building in case of emergency (i.e., non-ambulatory) or with certain medical conditions (e.g., hospice waiver). (California Health and Safety Code, Section 1569.269.)
What Are The Qualifications For Staff?

Minimal Training: Administrators must take a 40–hour certification program, pass a simple state exam, and obtain 40 hours of continuing education every two years. Staff must receive at least 10 hours of training at the facility within 4 weeks of employment, and at least 4 hours annually thereafter. For facilities advertising dementia care, staff must have additional training. Beginning January 1, 2016, training requirements for administrators and staff will increase significantly.

Minimal Qualifications: Administrators must be 21 years old and possess a high school diploma or equivalent for RCFEs with 15 beds or less. For larger RCFEs, the administrator needs additional education and experience. Staff must only be 18 years old and pass the criminal background check. Note: Because RCFEs are non–medical facilities, they are not required to have nurses, certified nursing assistants or doctors on staff. Check on the qualifications of the administrator and key staff.

Staff Ratios: There is not any specific staff to resident ratio for RCFEs. California law requires that facility personnel shall at all times be sufficient in numbers, qualifications, and competency to provide the services necessary to meet resident needs, and to ensure their health, safety, comfort, and supervision. (California Health and Safety Code, Sections 1569.269(a)(6), 1569.618(c).)

How Do I Find Out About the Track Record of a Facility?

Upon request, a facility must show you the most recent copy of its latest inspection report (Note: inspections are only required every five years, and annually if the facility is in non–compliance); and a copy of any substantiated complaints within the past year. The state posts very minimal compliance information on its website (see: www.ccld.ca.gov/PG3581.htm). The only way to view additional records is to go to one of the local offices of CCLD (see: www.ccld.ca.gov/res/pdf/ASC.pdf) and request to see the public record of the facility.

How Do I Find Out More About RCFEs?

You can contact the local CCLD office to receive a listing of facilities, or view a list online at the state website. Some Ombudsman Programs also have listings, offer pre-placement services, and provide access to licensing reports. For more information, see CANHR’s RCFE fact sheets – www.canhr.org/factsheets/ and Residential Care Guide, residential-careguide.org — a listing of all Residential Care Facilities for the Elderly in California. The Guide also provides helpful information on services, staffing and costs for a growing number of facilities that have responded to CANHR’s RCFE Questionnaire.

Where Do I File a Complaint?

To file a complaint about an RCFE, call the statewide toll-free public complaint hotline at 1-844-LET-US-NO [1-844-538-8766]. You should also send a written statement of your concerns to the Centralized Complaint and Information Bureau (CCIB). The CANHR RCFE Complaint Form - www.canhr.org/factsheets/ is an effective way to document your concerns.

The complaint may be sent 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

After you file your complaint, address future questions or concerns to the local CCL Adult and Senior Care Regional Office: www.ccl.ca.gov/res/pdf/ASC.pdf.

It is important for your elected representatives to know what is going on in California’s licensed facilities. Make a copy of the complaint you are sending to CCL, and send it to the California State Legislators who represent your district - leginfo.ca.gov/yourleg.html. If the complaint involves serious neglect or abuse, contact the Bureau of Medi-Cal Fraud & Elder Abuse (BMFEA), a division of the California Attorney General’s Office: 1-800-722-0432; http://ag.ca.gov/bmfea/; or mail BMFEA, P.O. Box 944255, Sacramento, CA 94244-2550.
Dear Skeptical in San Bernadino,

No! This form is illegal and is designed to shield the nursing home from liability, if they provide substandard care that results in skin breakdown for your mother. California nursing homes are required by law to use a Standard Admission Agreement (CDPH 327) (cdph.ca.gov/pubsforms/forms/Pages/LicensingandCertificationForms.aspx), developed by the Department of Public Health. You cannot be required to sign any document other than the Standard Admission Agreement, as a condition of admission to a nursing home. Furthermore, any form titled, “Acknowledgment of Risk of Liability for [Skin Breakdown/ Falls/ Elopement]” or “Waiver of Liability for…” is designed to protect the nursing home if their poor care results in injury for your mother. Waivers of liability are expressly prohibited in nursing home admission agreements, and should be seen as red flags. Skin breakdown is a sign of poor quality of care and low staffing ratios – it is not an expected or unavoidable consequence of nursing home care. If these documents are presented as part of an admissions agreement, contact CANHR at (800) 474-1116 and file a complaint with the Department of Public Health (see: www.canhr.org/factsheets/).

Dear Advocate,

My mom is moving into a nursing home, and there’s a form in the admission agreement called “Acknowledgement of Risk of Liability for Skin Breakdown.” They tried to get me to sign this along with the admissions agreement in their business office, before I could read everything carefully. What is this form? Do I have to sign it?

Sincerely,

Skeptical in San Bernardino
Past Speaking Engagements, Panel Discussions and Training Sessions

- **March 3:** Senior Staff Attorney Prescott Cole educated a class on Medi-Cal Long Term Care at the University of California Hastings College of the Law.

- **March 4:** Executive Director Patricia McGinnis presented a Webinar to legal services staff on “An Overview of the Long Term Care System in California.”

- **March 7:** Senior Staff Attorney Prescott Cole conducted a class on elder law at San Francisco Law School.

- **March 11:** CANHR co-hosted a special Oxnard training on dementia care for physicians with the Ventura County Long-Term Care Ombudsman program.

