AB 139 (Gatto) was recently signed by the Governor and became effective January 1, 2016. This new law allows for the transfer of real property on the death of its owner without a probate proceeding. The bill also provides 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 recovery. The new law creates a statutory form - the “SIMPLE Revocable Transfer on Death (TOD) Deed.” Unfortunately, there is nothing simple about this new law. Not only is it not simple, but it will surely complicate the lives of those it is aimed to assist, i.e., seniors who don't wish to pay or can't afford to pay attorneys fees who are looking for a cheap way to transfer their homes.

CANHR strongly opposed this bill - and similar bills over the years - as we believe it would not only make many elders even more susceptible to undue influence and elder abuse, but also subject many seniors to Medi-Cal estate recovery that could otherwise be avoided. Proposed as a low cost alternative for those seniors who cannot afford attorneys for trusts or other alternatives, the new law 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.”

It is important to note that thousands of California citizens who are 55 years of age or older and who have recently signed up for health care under California's Medi-Cal expansion program will now have their estates subject to Medi-Cal recovery when they die. If their homes were transferred before their deaths, transferred to an irrevocable trust or if they transferred the property and retained an irrevocable life estate (another cheap, but effective way to transfer property) there will be no estate claim on the home. But, because the TOD is revocable and the transfer of the property under a TOD does not occur until the death of the owner, these TODs are 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.

The new law also includes a provision requiring the California Law Revision Commission to report back to the Legislature by January 1, 2020 on the uses or misuses of the forms and include recommendations for changes. Unless the legislature acts otherwise, the law would sunset on January 1, 2021.

CANHR will be embarking on a campaign to educate consumers about the impact of this new law. For the text of the bill as passed, see http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB139

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CANHR News

CANHR Wins 2015 Gilbert Innovations in Alzheimer’s Award

California Advocates for Nursing Home Reform (CANHR) is among four nonprofit programs that has been awarded the 2015 Rosalinde Gilbert Innovations in Alzheimer’s Legacy Award. Each year, the Gilbert Foundation awards $20,000 each to programs that address the needs of Alzheimer’s Disease caregivers and their care recipients. This year, CANHR received the award for our efforts in the Campaign to End the Inappropriate Use of Psychotropic Drugs in Nursing Homes.

For years, CANHR has worked tirelessly to replace a “culture of drugging” within nursing homes. Nearly one-third of California’s nursing home residents with dementia still receive powerful antipsychotic drugs that are neither intended nor FDA-approved for their medical conditions. CANHR’s program seeks to eliminate the inappropriate use of antipsychotics, and replace drugging with person-centered, comfort-based care. We thank the Gilbert Foundation and the Family Caregiver Alliance for this recognition, and look forward to attending the award reception in March.

Support CANHR’s Media Campaign

CANHR is embarking on a statewide media campaign to highlight the problems with Medi-Cal recovery, nursing home quality of care and the enforcement system, as well the many problems in Residential Care Facilities for the Elderly in California. CANHR has been reaching out to consumers to tell real stories of abuse and neglect in long term care facilities and real stories of Medi-Cal recipients whose family members have suffered because of the punitive recovery system. In the case of the media, it is always helpful for journalists to contact real consumers in their geographical area and use their stories.

The Media Release form authorizes CANHR to release your name and contact information to interested media regarding the issues you indicate. No information will be provided to anyone unless a reporter is interested in doing a story on a specific subject. Once we receive the media release form, one of our staff will be contacting you to review.

If you are interested in being a part of CANHR’s 2016 media campaign, please contact us to get a copy of the media release form and return it to our office via scanned email or regular mail, or contact Pauline@canhr.org for a copy.

