On November 9, 2015, CANHR and three nursing home residents filed a lawsuit against the California Secretary of Health and Human Services, Diana Dooley, charging that the State is willfully violating federal laws that protect against dumping nursing home residents into hospitals.

For years, California nursing homes have been sending Medi-Cal residents to acute care hospitals and refusing to allow them to return to the nursing homes where they reside, the suit alleges. They do so in violation of the law in order to increase profits and make space for more lucrative Medicare and private pay residents.

Federal law forbids the practice by requiring states like California to offer a readmission hearing that provides for the “prompt” readmission of residents. While the California Department of Health Care Services (“DHCS”) provides a hearing, the State is refusing to enforce its own hearing decisions, leaving patients with no way to return home. As a result of the facilities’ refusal to readmit, residents are forced to remain in expensive hospital beds that have cost Californians over $70,000,000 for unnecessary hospitalization costs.

Individual plaintiffs Bruce Anderson, John Wilson and Robert Austin each won a federally-mandated readmission hearing last summer, but the nursing homes where they lived have refused to readmit them. Mr. Anderson has been chemically restrained with drugs and confined in a hospital bed for several months, even though he is able to walk. Mr. Wilson is stuck in a Camarillo hospital because its on-site nursing home refuses to readmit him for care that he desperately needs. Mr. Austin was shipped from Sacramento, where his family lives, all the way to Los Angeles because he had nowhere else to go, according to the complaint.

In each of the above cases, DHCS has done nothing to enforce its hearing order while the Department of Public Health (DPH) has taken no enforcement action.

In fact, in Mr. Austin’s case, DPH found no violations of state or federal eviction protections despite multiple obvious violations of state and federal eviction protections.

Patient dumping by nursing homes has become an epidemic in California, particularly since no state agency wants to take responsibility for enforcing the law. Until and unless it becomes more expensive for nursing homes to violate the law than to honor residents’ rights, nursing homes will continue this illegal and often life-threatening behavior. CANHR raised these concerns to the state for months but received nothing but promises to look into the matter.

We expect the lawsuit will expose the problem and hopefully push the State to enforce its laws and honor our commitment to vulnerable residents who need help.

CANHR is represented by Matt Borden, a partner of San Francisco and New York law firm Braun Hagey & Borden LLP.

To see the CANHR v. Dooley complaint, go to: http://canhr.org/newsroom/newdev_archive/2015/Complaint20151109.pdf
CANHR Receives 2015 Public Service Award

CANHR was selected to receive the National Consumer Voice for Quality Long-Term Care (Consumer Voice) 2015 Public Service Award for an organization whose work has profoundly expanded coverage and public understanding of long-term care issues. The award was presented at the awards luncheon during the Consumer Voice’s 39th annual conference in Arlington, Virginia on November 6. The Consumer Voice – formerly the National Citizens’ Coalition for Nursing Home Reform (NCCNHR) – has been the national voice for long term care reform for many years, and CANHR is truly grateful for the recognition. It will inspire us to continue to advocate for better care.

CANHR needs your Support

Over the past year CANHR has received numerous calls from consumers asking what they can do to help foster change in long term care and the short answer is – we need your advocacy and your donations!

Early in December you will receive CANHR’s annual holiday donation appeal in the mail. Please take a moment to look it over and send in the reply card with your donation. You may also take advantage of the reply envelope in the center of this issue of the Advocate. Or, if you prefer, you can visit our website at www.canhr.org and click the button that says “Donate Now” to make a secure, online donation. Help CANHR continue to grow and serve.

Thank you

We want to thank everyone who generously contributed money, time and/or resources to CANHR throughout the year. A very special thank-you goes to those of you who contributed to our trainings and newsletters; those of you who wrote letters to legislators in support of our bills; and particularly those of you who advocated on behalf of your family members and friends in long term care to make their lives better. We could not do our work without your support!

Donate to CANHR When You Shop on Amazon.com

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

Happy Holidays!

Warmest wishes for a happy holiday season and a great new year from the staff at CANHR!
Shlomo Rechnitz-Owned Nursing Homes Under Investigation Again

California’s largest nursing home operator, Shlomo Rechnitz, is back in the news yet again after the FBI raided his Alta Vista Healthcare & Wellness Centre in Riverside on October 22, 2015. The Sacramento Bee reported on October 24 that FBI agents executed search warrants “seeking evidence in relation to alleged criminal activity.” Details of the investigation have not been released.

In the same article, the Bee revealed that the former administrator and the director of nursing at another Rechnitz nursing home, the Mesa Verde Post Acute Care Center in Costa Mesa, are facing criminal charges in connection with the alleged abuse of two residents. In August 2015, the Attorney General’s Bureau of Medi-Cal Fraud and Elder Abuse charged Joseph Munoz III, the administrator, and Milagros Victoria Soqueno, the director of nursing, with four misdemeanor counts each of inflicting injury on an elder adult and failing to report elder abuse. Reportedly, the charges stem from failure to report knowledge that a resident at the facility had been inappropriately touching other residents in 2014. Munoz and Soqueno will be arraigned in Orange County on December 10.

Nursing Homes Reap Billion Dollar Windfall by Exploiting Medicare Billing System for Therapy

On September 30, 2015, the Inspector General of the Department of Health and Human Services issued a new report on wasteful payments to skilled nursing facilities (SNFs) for therapy services. The report, *The Medicare Payment System for Skilled Nursing Facilities Needs to be Reevaluated*, stated that Medicare payments for therapy greatly exceed SNF’s costs for therapy.

The Office of Inspector General (OIG) found that nursing homes are increasingly billing Medicare for the most expensive level of therapy – known as “ultra high therapy” – regardless of residents’ needs. According to the OIG, resident needs have not changed while Medicare therapy payments to SNFs have exploded. On average, nursing homes now receive $29 more than their therapy costs for every $100 in Medicare payments for therapy. The OIG reports this exploitative billing cost Medicare and taxpayers $1.1 billion in fiscal years 2012 and 2013.

It is not exactly breaking news that skilled nursing facilities are gaming the Medicare payment system, especially as it relates to therapy. The OIG has reported this finding previously and the Department of Justice has filed false claims act cases against nursing home chains for fraudulent therapy billing practices, including a lawsuit against HCR ManorCare earlier this year. Nonetheless, the revelations and recommendations in the new report make a strong case for Medicare payment reform.

CDC Advises Nursing Homes to Stop Misusing Antibiotics

On September 15, 2015, the Centers for Disease Control and Prevention (CDC) issued new recommendations to nursing homes aimed at reducing inappropriate use of antibiotics to protect residents from the consequences of antibiotic-resistant infections, or “superbugs,” such as C.diff. The CDC press release cites familiar but scary data. Antibiotics are the most frequently prescribed medication in nursing homes; about 70 percent of the 4 million people living in nursing homes receive at least one course of antibiotics each year; and up to 75 percent of antibiotics prescribed in nursing homes are given incorrectly.

The CDC is cracking down on indiscriminate use of antibiotics because unnecessary use is contributing to outbreaks of superbugs that are on the rise nationally. The CDC recommendations are found in a new resource, *Core Elements of Antibiotic Stewardship for Nursing Homes*. New fact sheets for residents and families and other resource materials are also posted on the CDC’s website.

CANHR Submits Extensive Comments to CMS about Nursing Home Rule Overhaul

CANHR submitted two sets of comments to the Centers for Medicare and Medicaid Services (CMS) in response to the draft of its first major overhaul of federal nursing home regulations in 25 years. One set of comments extensively reviews the state of dementia

*Long Term Care News ............... (continued on page 8)*
Some wins and some losses in the 2015 legislative session. Two of CANHR’s bills, SB 33 (Hernandez) and AB 927 (McCarty) are now two-year bills and will be heard in 2016. AB 601 (Eggman), which will establish disclosure and suitability of ownership criteria for RCFE licensees, was signed by the Governor.

**CANHR Sponsored:**

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

This bill would limit Medi-Cal recovery for those who are 55+ years of age to only what is required by federal law, and eliminate optional recovery for other services; eliminate recovery on surviving spouses’ estates; and allow hardship exemptions for homesteads of modest value. SB 33 is co-sponsored by Western Center on Law and Poverty. **Status:** SB 33 is now a 2-year bill.

**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:** Died in Senate Appropriations.

**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:** Signed by the Governor. Effective January 1, 2016.

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

This bill 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. Among other provisions, the bill would require the facility to make the lump-sum payment to the resident’s estate if the resident is deceased. **Status:** Vetoed by the Governor.