- **March 11:** Program Manager Pauline Mosher presented a webinar to legal services staff on “Frequently Asked Questions about Medi-Cal Eligibility and Recovery.”

- **March 13:** Staff Attorney Jody Spiegel participated in a meeting of the Department of social service’s Administrator Certification Section Advisory Committee.

- **March 13:** Staff Attorney Tony Chicotel presented at CANHR’s 12th symposium to improve dementia care and end the misuse of psychotropic drugs in long-term care facilities. The event was held in Napa and co-hosted with the Napa County Long-Term Care Ombudsman program and Napa Valley Hospice and Adult Day Services.

- **March 18:** Senior Staff Attorney Prescott Cole conducted a free Webinar – Elder Financial Abuse – Remedies and Restitution for Legal Services.

- **March 24:** Staff Attorney Tony Chicotel participated in the Board meeting of the California Culture Change Coalition in Sacramento.

- **March 24:** Executive Director Pat McGinnis testified at a joint Assembly Committee on Health and the Committee on Aging and Long-Term Care oversight hearing on nursing home oversight by the Department of Public Health.

- **April 2:** Senior Staff Attorney Prescott Cole attended the Support Centers Leaders And Field Program meeting in San Francisco.

- **April 3:** Staff Attorney Jody Spiegel met with Assembly Member Nazarian and Field Representative Dora Espanz in the Van Nuys district office to discuss CANHR-sponsored legislation.

- **April 7:** Program Manager Pauline Mosher testified in support of AB 348 (Brown) in Sacramento. The bill passed the Assembly Health Committee 18-0.

- **April 9:** Prescott Cole hosted a half day training for Adult Protective Services and Civil Litigators on financial elder abuse issues - Sacramento

- **April 10:** Staff Attorney Jody Spiegel participated in a meeting of the Department of Social Services’ Assisted Living Waiver Subcommittee.

- **April 10:** Pat McGinnis educated a group of Social Workers and Discharge Planners on Medi-Cal & Recovery at the Magnolia Place Family Center in Los Angeles.

- **April 17:** Pauline Mosher, and Julie Pollock educated a group of Social Workers and Discharge Planners on Medi-Cal & Recovery at St. Mary’s Cathedral in San Francisco.

- **May 19:** Tony Chicotel presented at a session on elder law issues at the Legal Assistance for Seniors 10th Annual Conference on Elder Abuse in San Francisco.
• April 20: Senior Staff Attorney Prescott Cole attended the National Center of Victims of Crime’s Oakland training, “Civil Justice for Victims of Crime in California”.

• April 21: Senior Staff Attorney Prescott Cole attended the National Center of Victims of Crime’s San Francisco presentation, “Taking Action: Assisting Victims of Financial Fraud”.

• April 21: Long Term Care Advocate, Julie Pollock testified in support of AB 348 (Brown) in Sacramento. The bill passed the Assembly Aging and Long Term Care Committee 7-0.

• April 23: Staff Attorney Jody Spiegel participated in the Department of Social Services’ Community Care Licensing Division Quarterly Advocates Meeting.

• April 24: Staff Attorney Tony Chicotel went to Oakland and presented to the California Public Health Association - North about the dangers of using antipsychotic drugs to restrain people with dementia.

• April 28: Pat McGinnis testified in support of AB 601 (Eggman) in Sacramento. The bill passed the Assembly Human Services Committee 7-0.

• May 1: Senior Staff Attorney Prescott Cole gave a presentation at the Central California Legal Services Elder Abuse Awareness Roundtable in Fresno.

• May 1: Staff Attorney Jody Spiegel hosted a CANHR information table at the South Pasadena Healthy Aging Fair.

• May 4: Senior Staff Attorney Prescott Cole presented a workshop on elder abuse at the California Long-Term Care Ombudsman Association Training in Sacramento.

• May 6: Pat McGinnis and Pauline Mosher presented a webinar on Medi-Cal Basics to private bar attorneys.

• May 8th: Administrative Assistant Daniel Guerrero hosted an information table at the San Mateo “Senior Showcase Fair” in Belmont.

• May 14th: Program Manager Pauline Mosher presented about CANHR services to the Contra Costa County Area Agency on Aging.

• May 19: Prescott Cole and Tony Chicotel presented a joint session on elder law issues at Legal Assistance for Seniors 10th Annual Conference on Elder Abuse in San Francisco.

• May 26: Prescott Cole hosted a half day training for Adult Protective Services and Civil Litigators on financial elder abuse issues in San Diego.

The appeals board was definitive: nursing home residents may not be confined against their will or have access restricted to family members, even if a power of attorney agent has consented. “Otherwise, nursing facilities could be turned into prisons in which family members lock their relatives away purely for the sake of convenience..... Residents of nursing facilities have rights and those rights include the right to freedom of movement.”

The facility was fined $5,650 a day for each day the resident was confined to the locked unit and $150 a day for the visitation restriction.