United Way Campaign Gearing Up

Keep an eye out for this year’s United Way Work Place Giving Campaign for 2016, coming soon to your work place. As a Certified Community Campaign Agency, California Advocates for Nursing Home Reform (CANHR) is 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.
California Court Prohibits Nursing Home Decisionmaking for Unrepresented Residents Due to Lack of Notice

The final judgment in CANHR v. Chapman has been issued, ending the practice of nursing homes making decisions – including whether to give mind-altering drugs and withdraw life-sustaining treatment - on behalf of “unrepresented” residents. The judgment prohibits the use of Health and Safety Code Section 1418.8, a 24 year old statute permitting nursing home staff members to make health care decisions for residents who lack capacity to make their own decisions and do not have a substitute decisionmaker. The court’s ruling follows its June 2015 decision that Section 1418.8 was unconstitutional because it lacks any requirements that nursing home residents be told critical decisions are being made for them. The court’s final judgment states “the use of Health and Safety Code section 1418.8 is prohibited” because it does not require residents be adequately notified in writing. The judgment also holds that section 1418.8 is prohibited for the administration of antipsychotic drugs and for withdrawing or withholding end-of-life care.

Nursing Home Industry and Legislature Team Up to Defeat AB 927 (McCarty)

AB 927 – The Nursing Home Ownership Disclosure Act of 2016 – died after its author, Assembly Member McCarty, pulled it on January 12, 2016 just prior to a scheduled hearing before the Assembly Health Committee. The bill, which was co-sponsored by CANHR and the San Diego County District Attorney’s Office, would have barred chain nursing home operators from acquiring more nursing homes under certain circumstances and made other reforms.

The bill was, of course, opposed by all of the nursing home industry providers. In the days before the scheduled hearing, Assembly Member Rob Bonta, the Chair of the Assembly Health Committee, insisted on amendments that would have gutted AB 927’s most critical provision. The amendment of greatest concern created an appeal system that would allow chain nursing home operators to bypass the bill’s most critical provision, which would have barred them from acquiring more nursing homes if they were subject to extreme sanctions, such as license revocation.

In so doing, the amendments would have preserved the status quo and allowed California nursing home operators with terrible track records to expand their operations and subject even larger numbers of California’s most vulnerable citizens to neglect, exploitation, abuse, suffering, misery and torturous deaths.

CANHR opposed the extraordinarily harmful amendments and, along with other supporters, urged the Health Committee to reject them. The bill was never heard and its greatly needed reforms are dead for now due to the nursing home industry’s strong grip on the Capitol.

California Hospital and Family Caregiver Act Takes Effect

On January 1, 2016, a new California law took effect that requires hospitals to identify a family caregiver and engage that person in discharge planning to help ensure that patients receive proper care when they return home. The law, SB 675 by Senator Carol Liu, is aimed at supporting family caregivers and ensuring that they are informed and consulted about discharge plans when a family member or friend is hospitalized.

Under the law, a hospital must: (1) record the name of a family caregiver identified by the patient; (2) notify the family caregiver as soon as possible if the patient is to be discharged to another facility or back home; and (3) provide an opportunity for the patient and her designated family caregiver to engage in the discharge planning process, which shall include providing information and instruction about the post-hospital care needs of the patient.

The law also requires hospital discharge planning policies to ensure that planning is appropriate to the condition of the patient being discharged and the discharge destination and meets the needs and acuity of patients.

The law defines “family caregiver” as a relative, friend or neighbor who provides unpaid assistance related to an underlying physical or mental disability.

CANHR is updating its fact sheet, Challenging Hospital Discharge Decisions, to include information on SB 675’s requirements.

California Court Refuses to Stop Sale of Keiro Long Term Care Facilities

On February 4, 2016, Judge Joanne O’Donnell denied an Ex Parte Application for a Temporary Restraining Order to stop the sale of four long term care facilities in the Los Angeles area owned by Keiro, a nonprofit senior healthcare
organization, to Pacifica, a for-profit real estate development company. The Application was brought by the Ad Hoc Committee to Save Keiro (AHC) against the California Attorney General. The AHC was represented by a pro bono legal team comprised of Bet Tzedek Legal Services and Gibson, Dunn and Crutcher, with assistance from CANHR and the Legal Aid Foundation of Los Angeles. The Judge also denied a Petition by the California Department of Fair Employment and Housing to stop the sale so that it could complete its investigation of discrimination claims against residents of the facilities as a result of the sale.

In California, the Attorney General must approve the sale of a nonprofit healthcare provider to a for-profit organization. In its Application, the AHC demonstrated that the Attorney General had abused her discretion in granting a waiver of the notice and consent requirements for the proposed sale without a public hearing or adequate consideration of the effects on Keiro’s unique Japanese American community, including potential degradations in healthcare services, changes in costs, impacts on employees and volunteers, and the future lack of Japanese culturally sensitive care. In spite of the ample demonstration of irreparable harm, the Court chose not to exercise her authority to postpone the sale.