**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 have increased the current home upkeep allowance of $208.33 to the actual minimum cost of maintaining the home, such as mortgage.
or rent, property taxes, and required insurance: set a limit of $7,500 on the total allowance; and established other eligibility criteria. In the end, this bill would have actually enabled residents to return home and would have saved the state funds by shortening nursing home stays. **Status:** Died in Senate Appropriations.

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

Dependent on federal approval, this bill would have increased the “any income deduction” from $20 to $50 for Medically Needy Only Medi-Cal applicants and beneficiaries. **Status:** Died in Senate Appropriations.

**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. Regretfully, AB 1387 was amended so that it no longer provides a system of appeal for consumers who file complaints against RCFEs. **Status:** Signed by the Governor.

**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:** Died in Appropriations.

**Oppose**

**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:** Signed by the Governor.

**More Misery for the Poor - AB 139 Transfer on Death Deeds Signed into Law**

AB 139 (Gatto) was recently signed by the Governor. With a sunset date of January 1, 2021, AB 139 creates the revocable transfer on death deed (revocable TOD deed), 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. The new law creates a statutory form - the “SIMPLE Revocable Transfer on Death (TOD) Deed.” Unfortunately, there is nothing simple about this 24-page poorly drafted new law. Not only is it not simple, but it will surely complicate the lives of those it is aimed to assist, i.e., those who don’t wish to pay or can’t afford to pay attorneys fees.

CANHR strongly opposed this bill - and similar bills over the years - as we believe it would make many elders even more susceptible to undue influence and elder abuse. These deeds are also subject to estate recovery, which means that those same low-income elders, who are likely to execute TODs will also be more likely to be on Medi-Cal and thus subject their estates to recovery. Proposed as a low cost alternative for those seniors who cannot afford attorneys for trusts or other alternatives, AB 139 will undoubtedly cause more harm than good. As one organization opposed to the bill noted, these deeds “will become the new form of easy, convenient, and cheap elder abuse.”

CANHR will be discussing this bill at our Elder Law Conference and embarking on a legal services and consumer education campaign to try to blunt the impact of this unfortunate bill.

Please check [www.leginfo.ca.gov](http://www.leginfo.ca.gov) for information on specific bills.
Nursing Home Residents Can Go Home for the Holidays

Nursing home residents and their family members often worry about losing their rooms or their Medicare or Medi-Cal status if they leave the facility for brief periods of time. While the rules for Medicare and Medi-Cal differ, both programs will permit, and reimburse the facility for, short leaves — depending on how long the leave is. This is particularly important during the holidays, when relatives want nursing home residents to join in the family festivities.

The Medicare Policy Manual, Chapter 1 § 30.1.1.1, states that residents who leave the facility for an “outside pass or short leave” can do so without losing their coverage. If they return by midnight, the facility can bill Medicare for the day. If the resident is gone overnight (past midnight) and returns the next day, this is considered a leave of absence and the facility can bill the beneficiary to hold the bed during an absence. In these cases, you should ask the facility what the cost will be, since the daily rate at a nursing home can be high.

Under Medi-Cal rules, a leave of absence (LOA) of up to 18 days per calendar year can be granted to a Medi-Cal resident of a nursing home in accordance with the resident’s plan of care, and the facility will continue to be reimbursed for care. Up to 12 additional days of leave per year can also be granted under certain conditions. (see 22 CCR §51335) This is a much more liberal leave policy than Medicare, but it is also subject to certain restrictions. The resident, family members and/or friends should ensure that provisions for leaves of absences are included in the resident’s care plan.

Dear Advocate,

My mother is entering a nursing home and I am being asked to sign a mountain of admission paperwork for her, including an arbitration agreement. I’ve read that it is a bad idea to sign an arbitration agreement, but I’m worried that the nursing home will not admit my mother if I don’t sign it. What should I do?

Sincerely,

Anxious in Antioch

Dear Anxious in Antioch,

Don’t sign the arbitration agreement! Nursing homes use them to prevent residents from being able to sue for abuse or neglect. It is never a good idea to sign an arbitration agreement at admission.

Under California law, the only document a nursing home can require you to sign as a condition of admission is the Standard Admission Agreement (CDPH 327) developed by the Department of Public Health. California Health & Safety Code §1599.61. Nursing homes cannot require you to sign an arbitration agreement and cannot present an arbitration agreement as part of the Standard Admission Agreement. California Health & Safety Code §1599.81, Title 22 California Code of Regulations §72516.

You do not need to tell the nursing home you are not going to sign the arbitration agreement. At admission, tell the nursing home you are going to take the form home to review it. Then simply don’t sign or return it to the facility.

If you have already signed the arbitration agreement, you have 30 days to rescind it by giving written notice to the facility. California Code of Civil Procedure §1295.

To learn more about your rights on this subject, visit CANHR’s webpage on arbitration and read our fact sheets on arbitration and California’s Standard Admission Agreement for Nursing Home Residents.
The Veterans Administration (VA) offers a special benefit to veterans who are 65 or older or permanently disabled and served during a time of war. The benefit is called the Aid and Attendance benefit, which is also available to surviving spouses. In order to qualify, the applicant must have limited income. Unfortunately, there is no asset limit set by law, so eligibility can be made at the discretion of the worker, although too many assets will disqualify the applicant. The benefit is calculated by subtracting the veteran’s unreimbursed medical expenses from his or her gross income, then, if the net amount is less than the maximum offered benefit, the VA makes up the difference. For example, in 2015 the maximum benefit for a single veteran is $1,072 per month. If the vet’s income were $401 per month (after subtracting expenses) then the VA Aid and Attendance benefit would be $671 ($1,073 minus $401 = $671).

Senior and disabled veterans need to know that there are professional scammers targeting them. They pose as “volunteers” or accredited VA representatives who are simply trying to help the veteran qualify for the benefit. Their real intent is to sell commission-based annuities or to charge fees for their services. They put on seminars or free luncheons and send out information to entice senior veterans with enough assets that would otherwise disqualify them from VA benefits to transfer these excess assets into deferred annuities and/or irrevocable trusts in order to qualify for the benefit. In California, it is illegal for an insurance agent or broker to either make a commission or to charge a fee for assisting in the VA benefit qualification process. If the “volunteer” is an insurance agent and sells an annuity to a veteran in order to help him qualify for benefits, he/she is breaking the law.

In honor of Veteran’s Day, the California Attorney General’s office released a consumer alert to regarding these scams targeting seniors who served in the military and their survivors and offers the following tips:

- Anyone who asks you to pay money or move assets in connection with applying for a VA pension benefit is likely not a VA-accredited representative. He or she may be an insurance agent or representative who receives a sales commission for selling you an annuity or irrevocable trust.

- Moving assets into an annuity or irrevocable trust could restrict your access to these funds and may have significant unintended tax or legal consequences that outweigh any financial benefit gained from receiving VA pension benefits.

- If you receive VA pension benefits based on false financial need, you could be required to repay any benefits received back to the government.

- If you are approached by someone offering to help you apply for VA pension benefits and you would incur any costs or fees in connection with the service being offered, contact your local VA to determine whether this assistance is reputable. Be wary of sharing personal information over the phone. VA representatives will tell you what you need to know and the advice is free.

A directory of VA centers is available at www.va.gov/directory/guide/vetcenter.asp

**Helpful Resources**

If you believe that you are a victim of a pension poaching scam and do meet the age, military service, and financial need requirements for a VA pension benefit, VA-accredited representatives including Veterans Service Organizations, agents, and attorneys are available to help you file a claim, free of charge.

If you or someone you know has purchased an annuity in connection with an application for the VA Aid and Attendance Benefit, contact CANHR to discuss what needs to happen. You can also file a complaint with the California Department of Justice by visiting http://oag.ca.gov/contact/consumer-complaint-against-business-or-company.

A searchable list of VA-accredited representatives is available at www.va.gov/ogc/apps/accreditation/index.asp or call 1-800-827-1000.

For more information about VA Aid and Attendance pension benefits, visit www.benefits.va.gov/pension or see CANHR’s Veterans Aid and Attendance Benefits Fact Sheet: www.canhr.org/factsheets/misc_fs/html/fs_aid_&_attendance.htm

The Department of Insurance: www.insurance.ca.gov; Complaints Online Complaint: (800) 927-4357.

CANHR’s Lawyer Referral Service (800) 974-1116.
New RCFE Ownership Disclosure and Suitability Requirements

Effective January 1, 2016, California regulators and consumers will have additional information to ensure the suitability of new owners of residential care facilities for the elderly (RCFEs). With this information, CANHR and elder justice advocates hope that California can prevent the operation of RCFEs by persons who have been linked to accusations of elder abuse and neglect in California and other parts of the country.

