In a disgraceful last minute effort to kill AB 348 (Brown) – a CANHR sponsored bill that would have set timelines for investigations of abuse and neglect cases reported by nursing homes – the Department of Public Health continued a long tradition of siding with perpetrators of abuse against their victims by taking an official position opposing the bill. As a result, this critical bill died in the Senate Appropriations Committee.

The Department of Public Health takes its position against AB 348 shortly after the Legislature gave it funding in June to add over 300 new positions – an extraordinary increase – for its Licensing and Certification Division and its counterpart in Los Angeles County. After representing to the Legislature that this vast expansion of its workforce would allow it to perform all of its workload, the Department now says it needs more than $18 million and more than 100 additional employees to investigate abuse cases that it is already funded to investigate.

Although the chronically mismanaged Department has been going through the motions this year of appointing new leaders, assessing itself and claiming to hold itself accountable, it is abundantly clear that nothing has changed. For years the Department of Public Health has been turning its back on victims of nursing home abuse and it has done so again.

The Department of Public Health stood alone in opposing AB 348. The bill had widespread support from numerous organizations, individuals, and the nursing home industry and had won unanimous support from the Legislature before being held in Senate Appropriations due to the Department’s fabricated cost estimate.
CANHR News

CANHR Updates

Congratulations to Kalinda Lisy, CANHR special projects staff, whose first child, Adelaide Sujitra Ramerth, was born August 18. Mom and baby are doing great, and we welcome Adelaide into the CANHR family.

A special thank you to Michele Cole for her administrative help this summer. Michele is now off to the University of California Santa Cruz to begin a whole new life’s journey.

CANHR welcomes Rehena Shakya, our fall intern who will help with research and other special projects. Rehena is a graduate student in San Francisco State University’s Gerontology Program.

Support CANHR

One of the easiest ways to make a meaningful donation is to leave CANHR a gift by Will or, bequest. Bequests are a valuable estate-planning tool, can reduce your taxable estate and may qualify for a full estate tax charitable deduction.

If you would like more information on how to make a bequest, please contact Robert Martien at the CANHR office. (415) 974-5171 or by email at robert@canhr.org.

You should always consult your attorney when drawing up or revising your Will to ensure your intentions are carried out properly.

Fall Workplace Giving Through United Way

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

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

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

Get the CANHR Advocate via email

Help save resources and money by requesting your “CANHR Advocate” be sent to you via email. Contact the CANHR office at canhrmail@canhr.org with your current email address and we can easily convert your subscription from paper to electronic. You still receive the same great newsletter, CANHR reduces our printing and mailing costs and the trees will thank you too!
Salinas RCFE Served with Suspension Order

Colonial Manor, a Residential Care Facility for the Elderly (RCFE) in Salinas, California, has been served with a temporary suspension order by the Department of Social Services – the first move in terminating the facility’s license. Licensed as an RCFE since 2012, the licensee of the 42-bed facility is listed as MP Acquisitions, LLC, a limited liability company incorporated in Nevada with Angel Marzan, of Yonkers, New York listed as “manager.”

Colonial Manor has had an extensive inspection history and received more than 190 citations since the MP Acquisitions and Mr. Marzan took over in 2012. Chronic food shortages, bed bug infestations, flies, mold, broken furniture, urine stained carpets, overflowing toilets, dirty clothes laying in piles, missing medications, missing client funds, inadequate staffing and inadequate supervision – these are only a few of the 224 pages of investigation findings by CCL over the past 3.5 years.

Despite the fact that RCFEs are not permitted to have more than 25% of residents who are under 60 years of age and despite the fact that an RCFE is inappropriate for those whose primary diagnosis is mental illness, over 25% of Colonial Manor’s residents are under the age of 60 and many are in need of mental health services – not a bed-bug and mold infested house of horror.

As recently as June 2015, Kolonial Manor Assistance Inc. filed Articles of Incorporation in the State of California, according to public records filed with California Secretary of State, and Angel Marzan is listed as President. Yep – it’s spelled “Kolonial” – not to be confused with “Colonial.”

Should AB 601 (Eggman), currently pending in Senate Appropriations, be signed into law, it is unlikely that Mr. Marzan will be granted another license to operate an RCFE in California – regardless of how he spells the name.

South Pasadena Convalescent Hospital is Center of Controversy

The former South Pasadena Convalescent Hospital is in the news again weeks after the Sacramento Bee reported that the Centers for Medicare & Medicaid Services had decertified the facility and the Department of Public Health had issued dozens of citations to it due to severe abuse and neglect of residents. On August 19, 2015, Arthur Miller, the South Pasadena Chief of Police, held a widely attended press conference to discuss a criminal investigation at the facility, to condemn troubling conditions that his force had encountered and to announce a new operator had taken over management of the facility.

The criminal investigation involved the horrific death of Courtney Cargill, a resident of the facility who died in November 2014 of tragic circumstances. Ms. Cargill, who suffered from a serious mental illness, bought a gallon of gasoline, lit herself on fire and died after the facility allowed her to leave unsupervised on a pass. In urging the Attorney General’s Office to bring negligent homicide or related charges, Chief Miller stated: “That should have never happened. She died the next day and what’s sad is this was completely preventable at every level.”

The press conference also addressed other shocking conditions, including the rerouting of emergency 9-1-1 calls to the nursing stations at the facility. Miller said: “We never heard about those calls until we started having to do foot beats through the hospital. That’s crazy. That’s insane that the people that were asking for help got rerouted to their captors. It’s just unheard of.”

Chief Miller also urged the Attorney General’s Office to bring charges for “loading this hospital up with people that should not have been there and then getting state and federal funding.”

Long Term Care News ............... (continued on page 7)
**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 of provide claims detail information to current or former Medi-Cal beneficiaries and to post how to obtain this information on their website. SB 33 is co-sponsored by Western Center on Law and Poverty. **Status: On the Assembly floor. Letters of support should be sent to Governor Jerry Brown**

**FAX: (916) 558-3160**

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

This bill would establish timelines for the Department of Public Health (DPH) to complete complaint investigations. The part of the bill dealing with timelines for public complaints has already been enacted through budget bill SB 75, which sets a 60-day timeline for completing investigations effective on July 1, 2018. AB 348, as amended, would require DPH to complete investigations of facility reports of abuse and neglect within the same timelines. **Status: DEAD.**

**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: On the Senate floor. Letters of support should be sent to the Governor.**

**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. The San Diego County District Attorney’s Office is co-sponsoring AB 927.**

**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 120 days after a formerly occupied unit has been vacated. The bill would also require any payment balance not paid to the resident within 120 days to accrue compound interest every 30 days at a rate not lower than 4% 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 compound interest every 30 days at a rate not lower than 6% 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: On the Assembly floor.**

**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: Signed by the Governor.**

**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: DEAD.**

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

Increases the “any income deduction” from $20 to $50 for Medically Needy Only Medi-Cal applicants and beneficiaries, dependent on federal approval. **Status: Dead.**

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

AB 1387 amends the RCFE citation appeals system, so that facilities will have two levels of appeal rather than four. Currently, with four levels of appeal for RCFE violations, it is nearly impossible for fines to be collected, even if they are assessed. Regrettably, AB 1387 was amended so that it no longer provides a system of appeal for consumers who file complaints against RCFEs. **Status: On the Senate Floor.**

**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: On the Senate Floor.**

**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: On the Senate floor.**

**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 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 AHCDs will continue to languish in a registry system that is ancient, unused, and virtually worthless. If the state is going to create a state of the art registry for POLST, it ought to include AHCDs. **Status: On the Assembly Floor.**

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.
**What is the Assisted Living Waiver?**

In general, Medi-Cal does not pay for care provided by Residential Care Facilities for the Elderly (RCFEs), because RCFEs do not provide medical care, but there are a few exceptions. Under the Assisted Living Waiver (ALW), Medi-Cal will pay for eligible seniors and persons with disabilities living in participating counties to receive assisted living and care coordination services if they meet financial and health/level of care requirements.

The California Department of Health Care Services developed the ALW to test whether assisted living as a Medi-Cal benefit could be an effective alternative to nursing home placement. The ALW offers Medi-Cal recipients the opportunity to receive necessary supportive services in less restrictive and more homelike settings. A key goal of the project is to enable Medi-Cal eligible seniors and persons with disabilities who would otherwise require nursing facility care, to remain in or relocate to qualified RCFEs or publicly subsidized housing.

**Which counties are participating in the ALW?**

As of August 2015, the ALW is available in the following counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, San Mateo, Santa Clara, and Sonoma. However, some of the counties in which the ALW program is operating do not currently have any RCFEs participating in the program. For a list of participating RCFEs, see [http://www.dhcs.ca.gov/services/ltc/Documents/ListofRCFEfacilities.pdf](http://www.dhcs.ca.gov/services/ltc/Documents/ListofRCFEfacilities.pdf).

**What are the eligibility requirements for participation in the ALW?**

Participants must be at least 21 years old, eligible for full-scope, no share-of-cost Medi-Cal, and require a nursing facility level of care. The level of care requirement is critical to eligibility because the program is designed to serve people who would otherwise need nursing home care.

**How can consumers apply for the ALW?**

Consumers should contact one of the Care Coordination Agencies (CCAs) in their county of residence to apply for the ALW. CCAs will verify Medi-Cal eligibility, and then conduct a pre-screening “assessment” over the phone before setting up an appointment for the actual assessment. CCAs use a standardized assessment tool to determine the applicant’s need for nursing home level of care. For a list of CCAs, see [http://www.dhcs.ca.gov/services/ltc/Documents/CareCoordinationAgencies.pdf](http://www.dhcs.ca.gov/services/ltc/Documents/CareCoordinationAgencies.pdf).

After the CCA conducts the assessment, the application is sent to the Department of Health Care Services (DHCS) for approval. There is currently a backlog of ALW applications, and applicants transitioning from nursing homes are given priority over “rollover” applicants, i.e., RCFE residents who would like to remain in their facilities as ALW participants. There are slots available for rollover applicants, but the application wait period is longer than that for applicants transitioning from nursing homes.

**How do ALW participants select an RCFE?**

CCAs are responsible for assisting applicants who have been approved for the ALW in selecting an RCFE. However, ALW participants have the right to choose the RCFE to which they will move (or continue to reside). It is helpful if family members, friends and/or legal representatives visit identified facilities with the participant to assist in the selection process. RCFEs are not required to accept every ALW participant who selects their facility, and an RCFE can choose to make any number of beds available to ALW participants at any given time. However, once a facility admits an ALW participant, it must provide necessary services as the resident’s needs change. All providers are required to serve residents at all service tiers.

For a list of participating RCFEs, see [http://www.dhcs.ca.gov/services/ltc/Documents/ListofRCFEfacilities.pdf](http://www.dhcs.ca.gov/services/ltc/Documents/ListofRCFEfacilities.pdf).

**Who pays the RCFE, and how much does it cost?**

Participants pay for their room and board, and Medi-Cal pays for their care and services. In 2015, for participants with monthly Social Security or SSI income of $1,145.00, the room and board rate is $1,014.00. For participants with income of $1,165 or greater, the room and board rate is $1,034.00. Medi-Cal pays the RCFEs and home health agencies for five levels of care and services, with daily rates...
South Pasadena Convalescent Hospital is owned by Shlomo Rechnitz, who is seeking approval from the Department of Public Health to sell it to new owners.