In its press release, the AHC said that along with the Keiro residents, family members, employees and volunteers, it was disappointed by the ruling. “However, we will ensure that Keiro, Pacifica, Aspen and Northstar strictly adhere to the Attorney General’s conditions of the sale. Should any violations occur or there be any degradation in the quality of culturally-sensitive care promised, it will be the legal responsibility of the Attorney General to fully-enforce the conditions of the sale.”

Center for Medicare Advocacy Issues Alert on Illegal Medicare “Discharges” by Skilled Nursing Facilities

On January 13, 2016, the Center for Medicare Advocacy (CMA) published a terrific new alert on the discharge rights of skilled nursing facility residents. The alert warns against the increasingly common practice of skilled nursing facilities forcing out residents after Medicare-funded stays by misinforming them about Medicare decisions and their right to stay in the facilities. These illegal evictions have drawn national media attention because they trample on both Medicare and discharge rights of nursing home residents. The CMA alert puts it this way: “The truth is that when a SNF tells a beneficiary that he or she is “discharged,” (1) at that point, Medicare has not yet made any determination about coverage and (2) a resident cannot be evicted solely because Medicare will not pay for the stay.”


Kindred/Rehabcare to Pay $125 Million to Resolve False Claims Act Allegations

The U.S. Department of Justice announced on January 12, 2016 that it settled a False Claims Act case against contract therapy providers RehabCare Group Inc., RehabCare Group East Inc. and their parent, Kindred Healthcare Inc., which will pay $125 million to resolve allegations they knowingly causing skilled nursing facilities to submit false claims to Medicare for rehabilitation therapy services that were not reasonable, necessary and skilled, or that never occurred.

According to the Department of Justice, RehabCare is the nation’s largest nursing home therapy provider, contracting with more than 1,000 skilled nursing facilities in 44 states to provide rehabilitation therapy services to their patients.

The government alleged that RehabCare and its nursing facility customers engaged in a systematic and broad-ranging scheme to increase profits by delivering, or purporting to deliver, therapy in a manner that was focused on increasing Medicare reimbursement rather than on the clinical needs of patients.

The press release states that the settlement shows the government’s emphasis on combating health care fraud. While this may be true, this case also illustrates that some nursing home chains and their affiliates continue to game and loot the Medicare system through systemic fraud.

The Department of Justice’s press release is posted at: http://www.justice.gov/opa/pr/nation-s-largest-nursing-home-therapy-provider-kindredrehabcare-pay-125-million-resolve-false
**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. SB 33 is co-sponsored by Western Center on Law and Poverty. **Status:** SB 33 is pending in Assembly Appropriations.

**SB 924 (Roth): Insurance: Annuity Transactions**

Under existing law insurance companies must comply with specific requirements regarding the purchase, exchange, or replacement of an annuity recommended to a senior consumer. The insurance company must have reasonable grounds to believe that the annuity transaction would be suitable for the senior based on certain information including: age, annual income, and whether the consumer has a reverse mortgage. This bill would add the requirement that an insurance company ascertain whether the purchase of an annuity is connected to an attempt to qualify for a government benefit. If a senior is trying to qualify for a government benefit, then the insurance company must determine whether or not it is a suitable transaction. **Status:** SB 924 has been referred to the Senate Committee on Insurance.

**SB 938 (Jackson): Protective proceedings: conservator authorizations**

This bill would help ensure appropriate care for people with dementia who are conserved. It requires greater detail from a conservatee’s treating health care provider to demonstrate that a proposed psychotropic drug prescription is appropriate and the least intrusive treatment alternative before a court can approve the use of psychotropic drugs for a conservatee with dementia. The bill also updates the definition of dementia to reflect the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) classification of “major neurocognitive disorders.” **Status:** SB 938 has been referred to the Senate Judiciary Committee.