For guidance on dealing with nursing home false imprisonment issues, please see CANHR’s publication “Your Right to Leave” - www.canhr.org/reports/. For guidance on dealing with nursing home visitation issues, please see “Your Right to Visit” - www.canhr.org/reports/ The appeals board decision is posted on the CANHR website.
CANHR welcomes memorial and honorary gifts. This is a great way to honor a special person or a loved one, while helping those who are long term care residents. Recent gifts have been made in the names of the following persons:

**MEMORIALS**

Helen and Theodore Muller  
*Helen Drachkovitch*

Jeanne Karos  
*Aliki Hill*

Paula C. Peterson  
*Clayton Pape*

Valdemar Lorentzen  
*Wendy Finch*

Jeanne Karos  
*Mary Mackie*

Malcolm Ossoff  
*Sandra Leib*

Hazel Mensching  
*Cristina Flores*

Edith Kirshner  
*Cristina Flores*

Ross and Olive Kerr  
*Janette Kassis*

Butterscotch  
*Jackie Johnson*

My beloved husband Jerry  
*Lamont Rogers*

Lamont Rogers  
*Gerri Rogers*

Lucy Forest  
*Eileen Bill*

Margaret Parker  
*Anne Brooks*

Floyd John Leach  
*Robert Leach*

**IN HONOR OF**

Ruth Gamba  
*Peter Gamba*

George Kindley  
*Cristina Flores*

Kim Valentine  
*Cristina Flores*

CANHR would like to acknowledge a generous grant received from the Fidelity Charitable fund made possible through the generosity and recommendation of the DiPaola Foundation, a donor-advised fund, in memory of Celia Rothman Leaderman. These funds will be used in CANHR’s work toward RCFE reform in California.

And a special thank you to the many other generous donors who gave to CANHR over the last quarter.
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Enclosed is my check for: □ $500 □ $100 □ $50 □ $30 □ Other _______________________

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CANHR prohibits the use of its name for the purpose of advertisement by attorneys, financial planners or any other organization or entity.
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Butte County

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

B $2000 Administration Injury Mandated Reporting Physical Abuse 1/14/2015

The facility was cited for failing to report an altercation between two residents to CDPH 19 days after the incident. Resident 1 was punched in the arm by Resident 2 on 12/5/14. Resident 1 reported the incident to her nurse and the nurse reported it to the Administrator and DON. The decision was made not to report the abuse allegation, but after several weeks, the DON reviewed the facility’s policy and procedures which state all abuse allegations must be reported within 24 hours. The facility failed to follow policy and was cited. Citation # 230011222.

**Windsor Chico Creek Care and Rehabilitation Center**
587 Rio Lindo Ave., Chico

B $2000 Patient Care 1/07/2015

A physician ordered that a urinary catheter be applied to a Parkinson’s resident for comfort and pain management. On 10/11/12 at 5 pm, two staff awoke the resident who was confused then became combative, began kicking, and was screaming in pain while they applied the catheter. During the procedure he sustained severe trauma to his urethra and began bleeding profusely. The resident ended up requiring two different emergency transfers to an acute care hospital for treatment for severe urethra trauma, urinary tract infections and severe sepsis. When one of the CNAs was asked why she did not stop the catherterization procedure, she explained that she was a new employee still on orientation and that she did not know the resident and thought this was his normal level of agitation. The facility was cited for causing physical and psychosocial harm to the resident. Citation # 230011190.

Humboldt County

**Granada Rehabilitation & Wellness Center, LP**
2885 Harris Street, Eureka

B $2000 Mental Abuse Verbal Abuse 1/27/2015

On 8/5/14, according to a facility investigation, a resident became physically aggressive towards the Charge Nurse.
The nurse responded by saying to the resident, “If you ever f***ing touch me like that again, I will break your f***ing neck. Do you understand me?” The incident was witnessed and reported by another staff member. The Charge Nurse was terminated on 8/11/14 and the incident was reported to the Department on 8/12/14. When asked why the facility waited seven days to report the incident the Administrative Staff responded that at first she did not believe the incident constituted abuse. The facility was cited for failure to report an allegation of verbal abuse to the department in a timely manner. Citation # 110010946.

A $20000 Mental Abuse Verbal Abuse 01/27/2015
On 8/5/14, a staff member heard the Charge Nurse say to a resident, “If you ever f***ing touch me like that again, I will break your f***ing neck. Do you understand me?” The same charge nurse continued to provide care to the resident after the incident. The resident stated he was fearful and hesitated to go into the hallway by himself following the incident. The facility was cited for failure to afford the resident the right to be free from verbal and mental abuse. Citation # 110011158.

Monterey County

Windsor Monterey Care Center
1575 Skyline Drive, Monterey
B $1000 Physical Abuse Verbal Abuse 4/14/2015
On March 19, 2015, a CNA came into a resident’s room, yelled at her to open her eyes, attempted to forcibly pry open her eyelids, and then hit her on the forehead with the heel of her open palm. Later that day, the CNA yelled at the resident about having to clean her up after toileting. The facility was cited for failing to ensure that residents were free from physical and verbal abuse. Citation # 070011377.

San Mateo County

The Sequoias
501 Portola Road, Portola Valley
A $20000 Fall Injury Patient Care Staff (Inservice) Training 3/11/2015
On 2/24/14, a strap-on sling broke while a resident was being transferred from a shower chair to his bed using a Hoyer lift, resulting in blunt force trauma to his head and neck when he hit the ground face first. The facility was cited for failing to follow the manufacturer’s recommendation to use the appropriate sling for the mechanical lift and for failing to reduce the known hazard related to the unsafe practice. A lone CNA who was assisting the resident at the time with the use of the mechanical lift, which requires two people to operate, was unsafe. The facility did not reevaluate the CNA’s competency after she received a rating of below standard during her 7/13/13 performance evaluation. The trauma caused by this failure resulted in the resident’s death after being transported to a General Acute Care Hospital. Citation # 220011317.