**The Shut Out: Why Have Humboldt County’s Skilled Nursing Facilities Stopped Accepting Patients**

On July 9, 2015, the *North Coast Journal published a lengthy article* with the above title that examines why some Humboldt County residents are being sent to Oregon and other counties in California when they need nursing home care. The article reports that five of six nursing homes controlling 449 of 457 skilled nursing beds in Humboldt County have been refusing to admit local residents needing skilled nursing care despite the availability of beds, apparently in pursuit of financial concessions from a local Medi-Cal managed care plan. The five nursing homes are owned by Shlomo Rechnitz, California’s largest nursing home operator. The North Coast Journal article provides a fascinating look at the differing interests of the powerful and the powerless and raises important questions about why government regulators have allowed an operator to gain near monopoly powers at the expense of Medi-Cal beneficiaries who need care.

**Governor Gives Nursing Home Operators Five-Year Rate Increase with No Staffing Increase**

On June 24, 2015, Governor Brown signed into law *AB 119*, a budget bill that extends the AB 1629 Medi-Cal rate system for freestanding skilled nursing facility by giving operators annual compounded 3.62 percent rate increases through July 2020. The Administration rejected CANHR’s call to tie the rate increases to comparable increases in California’s minimum staffing requirements for nursing homes. Over the five-year period, California nursing homes will receive about $2.4 billion in additional Medi-Cal payments due to this action.

**Nursing Home Industry Tries to Rig Federal Regulations**

Want to win an iPad? You have a chance if you work for a nursing home that submits 10 or more comments to CMS on the proposed rule on Requirements of Participation for nursing homes.

The American Health Care Association (AHCA), the largest lobby group for nursing home operators, is offering this reward to persuade its members to submit thousands of comments to the federal government. By, in essence, stuffing the ballot box, AHCA is trying to pressure CMS to weaken and stall the proposed regulations. According to AHCA, the proposed rule “goes too far, demands the changes too quickly and costs too much” and would lead to “Washington micromanaging even basic functions in our centers.”

What kind of micromanagement is AHCA concerned about? Among other changes it is seeking, it is urging its members to fight a proposed requirement that would prohibit a nursing home from using any person, including contract staff, who is incompetent. AHCA claims it is unreasonable to expect a nursing home to be responsible for the competency of contract staff. It might come as quite a shock to people living in nursing homes that operators do not think they are responsible for the competency and conduct of the people who are giving them care. If a nursing home cannot ensure the competency of contract staff, it should not use them.

What does it say about the nursing home industry that it is awarding prizes to induce its members to fight to allow them to use incompetent contract staff?

One would hope that CMS would see through this deplorable tactic. The proposed rules in question are the first major rewrite of the federal Requirements of Participation for nursing homes since they were published in 1991 to implement the Nursing Home Reform Act of 1987. Although CMS claims the proposed changes will modernize the Requirements, they would do little to ensure that nursing homes are adequately staffed and to stop the epidemic use of chemical restraints. The proposed rules have a 60-day comment period. Comments are due on September 14, 2015.
In spite of numerous and grave concerns raised by CANHR and other consumer advocates regarding privacy, resident rights and the legality of its process, the Community Care Licensing (CCL) Division of the Department of Social Services recently released a set of “guidelines” for using video surveillance in adult community care facilities and residential care facilities for the elderly.

CCL’s guidelines permit facilities to use video surveillance in “common areas,” regardless of whether residents consent to be recorded, and in “private areas” with residents’ consent. No audio component is permitted. Other elements of the policy require facilities to submit to CCL updated plans of operation, updated admission agreements with informed consent, and requests to waive regulations protecting residents’ privacy and dignity rights. The policy also recommends “best practices” regarding the storage of video surveillance recordings.

The policy is notable for its omissions, and raises far more questions than it answers. Issues not addressed by the guidelines include: What are the definitions of “common” and “private” areas”? How can private meetings in “common” areas be protected? Is a facility required to post signs warning people that they are under video surveillance? Which laws or regulations authorize a relative or “responsible party” to sign away a resident’s fundamental privacy rights? How are cameras monitored during operation? Who can have access to the recordings, and under what circumstance? How will the guidelines be enforced?

Perhaps most importantly, the guidelines fail to address residents’ rights to record their own private living area, an issue that has become increasingly important as residents invoke extraordinary efforts to ensure that they receive good care. No laws or regulations prohibit the use of video cameras by residents or their family members, and CCL does not have the authority to allow facilities to record residents, but deny residents the right to record themselves. Nonetheless, CCL ignored CANHR’s repeated requests to issue a comprehensive policy addressing both consumer and facility use of video surveillance, and instead chose to act on a piecemeal basis.

CCL’s issuance of its video surveillance policy in the guise of guidelines and best practices is disingenuous, and violates California’s mandated rulemaking process. California’s administrative procedures law requires that regulatory standards be developed through specified procedures involving public notice and comment. Instead, CCL chose to issue its video surveillance standards in its Evaluator Manual, an instructional guide for CCL employees. The Evaluator Manual does not state how employees can enforce guidelines or best practices. CCL’s failure to issue its video surveillance standards through the requisite regulatory process deprived stakeholders of the opportunity to provide input, and drastically limits CCL’s ability to bring facilities into compliance with its standards.

CANHR is very disappointed with CCL’s video surveillance policy, and is reviewing its options. It is a disservice to all stakeholders to release guidance that leaves so many questions unanswered, and fail to provide the Department with necessary enforcement tools. Consumers, facilities and licensing staff would have benefited from a comprehensive policy vetted by stakeholders through the regulatory process.

Dear Cash-Strapped:

Beginning in January 2014, the IRS issued a new rule that IHSS caregivers do not owe federal and state income taxes on their wages, so long as they live in the same home as the person getting the care. (Note: wages may still be subject to FICA tax.) Furthermore, if you received qualifying IHSS payments in the past, you can claim a tax refund within three years from the date you filed your tax return, or two years from the date the tax was paid, whichever was later.


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**Did You Know?**

**Continued SSI Benefits for Recipients who are in a Nursing Home less than 90 Days**

Generally, if an SSI recipient enters a nursing home and Medi-Cal is paying for the cost of care, the recipient’s SSI benefit will be lowered to $50 per month. However, if the SSI recipient is going to be in the nursing home for less than 90 days, the recipient may continue to receive his or her regular SSI benefit for up to 3 full months by providing certain information to Social Security. Social Security calls this short stay exception the “Temporary Institutionalization Benefit” (TI Benefit).

To obtain the TI Benefit, the recipient must provide to Social Security the following information:

1. A doctor must certify in writing that he or she expects the recipient to be in the nursing home for 90 consecutive days or less.

2. The recipient or someone knowledgeable about the recipient’s circumstances must submit evidence that the recipient needs to pay some or all of the expenses of maintaining a home or living arrangement while he or she is in the facility.

The above information must be received by the Social Security Administration or postmarked before the recipient leaves the facility, or by the 90th day the recipient is there, whichever is earlier. Social Security will work with facilities to assist recipients in establishing eligibility for TI Benefits.

For more information on the Temporary Institutionalization Benefit, see https://secure.ssa.gov/poms.nsf/lnx/0500520140.

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**Dear Advocate,**

I’m an In Home Supportive Services (IHSS) provider for my mother, who moved into my home when I started to care for her. Is it true that I don’t have to pay income taxes on my salary?

Sincerely,

Cash-Strapped in Canoga Park

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**Fall 2015**

**CANHR Advocate**
It turns out that the strength of continuing care retirement communities (CCRCs) may also be their biggest source of controversy. CCRCs exist largely to give its residents peace of mind that, regardless of their needs, they will have a high quality of life with all the assistance they may require. Access to services and diversity of needs are the hallmarks of a CCRC.

Unfortunately, for the management and some residents at select CCRCs, access is a one-way street and diversity is best denied than celebrated. The result is that residents housed in the assisted living or nursing home units of CCRCs are left out of the reindeer games played by those in the independent living units. From CCRC dining rooms to bingo halls, assisted living and nursing home residents are being forced to stay out of parts of their campuses they paid enormous sums to enjoy. As the New York Times described in recent articles “Tables Reserved for the Healthiest” and “An Unexpected Bingo Call: You Can’t Play,” residents with disabilities and greater care needs are sometimes barred from eating or participating in activities with their more able-bodied spouses and friends in independent living units.

The two likely reasons for the naked discriminatory policies of some CCRCs are marketing and old-fashioned prejudice. CCRCs rely on turnover in the units to generate income and nearly all prospective new residents are interested in the independent living units, enticed by an active lifestyle and vibrant neighbors. Those selling points may be less apparent when people with disabilities are mixed into the picture. Additionally, many of the prohibitions are sought by current residents who don’t like the “intrusion” of having to observe people with greater care needs. These residents prefer strict segregation and are vocal about their preferences.

The good news is that the residents subjected to exclusionary policies have fought back and have a strong set of federal and state anti-discrimination statutes to help. In Virginia, a CCRC named Harbor’s Edge was taken to task by the U.S. Department of Justice for fair housing violations and eventually was forced to end its dining room restrictions and pay $390,000 in fines and compensation to its victims. As one excluded resident’s son stated, he was able to take his father “to any restaurant . . . in the state of Virginia except the one in the building he paid $600,000 to move into to.”

With then national coverage and scrutiny of the federal government, CCRCs should be on notice that discriminating against its own residents in the enjoyment of available amenities is unacceptable. Nonetheless, it is very likely that such discrimination continues to exist in various forms. For that reason, all prospective CCRC residents should add “how are residents in assisted living and nursing home units integrated into the entire CCRC community?” to the list of key questions they ask before agreeing to pay huge chunks of their life’s savings for fancy dining rooms and heavy-action bingo games. A CCRC community, like a nation, should be judged by how it treats its most vulnerable citizens.

Assisted Living Waiver: FAQs ....(continued from page 6)
**Past Speaking Engagements, Panel Discussions and Training Sessions**

- **June 4:** Long-Term Care Advocate Efrain Gutierrez hosted a CANHR information table at a community town hall in Los Angeles, San Miguel Medical Clinic.

- **June 5:** Senior Staff Attorney Prescott Cole attended the 5th Annual San Francisco Community Boards Peacemaker Awards luncheon.

- **June 11:** Staff Attorney Jody Spiegel presented at a session on Representing Clients in Nursing Facilities and Assisted Living at the Pathways to Justice Conference in Los Angeles.

- **June 11:** Staff Attorney Prescott Cole gave a presentation at the Senior & Disability Action general meeting on reverse mortgages and elder abuse scams.

- **June 16:** Staff Attorney Tony Chicotel participated in the board meeting for the California Culture Change Coalition.

- **July 8:** Pat McGinnis, CANHR Executive Director, presented a free webinar on Medi-Cal Recovery to legal services staff throughout California.

- **July 9:** Prescott Cole presented a training on Long-Term Care Medi-Cal to Contra Costa HICAP volunteers.