**CANHR Support**

**AB 1655 (Dodd): Medi-Cal: personal needs allowance**

This bill would increase the personal needs allowance for Medi-Cal beneficiaries in skilled nursing facilities from $35 to $80 per month, and would require the department to annually increase this amount based on the percentage increase in the California Consumer Price Index. **Status:** Referred to Assembly Committee on Health.

**SB 939 (Monning):** 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:** Senate Human Services

**Oppose**

**AB 1779 (Gatto): Nonprobate transfers: revocable transfer on death deed**

Existing law creates the revocable transfer on death deed (revocable TOD deed), which can transfer real property on the death of its owner without a probate proceeding. AB 1779 would clarify that a beneficiary of a TOD may include an entity such as a trust. CANHR oppose the TOD, which is an instrument that will likely make many elders even more susceptible to undue influence and elder abuse. These deeds are subject to estate recovery, which means that the low-income elders who are likely to execute TODs in lieu of hiring an attorney, will also be more likely to be on Medi-Cal and thus subject their estates to recovery. CANHR opposes this bill unless amended to specifically exclude TODs from the beneficiary’s recoverable estate. **Status:** SB 1779 has been referred to the Assembly Judiciary Committee.

For details on specific bills, go to: www.leginfo.ca.gov.

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**Legislation Update 2016**

CANHR is sponsoring, supporting and/or closely following the following pieces of legislation this session. Since it is still early in the new session, not all bills have been introduced. Please check www.canhr.org for updated details on legislation, and www.leginfo.ca.gov for information of specific bills.
**Did You Know?**

Medi-Cal offers alternatives to nursing homes that also allow the spouse to keep some of the assets and income.

Home and Community Based Services (HCBS) are designed for seniors who want to stay at home or within their community and who are at high risk for nursing home placement. Under California law, Spousal Impoverishment protections allow the spouse of the HCBS beneficiary to retain assets, i.e., a community resource allowance (CSRA) of up to $119,220 and income – a maximum monthly maintenance needs allowance (MMMNA) of $2,981. These amounts are adjusted annually by a cost of living increase.

When one spouse in a married couple applies for Medi-Cal and indicates on the application that they would like to apply for HCBS, spousal impoverishment protections will be applied upon approval into the program. The HCBS program must work concurrently with the Medi-Cal eligibility worker during the application process to ensure spousal impoverishment is applied.

These programs can be a great alternative to institutionalization and allow access to some couples who would not otherwise be eligible for “community-based” Medi-Cal because of strict asset and income limits; however the areas of service available are limited by county and sometimes by zip code, and some programs may have waiting lists of up to two years.

Call to find out more about these programs or click the links below:

- All Inclusive Care for the Elderly (PACE) Phone: (916) 552-9105
- Assisted Living Waiver (ALW) Phone: 916-552-9105
- Multipurpose Senior Services Program (MSSP) Phone: 800-510-2020

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**Dear Advocate,**

I am 80 years old, and have been on Medi-Cal for 20 years. Thankfully, I have been relatively healthy, but Medi-Cal did pay for one hospital stay and for my doctor visits and prescriptions. I understand that Medi-Cal will make a claim against my estate after I pass away for the amount of money it spent on my behalf. Is there any way that I can find out in advance the amount of the Medi-Cal claim?

Sincerely,

Concerned in Cleveland

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Dear Concerned in Cleveland,

One of the most frequent complaints from Medi-Cal recipients has been the inability to find out exactly how much in benefits have been paid on their behalf. The state agency in charge of the Medi-Cal program, the Department of Health Care Services (DHCS), has created a new form to enable Medi-Cal recipients or their legally authorized representatives to request a record of Medi-Cal payments that may be subject to estate recovery in the future.

To obtain the information, you must complete and submit the “Request for Medi-Cal Expenses Subject to Estate Recovery” form (DHCS 4017) with the required documentation and a $25 processing fee to the address listed on the form.

For more information regarding DHCS 4017, see [http://www.dhcs.ca.gov/services/Pages/DHCS_4017.aspx](http://www.dhcs.ca.gov/services/Pages/DHCS_4017.aspx).

Dear Advocate................................. (continued on page 9)
Over the last several decades, CANHR has received numerous calls from individuals who tell heart wrenching stories of terrible things that have happened to their loved ones in nursing homes, expressing their frustration at the system and demanding that someone be held accountable. We hear over and over again that they just don’t want this to happen to anyone else’s loved one and they look to CANHR to advocate on their behalf. We at CANHR do what we can and we are constantly striving to do more.