Currently, there are very limited disclosure and suitability requirements for new RCFE operators. Background information is not cross-checked with other licensing agencies, allowing operators with poor track records in other states or involving other types of facilities to receive approval to operate RCFEs.

For example, the owner of Valley Springs Manor in Castro Valley, who abandoned 19 RCFE residents to the care of a part-time cook and janitor in 2013, had a previous history of hundreds of thousands of dollars in fines owed to federal and state licensing agencies for violations involving her ownership of four California nursing homes. Ten years later, she applied for and was granted licenses to run RCFEs. If the Department of Social Services (DSS) had known about her nursing home violations and fines, it would not have approved her RCFE license.

More recently, Colonial Manor, an RCFE in Salinas, California, was 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 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. While the staff at DSS/CCL was engaged in relocating the Colonial Manor residents, the owner basically abandoned the facility and refused to cooperate with the state agency staff. Now that AB 601 is law, Mr. Marzan will never be granted another license to operate an RCFE in California.

AB 601, authored by Assemblymember Susan Eggman and signed into law by Governor Jerry Brown, establishes specific suitability and disclosure requirements for applicants seeking a license to operate an RCFE. AB 601 requires applicants to submit information on ownership and prior ownership of any type of facility, in any state, including a history of compliance with applicable laws. It also requires the DSS to crosscheck the information provided by the applicant with the Department of Public Health, and allow DSS to deny or revoke a license for failure to disclose the required information.

For more information regarding AB 601 and other legislation impacting long term care, please see CANHR’s website at http://www.canhr.org/legislation/index.html.

Long Term Care News ................ (continued from page 3)
I feel it is important to explain to my readers why it is urgent that SB 338 (Morrell) be passed in the 2016 legislative session. SB 338 deals with penalties for mental abuse of elders by caregivers. At present, attorneys are leery of taking on such cases because there is no law to support such cases. Mental abuse of elders is not a new issue, so why is there no law to specifically protect the elderly? In my opinion it is because the industry providing care to elders is so fearful of such a law that they are determined to defeat such needed legislation.

SB 338 would provide that a person who knows or reasonably should know that the victim is an elder or dependent adult, and under circumstances or conditions likely to produce significant or substantial mental suffering, willfully causes or permits the victim to suffer unjustifiable mental suffering, is punishable by imprisonment in a county jail not exceeding one year, or by a fine not to exceed $6,000, or by both that fine and imprisonment, or by imprisonment in the state prison for 2, 3, or 4 years.

Some CCRC administrators have perfected a cynical method of frustrating residents with legitimate complaints. They ignore all attempts to get a return call. Nor do they reply to written communications. Sometimes when they do reply, they respond with false information and then hope it will be in the record as fact. Their objective is to get a resident angry enough to express themselves in a way that could be deemed offensive. Coupled with methods of stripping the right to sue for just cause out of legislation protects administrators who inflict mental abuse on residents in their care.

Recently, I received a report from a reliable source about pain medication being withheld from a 100 year old patient by a caregiver whose religious beliefs forbade the use of drugs even when prescribed by an MD. The patient was in agony for 12 hours until the next caregiver provided the medication. This “caregiver” should have her license revoked and charged with a felony, and the agency that supplied such a caregiver should be held accountable as well. This is the type of case that could be prosecuted under SB 338.

In another instance, a patient required an injection at 2:00 a.m. The RN on duty called the physician to confirm. The following day, the MD showed up in the patient’s room and began to berate her for disturbing his sleep. He claimed he could not fall asleep after the RN’s call. This humiliated the patient. When the patient complained, she was told to forget it.

What accounts for a society that allows seniors to be subjected to such treatment? Over a period of many years, I have observed a culture of contempt for the elderly in both the long-term care executives as well as in other staff and have previously written on this subject. Some years back I wrote a column that was published in California News on this subject. The title of the column was “How Can CCRC Residents be Protected from Elder Abuse (in particular psychological and emotional abuse.)” With SB 338, I am hopeful we can finally bring this pernicious, ugly practice to an end.

Pauline Mosher, CANHR program manager and a long-term care advocate wrote in The Advocate about my advocacy on AB 2171, the RCFE Residents Bill of Rights in 2014: “Lillian is blind and disabled and did all her work from her apartment at the CCRC where she lives. Lillian spoke with staff at the Governor’s office and called every committee member to put the pressure on legislators when the bill was stuck in suspension. AB2171 was signed into law and will be effective January 1, 2015. Lillian has been an invaluable advocate for many years and even more so during this past year’s legislative campaign.” I intend to do the same for SB 338 and I ask you to join me.

(Ms. Hyatt is a resident of a CCRC and AARP Policy Specialist. Professor Hyatt can be seen on YouTube on the USC School of Social Work Website)
**CANHR on the Move...**

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

- **September 8:** Senior Staff Attorney Prescott Cole was invited to speak at the Passages in Chico California on Elder Financial Abuse.

- **September 16:** Prescott Cole hosted CANHR’s training, “APS and Civil Litigators - Allies in the Fight Against Financial Elder Abuse” at the Institute on Aging in San Francisco.

- **September 18:** Program Manager Pauline Mosher and Long Term Care Advocate, Julie Pollock, presented on Medi-Cal & Recovery to Social Workers and Discharge Planners at the California State Rail Road Museum in Sacramento.

- **September 22:** Staff Attorney Tony Chicotel made a presentation on improving dementia care to the Alameda and Contra Costa Counties’ Long-Term Care Ombudsman programs.

- **September 24:** Outreach Coordinator Efrain Gutierrez hosted a CANHR information table at the Los Angeles Convention Center for the 15th annual Seniors Celebrating Life Social Luncheon, courtesy of Councilman Curren D. Price Jr.

- **October 1:** Prescott Cole made a presentation, “APS and Civil Attorneys – Allies in the Fight Against Elder Financial Abuse, at the National APS Association Conference in Orlando, Florida.

- **October 6:** Office Manager Armando Rafailan Hosted a CANHR information table at the 16th Annual Senior Health Faire in Newark at the Silliman Activity and Family Aquatic Center.

- **October 9:** Prescott Cole gave a presentation on financial elder abuse at the San Francisco’s Department of Aging and Adult Services San Francisco.

- **October 12:** Tony Chicotel presented at the Disability Rights California conference in Sacramento. The training topic was representing people with impaired or limited mental capacity.
• October 13: Prescott Cole taught a class at Hastings Law School’s Medical-Legal Partnership for seniors.

• October 14: Prescott Cole was a guest speaker at UC Berkeley Extension Course, “Navigating the Health Care System”

• October 16: Executive Director Pat McGinnis lectured on admission and retention issues at the San Francisco State University RCFE Administrator Certification Program.

• October 17: Long Term Care Advocate Julie Pollock presented on resident’s rights at a family council meeting in Water’s Edge SNF in Alameda.

• October 21: Tony Chicotel presented at the state Long-Term Care Ombudsman coordinators’ meeting in Folsom. He spoke about informed consent and medical decision-making.

• October 22: Jody Spiegel participated in the Department of Social Services’ Community Care Licensing Division Quarterly Advocates Meeting

• November 5: Tony Chicotel spoke at a meeting of regional managers from the Department of Social Services’ Community Care Licensing Division. The topic was caring for RCFE residents with limited capacity and no surrogate decision makers.

• November 10: Pauline Mosher presented on long-term care options and Medi-Cal at a free conference for Spanish-speaking family and friends caring for someone with dementia or an aging loved one. Family Caregiver Alliance hosted the event, and there were 30 caregivers in attendance.