Seton Medical Center
1900 Sullivan Ave., Daly City
AA $100000 Patient Care 3/4/2015
A female resident with pneumonia and respiratory failure went several minutes without breathing when her tracheostomy tube was left with an inflated cuff, causing an airway obstruction. Even after the resident was discovered not breathing and without a pulse, CPR was delayed by several minutes because the facility staff had to investigate her “code status.” The resident was subsequently revived, but left in a persistent vegetative state. Her family discontinued active treatment and the resident died shortly thereafter. The facility was cited for failing to follow its policy and procedure and the manufacturer’s recommendation for tracheostomy care in a way that presented substantial probability of death or serious harm. Citation # 220011305.

Solano County

Fairfield Post-Acute Rehab
1255 Travis Blvd., Fairfield
B $2000 Physical Abuse 4/1/2015
On 8/8/2014, Resident 1 was subject to physical abuse from an employee at Fairfield Post-Acute Rehab in the form of a strike with an open hand across her chest and shoulder and later with a fist. The facility failed to report an allegation of physical abuse to the Department of Public Health. Citation # 110011267.

Sonoma County

Broadway Villa Post Acute
1250 Broadway, Sonoma
A $20000 Supervision 1/13/2015
On 9/14/2014, the facility failed to provide adequate supervision to prevent falls for Resident 1. Resident 1 got out of bed and fell without the knowledge of the staff. This resulted in resident 1 sustaining a neck fracture, hematoma, humerus fracture, a rapid decline, and death 5 days later. The facility failed to follow Resident 1’s care plan which included a bed alarm that did not go off when Resident 1 got out of bed. Citation # 110011099.
Friends House
684 Benicia Drive, Santa Rosa
B $2000 Dignity Mental Abuse Patient Care
Verbal Abuse 3/10/2015
A 60 year-old resident experienced verbal and mental abuse by three unlicensed staff members on two separate occasions during his first week of admittance in the facility. The resident was yelled at and felt ashamed and humiliated by the staff when he required assistance. The facility was cited for violating regulations to treat the resident with dignity and respect causing the resident to experience increased pain and feeling ashamed. Citation # 110011273.

Golden Living Center - Petaluma
101 Monroe St., Petaluma
A $20000 Careplan Fall 02/11/2015
On August 3 and 17, 2014, a resident had two unwitnessed falls at the facility. The resident was admitted on July 29, 2014 following hip surgery due to a fall at home. The resident was assessed as a high fall risk and with difficulty following directions due to psychosis and delirium. The second fall resulted in a hospital readmission requiring a second surgery due to the loosening of his hip hardware. The facility was cited for failing to update the care plan to address the resident’s non-compliance and did not include additional interventions to prevent him from falling a second time. This action caused the need for a second surgical intervention. Citation # 110011264.

B $2000 Dignity Mental Abuse Patient Care 4/1/2015
In 2014, a Golden Living Center staff member deliberately sprayed a male resident with cleaning solution on his left shoulder. When the resident became irate and followed the staff member in his wheelchair, the staff member sprayed the resident a second time. The facility was cited for failing to ensure residents were treated with dignity and respect, and failing to prevent verbal and mental abuse. Citation # 110011341.

Sonoma Valley Hospital D/P SNF
347 Andrieux St, Sonoma
A $20000 Decubiti (Bedsores) 12/30/2014
The facility was cited for failing to notify the physician that the resident’s blister on her heel was open on 5/2/14. In addition, the facility failed to follow the facility’s policy and procedure to stage the pressure sore and provide ongoing measurements to reassess for alternative devices for pressure relief and obtain treatment order for the open pressure sore. These failures resulted in a delay in treatment from 5/2/14 to 5/18/14 that caused the resident’s pressure sore to progress to a stage III pressure sore. Citation # 110011192.

B $20000 Careplan Fall 12/30/2014
The facility was cited for failing to implement a 94 year old female resident’s care plan for fall precaution. This failure caused the Resident to sustain a left hip fracture after falling on 4/5/13, while getting up unassisted from the toilet in the bathroom and required the resident to undergo a left hip surgery. Citation # 110011193.

Sutter County
River Valley Care Center
9000 Larkin Road, Live Oak
B $2000 Physical Abuse 01/20/2015
On 10/1/13, a nurse assistant reported on two CNAs who had roughly handled a resident. The reported incident was where a CNA grabbed a 92 year-old resident’s wheelchair and pushed the resident, who was trying to resist being pushed, into a room. Once in the room, that CNA was joined by another and together they pulled the resident up by her arms and the back of her pants. The witness said, “They kind of just threw her onto the bed”, and that the resident “had a terrified look on her face”. Those same two CNAs were reported for roughly transferring a 101 year-old resident. That report was from resident’s roommate who stated that those two CNAs always picked up her roommate by the back of her pants and “never use the machine.” The facility was cited for failing to ensure the rights of the two resident to be treated with consideration, respect and dignity. Citation # 230011204.