- **July 13:** Staff Attorney Jody Spiegel presented a training on Medi-Cal Basics: Eligibility & Recovery at Public Counsel in Los Angeles.

- **July 16:** Long-Term Care Advocate Julie Pollock testified in support of AB 348 (Brown) in Sacramento. The bill passed the Senate Health Committee 9 - 0.

- **July 17:** Prescott Cole participated in a State Bar LRS Management Quarterly conference call.

- **July 28:** Pauline Mosher participated in the Department of Justice San Francisco District Office Residential Care Advocacy meeting.

- **August 8:** Staff Attorney Jody Spiegel participated in the Department of Social Services’ Community Care Licensing Division Quarterly Advocates Meeting.

- **August 17:** Long-Term Care Advocate Julie Pollock testified in support of AB 348 (Brown) in the Senate Appropriations Committee.

- **August 18:** Staff Attorney Tony Chicotel gave a presentation on capacity and conservatorships to a group of social workers at Bay Area Community Services in Oakland.


- **August 28:** Staff Attorney Tony Chicotel ventured to Sacramento to participate in a meeting of the Statewide Partnership to Improve Dementia Care.
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**

Betty Camfield  
Lee C. Camfield

My mother, Rosamond L. Gossett  
Edeline  
Gail Bean

Mr. Gin Yi Lee  
Shi Yin Rex Lee

William Palmtag  
Joan & James Palmtag

Lottie Shamis  
Judith Betts

My beloved mother, Rita Twomey  
Denise Twomey

Thomas Spear Walther  
Anthony Moy

Bruno and Evelyn Wartman  
Mr. & Mrs. John & Paddy Moran

Delores Wood  
Daralyne Baddour

**IN HONOR OF**

Christina Franklin  
Comelia Johnson

Douglas D. Hansen  
Dianne Hansen

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**CANHR Upcoming Events**

- **September 16**: Adult Protective Services & Legal Services (APS) Training - Price: FREE  
  Wednesday, September 16th, 2015  
  1:00pm-4:00pm  
  The Institute on Aging  
  3575 Geary Blvd, San Francisco, CA 94118  
  3.0 hours of CEU credits are available  
  3.0 hours of MCLE credits are available  
  RSVP to: prescott@canhr.org  
  For more information: canhr.org/trainings/aps-legal-services-training.html

- **October 3**: Long-Term Care Advocate Pauline Mosher will be presenting on long term care options in Spanish at the Health for Family Caregivers Workshop at the Mission YMCA  
  4080 Mission Street, in San Francisco from 8:30am – 12:30pm.  
Support CANHR...

If you appreciate our services and the information we bring to you, please help us by making a donation. Make a secure donation online at www.canhr.org or fill out this section and return it with your donation to: CANHR, 650 Harrison Street, 2nd Floor, San Francisco, CA 94107.

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

This gift is in memory of: ____________________________________________

(or) in honor of:

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

Name: ____________________________________________
Address: ____________________________________________
City/State: __________________ Zip: __________________
Telephone: __________________ E-mail: __________________
Facility Name: ____________________________________________

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Citation Watch - Consumer Report

The following citation summaries are compiled from the citations issued by the California Department of Public Health to Northern California skilled nursing facilities and received by CANHR as of the publication of this Advocate. CANHR makes every effort to assure that consumers are provided with accurate information. CANHR welcomes comments and suggestions or notice of errors. Please direct such comments to mis@canhr.org or by calling the CANHR office at (800) 474-1116.

Citations without summaries will be reprinted with summaries once received by the CANHR office. Citations from earlier months are included if a description was not printed in a previous Advocate. Appeals of citations and collection of fines can take up to three years. For up-to-date information on any citation or facility, visit the Nursing Home Guide through CANHR’s web site: www.canhr.org, or call the CANHR office.

Explanation of citation classifications: “AA” citations are issued when a resident death has occurred due to nursing home regulation violations, and carry fines of up to $100,000. A class “A” citation is issued when violations present imminent danger to resident or the substantial probability of death or serious harm, and carry a fine of up to $20,000. Class “B” citations are fined up to $2,000 and are issued for violations which have a direct or immediate relationship to health, safety, or security, but do not qualify as “A” or “AA” citations. “Willful material falsification” (WMF) violations also result in a fine. Fines are not always required to be paid. Citations can be appealed, requiring the Department of Health Services to substantiate the violation. Violations repeated within twelve months may be issued “trebled fines”— triple the normal amount.

### Alameda County

**All Saints Subacute and Rehabilitation Center**

1652 Mono Avenue, San Leandro

B $1500 Administration Patient Care Transfer 9/24/2014

The facility violated the law and was cited after it refused to readmit a resident who had been transferred to an emergency room once he was stable and ready to return to the facility. The private-pay resident, diagnosed with a brain injury, and in a permanent vegetative state, was sent to the hospital for treatment related to vomiting, and was transferred without a discharge plan. When he was ready to return to the facility, the administrator refused his return stating his outstanding balance due as the reason. The resident was forced to stay in the hospital and was not able to return to an appropriate level of care. Citation # 020010964.

B $1500 Physical Abuse 4/17/2015

On 1/24/15, during an incontinence change of a screaming 58 year-old resident who suffered from dementia and psychotic disorders a CNA discovered an oral use lemon swab sticking out of the resident's anus. The resident was not able to respond to investigators questions, but because of the resident's physical limitations it was determined that she would not have been able to have done this to herself. The facility was cited for failure to protect the resident from physical abuse. Citation # 020011376.

**Bay View Rehabilitation Hospital, LLC**

516 Willow St., Alameda

B $1500 Administration Transfer 9/26/2014

The facility failed to properly provide discharge evaluation and planning for three residents, causing them to be released from the facility and denied access at a second facility due to their medical needs. Bay View refused to readmit the residents, and all three were instead sent to the hospital for treatment of possibly dehydration and missed medications Citation # 020011017.

**Castro Valley Healthcare and Rehabilitation Center**

20259 Lake Chabot Rd., Castro Valley

B $1500 Patient Care 11/04/2014

On 9/10/14, a female resident fell out of her wheelchair and was sent to the hospital with a laceration to her head. Physician's orders indicated she was to have a seat belt on while sitting in her wheelchair. The facility failed to follow the physician's orders to apply a seat belt on the resident when up in the wheelchair, resulting in the resident falling out of the wheelchair and sustaining an abrasion due to hitting her head on the floor. Citation # 020011104.

B $1500 Patient Rights 11/04/2014

On 8/27/14, a female resident in a powered wheelchair came into a male resident's room and ran him off of his wheelchair and onto the railing of the balcony outside of his room. The resident stated that he reported the incident to staff but felt that the staff swept the incident under the rug. He also said the other resident hit him in the face the next day. Recognizing that the female resident was using her electric wheelchair as a weapon, the facility replaced her wheelchair with a manual one 3 days later. The facility failed to prevent the resident's right to be free from physical abuse by another resident. Citation # 020011101.

**Crestwood Manor - Fremont**

4303 Stevenson Blvd., Fremont

AA $100000 Patient Care Supervision 7/13/2015

A female resident with a well-documented history of problems with eating and swallowing died on 7/26/2014 after choking. The facility's records showed the resident was left alone with her meal tray in the dining room. Later her face appeared...
bluish and she was given the Heimlich maneuver. One nurse noted her meat was not chopped as it should have been and the arriving emergency medical technicians found a large piece of meat in the resident's airway. In the emergency room, another large piece was found obstructing her left main stem bronchus. The facility was cited for failing to follow choking precautions, which led to the death of the resident. Citation # 020011617.

Driftwood Healthcare Center - Hayward
19700 Hesperian Blvd., Hayward
B $1500 Injury Mandated Reporting Physical Abuse Verbal Abuse 11/19/2014
On 6/4/14, facility staff found a male resident yelling at his roommate and assaulting him. The staff separated the two residents, and then left. Shortly thereafter, the same resident struck his roommate, causing bruises and bleeding near his nose and mouth. The facility was cited for failure to protect the resident from further abuse after an altercation. Citation # 020011051.

B $1000 Fiduciary Patient Rights Theft & Loss 1/15/2015
On 3/7/14, a 36 year-old male resident with Paraplegia sent $1000 to Driftwood Healthcare Center to set up a trust account for himself. The check was cashed by the facility; yet, on 3/17/14 when he asked for money from his trust account, the resident was told that they never received the check. When he became upset and yelled at the nurse's station, the facility sent him to the hospital on a 5150. On 5/15/14, the facility still had not located the $1000 and suggested the resident send an additional $500 to open a trust account. The facility subsequently cashed, then lost the second check of $500. It was not until July 2014 that the facility discovered it had mistakenly processed the funds as the resident's share of cost. The staff did not even attempt to help the resident purchase the tooth brush and clothes he desperately needed during the three months his money was lost. The facility was cited for failure to safeguard the resident's personal funds. Citation # 020011230.

A $18000 Careplan Deterioration Hydration Medication Notification Patient Care Staff (Inservice) Training 06/25/2015
On 9/16/14, the facility failed to follow a nurse practitioner's order to give intravenous fluids to a resident to prevent dehydration. The RN was unsuccessful in starting the IV and called the IV nurse, but did not follow up to ensure the IV nurse arrived to start the IV or inform the NP of the failure when her shift ended. The facility also failed to reevaluate the resident's medication, which caused the resident to suffer severe dehydration because she was on diuretic medication while she had diarrhea. These failures resulted in her death on 9/28/14 due to complications of dehydration. Citation # 020011522.

Kaiser Permanente Post Acute Care Center
1440 168th Avenue, San Leandro
B $1500 Patient Care 12/03/2014
On 8/10/14, a female resident fell due to a failure of the alarm on her person which is supposed to alert staff when she attempts to get up. She sustained a traumatic cerebral hemorrhage which required an 18 day hospitalization. The facility failed to ensure the resident's environment remained free of accident hazards and that she received adequate supervision and assistance to prevent accidents. Citation # 020011148.

Masonic Home
34400 Mission Blvd., Union City
B $1500 Careplan Fall Patient Care Supervision 6/25/2015
A 89 year-old resident experienced a fall on 4/24/15 resulting in a hip fracture. The resident had also experienced falls on 3/18/15, 4/5/15, and 4/20/15, which also resulted in a fracture in his right hip. The resident had just been readmitted on 4/24/15 following surgery on his right hip. The resident fell when he was left unattended on the toilet and attempted to get up on his own, while the CNA walked across the room to retrieve his pants. A review of his care plan showed that the resident required two staff persons to help him to use and transfer from the toilet. The facility was cited for failing to ensure proper staff supervision resulting in the resident's second hip fracture. Citation # 020011580.

Piedmont Gardens Health Facility
110 Forty First St., Oakland
B $1500 Patient Rights Physical Abuse 3/23/2015
On 12/31/14, a CNA was witnessed by another CNA slapping the face and hands of a resident. The alleged abuser then punched the resident in the chest. Sometime later the witness told the charge nurse what he had seen. The facility was cited for failure to implement abuse policies when the witnessing CNA did not intervene immediately and the alleged abuser was allowed to continue providing care. Citation # 020011348.