As a non-profit 501(c) (3) advocacy organization, CANHR’s survival depends on grants, donations, and memberships. In our continuing efforts to expand our advocacy, we have built a network of experienced elder abuse litigators who pursue cases on behalf of residents who have been neglected or abused in institutions. Within this network is a band of attorneys who have committed to donating a small fraction of the fees they receive in case settlements involving abuse and neglect.

These attorneys are CANHR’s “Elder Justice Advocates.” CANHR’S Elder Justice Advocate attorneys don’t just commit to making donations - they also encourage their clients to contribute to CANHR to help in our mission to speak for those who cannot speak for themselves. Consumers are under no obligation to participate and participation has no bearing on our or the attorney’s efforts on their behalf. CANHR’s mission is to improve the lives of all residents.

Over the past several years, we have seen this voluntary program grow to where it is now one of the pillars of CANHR’s financial stability. The fact that so many attorneys and their clients are willing to participate and donate is a wonderful comfort. It is gratifying to know that CANHR’s work is valued. The Elder Justice Advocates are CANHR’s super heroes.

How the Elder Justice Advocates Programs Works

At the acceptance of a case, the Elder Justice Advocates attorneys and their clients agree to contribute a small portion (no more than 2%) of any settlement received.

A typical settlement agreement between the attorneys and their clients is a sixty / forty split.

For example, if the net settlement in a case was $100,000.00, and the donation to CANHR was 2% of the settlement, then CANHR would receive $2,000: $1,200 from the client and $800 from the attorney.

The contributions received are used for CANHR’s elder abuse prevention programs.

All donations are tax deductible. For more about CANHR, please visit www.canhr.org.
CANHR on the Move...

Past Speaking Engagements, Panel Discussions and Training Sessions

- **January 13:** Staff Attorney Tony Chicotel spoke to the Trial Practice students at Golden Gate University Law School about interviewing techniques for clients with cognitive disabilities.

- **January 20:** Pauline Mosher presented at the Palo Alto Medical Foundation, Long Term Care Preparedness Seminar on Medi-Cal and Medi-Cal recovery.

- **January 19:** Pauline Mosher, spoke about Long Term Care and Payment Options to the residents at the Eastern Park Apartments in San Francisco. Simultaneous translations services were available in Chinese and Russian for the 75 residents in attendance.

- **January 23:** Prescott Cole spoke at the Institute on Aging in San Francisco on “Exposing the Elder Financial Abuse and Exploitation Epidemic.”

- **January 27, 2015:** Staff Attorney Prescott Cole participated on a conference call with the NAPSA Financial Elder Abuse Advisory Board.

- **January 29:** Pauline Mosher spoke to a group of Geriatrics Fellows at UCSF about CANHR services, resident’s rights, and transfer and discharge rights.

- **February 3:** Efrain Gutierrez hosted an information table at the Theresa Lindsay Senior Center.

- **February 4:** Staff Attorney Prescott Cole made a presentation on Long Term Care and how to navigate senior living options at the Jewish Family Services, San Francisco.

- **February 8:** Staff Attorney Prescott Cole made a presentation on Long Term Care and financial elder abuse at the monthly meeting of the East Bay Estate Planning Counsel.

- **February 17:** Efrain Gutierrez visited Kaiser in Pasadena for outreach to Social Workers on CANHR services.

- **February 18:** Tony Chicotel spoke to the Contra Costa County Nursing Home Task Force about decision-making for unrepresented residents of nursing homes.

- **February 19:** Staff Attorney Jody Spiegel and Long Term Care Advocate Julie Pollock attend the RCFE Advocates Quarterly Meeting with Community Care Licensing in Sacramento.

Eastern Park Apartment residents attended Pauline Mosher’s presentation on Long Term Care and Payment Options on January 19th, 2016.

CANHR Up Coming Events

**April 22: Los Angeles: CANHR Social Worker Long Term Care Medi-Cal Training**

For social workers and discharge planners, the training will review the eligibility requirements for Long Term Care Medi-Cal and community based Medi-Cal. It will also address Medi-Cal Recovery issues, and will include a walkthrough of the new Medi-Cal application.