CANHR Upcoming Events

• December 2: CANHR Staff Attorney Prescott Cole, and Tony Chicotel will be presenting at the Defending The Defenseless Workshop at the Hyatt Vineyards Creek in Santa Rosa from 1:00pm to 4:30pm. This panel will discuss on one of the most underappreciated and overlooked forms of violence – elder abuse. What you learn could save and improve the lives of your clients. Please call in your reservation to 707-202-5511 or email awilkes@mollandlaw.com.
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**

- **Thomas Ambrogi**  
  *Pat McGinnis*
- **Thelma Benjamin**  
  *Mark Benjamin*
- **Genevieve Ciotti, My Wife**  
  *Tom Ciotti*
- **My Client**  
  *Ghezahegn Asamere*
- **Joan’s Father**  
  *Susan Cohen*
- **Kristin Hackler**  
  *Sandi Schaffer*
- **Our Parents**  
  *Mr. & Mrs. K. C. Burchill*
- **Dolores Sakaue**  
  *Kim Sakaue*
- **Vernon Windrath**  
  *Shirley Windrath*

**IN HONOR OF**

- **David Bohnet**  
  *Rita Neely*
- **Felicia Curran & Ruth Gamba**  
  *Cristina Flores*
- **Douglas D. Hansen**  
  *Dianne Hansen*
- **Lillian Hyatt**  
  *CANHR Staff*
- **Frank Lobo**  
  *Kelina Lobo*
- **Tedd McGee**  
  *Virginia Jamieson*
- **In Honor of My Mother**  
  *Charlotte Turner*

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**Suggested Gifts for Long Term Care Residents**

It’s the holiday season again and, as you make out your shopping list, we have some suggestions for possible gifts for a special long term care resident:

- A new pair of comfortable slippers or robe in a favorite color.
- A gift certificate for a haircut, massage or manicure and pedicure. Treat yourself and go with the resident.
- Pictures taken in the last year of friends and family, arranged in an album, frame or on a bulletin board to hang up.
- A calendar with important dates, such as birthdays and anniversaries. Select some cards and provide stamps for the resident to send.
- A videotape/DVD to enjoy together at the facility. Record a family event, such as a baptism or a graduation for the resident to share in the celebration.
- Subscribe to a hometown newspaper or a favorite magazine.
- Crossword or word search books – in large print if need be.
- A television for the resident’s room, or wireless headphones to hear the television.
- A favorite book, books on CD/tape or a wireless reading device.
- Brighten up the resident’s room with a quilt or lap blanket. Bring in a plant or have flowers delivered on a regular basis.
- If the resident is in a wheelchair or uses a walker, find a tote bag that can attach to it.
- Check with the nursing home staff about other appropriate items, such as powder, lotion, toothpaste, soap, aftershave, etc.
- One of the best gifts for a nursing home resident, of course, is the gift of your visits.

Happy Holidays!
Happy Holidays and Best Wishes From the CANHR Staff

San Francisco:
Front Row: Julie Pollock, Pauline Mosher, Avigail Tucker, Armando Rafailan and Pat McGinnis
Back Row: Robert Martien, Daniel Guerrero, Tony Chicotel, Prescott Cole, Maura Gibney and Efrain Gutierrez with daughter Ciara

South Pasadena:
Left to Right: Efrain Gutierrez, Jody Spiegel and Michael Conners

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**Contra Costa**

**Willow Pass Healthcare Center**

3318 Willow Pass Rd. Concord  
B $1200 Medication Patient Care 12/08/2014

The facility was cited for failing to give the resident Fosrenol (a medicine that lowers blood phosphorous) appropriately to absorb phosphorus from food and prevent complications during dialysis treatment. The facility failed to coordinate with the dialysis center to receive crucial lab results of phosphorous levels. The facility failed to recognize abnormally elevated serum phosphorous levels that could be life threatening to the resident, risking loss of calcium in the bones and heath vessel calcification. These violations had a direct relationship to the health, safety or security of patients. Citation # 020011159.

**Marin**

**The Redwoods, a Community of Seniors**

40 Camino Alto Mill Valley  
B $2000 Fall 08/27/2015

On August 10, 2013, a resident fell out of her wheelchair and hit her head on the floor mat. The resident was assessed by a licensed staff member who found a small bump on her forehead, and then transferred her back into bed. The resident sustained a neck fracture. The facility was cited for failing to implement the Nursing Services policy and procedure, because it transferred the resident without the use of a device to immobilize her head and neck after a fall. Citation # 110011159.

**Napa**

**Meadows of Napa Valley Care Center, The**

1900 Atrium Parkway Napa  
A $20000 Fall 07/08/2015

On 2/8/14, a resident with congestive heart disease and acute kidney failure went to the ER with a lacerated scalp after falling from his recliner chair. On 2/11, after returning to the facility, he fell and was found sitting on the floor with a skin tear on his hand. On 2/21, he broke his hip when he fell in the bathroom. He was transferred to the acute hospital where he was put on comfort care and died on 2/23/14. The facility was cited for failing to ensure adequate supervision to prevent falls. Citation # 110011290.

On 2/8/14, a resident with congestive heart disease and acute kidney failure went to the ER with a lacerated scalp after falling from his recliner chair. On 2/11, after returning to the facility, he fell and was found sitting on the floor with a skin tear on his hand. On 2/21, he broke his hip when he fell in the bathroom. He was transferred to the acute hospital where he was put on comfort care and died on 2/23/14. The facility was cited for failing to ensure adequate supervision to prevent falls. Citation # 110011290.

**San Francisco**

**Central Gardens**

1355 Ellis Street San Francisco  
B $2000 09/18/2015

In 2015, a CNA put his hands in a resident’s pants during a transfer. The resident felt abused and reported the incident to Social Services who reported it to a Licensed Nurse. The Nurse did not consider it abuse, and did not investigate, nor report the incident. The facility was cited for failing to report an allegation of abuse within 24 hours. Citation # 110011524.

The facility failed to provide adequate supervision to prevent the elopement of a resident when there was no documented evidence for the one to two hourly visual checks before 4/18/15 when the elopement took place. The resident had to be rushed to the emergency room to treat a head injury and facial contusion related to a fall outside the facility after she eloped. The findings also found that the front door alarm was turned off on 4/18/15, allowing the resident easier access to leave the facility. These deficient practices resulted in a fine for the facility. Citation # 220011716.
Santa Clara

Amberwood Gardens
1601 Petersen Avenue San Jose

B $1000 Mandated Reporting 04/29/2015
The facility was cited for failing to implement its abuse policies for three residents during March and April 2015. The facility failed to investigate or report to the appropriate state agencies that one resident alleged that he was slapped in the face by a staff member when he was assisted to the bathroom, and also scratched during incontinence care resulting in skin care to his nose. The facility also failed to thoroughly investigate skin tear injuries to the knee and hip of two other residents to determine whether the residents were being mistreated. Citation # 070011398.

B $1000 Bed Hold 07/16/2015
The facility failed to readmit a resident for approximately seven months from December 2014 through July 2015 following a hospitalization that exceeded the bed-hold period. Hospital staff stated that they had contacted the facility several times regarding readmission, and it stated multiple reasons why it could not readmit him including no male bed availability. Records and interviews indicated male bed availability during the relevant time period. The facility was cited for failing to follow its policy on readmission, which resulted in a violation of the resident’s right to readmission as required by law. Citation # 070011620.

Herman Health Care Center
2295 Plummer Avenue San Jose

B $1000 Mandated Reporting Physical Abuse Staffing 09/04/2015
The facility was cited for failure to properly investigate and report alleged abuse after bruises were discovered on the arms and back of a resident diagnosed with dementia. Upon seeing the bruises staff did not file an incident report, properly investigate, or report the incident to the state or ombudsman. Citation # 070011680.

B $2000 Mandated Reporting Notification Patient Care Retaliation Against Resident Verbal Abuse 09/04/2015
On 7/14/15, a resident-to-resident altercation occurred between Resident 1 and Resident 2 that was not reported to the appropriate agencies as required by current law within 24 hours of the incident. The facility failed to follow it's "Unusual Occurrence Reporting" after Resident 1 yelled "I want this f*cker out of here" to Resident 2. The facility failed to follow its implemented policies that enforces notification to prevent further abuse. Citation # 070011698.

B $1000 Mandated Reporting Notification Physical Abuse 09/04/2015
After a family member of a resident with dementia reported bruising on resident's arms and back the facility was cited for failure to properly investigate and report alleged abuse. Upon seeing the bruises staff did not file an incident report, properly investigate, or report the incident to the state or ombudsman. Citation # 070011679.

Milpitas Care Center
120 Corning Ave. Milpitas

B $2000 Mandated Reporting Patient Care Physical Abuse 07/24/2015
On 6/7/15 a CNA identified a skin discoloration on a female resident's right upper arm. She notified the nurse staff that day. A nurse did not assess her arm until 6/9/15. The nurse stated that no investigation was started as to why and how she sustained the skin discolorations. An X-ray showed a complete displacement and fracture. The facility failed to report an injury of unknown origin within 24 hours to the Department within 24 hours of identification. Citation # 070011591.

B $500 Mandated Reporting Patient Care Physical Abuse 07/24/2015
On 6/7/15 a CNA identified a skin discoloration on a female resident's right upper arm. She notified the nurse staff that day. A nurse did not assess her arm until 6/9/15. The nurse stated that no investigation was started as to why and how she sustained the skin discolorations. An X-ray showed a complete displacement and fracture. The facility failed to report an injury of unknown origin within 24 hours to the Department within 24 hours of identification. Citation # 070011592.