Yuba Skilled Nursing Center
521 Lorel Way, Yuba City
B $2000 Careplan Elopement Patient Care Security Supervision 1/14/2015
A 70 year old resident eloped from the facility on 3/11/13 and 9/15/13. He was missing for 45 minutes before the facility staff realized he was gone and the staff could not find him. Local police found him seven hours and fifteen minutes later, in a parking lot two miles from the facility. All staff were aware of the resident’s elopement risk after his first elopement. However, a Behavioral and Elopement/Wandering care plan was not enacted until after his second elopement. The facility was cited for failing to develop, reevaluate and update the resident’s elopement plan to ensure sufficient, effective interventions and care to prevent elopement. Citation # 230011172.
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**Kern County**

**Bakersfield Healthcare Center**

730 34th Street, Bakersfield  
**A $20000 Fall 3/18/2015**

On November 12, 2014, a certified nursing assistant failed to use a mechanical lift properly while transferring an alert 57 year old resident causing the resident to fall to the floor and sustain multiple fractures. The resident broke bones in her hip, thigh and arm, and was transferred to the hospital where she underwent surgery. The facility was cited for failing to ensure that the resident received adequate supervision and assistance to prevent accidents. Citation #120011331.

**Corinthian Gardens Health Care Center**

1611 Height Street, Bakersfield  
**A $20000 Physical Abuse Verbal Abuse Supervision 04/6/2015**

Following a recertification survey in October 2014, the facility was cited for failing to provide adequate supervision for a resident, which resulted in actual harm to four residents and placed 108 residents at risk for potential harm from verbal and physical abuse. Interviews and record reviews revealed that the offending resident’s behaviors included: threatening to slice a resident’s throat while she slept, ramming her wheelchair into a resident and family members, and kicking, hitting, pinching, and biting a resident. The resident was admitted to the facility with diagnoses including schizophrenia and bipolar disorder, and was transferred to a psychiatric facility on October 27, 2014. Citation #120011359.

**Los Angeles County**

**Bellflower Convalescent Hospital**

9710 E. Artesia Ave., Bellflower  
**B $2000 Patient Care 12/18/2014**

A female resident diagnosed with high blood pressure, diabetes, Parkinson’s, and rheumatoid arthritis had a physician order to receive physical therapy involving range of motion exercises to prevent further contractures and weakening of muscles. The facility failed an initial and ongoing assessment of the resident’s extremities, to provide range of motion exercises as ordered by the attending physician, putting her at risk for further contractures and a decline of her weakened muscles. Citation #940011184.

**Broadway By The Sea**

2725 East Broadway, Long Beach  
**A $10000 Hydration Neglect Nutrition Patient Care 12/04/2014**
On 4/23/12, a female resident was sent to the ER for septic shock, urinary tract infection, dehydration, pneumonia, and sudden kidney failure. She was admitted to the facility on 2/24/12, with a high risk for dehydration. During her two months at the facility, the resident’s fluid intake was continuously documented as less than what she required, yet the facility failed to re-assess her risk of dehydration or monitor her urine output. The facility was cited for failing to provide the necessary care and services to prevent dehydration. Citation # 940011067.

**Chino Valley Health Care Center**
2351 S. Towne Ave., Pomona  
AA $100000 Physical Abuse 3/25/2014

A 91 year old resident died on 12/4/2010, eleven days after being assaulted by his 46 year old roommate while in bed. Facility staff found the victim in bed on the morning of 11/23/2010 with his face bloodied and swollen and his right arm pointed up over the right side rail while his right forearm was twisted around and pointed down between the bedside rail and mattress, with his humerus bone fully exposed and right elbow joint totally displaced. His roommate was sitting at the foot of the bed with blood on his hands and gown. The victim was transferred by EMS helicopter to a hospital where he remained until he died. An autopsy report revealed that the resident suffered facial trauma and multiple blunt force injuries that led to amputation of his right arm and caused his death. The deputy medical examiner ruled that the resident’s death was a homicide.

The resident who assaulted him had a history of psychiatric treatment, hospitalizations due to destructive behavior, and aggressive, physically abusive behavior to others. The nursing home’s records documented that the resident had more than 150 episodes of sudden angry outbursts during the 10 week period prior to 11/23/2010 when he attacked his roommate. The facility was cited because it did not appropriately address this resident’s aggressive behaviors and failed to protect the victim from physical abuse that caused severe injuries and his death. Citation # 950009835.

**Imperial Crest Health Care Center**
11834 Inglewood Ave, Hawthorne  
A $10000 Physical Abuse 10/15/2014

On 8/5/13, a resident was hospitalized with a fractured finger, skin laceration, and intense pain. The resident reported a CNA got upset with him after he asked her to delay cleaning him up because he was having a bowel movement in his disposable adult brief. The CNA roughly snatched away a phone the resident was holding in his left hand, causing a popping sound and bleeding. The resident called 911 and the fractured finger was treated at the local hospital. Prior to this incident, the resident had repeatedly requested this CNA not be assigned to him because she was rough during care, but the facility failed to intervene. The CNA had a history of complaints about rough care at the facility and had previously been suspended for this reason. She was terminated from her position on 3/6/14. Citation # 910011064.

**Lynwood Healthcare Center**
3611 Imperial Hiway, Lynwood  
A $10000 Fall 12/23/2014

An 86 year old resident was found on the floor of his room after an apparent fall on 9/22/13. A couple of days later, he began to complain of pain and was hospitalized for a fractured hip. The fall was the resident’s seventh since his admission two years prior. The facility was cited for failing to revise and update the resident’s careplan after each fall and for failing to follow its own recommendation to prevent further falls after the resident’s third fall. Citation # 940011181.