B $1500 Physical Abuse 3/23/2015
On 1/1/2015, around 12:35 a.m., a CNA told the charge nurse that another CNA slapped a female resident on both of her cheeks, the tops of both her hands, and punched the resident on the mid chest. The CNA "Was complaining about how the resident was giving her a hard time because she was disrobing...trying to get up..." The CNA said when she arrived that evening, the resident was covered in feces and the resident was not cooperative because, "She doesn't like to be washed." She said the resident reached out to grab her uniform top. The CNA said she put her hand over the resident's mouth and told her to be quiet. The facility failed to protect the resident from the initial and repeat abuse from the CNA. Citation # 020011347.
On December 24, 2013, a resident was transferred to an emergency room following significant changes of condition and symptoms of aspiration, respiratory distress, infection and dehydration. A physician determined that the resident was in severe distress, unresponsive and dehydrated. The resident was subsequently transferred to another hospital where a physician determined that he was extremely dehydrated, and diagnosed him with severe blood/fluid loss, acute kidney injury and sepsis. The resident died in the hospital on December 31, 2013 due to acute respiratory failure and septic shock. The facility was cited for failing to recognize, intervene, promptly notify the physician of, and provide treatment for significant changes of condition and symptoms, and to ensure the provision of sufficient fluids to maintain proper hydration and prevent dehydration. Citation # 230011084.

Five certified nursing assistants (CNAs) took and shared illicit photos and videos of residents in a manner that humiliated and abused them. One of the videos showed a CNA “twerking” (dancing to popular music in a sexually provocative manner involving thrusting hip movements and a low, squatting stance) over a resident’s head. In another instance, a photo was taken of a resident, who was wearing only a brief, being carried by a male CNA over his shoulder. Some of the pictures involved residents who were inappropriately exposed and/or deceased. One of the CNAs stated that pictures and videos were sent on many occasions to multiple staff in the facility. A CNA who reported the abuse to the Administrator said she was “absolutely disgusted by the lack of respect this showed for human life and for a person who had passed.” The facility was cited because the Administrator did not report the abuse or start an investigation after it was reported to him on 4/29/14. This failure resulted in the offending CNAs continuing to work with residents, thus jeopardizing their safety and well-being. On 7/14/14, a new Administrator for the facility reported that five CNAs who had been involved were fired after Department of Justice investigators had taken staff phones and retrieved deleted data showing which CNAs were fired after Department of Justice investigators had taken.

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The facility was cited for abuse of residents by subjecting them to mistreatment that was undignified and humiliating. On 7/14/14, a new Administrator for the facility reported that five CNAs who had been involved were fired after Department of Justice investigators had taken staff phones and retrieved deleted data showing which CNAs and residents were involved. Citation # 230011220.

A $10000 Patient Care 3/20/2015
On March 11, 2014, a 64 year old resident with a history of heart disease complained of severe chest pain for over eight hours before he was sent by ambulance to the emergency room, and subsequently transferred to another hospital for a cardiac catheterization and placement of a coronary stent. When interviewed, the licensed nurse assigned to care for the resident stated: “it was my first night on my own;” she knew that the resident had “a history of heart problems but she was never trained on emergencies;” and “they never taught me in school how to call the doctor.” The facility was cited for failing to recognize, intervene, promptly notify the attending physician of, and provide treatment for the resident’s sudden, adverse symptoms and change in condition, complaining of ongoing, severe chest pain for more than eight hours, and for failing to ensure prompt emergency care. These failures placed the resident at risk for worsening of an existing heart condition and heart attack and/or death. Citation # 230011082.

B $2000 Mandated Reporting Patient Rights Physical Abuse 5/29/2015
On 4/3/15 a Licensed Nurse physically restrained a resident by holding his arms to his chest against his will, while CNAs changed his brief. On 4/9/15 the nurse physically restrained a resident by holding her arms tightly to her chest against her will, while CNAs changed her brief. A registered nurse reported the abuse allegations but did not report them to DPH. The facility failed to report to the Department of Public Health abuse allegations for the residents within 24 hours. Citation # 230011477.

Oroville Hospital Post-Acute Center
1000 Exec. Parkway, Oroville

B $2000 Careplan Patient Care 4/16/2015
A 76 year old male resident underwent brain surgery on 1/4/13. He was re-admitted to the facility on 1/9/13. The facility staff failed to notify a physician when the resident complained of severe, persistent head pain for several days following the surgery. The nursing staff also failed to follow the physician's orders to administer oxygen and inhalant medication for the resident's respiratory condition. They failed to initiate CPR when he was found unresponsive, breathless and pulseless on 1/13/13. The resident died on 1/13/13. Citation # 230011355.

Twin Oaks Post Acute Rehab
1200 Springfield Dr, Chico

B $2000 Medication Patient Rights 6/15/2015
On 2/3/14, a male resident was put on antipsychotics, as well as an antianxiety medication and a mood stabilizing medication. The resident's son, who was his Responsible Party said that the physician did not talk to him about his father's medication. The resident was taking the antipsychotic medication for five weeks, when he fell in his room sustaining a right broken hip. He was admitted to the hospital, where he died 19 days later. The facility failed to ensure that informed consent was obtained from the resident's responsible party prior to the facility starting him on an antipsychotic medication. Citation # 230010658.

A $10000 Fall 6/15/2015
An 87 year old male resident fell and broke his hip on 3/11/14 and died from his injuries nineteen days later. The resident had an order for one-to-one supervision, under which a staff person would provide constant supervision, 24 hours a day. On 3/11/14, the resident was left alone when his assigned CNA was assisting another CNA with other residents. When she returned to the resident's room, he was on the floor. The facility was cited for failing to provide adequate supervision Citation # 230010660.

Contra Costa County

Greenridge Senior Care
2150 Pyramid Drive, Richmond

B $1500 Patient Care 11/25/2014
On 7/19/14, a female resident, who was at high risk for falls due to poor balance as well as poor short term memory, was left alone in the hallway while the CNA went to find a wheelchair. She attempted to follow the CNA and fell over a Hoyer lift, sustaining a laceration and fracture of her arm. There was no care plan in the record to prevent falls for her. The facility failed to supervise the resident properly and provide an environment free from accidents and falls. Citation # 020011135.

Martinez Convalescent Hospital
4110 Alhambra Way, Martinez

AN $15000 Staffing 9/26/2014
On 4 out of 24 randomly selected days from March 17 through June 16, 2104 the facility was found to have fallen below the required 3.2 hours per resident per day of actual nursing hours to be performed by properly licensed direct caregivers. The facility was cited for having staffing levels of 3.09 on 5/17, 3.03 on 5/22, 3.12 on 5/28, and 3.16 on 5/29/14. Citation # 020011018.

Orinda Rehabilitation And Convalescent Hospital
11 Altarinda Road, Orinda

B $1500 Deterioration Medication Notification Patient Care 6/10/2015
The facility was cited for failing to provide anti-seizure medication for a resident on 2/7/15 when he started having a seizure which continued over the next hour and a half...
and for failing to inform the physician of another resident's change in condition due to a stroke, delaying that resident's treatment. In both cases, phone messages were left with the Medical Director and the Co-Medical Director but neither responded. By failing to provide "on-call" availability and responding at all times to medical, regulatory, or other emergencies in the facility, the two medical directors placed the residents at risk. Citation # 020011532.

San Miguel Villa
1050 San Miguel Road, Concord

B $1500 Deterioration Injury Neglect Patient Care
Physical Environment Supervision 10/2/2014

On 7/14/14 a 71 year-old resident was discovered unresponsive after she had wheeled herself out to the patio, almost an hour earlier, when temperatures were over 100 degrees. She was diagnosed with heat stroke and second degree burns. She was wearing a long sleeved shirt and long pants at the time. The resident, who had difficulty with decision making and communicating and required supervision, was unsupervised at the time and the RN stated that she had no idea the resident was outside. The facility was cited for failing to protect the resident from the harmful effects of the sun, resulting in hospitalization, heat stroke and second degree burns. Citation # 020011038.

B $1500 Fall Injury Patient Care 10/9/2014

Between 10/13/13, and 3/20/14, a resident fell five times, usually when trying to get out of bed unsupervised. There was no bed alarm in place and no protective mat on the floor by the bed. Another resident would bang his bed rails with the back of his hand which were noted to be discolored purple over three quarters of the hand. The care plan stated staff would "prevent residents from hitting and banging walls." The facility was cited for failure to protect the residents from accidents with injuries. Citation # 020011061.

B $2000 Fall Injury Patient Care 2/13/2015

On 9/13/14, an elderly female resident with Alzheimer's disease fell out of her bedside chair and fractured her thigh bone. The chair was an upright wooden non-reclining chair, which the resident would often sleep in. The facility failed to accurately assess the resident's fall risk, failed to evaluate whether the chair was safe for sleeping, and failed to provide adequate supervision to prevent the resident from falling out of the chair. Citation # 020011276.

B $2000 Careplan Fall Injury Patient Care 2/13/2015

A female resident with dementia and a high risk for falls fell three times in one week at San Miguel Villa, on 7/23/14, 7/27/14, and 7/29/14, resulting in a left hip fracture. The resident was sent to the hospital on 7/30/14, where she received hip surgery. After each fall, the staff failed to revise the resident's care plan or increase her supervision. Furthermore, they failed to lock the resident's wheelchair, which caused the fall on 7/29/14. The facility was cited for failure to provide sufficient supervision to prevent accidents. Citation # 020011279.

Windsor Manor Rehabilitation Center of Concord
3806 Clayton Road, Concord
B $500 Bed Hold Evictions Patient Rights
11/6/2014

A female resident was sent to the hospital on 9/22/14, and was ready to return to Windsor Manor on 9/30/14, but the facility refused to re-admit her, stating the seven day bed hold had expired. Records indicate that there were 21 vacant beds on the day the facility refused to readmit her. Yet the facility had no policy in place to direct staff to re-admit residents to the first available bed after the 7 day bed hold expires, as required by law. Citation # 020011113.

Lassen County

Lassen Nursing & Rehabilitation Center
2005 River Street, Susanville
A $10000 Infection 3/19/2015

A resident died of septic shock on 2/2/13 due to a urinary tract infection untreated by the facility for over two months, and blood poisoning from infected urine. Over the course of several weeks, the facility incorrectly submitted three urine specimens from the resident to the laboratory. The first specimen was not correctly labeled, the second specimen was contaminated by “numerous bacteria that don’t live in humans,” and the third specimen was contaminated because it was put in a cup instead of the “specimen tube with preservatives.” The facility was cited for failing to timely obtain and report laboratory results, notify the physician of acute changes in the resident’s condition, and recognize and ensure timely treatment for infection when the resident was at an increased risk for urinary tract infection and blood poisoning due to the use of an indwelling catheter. Citation # 230010145.