Mission De La Casa Nursing & Rehabilitation Center
2501 Alvin Avenue San Jose

A $4000 Careplan Injury 07/27/2015
The facility was cited for failing to ensure that the resident received adequate assistance to prevent accidents, when the resident sustained a broken arm after a staff member lifted her from her bed to a shower chair and back again without the assistance of a second person or the use of a mechanical lift, as indicated in the resident's care plan. Citation # 070011494.

Skyline Healthcare Center - San Jose
2065 Forest Avenue San Jose

B $1000 Careplan Patient Care Supervision 09/01/2015
The facility failed to provide the necessary care and services for Resident 4 who had a change in condition when a registered nurse failed to properly assess the resident who had severe symptoms of a heart attack. These failures led to a delay in treatment placing the resident at risk for health complications. The facility was fined for failing to care of Resident 4's needs in order to prevent a heart attack. Citation # 070011667.

### Golden Living Center - London House Sonoma
678 2nd Street West Sonoma
B $2000 Administration Careplan Fall Patient Care 06/16/2015
The facility failed to follow the care plan for a 97 year old resident which stated she must have a tab alarm on her wheelchair to alert staff when the resident attempts to get up from the chair. The facility was cited after the failure to follow the care plan resulted in the resident falling out of the wheelchair and fracturing a bone in her face. Citation # 110011503.

### Golden Living Center- Santa Rosa
4650 Hoen Avenue Santa Rosa
B $2000 Careplan Fall Injury Supervision 07/02/2015
The facility was cited for failing to implement the resident's care plan to ensure that the resident was adequately monitored and supervised to prevent a fall. This failure resulted in the resident sustaining a hip fracture and two hospitalizations, exacerbated physical pain, and undergoing surgery to repair the damage caused by the fall. Citation # 110011588.

### Summerfield Healthcare Center
1280 Summerfield Rd. Santa Rosa
B $2000 Dignity Patient Care Sexual Abuse 05/05/2015
Resident 1 experienced an encounter of sexual abuse dated 9/3/2014 when an Unlicensed staff member washed the resident's genitals inappropriately and touched her labia and vagina with a washcloth. This brought sudden anxiety and discomfort to the resident, which caused further emotional trauma. The facility failed to ensure Resident 1 was free from sexual abuse. Citation # 110011361.

### Yuba
Marysville Care Center
1617 Ramirez Street Marysville
B $2000 Verbal Abuse 08/07/2015
On 1/19/14, a resident asked a CNA for an egg salad sandwich for her dinner. The resident stated that when she did this the CNA became “rude and snotty”, asking her how she would know what was on the menu, then started cursing at her. This caused the resident to feel angry and demeaned for several days. The facility didn't notify the Department of the incident until four days after it occurred and was cited for failing to make the report within 24 hours as required. Citation # 230011643.
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**Imperial**

**Imperial Manor**

100 E. 2nd Street Imperial

AN $15000 Patient Care Staffing 11/26/2014

Based on findings from a visit on 12/6/14, the facility failed to maintain the 3.2 Nursing Hours per Patient Day as required between five and 49 percent of the audited days. Citation #090011131

**Kern**

**Delano District Skilled Nursing Facility**

1509 Tokay Street Delano

A $10000 Patient Rights Physical Restraints 08/17/2015

On 6/18/15, an 83 year old female resident was found crying and restless in her bed, after the nursing staff tied her legs together with a blanket for their own convenience, to prevent her from getting out of bed. The facility was cited for failure to ensure residents were free from physical restraints. Citation #1200011608.

**Evergreen Arvin Healthcare**

323 Campus Drive Arvin

A $20000 Full Medication Patient Care 09/14/2015

After Resident 1 had an injury due to a fall on 7/15/15, he told his therapist that the pain was getting worse. The therapist failed to notify the Director of Nursing, which went against the facility's "Pain Management" policy. The policy states that when there is a change in pain level, there should be a discussion between the physician and Licensed Nurse in order to provide the appropriate treatment. These failures resulted in Resident 1 suffering from unrelieved pain due to a fractured pelvis. Citation #120011683.

**Evergreen Bakersfield Post Acute Care**

6212 Tudor Way Bakersfield

B $2000 Mandated Reporting Notification Other Patient Care Physical Abuse 07/21/2015

On 5/16/2015, two CNAs heard "a slapping sound and looked over." The CNAs witnessed Resident 1's daughter slapping her in the face in order to get her to eat. The CNAs did nothing and failed to report the incident to appropriate staff. The facility failed to report an allegation of abuse to the Department of Public health within 24 hours of the incident date. Citation #120011625.

**B $2000 Careplan Neglect Notification Patient Care Staff (Inservice) Training 09/14/2015**

The facility failed to ensure call lights were answered in a timely manner for 4 of 4 sampled residents (Residents 1,2,3,4). This failure resulted in mental anguish for three residents (1,3,4) and a fall for Resident 2. Residents 1,3,4 all require assistance for the need to use the toilet, and Resident 2 is dependent on staff for weight bearing support. The facility was fined for failing to answer the call lights when Residents 1,2,3,4 needed support. Citation #120011662.

**Glenwood Gardens SNF**

350 Calloway Drive Bakersfield

A $20000 Hydration Nutrition 09/08/2015

An 80 year old male resident with a number of serious chronic health conditions suffered dehydration after facility staff continuously failed to provide sufficient water and liquid food through his feeding tube. Over a 17-day period in May 2015, the resident was supposed to receive 40,800 ml of fluid but only received less than half of that - 19,060 ml. On 5/28/2015, the resident was lethargic and unresponsive and had to be hospitalized and died. Citation #120011661.

**Parkview Healthcare Center**

329 North Real Road Bakersfield

A $20000 Physical Abuse 09/14/2015

On 5/27/15, a 58 year old male resident who had a history of abusing other residents slapped and then hit an 84 year old female resident on the face with a closed fist after she resisted his efforts to get into her purse. She suffered a hematoma to her head. A nursing assistant said the abusive resident usually received one-to-one supervision due to his behavior but not always due to conflicting assignments. Resident witnesses said that facility staff were not in the dining
room where the abuse occurred and that they had to yell for staff and try to stop the attack before the staff arrived. Citation #120001664.

**Parkview Julian Convalescent**

1801 Julian Avenue Bakersfield  
A $20000 Fall Patient Care 08/03/2015  
On 4/4/15, a 73 year old male resident fell next to his wheelchair, resulting in a right hip fracture that remained undetected by the facility for two weeks. The resident endured increasing pain in his right hip until 4/26/15, when his wife took him to the hospital and he was diagnosed with a fracture. Citation #120001181.

**The Rehabilitation Center Of Bakersfield**

2211 Mount Vernon Ave Bakersfield  
B $2000 Fall Mandated Reporting Mental Abuse Notification Patient Care 09/15/2015  
On 8/24/15 Resident 1 stated that a young male CNA took her into her room and ridiculed her about falling to the floor. She reported the incident to the Director of Nursing and a Licensed Vocational Nurse, but neither took the initiative to contact the Department. The facility was fined for failing to contact the appropriate authorities about an incident of abuse. Citation #120001715.

**Los Angeles**

**All Saints Healthcare**

11810 Saticoy Street North Hollywood  
B $2000 Patient Care Physical Abuse Retaliation Against Staff Verbal Abuse 09/08/2015  
On November 6, 2011, during a diaper change, a CNA working at the All Saints Healthcare slapped a resident on the head and called her a "bitch". There were two witnesses in the room when the incident took place. The facility was fined for failing to keep residents safe from any physical and verbal abuse. Citation #920001703.

**Bell Convalescent Hospital**

4900 E. Florence Ave Bell  
B $2000 Administration Mandated Reporting Notification Sexual Abuse Staffing 04/24/2015  
The facility failed to properly investigate an alleged incident of sexual abuse and staff failed to report the alleged incident to the administrator, the Department, the Ombudsman and local law enforcement. Staff also failed to ensure that the resident alleged to have sexually harassed other female residents, was separated from them to ensure prevention of further harassment. Citation #9400011417.

**Bellflower Convalescent Hospital**

9710 E. Artesia Ave. Bellflower  
B $2000 Physical Environment 07/09/2015  
On 6/8/15, during an unannounced inspection, it was discovered that the hot water temperature was 120 degrees Fahrenheit in residents’ common bathrooms and shower room which placed residents at risk for burns and scalding temperatures. The facility was cited for not maintaining an environment that was free from hazards. Citation #9400011609.