**Memorial Hospital Of Gardena D/P Snf**
1145 W. Redondo Beach, Gardena  
B $2000 Physical Environment 12/02/2014

As a result of a 10/15/14 review of the facility’s fire safety and evacuation procedures, the facility was cited for not conducting monthly trainings for all staff or fire drills for each shift, and also for not having enough sprinklers. It was noted that of the 68 residents in the facility, 68 were bed bound, on
oxygen, and had tracheotomy tubes. Also, of those 68 residents, 65 of them had gastrointestinal tubes and 44 were on ventilators. Citation # 930011139.

North Walk Villa Convalescent Hospital
12350 Rosecrans, Norwalk
B $2000 Medication 6/2/2014
On 3/3/2014, the facility failed to act upon the pharmacist consultant’s monthly documented recommendations for three months, regarding clinically significant risks and existing medication adverse consequences for Resident 1. Resident 1 was receiving large doses of morphine without monitoring of the resident’s respiratory rate. Citation # 940010742.

Palmcrest Care and Rehabilitation Center
3501 Cedar Avenue, Long Beach
A $10000 Fall 1/26/2015
A resident with a very high risk of falls due to muscle weakness, gait abnormalities, dementia, and receipt of disorienting drugs fell and broke his nose on 5/18/14. The resident’s careplan called for staff assistance with walking but prior to his fall, the resident was walking in the hallways without assistance even though multiple staff members saw him. The facility was cited for failing to provide the resident with assistance in walking. Citation # 94001194.

Ramona Nursing & Rehabilitation Center
11900 Ramona Blvd., El Monte
A $20000 Fall Patient Care 3/25/2015
On August 4, 2014, a male resident who was a left leg amputee, was left unsupervised in the bathroom, fell to the floor, and fractured his left hip. He stated that it was routine for the staff to leave him unsupervised in the bathroom, even though he was a high risk for falls, and his care plan stated he needed extensive assistance from staff during toileting. Citation # 940011286.

Regency Oaks Post Acute Care Center
3850 E. Esther Street, Long Beach
B $2000 Injury 7/31/2014
On 6/4/14, a resident sustained blunt head trauma in an altercation with another resident. The injured resident’s doctor ordered the facility to perform neuro-checks every day for 72 hours. The facility was cited for not performing the neurological checks accurately and for allowing a LVN to perform the neuro-checks, which was beyond her scope of practice. Citation # 940010900.

Sharon Care Center
8167 W 3rd Street, Los Angeles
A $20000 Infection 2/5/2015
On January 1, 2013, The Sharon Care Center failed to have policies and procedures in place to indicate how to apply, care for, and monitor a wound vacuum (a machine to enhance wound healing.) The failure resulted in a sponge being left in Patient A’s abdominal wound, which further caused an infected ileostomy, that was located several inches from the wound. Citation # 910011246.

B $2000 Elopement 2/18/2015
On 10,9, 2011, Patient 5 fell while out of the facility and sustained a fractured nose, and facial lacerations. The facility failed to implement the facility’s elopement policy and procedure by not testing the door alarm and documenting the test results daily. Citation # 910011274.

Shoreline Healthcare Center
4029 E. Anaheim St, Long Beach
B $2000 Careplan Elopement Mandated Reporting Patient Care Security 12/10/2014
A 53 year old patient eloped from the facility on 11/8/13 and was not found until 11/22/13, 14 days later. The patient’s desire to purchase cigarettes led to her elopement and her habit of smoking was never addressed in her careplan, even with her diagnosis of asthma. The facility failed to report the elopement within 24 hours as indicated by State requirements and the facility’s policy and procedure of reporting elopements and missing patients. Citation # 94001134.

Socal Post-Acute Care
7931 Sorenson Avenue, Whittier
A $10000 Patient Care 12/10/2014
On 9/25/12 a female resident was found bleeding from her shunt, which is used as an artificial replacement for the loss of kidney function. Pressure was applied in an attempt to control the bleeding and vital signs were attempted, but the resident had none. 911 was called but the resident died. Because it was known that the resident had “scratching AV shunt behavior” and had scratched at it before, the facility failed to update and revise the existing care plan based on this behavior. Citation # 940011129.

Verdugo Valley Skilled Nursing & Wellness Centre
2635 Honolulu Avenue, Montrose
A $5000 Fall Injury 2/5/2015
On 11/15/14, a resident fell and fractured her right ankle, causing four days of hospitalization. Prior to the fall, the resident walked by several staff members on her way to the patio, but did not have her walker, as called for in her care plan, to keep her safe. She lost her balance and fell. The staff failed to provide her with the walker in accordance with her care plan or to ensure she had supervision while they went to get it. Citation # 920011265.

Vernon Healthcare Center
1037 W Vernon, Los Angeles
A $20000 Fall Injury 03/31/2015
On 5/19/13, a resident fell from bed, was found on the floor and put back to bed. A few hours later he suffered a seizure and was hospitalized. It was found that he had suffered bleeding deep in his brain and intracranial hemorrhage. The resident was put on hospice care, transferred to another skilled nursing facility and died on 6/9/13. The facility was cited because it failed to provide the resident, who was identified as being at high risk of falls, with a safe environment and plan of care to protect him from falls from bed. Citation # 940011362.

View Heights Convalescent Hospital
12619 S. Avalon Blvd., Los Angeles
B $1000 Mandated Reporting Sexual Abuse 8/27/2014
The facility was cited for failure to report an incident of abuse within the required 24 hour reporting timeframe as required by law, after three residents were assaulted by the facility housekeeper. One resident made a report to facility staff of a male housekeeper making inappropriate advances towards her and entering her room for no reason. Staff did not report the alleged abuse until three days later upon receiving handwritten letters from three residents alleging unwanted sexual advances from the same male staff member. Citation # 940010963.