10:00am-1:00pm at the Magnolia Place Family Center, 1910 Magnolia Ave., Los Angeles, CA 90007. Participants are eligible for 3.0 hours of CEU credits – Board of Behavioral Sciences. Fee: $30

For more information, please contact Pauline Mosher at pauline@canhr.org or at (414) 974-5171.
Two of the features that make Continuing Care Retirement Communities unique in the long-term care world are the continuum of services provided, from independent living to skilled nursing care, and the enormous entrance fees paid by residents when they move in. These two features go hand-in-hand: the CCRC promises to provide care despite the level of care or services needed and the resident pays handsomely for that promise. Entrance fees are typically hundreds of thousands of dollars and often represent most of or the entire net worth of the residents.

When residents of CCRCs pass away, refunds of the entrance fees can become a source of frustration and anger for their heirs. CCRCs differ, often significantly, on how they handle refunds in the contracts they sign with the residents. Residents and, more importantly, prospective residents, of CCRCs should carefully read and understand refund provisions and consider them when choosing a CCRC.

A common CCRC entrance fee refund structure uses a declining scale: e.g., 90% refund if the resident moves out or passes away in the first six months, 75% in the next six months, 50% in the second year, etc. Other arrangements may offer a full refund or no refund at all. Obviously, the ability of a resident or their heirs to receive a refund is an important feature of a CCRC contract.

Aside from the availability or size of entrance fee refunds, another issue is the timing. Refunds are often contingent on the resident’s unit in the CCRC being re-sold or re-occupied by a new resident. This contingency can lead to problems. Heirs of former CCRC residents complain that the CCRC does not work hard enough to market the unit and re-sell it or that the CCRC places units with a refund attached at the bottom of the list of available units when selling them. The heirs may have to wait years until the unit is re-sold and the refund is received, with no interest accrued.

Last year, Senator Bill Monning authored SB 475, legislation intended to give CCRC residents and their heirs partial refunds regardless of whether units are re-sold, interest on refunds, and more assurances that the CCRCs are making good faith efforts to re-sell units. Senator Monning stated the bill would “level the playing field” for CCRC residents. Unfortunately, the bill was vetoed by Governor Brown who cited reluctance to “change the terms” of CCRC contracts and to engage the Department of Social Services in “contract disputes.” Senator Monning has re-introduced the bill this year as SB 939.

Hopefully Senator Monning will have success in leveling the playing field for CCRC residents regarding entrance fee refunds. Regardless of whether SB 939 passes, residents, their family members, and their advisors should choose CCRCs carefully and review and compare all the contractual terms, especially refund provisions. If a contract makes refunds conditional to re-selling the unit, residents should understand that their refundable entrance fees (possibly the biggest asset for their heirs) may be held up for years in acrimonious suspense.

(For more information on CCRCs in California see CANHR’s CCRC web page at http://www.canhr.org/CCRC/)

Dear Advocate..........................(continued from page 6)

After a Medi-Cal recipient dies, State and Federal laws allow the state to seek repayment for the cost of services received. For more information on Medi-Cal Recovery, see CANHR’s updated publication “Medi-Cal Recovery: What you Need to Know and How to Avoid it.” The publication is available in English, Spanish, and Chinese. Click the link for free download: http://www.canhr.org/medcal/medcal_recoveryinfo.htm.

At this time, the best way to avoid recovery is to have nothing in the Medi-Cal beneficiary’s name at the time of death. Since an outright transfer can have tax and other consequences, this is not generally recommended. However, there are several alternatives, such as grant deeds with occupancy agreements or irrevocable life estates, that can avoid recovery, avoid probate, avoid tax consequences and still leave the beneficiary with the right to live in the home. Any such transactions should always be discussed with a qualified estate planning attorney.