A $10000 Infection 3/19/2015

A resident had to be transferred to the hospital on two separate occasions on 2/2/13 and 3/2/13 when he became septic in the facility. Nursing staff inadequately assessed, documented, monitored, evaluated, and reported changes in the resident’s condition, and laboratory testing that should have been available, was not. When asked about reporting changes in the resident’s condition, a nurse stated: “We had problems with student nurses documenting things in the resident’s records without informing us” and when brought to the Director of Nursing’s attention, he stated, “Oh well.” The facility was cited for failing to timely obtain and report laboratory results, notify the physician of acute changes in the resident’s condition, and recognize and ensure timely treatment for infection when the resident was at an increased risk for urinary tract infection and sepsis due to an atrophied right kidney. Citation # 230011339.
Mendocino County

Redwood Cove Healthcare Center
1162 S. Dora Street, Ukiah
A $20000 Fall Supervision 12/23/2013
On 6/19/14, a female resident with Alzheimer's disease was sitting outside on a patio when she pushed her wheelchair past a gate onto a sidewalk and rolled downhill before falling from the chair. The resident fell near a busy street. A Wanderguard alert system did not engage the staff members to prevent the accident. The facility was cited for failing to provide adequate supervision. Citation # 110011033.

Napa County

Napa Nursing Center, Inc.
3275 Villa Lane, Napa
A $20000 Fall 4/25/2015
A 90 year old resident who was at high risk for falls was admitted to the facility in April 2009 with diagnoses including dementia with delusions and osteoporosis. The resident suffered four falls in 13 months, which all resulted from her getting out of her wheelchair unassisted. The first three falls occurred while the resident was seated at the nursing station. The third fall on August 2, 2010 resulted in a forehead laceration with significant bleeding and bone exposure, and the resident received sutures in the emergency room. Approximately 10 hours after the resident was returned to the facility, she fell in the hallway and suffered a cervical fracture and reopened her forehead laceration from the previous day. The facility was cited for failing to ensure that the resident, who was at high risk for falls and known to make ongoing attempts to get out the wheelchair unassisted, was assessed for adequate supervision, and the nursing care plans revised to include effective interventions. Citation # 110009855.
B $1000 Dignity Verbal Abuse 7/16/2015
The facility was cited for failure to keep a resident free from verbal abuse after a staff member verbally abused a 78 year old resident. The resident, suffering from multiple diagnosis including depression, was told by a facility staff that he was "a fat old man," and that her tax dollars were paying for his facility stay. Citation # 110006879.

Placer County

Auburn Oaks Care Center
3400 Bell Road, Auburn
B $2000 Dignity Mental Abuse Patient Care Sexual Abuse 11/13/2014
The facility was cited for failing to protect a resident from sexual abuse from a CNA. On five separate occasions, 4/5/14, twice on 4/9/14, 4/30/14, and 5/7/14, a female resident was sexually abused by a CNA while he was assisting her in the shower. The CNA forcefully kissed and exposed himself to her. The resident requested a new CNA and reported the abuse. The CNA confessed to all incidents without prompting or mentioning of any specific residents. The facility failed to recognize changes in the resident's reported behavior after the sexual assaults and failed to provide a safe environment for the resident. Citation # 030011094.

Sacramento County

Arden Post Acute Rehab
3400 Alta Arden Expressway, Sacramento
B $1000 Patient Care 10/17/2014
On 4/11/13 a caregiver refused to change a male resident because she said she had just changed the incontinent resident and she was busy. She said she would return after she'd taken the other residents out to smoke. It was also noted that she would enter his room and not announce what she was doing. The family complained about the incident. The facility failed to follow California law regarding alleged and suspected abuse reporting requirements. It was determined that the facility failed to report the allegation of abuse reported to them on 4/11/13. Citation # 030011076.

Eagle Crest
8336 Fair Oaks Blvd., Carmichael
B $2000 Neglect Patient Care 10/17/2014
On 12/16/13, a 73 year-old resident, with a history of dementia and difficulty swallowing due to a stroke, died after consuming another resident's peanut butter sandwich. According to the resident's dietary plan, he was not allowed to eat any foods that were very hard, sticky or crunchy, peanut butter was specifically indicated that it should be avoided. The CNA was passing out nourishments from the nourishment cart, which are open with the food sitting on top, uncovered, easily in reach of someone in a wheelchair, and left the cart unattended in front of the resident's room. The resident stole another resident's peanut butter sandwich and consumed it quickly by shoving it into his mouth. The CNA chased after the resident and noticed when he began to choke. The physician was notified and 911 was called. The resident died due to a large amount of peanut butter stuck in his upper airway. The facility was cited for failing to adequately supervise the resident to prevent his access to the open nourishment cart, causing him to steal another resident's sandwich and to choke to death. Citation # 030011077.

San Francisco County

Kindred Transitional Care and Rehabilitation-Tunnell Center
1359 Pine Street, San Francisco
B $2000 Mandated Reporting 7/8/2015
On April 12, 2015, a resident complained to a nurse that during the night, a CNA took away his cell phone, placed his call light out of reach, and made a “racist comment” as she left the room. The facility notified the Ombudsman of the incident on April 14, 2015, and the Department on April
15, 2015, 72 hours after the incident was reported. The nurse and the Director of Nursing stated that their understanding was that reporting to the Ombudsman was all that was required; they thought the Ombudsman reported incidents to the State. The facility was cited for failing to report an allegation of abuse to the Department immediately or within 24 hours. Citation # 220011607.

**Santa Clara County**

**Greenhills Manor**

238 Virginia Ave., Campbell

B $1600 Administration Patient Rights Verbal Abuse 1/16/2015

After a verbal exchange including inappropriate language between two residents, the facility failed to investigate, document or properly report the alleged verbal abuse as required by law. The facility failed to assess the situation and create a care plan to address the issue, and it did not report the abuse within the guidelines of the law. Citation # 070011214.

**Milpitas Care Center**

120 Corning Ave., Milpitas

B $1000 Medication 3/24/2015

Two days after a female resident was admitted to the facility, it was discovered by the dietary service supervisor that the resident was receiving the wrong medications. A review of the resident's medication administration record dated 2/2015 indicated that the resident received several doses of medication that were under a different name. The LVN who admitted the resident did not check the name on the medication order list. She stated after all the orders were verified with the primary physician, the medication order list was faxed to the facility's pharmacy. The facility failed to ensure the resident was free from significant medication errors. Citation # 070011333.

**San Jose Healthcare Center**

180 North Jackson Avenue, San Jose

B $2000 Careplan Fall Injury Patient Care 12/09/2014

The facility failed to ensure a resident was provided with adequate supervision when the resident used a bedside commode (a movable toilet). The resident fell to the floor when a CNA left the resident alone on the bedside commode and sustained an acute subdural hematoma (a collection of blood on the surface of the brain), intraventricular hemorrhage (bleeding inside or around the ventricle spaces in the brain), and subarachnoid hemorrhage (bleeding in the area of thin tissue around the brain). According to the resident's careplan, she was to be supervised at all times when using the bathroom. The facility failed to provide adequate supervision to the resident resulting in physical injuries. Citation # 070011143.

**Driftwood Healthcare Center - Santa Cruz**

675 24th Avenue, Santa Cruz

B $900 Patient Care 4/17/2015

On 3/15/15 a female resident complained to staff about rough treatment and a cold shower. The facility took 9 days before it began an investigation of the alleged abuse. The facility also allowed the alleged abuser access to the resident prior to the completion of the abuse investigation. The facility failed to act on the allegations of rough treatment and a cold shower for at least 3 days after the first accusation as well as report to the CDPH within 24 hours. The facility also failed to protect the resident from abuse and harm. Citation # 070011383.

**Kindred Nursing and Transitional Care-Santa Cruz**

1115 Capitola Road, Santa Cruz

FB $6900 Patient Records 11/4/2014

The Department cited the facility for failing to report to the Department of Public Health for the disclosure of a resident's medical information within five business days from the date when they had notification of the breach. The Department determined that an unauthorized access occurred on 6/29/14, and that access was detected on 6/30/14, but the facility did not report it until 8/6/14. The $6,900 was determined by multiplying the number of days of unauthorized access not being reported (69) by $100 per day. Citation # 070011107.

**Stanislaus County**

**Vintage Faire Nursing And Rehabilitation Center**

3620 B Dale Road, Modesto

B $2000 Evictions 07/06/2015

As part of an effort to "free up more space for... residents from the acute care setting who needed short term rehabilitation" the facility transferred seven residents in March 2015. The residents were not given written or advance notice, preparation, or orientation and had not sought a transfer. Some of the residents had been at the facility for years and had friends and family who lived nearby but were nonetheless transferred to other nursing homes 35 or more miles away. Many of the friends or family members (including responsible parties) were not told of the move until they came to the facility to visit. The facility was cited for failing to provide safe and orderly transfers. As a result of the transfers, the residents were sad, depressed, and confused. Citation # 040011595.
Citations without summaries will be reprinted with summaries once received by the CANHR office. Citations from earlier months are included if a description was not printed in a previous issue. Appeals of citations and collection of fines can take up to three years. For up-to-date information on any citation or facility, visit CANHR's Nursing Home Guide at www.nursinghomeguide.org or call the CANHR office.

Explanation of citation classifications: “AA” citations are issued when a resident death has occurred due to nursing home regulation violations, and carry fines of up to $100,000. A class “A” citation is issued when violations present imminent danger to a resident or the substantial probability of death or serious harm, and carry a fine of up to $20,000. Class “B” citations are fined up to $2,000 and are issued for violations which have a direct or immediate relationship to health, safety, or security, but do not qualify as “A” or “AA” citations. “Willful material falsification” (WMF) violations also result in a fine. Fines are not always required to be paid. Citations can be appealed, requiring the Department of Health Services to substantiate the violation. Violations repeated within twelve months may be issued “trebled fines”— triple the normal amount.

**Fresno County**

**Willow Creek Healthcare Center**
650 West Alluvial Avenue, Clovis

B $1500 Administration Other 6/19/2015

On 10/23/14, the Business Office Manager gave $300 cash to the Social Services Director from a female resident's trust account. A review of the facility's policy states that authorized signatures do not come from business office staff, social services and activities. The facility failed to protect the resident from misappropriation of resident property when the Business Office Manager did not follow the Trust Fund Policy and Procedure and gave $300 of the resident's funds away without authorization. The result was the resident exhibiting behavioral changes such as wringing of hands, refusal to eat, and refusal to participate in social dining along with episodes of crying about the loss of property. Citation # 040011572.

**Imperial County**

**Imperial Manor**
100 E. 2nd Street, Imperial

AN $15000 11/26/2014

CitationWatch description will be published once citation is received. Citation # 090011131.

**Kern County**

**Bakersfield Healthcare Center**
730 34th Street, Bakersfield

B $2000 Decubiti (Bedsores) Patient Care 6/16/2015

On 8/16/15 a male resident was admitted with a plan of care to provide a pressure reducing mattress and keep him clean, dry at all times after episodes of incontinence. On 2/23/15 records indicate that he had a scratch on his right buttock. On 3/24/15 a male resident was found screaming due to "a big sore on his bottom where he is hurting." When asked about the resident being left wet, the CNA stated that when she arrived in the morning, his diaper was dry but his bed was wet. He also never received a pressure reducing mattress until 3/24/15. By then the scratch had become a pressure wound with dead tissue. The facility failed to implement their care plan for the resident resulting in a painful open wound. Citation # 120011525.