Vista Cove Care Center at Long Beach
3401 Cedar Avenue, Long Beach
B $2000 Physical Abuse 10/22/2014
The Vista Cove Care Center at Long Beach Inc., was cited for failing to report three separate allegations of physical, sexual, and verbal abuse. The Administrator was unable to provide a log or record indicating the allegations he had investigated. The health, safety, and security of the residents was put at risk by failing to provide notifications to all parties involved, including notifying the DHS or the Long term care ombudsman. Citation # 940011087.

B $2000 Physical Abuse 11/12/2014
On 9/4/13 Resident A’s family member reported the resident got into a verbal and physical altercation with a staff member. The staff resident hit the staff member and the staff member hit the resident back. The facility failed to report this incident to the State Licensing and Certification Agency immediately or within 24hrs, which went against the facility’s policy. Citation # 940011123.

Windsor Palms Care Center of Artesia
11900 East Artesia Blvd, Artesia
A $10000 Patient Care 9/23/2014
The facility was cited for failure to ensure that a visually impaired quadriplegia resident was not verbally and physically abused when on 9/30/13 her roommate called her a “bitch” and violently beat her about the face because she requested that a CNA turn her radio on in the middle of the night. As a result of the beating, the resident sustained multiple bruises and a fractured eye socket. The aggressive roommate had a history of yelling at other residents, being verbally and physically abusive, and scratching...
the staff members when providing care. Her care plan indicated she suffered from psychosis and was a paranoid schizophrenia. Citation # 940010691.

### Woodruff Convalescent Center
17836 S Woodruff Ave, Bellflower

**A $10000 Careplan Fall Supervision 12/10/2014**

A 64 year old resident experienced falls on 7/15/13, 7/23/13, 8/14/13, and 11/30/13. There was neither any revision to her careplan nor additional supervision provided after the first fall. The final fall resulted in a fracture to her right scapula and pelvic bones. The fractures were not discovered until 12/3/13 and 12/4/13. The facility was cited for failing to provide adequate supervision and revising resident’s careplan after each fall. Citation # 940011147.

### Orange County

### Mesa Verde Post Acute Care Center
661 Center Street, Costa Mesa

**B $2000 Transfer 11/14/2014**

On 8/12/14, a resident who required extensive assistance with activities of daily life was discharged to his family’s home with no documented evidence that the resident’s family was given advance notice, education, or sufficient preparation and orientation to ensure a safe discharge. The resident’s discharge plan listed 16 different medications, including two different types of insulin that required injection. There was no documented evidence as to how much of each medication was provided to the family, if any instructions were provided or if the family understood how to administer them. The resident’s family took him to the acute care hospital on 8/16/14 with a cough, fever, and urinary tract infection. The facility was cited for failure to provide a safe discharge from the facility. Citation # 060011127.

### San Diego County

#### Clairemont Healthcare & Wellness Centre, LLC
8060 Frost Street, San Diego

**B $2000 Bed Hold 2/6/2015**

On September 10, 2014, the facility refused to readmit a resident who was transferred to the emergency room for evaluation of his behavior and medication adjustment. The resident demonstrated no behavioral issues during his 18 hour stay in the emergency room, and was cleared for discharge back to the facility by the hospital psychiatrist. According to the emergency room records, the facility LN “Stated, we are not accepting the patient back to our facility. I have spoken to the administrator and we are aware of the penalties and fines for patient dumping and do not care.” Citation # 080011255.

**B $2000 Patient Care 2/6/2015**

Between January and September of 2014, seven A facility was cited for failing to receive and administer proper pain medication for a resident for nine days causing the resident to experience excruciating pain. As a result of the pain, the resident did not want to move, causing an existing pressure ulcer to worsen. The facility failed to follow policy and procedures of informing the Director of Nursing or Medical Director when the primary physician could not be reached to confirm the refill for the resident’s pain medication causing the delay. Citation # 060011418.
of 20 residents were not given adequate nutrition, including two residents identified as nutritionally high risk. The failure to assess and address the residents’ nutritional needs resulted in a variety of issues from severe weight loss to bedsores not properly healing. The facility was cited for failure to implement a comprehensive, systematic approach to ensure effective monitoring and systems to maintain acceptable parameters of nutritional status. Citation # 080011257.

B $2000 Administration 02/06/2015

On September 10, 2014, a survey team called an Immediate Jeopardy related to the facility’s lack of a comprehensive Infection Control Program, and requested that the Administrator provide it with immediate measure that would ensure that a Quality Assurance Committee was implemented. Following a record review and interviews with staff and consultants, the Administrator acknowledged that there was no Quality Assurance Committee program for the facility. Citation # 080011258.

B $2000 Medication Patient Records 02/06/2015

During an inspection survey in September 2014, the facility demonstrated frequent and repeated failures to document the administration of controlled substances. A review of eight resident’s medical records showed that controlled medications, including Percocet and oxycodone, were not accurately accounted for, in five of the eight patient records. The facility was cited for failing to employ a pharmacist to establish a system of records for disposition of all controlled drugs, and failing to store all controlled drugs in separate locked compartments. Citation # 080011260.