**Buena Ventura Post Acute Care Center**

1016 S Record Avenue Los Angeles  
A $20000 Patient Care 06/11/2015  
A resident who was paralyzed on her right side suffocated on a pillow while lying on her left side during the receipt of care on 6/28/14. A visitor entered the resident’s room and found a nurse standing right beside the resident with a pillow on her face. The nurse said she noticed the resident was suffocating "almost at the same time" as her visitors arrived. The facility was cited for failing to immediately perform CPR, activate the facility's emergency response team, call 911, and other failures regarding emergency care. The resident died from lack of oxygen to her brain on 7/7/14. Citation #940011546.

**Country Villa Rehabilitation Center**

340 S. Alvarado St. Los Angeles  
B $1000 Injury Patient Care 07/22/2015  
On 6/17/11, a female resident was hospitalized after her leg was cut open due to an improper transfer from wheelchair to bed. Only one CNA did the transfer, even though the resident required two CNAs. The CNA did not follow protocol and remove the wheelchair footrests. The facility was cited for failing to ensure the environment remained free of hazards and residents received adequate supervision to prevent accidents. Citation #9100011627.

**Del Rio Gardens Care Center**

7004 E Gage Avenue Bell Gardens  
B $2000 Mandated Reporting Notification Physical Abuse Retaliation Against Resident 05/20/2015  
On 11/6/2015 A resident witnessed his roommate hit another resident in the head. The victim was a 55 year old woman in a wheelchair. The facility failed to report the incident to an administrator and failed to implement a system that would prevent further abuse or altercations between residents. Citation #9400011481.

**Downey Care Center**

13007 South Paramount Downey  
B $2000 Physical Environment 04/17/2015  
On 4/6/15, the hot water temperatures in the hand washing sinks in four bathrooms used by residents exceeded 130 degrees Fahrenheit, placing the residents at risk of burn and scalding temperatures. The facility was cited because the unsafe water temperatures exceeded the facility's policy of providing safe hot water temperatures between 105 and 120 degrees Fahrenheit. Citation #9400011403.

**El Encanto Healthcare And Habilitation Center**

555 El Encanto Road City Of Industry  
A $12,000 Careplan Injury Patient Care 03/18/2015  
After an 82 year old resident diagnosed with a seizure disorder fell multiple times, the facility was cited for failure to update the care plan so as to prevent future falls. Additionally, the facility failed to create a care plan to address the patient's decreased ability to walk and sudden lack of interest in activities or therapy. Citation #9400011312.
El Rancho Vista Health Care Center  
8925 Mines Avenue Pico Rivera  
A $20000 Patient Care 09/18/2015  
On 8/4/14, a resident who was at high risk for fractures complained of chest pain. A physician was notified and x-rays were ordered. The x-rays showed she had fractured ribs. The resident told a family member that she sustained the rib fractures while being transferred from the wheelchair to her bed. The resident told the state investigator that on the day of the incident she asked for help getting into her bed. She needed help because she was having trouble standing up due to a recent ankle fracture. She told the CNA that there should be two staff helping her but was told no, that everyone else was busy and she could do it by herself. The CNA then grabbed her from behind her wheelchair, pulled her up and transferred her onto the bed. The transfer broke her ribs. A review of the resident's care plan indicated that she was to be transferred by two staff using a gait belt or a mechanical lift. The facility was cited for an improper transfer. Citation #940011704.

Holiday Manor Care Center  
20554 Roscoe Blvd Canoga Park  
A $20000 Patient Care 08/25/2015  
After several previous falls at the facility, an 89 year old female resident with dementia fell again on May 23, 2012. The resident was found on the floor at the foot of her bed in the sitting position, and was sent to the Acute Care hospital, where she was diagnosed with a broken hip. She had surgery the next day to repair the fractured hip. After returning to the facility, she was taken to the shower, had complications and died on 6/1/12. The facility failed to ensure the resident, who was assessed as being a high risk for falls, was provided one-to-one supervision and assistive devices to prevent avoidable accidents. Additionally, the facility failed to provide pain management after her fourth fall incident that resulted in a broken hip. Citation #920011508.

Inland Valley Care And Rehabilitation Center  
250 W. Artesia Pomona  
$500 Mandated Reporting 12/17/2014  
On 12/20/13, a complaint investigation was conducted regarding an allegation of abuse by a resident. The facility indicated that the police were notified but not the Department of Public Health as required. The facility was cited for failure to report the allegation to the Department within 24 hours. Citation #950011183.

Intercommunity Care Center  
2626 Grand Avenue Long Beach  
A $200000 Patient Care 02/05/2015  
On 9/19/12, a residents' urinary catheter was pulled out by a nurse in a manner that ripped the urethra of a 54 year-old resident causing him to bleed and be hospitalized for three days. A follow-up investigation was conducted on 9/5/14 where investigators examined the facility's in-service education records and determined that since the time of the incident there was no evidence that the licensed nursing staff were being trained on the proper insertion and care of indwelling urinary catheters. The facility was cited for failing to follow proper urinary catheter procedures that led to physical harm to the 54 year old resident. Citation #940011250.

A $200000 Elopement 07/10/2015  
On 12/1/14, a 47 year-old resident who was admitted into the locked facility managed to elope and was never found again. The resident had traumatic brain injury secondary to being assaulted with a baseball bat with multiple skull fractures and been diagnosed with dementia. There was evidence that the resident might have used a large plastic trash can to scale the eight foot chain-link fence that separated the facility from a freeway, or had used a chair to climb onto a storage shed in order to jump over the fence. It was noted that, although the resident had a history of elopement, there was no elopement risk assessments conducted by the facility. The facility was cited for not providing a safe and secure environment for the resident. Citation #940011606.

Lighthouse Healthcare Center  
2222 Santa Ana Blvd Los Angeles  
A $20000 Physical Abuse 07/01/2015  
On 1/21/14, a complaint from Resident #1 regarding his care, medications, food, and missing items led to a finding that resident #1, a diagnosed schizophrenic, had been subjecting residents and facility staff to months of verbal, mental, and physical abuse. Resident #1 refused to take his prescribed medication and the investigators observed him in his room wearing dark glasses with headphones while playing video games. His room cluttered with boxes, a fax machine, a large screen TV, and other personal items. Resident #1 had several instances of physical altercations with other residents and outbursts of anger and threats which caused the residents and staff alike to be in fear of him. The facility was cited for not thoroughly investigating various incidents of alleged abuse by resident #1 and for not ensuring that their residents were free from abuse and mental anguish. Citation #940011573.

A $20000 Medication 07/01/2015  
A 37 year-old male resident with schizophrenia was receiving two narcotic pain relief medications, anti-anxiety drugs, and a muscle relaxer despite having only generalized complaints of pain and problems with alcohol and marijuana. The resident was asking for and receiving scores of pills subject to abuse which he would mix with alcohol while out of the facility on pass. The facility was cited for administering narcotics without a clear indication for use, in the presence of a potential adverse reaction, and in duplicate therapy. The facility was also cited for its consultant pharmacist's failure to note the resident's drug irregularities. Citation #940011570.

B $10000 Mandated Reporting Other 05/13/2015  
The facility failed to post the overall facility star ratings given by the Centers for Medical and Medical Services (CMS) to the facility. The facility is supposed to post the overall facility rating information determined by the Federal Centers for Medicare and Medicaid Services (CMS) in the lobby or a visible place that every resident/employee/visitor can acknowledge. Citation #940011471.

B $20000 Patient Care Physical Abuse Retaliation Against Resident Staff (Inservice) Training 07/02/2015  

On 4/27/14, CNA 1 observed CNA 2 hit a resident with a folded sheet during provision of care. CNA 2 further stated that the resident "does not let [him] concentrate." The resident's face appeared to be red right after the hit, as stated by CNA 1. The facility failed to ensure that a resident was free from physical abuse. Citation #940011590.

Long Beach Care Center
2615 Grand Avenue Long Beach
A $20000 Mandated Reporting Neglect Other Patient Care 06/29/2015
On 8/12/12, the Department of Public Health received an entity reported incident (ERI) from the facility indicating a resident was found unresponsive and compromised. Shortly after receiving the ERI the Department received an unsigned letter alleging the facility didn't provide the police, family or Department with information of what actually happened in the death of the resident. The letter stated that a bottle of medication was found at the bedside, that there was vomitus seen on the resident and there was a suicide note. The resident's record indicated many episodes of anxiety, sleeplessness, depression, and complaining. Citation #940011579.