**Corinthian Gardens Health Care Center - CLOSING**

1611 Height Street, Bakersfield

A $20000 Verbal Abuse 6/02/2015

On 2/16/15, a male nurse yelled at and refused to give pain medication to a 58 year-old resident who had a tracheostomy and gastrostomy tube and suffered from acute respiratory failure, encephalopathy and general muscle weakness. The resident submitted a grievance and when she interviewed, she said that she was in so much pain that she was shaking and crying. The facility was cited for failing to follow its abuse policy and procedure when four
staff (the Director of Nursing, Social Services Assistance, and two Licensed Nurses) were made aware of an allegation of abuse and did not investigate or report it. Citation # 120011468.

**Delano District Skilled Nursing Facility**
1509 Tokay Street, Delano

<table>
<thead>
<tr>
<th>A</th>
<th>$20000</th>
<th>Fall Injury Patient Care Supervision</th>
<th>6/23/2015</th>
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</table>

On 3/2/2015 resident 1 was left alone in the dining room unsupervised, which led to her falling and fracturing her hip bone. The Resident's "Fall Risk Assessment" was scored very high (12 out of 10), which meant she was at a very high risk for falls. The facility failed to supervise resident 1 which led to Resident 1 being severely injured due to a fall. Citation # 120011566.

**Delano Regional Medical Center D/P SNF**
1401 Garces Hwy, Delano

<table>
<thead>
<tr>
<th>B</th>
<th>$2000</th>
<th>Patient Care Physical Abuse Verbal Abuse</th>
<th>5/5/2015</th>
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</table>

On 2/2/2015 two CNAs were verbally and physically abusive to a Resident staying at the Delano Regional Medical Center D/P SNF. While adjusting her bed, they "pulled her arms when they turned her and were rough with her, and were verbally abusive". The facility failed to ensure Patient 1 was free from verbal or physical abuse which adversely affected her physical and emotional well-being. Citation # 120011425.

<table>
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<tr>
<th>B</th>
<th>$2000</th>
<th>Mental Abuse Notification Patient Care Staff (Inservice) Training Verbal Abuse</th>
<th>5/5/2015</th>
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On 2/5/2015, A resident staying at the Delano Regional Medical Center gave a Registered Nurse a written report of verbal abuse she had experienced by two CNAs. The RN failed to report to the California Department of Public Health about the allegation of abuse. Therefore, the facility failed to notify the department of an incident of abuse within 24 hours in accordance with Health and Safety Code 1418.91. Citation # 120011410.

**Parkview Healthcare Center**
329 North Real Road, Bakersfield

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<tr>
<th>A</th>
<th>$10000</th>
<th>Careplan Fall Injury Patient Care Supervision</th>
<th>06/22/2015</th>
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On 7/9/2015, A resident was being pushed around by a CNA when the resident's wheelchair malfunctioned and caused her to fall out of her chair. According to the resident's careplan, she was to have a skid pad on her wheelchair to prevent her from falling. The facility failed to follow the resident's careplan by failing to provide the proper equipment necessary to prevent any physical harm for the resident. The fall resulted in a hip fracture. Citation # 120011478.

**Los Angeles County**

**Bell Convalescent Hospital**
4900 E. Florence Ave, Bell

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<th>B</th>
<th>$2000</th>
<th>4/24/2015</th>
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CitationWatch description will be published once citation is received. Citation # 940011417.

**Bellflower Convalescent Hospital**
9710 E. Artesia Ave., Bellflower

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CitationWatch description will be published once citation is received. Citation # 940011609.

**Brier Oak On Sunset**
5154 Sunset Blvd., Los Angeles

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<tr>
<th>B</th>
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<th>Mandated Reporting Patient Rights Physical Abuse Supervision</th>
<th>12/24/2014</th>
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</table>

On 9/16/12, a 29 year-old resident, resident 2, observed a CNA slapping a 84 year-old resident, resident 1, in the face as the CNA was feeding her. Resident 1 reported the abuse to the Administrator and the CNA was suspended on 9/19/12 and later terminated on 9/26/12 after the report was substantiated. The facility was cited for not ensuring that Resident 1 was free from physical abuse by a staff member and failing to supervise and monitor Resident 1's care being rendered by the CNA. Citation # 920011177.

**Buena Ventura Post Acute Care Center**
1016 S Record Avenue, Los Angeles

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<th>6/11/2015</th>
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CitationWatch description will be published once citation is received. Citation # 940011546.

**California Convalescent Center 1**
909 S Lake Street, Los Angeles

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<th>A</th>
<th>$10000</th>
<th>Careplan Supervision</th>
<th>3/18/2015</th>
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SC-2 CANHR Advocate Fall 2015
The facility was cited for failing to follow the plan of care and provide close supervision for a resident with a history of elopement. On 03/25/14, the resident eloped from the facility and was found three days later. When found, the resident was immediately transferred to the acute care hospital for dehydration, hypoglycemia, and altered level of consciousness. Citation # 910011310.

**Century Villa, Inc.**

301 N Centinela Ave, Inglewood

A $10000 Fall 12/23/2014

On 2/5/12, a 95 y/o wheelchair bound resident was found on the floor in her room between two beds. The resident was sent to an acute care hospital where she was treated for a fractured left shoulder, then transferred to a second hospital for treatment of a fractured cheekbone. The facility Director of Nurses speculated that she had wheeled herself into her room and attempted to get out of her chair without help and fell. The facility was cited for failing to develop a plan of care to address the resident risk for falls while in a wheelchair, her wandering behaviors while in a wheelchair, and attempts to stand unassisted while in a wheelchair. These failures resulted in the resident falling and sustaining a fractured shoulder and multiple facial fractures. The resident died two days after being transferred to the second hospital. Citation # 910011180.

**Country Villa Claremont Healthcare Center**

590 S. Indian Hill Blvd, Claremont

B $2000 Dignity Mental Abuse 1/2/2015

During a resident council meeting on 7/18/13, a resident reported feeling threatened and humiliated when a staff member pointed her finger at the resident and said, "I could kill you." The facility was cited for failure to treat the resident with respect and support the resident's sense of safety and security. Citation # 940011312.

A $15000 Elopement 2/6/2015

A 90 year old female resident with cognitive impairments due to Alzheimer's disease walked out of the facility unnoticed on the evening of 11/15/13. The resident was known to be confused with poor safety judgment and problems walking. She was found lying in a street in the early morning of 11/16/13 by a motorist who helped her to the curb. The resident had multiple cuts and a broken right femur that required hospital treatment. The facility had only three CNAs for 87 residents at the time of the fall instead of the five CNAs that its staffing grid required. The facility was cited for failing to prevent accidents, failing to provide adequate supervision, and for failing to provide adequate staff to meet the needs of the facility residents. Citation # 950011266.

**Country Villa Rehabilitation Center**

340 S. Alvarado St., Los Angeles

B $1000 7/22/2015

CitationWatch description will be published once citation is received. Citation # 910011627.

**Del Rio Gardens Care Center**

7004 E Gage Avenue, Bell Gardens

B $2000 5/20/2015

CitationWatch description will be published once citation is received. Citation # 940011481.

**Downey Care Center**

13007 South Paramount, Downey

B $2000 4/17/2015

CitationWatch description will be published once citation is received. Citation # 940011403.

**El Encanto Healthcare And Habilitation Center**

555 El Encanto Road, City Of Industry

A $12000 3/18/2015

CitationWatch description will be published once citation is received. Citation # 940011312.

**Inland Valley Care And Rehabilitation Center**

250 W. Artesia, Pomona

B $500 12/17/2014

CitationWatch description will be published once citation is received. Citation # 950011183.

**Intercommunity Care Center**

2626 Grand Avenue, Long Beach

A $20000 2/5/2015

CitationWatch description will be published once citation is received. Citation # 940011250.

**Ivy Creek Healthcare & Wellness Centre**

115 Bridge Street, San Gabriel

A $20000 Careplan Fall Patient Care 9/3/2014
On 6/27/2014, a resident at the Ivy Creek Healthcare & Wellness Center experienced a fall face forward from the shower chair to the floor. This resulted in a laceration, knee swelling, and a T4 compression fracture. The facility failed to ensure the resident was provided care to prevent any falls by ignoring the requests made by the resident's family. The requests included ensuring the resident had an assistive device while in the shower chair, and to not use a gurney in accordance with the facility's policy for the resident who had a history of rocking back and forth and had poor sitting balance. Citation # 950010956.

**Landmark Medical Center**

2030 N. Garey Ave., Pomona

A $20000 Patient Care Supervision 9/12/2014

On 1/7/10, 2/20/10, and 6/9/10, a 47 year old male resident with Schizophrenia and Pica Disorder (persistent eating of substances with no nutritional value) swallowed a toothbrush and had to be transferred to the acute hospital for surgical removal. The resident had a history of swallowing foreign objects due to voices telling him to do so. His care plan included interventions to address the behavior, but did not include a plan for monitoring the resident to prevent future incidents. The facility failed to update the resident's care plan or provide one-to-one supervision after the first swallowing incidents. The facility was cited for failure to ensure the environment remains free of accident hazards and failure to ensure the resident received adequate supervision. Citation # 950010968.

**Lighthouse Healthcare Center**

2222 Santa Ana Blvd, Los Angeles

B $1000 5/13/2015

CitationWatch description will be published once citation is received. Citation # 940011471.

**Memorial Hospital Of Gardena D/P Snf**

1145 W. Redondo Beach, Gardena

A $15000 Fall 2/5/2015

On 6/2/2014, a comatose resident fell in her room when being returned from a shower. She was transported on a gurney that had a large hole in one strap. The strap broke and the resident fell from the gurney, causing an open wound and a subdural hematoma in the front part of her head. The facility was cited for failing to keep the resident safe from injury that resulted in serious physical harm. Citation # 930011151.

**North Walk Villa Convalescent Hospital**

12350 Rosecrans, Norwalk

A $20000 6/2/2015

CitationWatch description will be published once citation is received. Citation # 940010714.

**Ramona Nursing & Rehabilitation Center**

11900 Ramona Blvd., El Monte

A $20000 5/4/2015

CitationWatch description will be published once citation is received. Citation # 940011388.

**Skyline Healthcare Center-Los Angeles**

3032 Rowena Avenue, Los Angeles

B $2000 Patient Rights 5/22/2015

On January 25 2013, a male resident left the facility on a pass. The pass was good for 4 hours, but he came back after 26 hours. Facility policy is to have a post-discharge plan of care. Upon returning to the facility, he was then escorted out by police. His belongings were put on the sidewalk by an LVN. He was not given his medication, food, or water and he had no place to go. He had a cast on his right foot, could hardly walk, and only had 20 dollars. The facility failed to provide a post-discharge plan of care resulting in the resident calling the paramedics, who arrived and transported the resident to an acute care hospital for evaluation and treatment. Citation # 920010739.

**South Pasadena Convalescent Hospital**

904 Mission Street, South Pasadena

B $2000 Mandated Reporting Physical Abuse 11/26/2014

On 7/13/13, a resident suffered multiple skin tears to her left hand and skin discoloration to her left cheek resulting from an altercation with another resident. The facility was cited because it failed to report the alleged abuse to the Department of Public Health within 24 hours. Citation # 950011142.