B $2000 Administration Patient Care Staff (Inservice) Training 2/6/2015

The facility failed to establish an adequate Infection Control Program. During an annual survey on 9/8/14, a resident was found with three catheter bags full of urine laying on his bedside table, near his food tray. Another resident with a bacterial infection was placed on contact isolation, yet several staff members entered and exited the room without washing their hands, often touching other residents’ meal trays immediately after exiting. The facility’s bathroom shower curtains and tiles were coated with a black and brown substance. The facility did not have infection control policies and procedures in place, and failed to train staff on infection control protocol and hand-washing. Citation # 080011259.

A $20000 Mandated Reporting Patient Care Physical Abuse 2/6/2015

The facility failed to report two allegations of abuse, putting the residents at the facility at risk of further abuse. The first incident occurred on 7/14/14, when a male resident with a history of aggressive behavior was observed touching a female resident’s thigh close to her genitals. A CNA attempted to separate the two, and was struck in the mouth by the male resident. The facility did not investigate or self-report to the Department of Public Health until 68 days later, when informed of the duty to report by a surveyor. The second incident occurred when the facility staff failed to report a resident’s allegation that a member of the Physical Therapy team “has it out for him.” Citation # 080011263.

A $20000 Careplan Dietary Services Feeding Hydration Patient Care 2/6/2015

On 7/10/14, a male resident was sent to the emergency room for dehydration. He was admitted to the facility on 3/5/14, with a feeding tube in the stomach, difficulty swallowing, and a high risk for dehydration. Despite his care plan, the staff failed to properly monitor his fluid intake or act upon abnormal lab values to prevent dehydration. Furthermore, there was no documentation that he was seen by his attending physician in person after admission, as required by law. The facility was cited for failing to provide sufficient fluid intake to maintain proper hydration. Citation # 080011262.

A $20000 Patient Care Patient Rights Transfer 02/06/2015

A female resident was admitted to the facility on 4/15/14 with diabetes, muscle weakness, inability to ambulate, urinary tract infection, dehydration, and inability to care for herself. She had a small companion dog named Skylark. On 9/9/14, during the facility’s annual survey, the Administrator told a staff member to hide the resident’s dog outside, and tell the resident she could no longer have the dog in
the facility. The resident responded that if she could not have her dog, she wanted to go home. She was then discharged that day, on 9/9/14, taken by taxi to her trailer, without a physician being notified. At discharge, she had a urinary catheter that she could not change. She could not walk, get out of bed, or use the toilet. She did not have her medications, a means to test her blood sugar levels, or a phone to call for help in an emergency. Upon arrival at the trailer, a neighbor called the police, who arrived four hours later to find the resident dirty and without food. The resident was admitted to the ER that night, with two pressure ulcers and a clogged catheter, smelling of urine and feces. Citation # 080011261.

Lakeside Special Care Center
11962 Woodside Avenue, Lakeside
B $1000 Mandated Reporting Physical Abuse 3/6/2015

On 11/11/14, a resident was described to have assaulted a female resident, which left a red mark on her face. The facility, however, did not report the abuse to the Department of Public Health. The facility administrators claimed that they do not report abuse if there were no marks on the resident. According to the facility policy, they are supposed to report an incident to the local Ombudsman and Department of Licensing and Certification immediately. The facility failed to follow their own policy for reporting abuse. Citation # 080011307.

Rancho Vista
760 E. Bobier Dr., Vista
A $20000 Careplan Notification Patient Care Patient Rights 2/17/2015

On 7/21/14, the facility failed to notify and update the physician for a resident when he had respiratory distress, abnormal vital signs, and abnormal respiratory assessment. The resident was repeatedly treated by Licensed Nurses when he was found in respiratory distress, but the Registered Nurse and Physician were never informed of his change in condition after treatments and no records were kept documenting the assessment, vital signs, or administration of treatment for the resident. When the resident was found unresponsive, not breathing, and with no pulse, the resident was not administered CPR even though he indicated he wanted full resuscitative measures. The facility failed to follow proper policy and procedures for identifying the code status for 21 of 21 sampled residents and to maintain a Do Not Resuscitate master list in each Medical Administration Record and Treatment Administration Record. This potentially puts other residents at risk for their advance directives to not be honored if they are found unresponsive. Citation # 080011187.

Villa Monte Vista
12696 Monte Vista Road, Poway
A $20000 Patient Care 2/5/2015

On 8/15/13, the resident was admitted into the facility and assessed to be at risk for developing pressure ulcers. On 9/30/13, the resident went to the ER and died three days later from infection and decubitus ulcer complications. The facility was cited for failing to give the resident adequate treatment while the wound on his back developed tissue loss, exposed bone and bacterial infection. When the nurse who was in charge of the resident was asked if he thought that the wound should have been debrided, the nurse stated he “never considered it”, and, when asked if he was wound-care certified he said, “No,” but he was “taking classes towards certification”. The investigation noted that there was no documented evidence that a physician or wound care consultant observed the resident’s pressures sores. Citation # 080011251.

Tulare County
Providence Sun Villa
350 North Villa St., Porterville
A $20000 Dietary Services Injury Patient Care Supervision 3/2/2015

The facility was cited on 7/16/2014 for failing to ensure a hot beverage was served at a safe temperature and failing to supervise Resident A, a 93 year old resident with Alzheimer’s disease, and Resident B, a 32 year old resident with profound intellectual disabilities and bipolar disorder. This resulted in severe burns for Resident B when Resident A threw her hot beverage on him. Citation # 120011037.