Lynwood Healthcare Center
3611 Imperial Highway Lynwood
A $20,000 Patient Care Privacy Sexual Abuse 09/10/2015
The facility failed to keep residents free from any intruders by lacking provisions to keep security standards for residents up-to-date. The facility failed by not ensuring the doors were secured locked and the alarm was functioning, allowing an intruder to enter the building. This allowed resident 1 to be subject to sexual abuse by the intruder. The intruder was found naked in Resident 1's bed. Therefore, the facility was cited for failing to provide a safe, functional, and abuse free environment for the residents and its staff. Citation #940011696.

Magnolia Gardens Convalescent Hospital
17922 San Fernando Mission Blvd Granada Hills
AA $60000 Neglect Patient Care 04/09/2015
On 1/21/12, a 77 year-old female resident went into cardiac arrest and died in the facility, just 11 days after she was admitted, after the nursing staff's repeated and documented failures to provide necessary medical care. The nursing staff failed to follow physician's orders to monitor the resident's oxygen saturation, administer oxygen for labored breathing, suction the resident's mouth every two hours, or administer breathing treatments every four hours as needed. Nursing staff also failed to notify the physician of signs of congestion or shortness of breath. When the resident was found unresponsive in her bed on 1/21/12, the nursing staff failed to implement CPR in accordance with the resident's advanced directive and facility policy. Citation #920011270.

North Walk Villa Convalescent Hospital
12350 Rosecrans Norwalk
A $20000 Medication 06/02/2015
A female resident with multiple sclerosis was receiving massive amounts of pain medications including 2-1/2 times the maximum recommended doses of morphine. The resident was observed to be constantly drowsy with slurred speech. When asked about the large doses and duplicate medications the resident was receiving, her physician asked "she's still alive isn't she?" The facility was cited for administering excessive medication, in the presence of adverse consequences, and without monitoring the resident's respiratory rate. Citation #940010714.

Oakpark Healthcare Center
9166 Tujunga Canyon Tujunga
AA $75000 Chemical Restraints Infection Medication Patient Care 09/16/2015
A female resident was transferred to the ER on 1/16/13, after developing a severely infected gangrene wound on her left heel, an infection of the bone, and a blood infection. She died on 1/27/13. The resident was admitted to the facility on 5/11/12 with kidney disease, dementia, and diabetes. On 11/12/12, it was documented that she had a Stage 2 left heel wound, but nursing notes since that date failed to document the condition or progression of the wound. The nursing staff also failed to monitor the wound for signs of infection, or obtain a wound consultation in a timely manner per physician's orders on 12/19/12. The resident repeatedly cried out "help me" to nursing staff, who responded by increasing her prescriptions for psychoactive medications, including Haldol. Her care plan did not include determining if the screaming for help was related to severe pain from her gangrene wound. Citation #920011543.

Ramona Nursing & Rehabilitation Center
11900 Ramona Blvd. El Monte
A $20000 Patient Care 05/04/2015
On 7/4/14, a resident witnessed a male resident crash to the floor in his room. The resident reported the fall to a CNA who found the resident on the floor of his room, face-down, and unresponsive. She did not check vital signs or initiate CPR. Instead she called a nurse who took vital signs and found the resident not breathing and with a very weak pulse. She did not initiate CPR. Instead she called another nurse who brought an oxygen tank that turned out not to have enough oxygen. She left to get another oxygen tank. Meanwhile two CNAs moved the resident to his bed and rather than initiate CPR, began cleaning him. The resident died. The facility was cited for failing to ensure the staff immediately initiated CPR when it was warranted. Citation #940011388.

The Rehabilitation Center on La Brea
505 N. La Brea Ave Los Angeles
A $20000 Decubiti (Bedsores) 09/29/2015
On 5/28/15, the resident was admitted into the facility with a broken leg. He had Alzheimer's and his left leg was encased in a hard cast that extended from his thigh to the beginning of his toes. The physician's order, dated May 29, indicated the necessity to monitor the resident's leg for any changes. On May 29, at 4:15 p.m., the resident was found at his bedside, face-down, and without monitoring the resident's respiratory rate. The facility was cited for administering excessive medication, in the presence of adverse consequences, and without monitoring the resident's respiratory rate. Citation #940010714.

The Rehabilitation Center on La Brea
505 N. La Brea Ave Los Angeles
A $20000 Decubiti (Bedsores) 09/29/2015
On 5/28/15, the resident was admitted into the facility with a broken leg. He had Alzheimer's and his left leg was encased in a hard cast that extended from his thigh to the beginning of his toes. The physician's order, dated May 29, indicated the necessity to monitor the resident's leg for any changes. A review of the resident's progress notes indicated that "the resident had a cast", but from May 29 up until June 29 there was no documentation of assessments regarding the skin condition of the left toes. On June 29 at 4:15 p.m., the resident went to a physician's appointment and was found to have dry gangrene on his left toes and Stage III and IV pressure sores. The recommendation was for an amputation of the
toes. The facility was cited for failing to provide the resident with the necessary care and services. Citation #940011713.

**Tarzana Health And Rehabilitation Center**  
5650 Reseda Boulevard Tarzana  
**B $2000 Physical Environment 09/16/2015**  
On August 13, 2015, the Department received a complaint alleging the facility was hot, without air conditioning, and no air was coming through the vents in three residents' rooms. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71F-81F. The facility failed to maintain comfortable and safe temperature levels in three residents' rooms and provide cooling measures to protect compromised residents against heat stroke, dehydration, and possible death for eight sampled residents. In addition, the facility failed to maintain the air conditioning unit equipment during disruption of services. Temperatures were measured in the three affected rooms to range from 84F to 89F. Citation #9200011720.

**Vernon Healthcare Center**  
1037 W Vernon Los Angeles  
**A $20000 Patient Care Physical Abuse Supervision 05/06/2015**  
A male resident with aggressive behavior toward other residents punched another resident in the stomach on 8/16/14. The resident was known to enter other residents' rooms and sit on their bed and occasionally hit them when he felt threatened. The facility started a plan to supervise the resident directly 24 hours a day but failed to implement the plan, leading to several incidents when the resident again entered the rooms of other residents and hit one of them. The facility was cited for failing to identify the hazards of the resident's behavior and failing to implement a plan to resolve those hazards. Citation #940011435.

**B 2000 Mandated Reporting Notification Patient Care Physical Abuse Retaliati**

**on Resident 05/06/2015**  
The facility failed to implement its policy and procedure for reporting abuse or altercations between residents. On four separate occasions between 7/7/14 and 8/16/14, a physical altercation between resident 1 and 2, resident 11 and 12, resident 5 and 17, and resident 6 and 17, were not reported to the administrator in a timely manner (within 24 hours of each incident.) The facility was fined due to lack of investigation. Citation #940011431.

**Villa Maria Elena Healthcare Center**  
2309 N Santa Fe Ave Compton  
**A $10000 Patient Care Physical Abuse 09/23/2015**  
A 78 year-old female resident with right-side paralysis from a stroke fell from her bed and broke her hip and cut her head while her bed linens were being changed on 8/9/14. The resident required two staff members to assist with all of her movement and was deemed a high risk for falls; nonetheless, only one CNA was helping her when she fell. The CNA stated that she had been told during her orientation that CNAs normally perform two-person assistance with just one person. The facility was cited for failing to ensure the resident was provided with the two-person assistance needed to prevent her from falling. No mention was made about the sufficiency of the facility's staffing to meet the needs of the residents. Citation #040011710.

**B $1000 Fall Neglect 09/23/2015**  
A 78 year-old female resident with right-side paralysis from a stroke fell to the ground outside of the facility while unattended in her wheelchair on 8/24/14. The resident was given a manual wheelchair after she had problems controlling her electric wheelchair. The resident was not trained in using the manual wheelchair and there was no revision of her care plan. Prior to the fall, the resident was outside and began to roll down a hill and could not stop her momentum. A passerby found her on the ground with a broken leg and she later developed a dangerous blood clot. The facility was cited for failing to update and revise the resident's care plan to account for her safety in a manual wheelchair. Citation #040011741.

**Orange**

**Laguna Hills Health and Rehabilitation Center**  
24452 Health Center Drive Laguna Hills  
**B $15000 Careplan Infection Injury Neglect Patient Care 07/28/2015**  
The facility failed to ensure that two residents' pressure ulcers were evaluated and taken care of to prevent any further damage or loss of tissue. The facility further failed to assess the resident's skin integrity to identify pressure ulcers in accordance with the facility's P&P. The facility also failed to implement measures to prevent the development and/or deterioration of pressure ulcers for Residents 1 and 2. Citation #060011642.
Town And Country Manor
555 East Memory Lane Santa Ana
B $1500 Decubiti (Bedsores) Patient Care 10/27/2015
On August 21, 2015, a 64” resident was admitted into the facility and placed in a bed that was too short for him. The resident communicated his concern to staff and his physician, but was not given a longer bed until September 14, 2015. The resident was unable to roll, sleep on his side or properly reposition himself, and developed a Stage 3 bedsore on his tailbone. The facility was cited for failing to timely accommodate the resident’s individual needs. Citation #060011798.