A $20000 Patient Care 3/5/2015

During a Recertification Visit on 5/13/14, a Code Blue was called for a 67 year old resident. During the Code Blue, the nursing staff did not use the proper techniques for chest compressions and did...
not deliver the correct amount of chest compressions, and the resident died. Subsequent interviews revealed that staff members responded with incorrect information regarding CPR guidelines and proper procedures to follow for unresponsive residents. The facility was cited for failing to ensure that CPR was performed correctly, and putting other residents at risk for provision of ineffective resuscitation. Citation # 950011293.

A $20000 Injury Neglect Supervision 4/3/2015

On 11/7/14, a 57 year old resident who suffered from mental illness signed herself out on pass from the facility at 7:30 am, purchased gasoline, poured it on herself and lit herself on fire. She suffered second and third degree burns over 90 percent of her body and died the next day in a hospital burn unit. The facility was cited because it failed to provide adequate supervision for the resident by not ensuring that her physician conducted an assessment prior to allowing the resident to leave on pass unaccompanied by a responsible adult. Although her physician wrote an order on 10/21/14 that the resident "may go out on pass," there was no documented evidence that her psychiatrist made a determination that she was capable of being on an independent, unsupervised pass. When interviewed about her death, her physician said he relied on the licensed nursing staff's judgment and that he does not feel comfortable for a resident with psychological problems to go out on pass alone. Citation # 950011289.

B $2000 Injury 04/10/2015

On 5/8/14, a resident's knee was injured while a nursing assistant transferred her from bed to a wheelchair with the use of a mechanical lift. During the transfer, the nursing assistant uncrossed the resident's legs while she was in mid-air, putting a strain on her left knee. The resident suffered swelling and pain for days afterward. The facility was cited because it failed to handle the resident carefully and gently during the provision of care in accordance with her care plan, causing pain and injury to her knee. Citation # 950011367.

B $2000 Elopement Physical Environment Supervision 4/10/2015

On 11/1/13, a resident who was mentally ill eloped from the facility at about 7:00 am. The staff notified the police after discovering him missing and searching the surrounding area. The police located the resident unharmed later that day at a nearby restaurant and the staff brought him back to the facility. It was observed that the resident had removed the Wanderguard alarm bracelet his physician had ordered for him to help monitor his whereabouts. The facility was cited because the staff were aware that the resident had a pattern of removing the Wanderguard bracelet but had not updated his plan of care to address this situation. Citation # 950011382.

B $2000 Physical Abuse Verbal Abuse 4/10/2015

On 11/11/14 or 11/12/14, a resident reported to a certified nursing assistant (CNA) that another CNA was rough to his roommate when removing his pants. The resident confronted the abusive CNA and told him he needed to treat residents with respect. The facility staff did not report the allegation to the administrator and the CNA was not reassigned. On 11/18/14, the resident who originally reported the abuse said he was confronted again by the CNA, who said he could kill him by using his hands. The facility was cited because it failed to report the alleged abuse to the Department of Public Health within 24 hours. Citation # 950011370.

B $2000 Mandated Reporting Physical Abuse 4/10/2015

On 3/3/2014, the police received a report that a security guard assaulted a resident by pushing him three times, causing him to fall onto a couch. The security guard denied ever touching the resident and the Administrator reported that the previous director of nursing and registered nurse supervisor were witnesses to his innocence. A resident witness stated she saw the security guard shove the resident, causing him to fall on the couch. She said the facility staff lied to the police about the incident. The facility was cited for failing to report the alleged abuse to the appropriate authorities. Citation # 950011366.

B $2000 Physical Abuse 4/10/2015

On 3/3/2014, the police received a report that a security guard assaulted a resident by pushing him three times, causing him to fall onto a couch. The security guard denied ever touching the resident and the Administrator reported that the previous director of nursing and registered nurse supervisor were
witnesses to his innocence. A resident witness stated he saw the security guard shove the resident, causing him to fall on the couch. She said the facility staff lied to the police about the incident. The facility was cited for failing to thoroughly investigate the resident's allegation of physical abuse by the security guard. Citation # 950011368.

B  $1500 Dietary Services  4/10/2015

Between November 2014 and February 2015, a resident suffered a 30 pound weight loss, 16.4 percent of her body weight. During this period, the registered dietitian did not evaluate the resident's nutritional needs and document findings monthly as required in her job description. The facility was cited because the registered dietitian did not actively participate in the resident's care, as it relates to dietary, and allowed the dietary service supervisor to work beyond her scope of practice by evaluating the resident. Citation # 950011349.

B  $1000 Elopement Mandated Reporting  4/10/2015

The police were dispatched to the facility on 5/25/14 about a 49 year old resident who went missing the day before. It was later discovered that the resident, who was mentally ill, went to a hospital and refused to go back to South Pasadena Convalescent. The facility was cited because it did not follow its policy on elopement, did not investigate the whereabouts of the missing resident and failed to report the resident's elopement to the Department of Public Health or to the police in a timely manner. Citation # 950011329.

B  $1000 Mandated Reporting  Physical Abuse  4/10/2015

A police report dated 11/17/14 stated that a female resident called the police after a male resident in a wheelchair entered her room in the evening, saying it was his room. The female resident reported the male resident hit her with his fist after she got out of bed and attempted to push him out of her room. Although the assistant director of nursing heard the resident scream and learned from her that she had been hit, the facility administrator did not report the alleged abuse to the Department of Public Health as required. Citation # 950011336.

B  $750 Mandated Reporting  Theft & Loss  4/10/2015

On 10/11/14, a resident reported that a silver necklace was missing from his room shortly after the resident discovered another resident rummaging through his night stand. The administrator of the facility reported that an investigation was done, an unsuccessful search was conducted and the resident
was offered and accepted $100 in compensation for the necklace, which the resident said had a value of about $1,000. The facility was cited because it did not report the alleged theft to the Department of Public Health. Citation # 950011337.

B $750 Theft & Loss 4/10/2015

On 6/8/2014, the police went to the facility to assist a 38 year old resident who complained that someone had stolen $200 from him. The alleged theft took place three days after the resident withdrew $1,300 in cash from his trust account at the facility. The police took the resident to the hospital for assessment because he was hitting staff and saying that he did not want to live anymore. The facility was cited because it did not report the alleged theft to the Department and failed to investigate the matter. Citation # 950011334.

A $20000 4/10/2015

A 77 year old diabetic resident died at the facility on 4/15/14, two days after nursing staff found that his blood sugar was highly elevated (589 mg/dL). He was given an insulin injection on 4/13/14 as ordered by his doctor but the facility did not recheck his blood sugar six hours later as ordered. When it was checked 10 hours later, the facility did not notify his physician that his blood sugar remained elevated. The resident received another insulin injection in the morning on 4/14/14 but there was no documented evidence that his physician was notified after testing that afternoon showed his blood sugar was still elevated. The resident was found unresponsive the next morning, 4/15/14, and was pronounced dead by paramedics. The death certificate listed arteriosclerotic heart disease as the immediate cause of death. The facility was cited because it failed to recheck the resident's blood sugar as ordered after administration of insulin and failed to notify his physician on two separate occasions of the resident's blood sugar being above 250 milligrams per deciliter, as stipulated in the physician's order. Citation # 950011381.

A $12000 Medication Neglect Nutrition 4/10/2015

A 73 year old resident who was refusing medications and treatment and was eating and drinking poorly lost 30 pounds in a four month period from November 2014 to February 2015, developed a urinary tract infection, suffered mental instability and jeopardized the healing of a large Stage IV pressure sore. The facility did not notify her family, physician or its medical director of her deteriorating condition due to her refusal to take her life sustaining medications, eat and drink at times. The facility also failed to intervene after the resident's physician documented that she did not have the capacity to make decisions and allowed her to refuse life sustaining medications and treatments. Citation # 950011330.

A $10000 Infection Neglect Notification 4/10/2015

During an inspection on 2/9/15, an inspector observed a resident lying flat in bed with a catheter bag that had a small amount of thick, dark-orange amber colored urine with sediment. The room had a strong smell of urine. A treatment nurse at the facility initially stated that the resident's urine looked normal and had not documented that the resident's urine was concentrated and dark in color. A urinalysis determined that the resident had a urinary tract infection. The assistant director of nursing stated that the nurses should have been monitoring the urine and reporting the results to the patient's physician. The facility was cited for these failures. Citation # 950011326.

A $8000 Decubiti (Bedsores) Medication 4/10/2015

On 2/11/15, an inspector observed that a resident was moaning in pain while a nurse was treating a large, deep sacral pressure sore that had bloody drainage. The resident's physician had ordered pain medication to be given to her a half-hour before the pressure sore was treated, but it was not given. The nurse claimed that the resident had been refusing the medications, but her physician had not been informed. The resident's care plan called for her to be turned every two hours but the inspector observed that she was often lying flat on her back and not being repositioned every two hours. The facility was cited for not implementing the resident's care plan and for failing to give the resident pain medications prior to providing wound care to such a large, deep pressure sore. Citation # 950011328.

A $7500 Medication 4/10/2015

On 1/13/15, a resident was hospitalized for 6 days
with dehydration, severe abdominal pain, nausea and vomiting. Hospital records indicated the resident thought his symptoms were due to morphine withdrawal since he had been on morphine for ten years and had not received it for two days. The resident did not receive the ordered morphine on 1/12/15 or 1/13/15 because the facility had not received the medication from the pharmacy. A pharmacist from the dispensing pharmacy stated that they had many problems dispensing narcotics in a timely manner to the facility because the nurses sent over the requests too late for the pharmacist to get the physicians to approve. The facility was cited for failing to order the prescribed morphine in a timely manner and failing to administer it to the resident as prescribed. Citation # 950011327.

A $20000 Patient Care 4/17/2015

On 4/23/14, an 87 year old resident was found unresponsive in his bed and died after nursing staff failed to provide timely CPR in accordance with his physician's orders. The nursing staff did not start CPR until three minutes after a nursing assistant found the resident unresponsive. The nursing assistant and a licensed vocational nurse and registered nurse who were summoned did not follow the established guidelines for CPR. Paramedics were called, responded to the scene, took over CPR and pronounced the resident dead when lifesaving actions were unsuccessful. The facility was cited for failing to immediately provide CPR as ordered by the physician in accordance to CPR guidelines and the facility's policy and procedure. Citation # 950011405.

A $20000 Infection Neglect 4/17/2015

On 2/9/15, an inspector observed that a 64 year old female resident in a wheelchair had an indwelling urinary catheter draining cloudy urine with sediment. The resident was tested and found to have a urinary tract infection. The resident had the indwelling catheter for over seven months after admission without any medical indication for its use, which resulted in three recurrent urinary tract infections within four months of admission, on 6/25/14, 8/6/14, and 10/6/14. All the urinary tract infections required antibiotics for seven days to treat the infections and the October 2014 infection required intravenous antibiotic treatment. The recurrent infections put the resident at risk of developing urosepsis, a life-threatening infection. The facility was cited because it failed to assess the need for the catheter, failed to assess her urine for signs of infection, and failed to follow its own catheter management interventions to prevent urinary tract infections. Citation # 950011371.

A $20000 Physical Environment Supervision 4/17/2015

On 8/20/14, the Department of Public Health received a faxed letter stating: "Help us a resident is smoking drugs in his room every day and the administrator was informed, but does nothing. Please help us, we are in danger." The Department's investigation determined that the resident had just returned from a hospital stay related to smoking methamphetamine in his bathroom. The resident used oxygen, creating an added danger to him and his roommate when he smoked in his room. An employee stated that the resident was definitely using drugs in the facility, was hostile and threatening toward staff and other residents, and smoked cigarettes in his room. These actions created a hazardous environment that endangered residents and staff. Citation # 950011399.

A $20000 Medication 4/17/2015

On 8/20/14, the Department of Public Health received a faxed letter stating: "Help us a resident is smoking drugs in his room every day and the administrator was informed, but does nothing. Please help us, we are in danger." The Department's investigation found that a 51 year old resident had been hospitalized due to altered mental status and respiratory depression on 8/6/14 after smoking methamphetamine in the bathroom. The facility was administering a number of controlled drugs to the resident, including a Fentanyl patch. The facility's previous medical director said the facility had a large amount of drug abusing residents and they were quite manipulative and pushy about getting their drugs. The facility was cited for administering a narcotic without adequate indication for its use, continuing to administer the prescribed narcotics when the resident was abusing illegal drugs and alcohol in the facility, not adequately monitoring the resident for respiratory depression and related violations. Citation # 950011396.
Orange County

Laguna Hills Health and Rehabilitation Center
24452 Health Center Drive, Laguna Hills
B $1500 7/28/2015

CitationWatch description will be published once citation is received. Citation # 060011642.

Newport Specialty Hospital D/P SNF
14662 Newport Avenue, Tustin
B $2000 Injury Patient Care 4/15/2015

On 1/18/2015, a CNA helped a non verbal resident with contractures in her arms and hands with a bath. While attempting to dry the resident's hair with a blow dryer, the CNA at the facility placed the hairdryer in close proximity to the resident's hand while turned on. The resident suffered multiple open, weeping fluid blisters and a second degree burn to her left hand. The resident was given medication for the pain and ointment to treat her wounds. When the CNA was asked if she thought the burn could have been caused by the hairdryer, she stated the hairdryer was "the only thing it could have been." The facility failed to ensure resident was free from accidental hazards. Citation # 060011387.

Riverside County

Miravilla Care Center
9246 Avenida Miravilla, Cherry Valley
B $2000 Physical Abuse 6/8/2015

Three male residents were subjected to multiple observed instances of having their nipples rubbed and twisted by two CNAs. The CNAs would stimulate the residents' nipples to "get them to do what I want them to do." Despite the apparent long history of this conduct, the sexual abuse was not reported until the facility activities director attended a mandatory sexual harassment meeting on 6/3/2014. The facility administrator said the abuse was not inappropriate because "I felt it calms the residents down... the incident had not gone beyond the playfulness by the two CNAs." The facility was cited for failing to prevent sexual abuse of its residents. Citation # 250011495.

B $2000 Sexual Abuse 6/8/2015

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B $2000 Abuse Theft 6/30/2015

In October 2013, the facility’s Business Office Manager admitted to “mismanaging” resident trust funds. The facility contacted an auditing firm, and the State Auditors identified a discrepancy in excess of $97,000 in resident trust fund accounts during 2012. The facility was cited for failing to safeguard the trust fund accounts of four residents and prevent financial abuse. Amounts totaling $390, $561.46, $418.17 and $607 were withdrawn from resident trust funds accounts as a Share of Cost for a resident without a Share of Cost, additional Share of Cost for residents even though their Share of Cost had already been withdrawn, and “personal items” for residents without receipts or receipts not coinciding with date of purchase. Citation # 250011529.

B $2000 Abuse Theft 6/30/2015

In October 2013, the facility’s Business Office Manager admitted to “mismanaging” resident trust funds. The facility contacted an auditing firm, and the State Auditors identified a discrepancy in excess of $97,000 in resident trust fund accounts during 2012. A total of $2,160.50 was withdrawn from a resident’s trust account from November 2012 to January 2013, and labeled as Share of Cost, even though the Share of Cost had already been withdrawn. The facility was cited for failing to safeguard the resident’s trust fund account and prevent financial abuse. Citation # 250011534.

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the State Auditors identified a discrepancy in excess of $97,000 in resident trust fund accounts during 2012. A total of $10,542 was withdrawn from a resident’s trust account, without evidence of where the money went. These funds included $9,397 withdrawn as “SOC” [Share of Cost] from November 2012 through October 2013, even though the resident never had a Share of Cost. The facility was cited for failing to safeguard the resident's trust fund account and prevent financial abuse. Citation # 250011536.

B $2000 Fiduciary 6/30/2015
A state auditing agency conducted an investigation and found discrepancies of over $97000 in resident trust funds occurring from January 1 through December 31, 2012. The facility administrator stated that the business office manager (BOM) had admitted to him that she had been padding the pay checks of a family member who worked in the facility and was mismanaging the resident trust funds. A review of some of the checks from resident trust accounts revealed that they had been endorsed and deposited into the BOM's personal account. The facility was cited for failure to safeguard the resident's trust fund accounts. Citation # 250011541.

B $2000 Fiduciary 06/30/2015
During an investigation conducted on 10/9/13 about allegations of financial abuse by the business office manager (BOM) it was determined that $7,733.97 had been withdrawn from a resident's account by the BOM when the resident's share of cost was only $10 per month. It was also discovered that some of the checks from resident trust accounts were made out to the BOM, endorsed by the BOM, and ended up in the BOM personal account. A review of the BOM's employee file revealed she was hired without any reference checks. The facility was cited for failing to safeguard the resident's trust fund accounts. Citation # 250011550.

B $2000 Fiduciary 6/30/2015
On 10/9/13, an investigation began in the facility about allegations of residents' trusts financial abuse. It was revealed that the business office manager (BOM) had misappropriated $5,217 from a resident's trust fund. The Account Biller (AB) stated that the BOM had written a number of checks that were not legitimate, posted erroneously, or were fraudulent and that there was no oversight of the BOM's work. The facility was cited for failure to safeguard the resident's trust fund account. Citation # 250011575.

San Diego County

Palomar Vista Healthcare Center
201 N. Fig Street, Escondido
B $2000 Medication Patient Care Patient Records Staff (Inservice) Training 7/14/2015
The licensed nursing staff did not operate the glucometers (devices used to measure blood sugar levels) correctly. Multiple licensed nurses knowingly documented inaccurate test results on the Quality Control Record and administered insulin to residents based on those inaccurate results. This put 17 residents with diabetes at risk for over and under dosing on insulin, insulin shock, and diabetic coma. The licensed nursing staff also failed to administer pain medication to a female resident, per the physician's orders, and admitted to falsifying this resident's records by documenting that a muscle relaxant was administered, when it was not. Citation # 080011611.

Santa Barbara County

Atterdag Care Center
636 Atterdag, Solvang
A $5000 9/11/2014
On 6/3/14, a 96 year-old resident who had dementia fell and fractured her hip while left alone in the bathroom. The resident was known to be at risk for falls and was to have assistance in toileting. The facility was cited for failure to provide the necessary supervision for the resident. Citation # 050010901.

Buena Vista Care Center
160 South Patterson Avenue, Santa Barbara
A $5000 Fall 1/9/2015
A 91 year old male resident with Parkinson's disease was severely injured on 9/7/14 when a CNA attempted to reposition him by himself despite a careplan calling for two staff members for all repositioning. The resident suffered a laceration to his groin, facial injuries, and a fractured left thumb that required amputation. The facility was cited for failing to create a safe environment, free from accidents, for the resident. Citation # 050011086.

Santa Maria Care Center
820 W Cook Street, Santa Maria

$5000  Fall  5/18/2015

A 74 year old female resident with dementia and muscle weakness got up from bed unassisted, walked unsupervised, and fell face down in a hallway on 3/13/14. She sustained multiple facial fractures. A bed alarm system did not help prevent the fall and the facility failed to consider moving the resident's room closer to a nurses' station as part of her fall prevention program. The facility was cited for failing to provide adequate supervision and prevent accidents. Citation # 050011093.

Vista Del Monte

3775 Modoc Road, Santa Barbara

$5000  Fall  10/16/2014

On 6/30/14, a resident with an indwelling catheter fell in the bathroom and broke his hip. The resident had an unsteady gait, impaired vision, poor memory and a history of falls. The facility was cited for failure to provide adequate supervision and assistive devices for a resident which lead to the resident falling in the bathroom and fracturing his hip. Citation # 050010903.

Tulare County

New Covenant Care Center of Dinuba

1730 South College Avenue, Dinuba

$2000  Mandated Reporting  Notification  Patient Care  5/12/2015

The New Covenant Care Center of Dinuba received a complaint on 2/13/15 of an allegation of abuse by a resident to medical clinic staff during an appointment. The Director of Nursing failed to report the incident to the Department of Public Health. This resulted in a fine and a citation. Citation # 1200011437.

Providence Valley Care Center

661 West Poplar Avenue, Porterville

$2000  Mandated Reporting  Mental Abuse  Physical Abuse  Verbal Abuse  6/15/2015

On 12/31/14 and 1/1/15, a 81 year-old resident was physically and verbally assaulted by three CNAs. A CNA heard the resident screaming from the shower room. When she went to investigate, she saw three other CNAs in the room with the resident. They had twisted his arm and slammed it down as they held him down in the shower chair while one CNA shouted expletives at him. The DON stated during an interview that the CNA who had discovered the incident was suspended for failure to report the abuse on 12/31/14. No mention of action was made of the three CNAs involved with the abuse. The facility was cited for not reporting an allegation of abuse to the Department within 24 hours. Citation # 120011441.

On 1/1/2015, 3 CNAs forced a resident to shower against his will and held him down with force that led to bruising in his wrists and arms. While attempting to shower the resident, the CNAs were verbally and physically abusing the resident by laughing at him, spraying his face with water, and flicking his chest with a towel. The facility failed to protect the Resident from physical and verbal abuse to the resident, which led to mental and physical anguish. Citation # 120011440.

Ventura County

Ojai Gardens Nursing Center

601 N Montgomery Avenue, Ojai

$5000  2/5/2015

On 9/7/14, a wheelchair bound resident opened the facility's iron front gate then tumbled down six concrete steps and landed face down on the sidewalk. The fall caused the resident to sustain shoulder and chest abrasions, bruising, and lacerations required sutures. The facility was cited for failing to provide supervision to a resident who was an elopement risk. Citation # 050011023.

Oxnard Manor Healthcare Center

1400 W Gonzales Rd, Oxnard

$1000  Administration  Sexual Abuse  1/02/2015

The facility was cited after staff failed to report to the CA Department of Public Health an incident of suspected sexual abuse after a male resident grabbed a female resident's hand and touched his privates with her hand. This failure to report within the 24 hour period required by law, placed the resident at risk for further abuse. Citation # 050010993.