Riverside

Desert Springs Healthcare & Wellness Centre
82-262 Valencia Avenue Indio
B $2000 Fiduciary 08/27/2015
From September to December 2014, a facility staff member stole thousands of dollars from an 86 year old male resident with dementia, who had no family or friends. The staff member would pick up the resident on Sundays, and take him to Kmart and Walmart, where he spent a total of $6628.88 on ladies jewelry and cosmetic items. The staff member then attempted to cash two checks in the amount of $10,000 each from the resident, likely with a forged signature. The staff member had been disciplined two years before, when she tried to discharge another resident directly to her own home. The facility was cited for failure to prevent financial abuse. Citation #250011684.

Magnolia Rehabilitation & Nursing Center
8133 Magnolia Avenue Riverside
B $2000 Patient Care Sexual Abuse 09/03/2015
On 5/12/2015, A CNA at the Magnolia Rehabilitation & Nursing Center kissed a patient on her cheek without any given consent, making the patient feel uncomfortable. The CNA further asked personal questions that seemed inappropriate. The facility failed to ensure that Patient 1 was free from any sexual abuse committed by the CNA, which had a direct relationship to the health, safety, and security of the patient. Citation #250011699.

Miravilla Care Center
9246 Avenida Miravilla Cherry Valley
B $2000 Mandated Reporting Physical Abuse 06/24/2015
On 12/17/2013, a nursing supervisor notified the director of nurses that a nursing assistant slapped a 67 year old resident on the left side of his face. On 2/27/14, A Licensed Vocation Nurse (LVN) went to investigate a disturbance that was coming from a resident's room and encountered a resident who was dry heaving while the daughter of the resident and a nurse were screaming at each other. The daughter told the LVN that the nurse was refusing to help her mother. Earlier on, there had been harsh words between the resident and that nurse over the resident's medication. The inci

Monterey Palms Health Care Center
44610 Monterey Avenue Palm Desert
B $2000 07/14/2015
On November 12, 2013, a 66 year old resident slipped and fell in water on her bathroom floor. The fall caused the resident to hit her head and re-injure her left upper arm bone that had been surgically repaired with a metal plate prior to the resident’s admission to the facility in September 2013. The facility was cited for failing to ensure that a plumbing leak in the resident’s bathroom had been repaired after she had reported it to maintenance. Citation #250011604.

Palm Grove Healthcare
1665 East Eighth Street Beaumont
B $2000 Fiduciary Patient Records 06/30/2015
A former Business Office Manager was in charge of handling resident funds from 2008 through August of 2013. The BOM also was able to withdraw monies from resident accounts, with the co-signature of the facility administrator. In August 2013, the administrator noticed the payroll was incorrect and the BOM "admitted to" adding "the paychecks" of a family member, who also worked in the facility. In October 2013, discrepancies were identified in resident trust funds. The facility failed to ensure the safe keeping and security of the resident's trust fund accounts. The facility also failed to implement a policy of prevention and prohibition of financial abuse with resident's monies as well as demonstrate and implement a check and balance protocol to prevent widespread financial abuse of the resident's trust funds. Citation #250011547.

Palm Springs Healthcare & Rehabilitation Center
277 S. Sunrise Way Palm Springs
B $1000 Verbal Abuse 09/16/2015
On 2/27/14, A Licensed Vocation Nurse (LVN) went to investigate a disturbance that was coming from a resident's room and encountered a resident who was dry heaving while the daughter of the resident and a nurse were screaming at each other. The daughter told the LVN that the nurse was refusing to help her mother. Earlier on, there had been harsh words between the resident and that nurse over the resident's medication. The inci...
dignity and respect in full recognition of his/her individuality. Citation #250011714.

**Palm Terrace Care Center**

11162 Palm Terrace Ln Riverside  
**A $10000 Careplan Fall 09/10/2015**

On January 18, 2014, an 82 year old male resident fell off his bed while receiving care from a nursing assistant, resulting in a fractured thigh bone. The nursing assistant was working alone, despite the fact that the resident's care plan indicated he required a two-person assist for turning and repositioning while in bed. The facility was cited for failure to ensure each resident receives adequate supervision to prevent accidents. Citation #250011707.

**Riverside Behavioral Healthcare Center**

4580 Palm Ave. Riverside  
**B $2000 Physical Abuse 09/23/2015**

On April 22, 2015, a resident came out of his room and reported he was hit one time on his left jaw by his roommate. The facility failed to ensure the licensed charge nurse immediately reported the alleged incident to the Administrator and DON. The facility was cited for failing to report to the Department within 24 hours of the incident, and instead reported it approximately one and half days later to the Department, local law enforcement and the Ombudsman. Citation #250011700.

**San Bernardino**

**Hi-Desert Medical Center - CONTINUING CARE**

6601 Whitefeather Rd Joshua Tree  
**B $1500 Careplan Fall Patient Care 01/09/2015**

On August 5, 2014 a patient at the Hi-Desert Medical Center fell while attempting to transfer back to bed from the bedside commode without any assistance. As outlined in her plan of care, the patient was at risk for falls due to a "self care deficit related to post-left knee surgery." The facility was fined due to failure to ensure the residents safety was addressed as outlined in her plan of care. Citation #240011213.

**San Diego**

**Edgemoor Hospital DP/SNF**

9065 Edgemoor Drive Santee  
**B $1000 Patient Care 10/10/2014**

On May 30, 2010, a resident fell out of bed and the facility did not answer the call light for 25 minutes after his roommate called for help, delaying emergency care being rendered to the resident. The facility was cited for failing to comply with the resident’s care plan and facility policy to answer call lights promptly and keep the call light within reach of the resident. Citation #090011003.

**Presidio Health Care Center**

8625 Lamar Street Spring Valley  
**B $2000 Nutrition 02/12/2015**

The facility was cited for a lack of sufficient food supplies. The staff did not have the means to meet the resident's nutritional needs in their day to day meal planning. The lack of sufficient emergency food supplies could also result in not meeting the nutritional needs of the residents during a disaster. Citation #090011000.

**Rancho Vista**

760 E. Bobier Dr. Vista  
**B $2000 Decubiti (Bedsores) Infection Injury Patient Care 08/05/2015**

On February 22, 2014, a CNA placed a resident in a geri-chair with a lap tray for more than two hours without a physician's order or the consent of the resident's responsible party, because the CNA had to make rounds and was not able to watch the resident. The facility did not report the suspected abuse incident to the Department until three days later on February 25, 2014. Staff acknowledged that it used the geri-chair with a lap tray for its convenience, that it was an unnecessary use of physical restraints, and that it failed to report an allegation of physical abuse to a resident in a timely manner. The facility was cited for compromising and violating the resident’s safety and rights, resulting in harm to the resident including bruises and high anxiety. Citation #080011648.

**Shea Family Care Parkside**

444 W. Lexington El Cajon  
**B $2000 Physical Restraints 02/27/2015**

On February 22, 2014, a CNA placed a resident in a geri-chair with a lap tray for more than two hours without a physician’s order or the consent of the resident’s responsible party, because the CNA had to make rounds and was not able to watch the resident. The facility did not report the suspected abuse incident to the Department until three days later on February 25, 2014. Staff acknowledged that it used the geri-chair with a lap tray for its convenience, that it was an unnecessary use of physical restraints, and that it failed to report an allegation of physical abuse to a resident in a timely manner. The facility was cited for compromising and violating the resident’s safety and rights, resulting in harm to the resident including bruises and high anxiety. Citation #090011283.

**Tulare**

**Kaweah Manor Convalescent Hospital**

3710 West Tulare Ave Visalia  
**A $20000 Dignity Mental Abuse Physical Abuse 08/25/2015**

The facility was cited for failing to prevent the abuse of a 71 year old male resident. Statements by other CNAs alleged the CNA was changing a resident, when the resident didn't want to stand up, she pulled him up by his arm in a quick and hard motion. This agitated the resident who then tried to bite her while grabbing her left arm and digging his nails into her arm. The CNA hit him in the back of his neck with a closed fist and shoved him. The CNA left the room and came back and slapped him saying, "I hope you die motherfucker." Citation #120011622.