If you need an attorney, CANHR has a statewide, state bar-certified referral service for attorneys specializing in estate planning for long term care. For more information, call CANHR at 800-474-1116.
CANHR welcomes memorial and honorary gifts. This is a great way to honor a special person or a loved one who has been a nursing home resident, while helping those who are nursing home residents. Recent gifts have been made in the names of the following persons:

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<tr>
<th>Name</th>
<th>Memorial/Handyman</th>
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<td>Mary Fitzgerald Aubrey</td>
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<td>Mary W. Ballantyne</td>
<td>From Robert Peterson</td>
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<td>Isabel Brown</td>
<td>From Barbara Brown Johnson</td>
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<td>Helen M. Brucia</td>
<td>From Larry Ross</td>
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<td>Betty Camfield</td>
<td>From Mr. Lee Camfield</td>
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<td>Mrs. Cele Charnow</td>
<td>From James Branson</td>
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<td>From Ronald Lozano</td>
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<td>From Jeannette Santage</td>
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<td>From Dan Putman &amp; Kathy Williams</td>
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<td>Don and Jeannette Montgomery</td>
<td>From Katherine Montgomery</td>
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<td>Theodore (Ted) Muller</td>
<td>From Helen Drachkovitch &amp; N. Sault</td>
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<td>Patrick Nobis</td>
<td>From Carole Nobis</td>
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<td>From Anne Brooks</td>
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<td>Martha L. Pauly</td>
<td>From John Pauly</td>
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<td>Franklin &amp; Rosita Pennill</td>
<td>From Lee Pennill</td>
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<td>From Lynn Dunn</td>
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<td>Denis J. Powell</td>
<td>From Argene R. Powell</td>
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<td>John Reisbig, 1918-2016</td>
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<td>From Barbara B. Riley</td>
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<td>Larry Roth</td>
<td>From Penny Deleray Taylor</td>
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<tr>
<td>Esme Springer</td>
<td>From Alan Springer</td>
</tr>
<tr>
<td>Burton Sukhov</td>
<td>From Amy Sukhov</td>
</tr>
<tr>
<td>Don &amp; Eunice Stuart</td>
<td>From Ms. Kathleen Stuart</td>
</tr>
<tr>
<td>William F. Taylor</td>
<td>From Martha Taylor</td>
</tr>
<tr>
<td>Rita Twomey My Beloved Mother</td>
<td>From Denise Twomey</td>
</tr>
<tr>
<td>Helen C. Wu</td>
<td>From Lang Ju Chen</td>
</tr>
<tr>
<td>Helen C. Wu</td>
<td>From Li Chen</td>
</tr>
<tr>
<td>Helen C. Wu</td>
<td>From Olive Chen</td>
</tr>
</tbody>
</table>
CANHR welcomes memorial and honorary gifts. This is a great way to honor a special person or a loved one who has been a nursing home resident, while helping those who are nursing home residents. Recent gifts have been made in the names of the following persons:

**IN HONOR OF**

- Sharon Berry  
  *From Donna Ambrogi*

- Richard M. Frost  
  *From Robert Frost*

- Felicia Curran, Joe Earley and Ruth Gamba  
  *From Cristina Flores*

- Mary Gerber  
  *From Janette Tom*

- Mrs. Sabita Goswami  
  *From Subrata Goswami*

- In Honor of my mother, Marion S. John  
  *From George John*

- Gloria Katz  
  *From Naomi Katz*

- Eleanor Lowry  
  *From Kathryn Del Pino*

- Pat McGinnis  
  *From David Ishida*

- Patti S. Medlin  
  *From Michael D. Medlin*

- Meg & Dick O’Malley  
  *From Suzanne Reed*

- Mike, Tony, Janet, and Pat  
  *From Toby Edelman*

- Dr. Nicholas Petrakis  
  *From Elizabeth Boileau*

- Jane Schuman  
  *From Melinda Rieboldt*

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- Join a statewide network of informed and concerned consumers, caregivers, and advocates.
- Receive our quarterly newsletter, The Advocate, which includes important long term care information and a detailed report of citations issued against individual nursing homes.
- Receive periodic updates on important legislation.

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

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(or in honor of: ________________________________________________________________

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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 issue of the Advocate. CANHR makes every effort to ensure 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 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](http://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.

<table>
<thead>
<tr>
<th>Humboldt County</th>
<th>Jerold Phelps Community Hospital D/P SNF</th>
<th>733 Cedar St, Garberville</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> $20000</td>
<td>Careplan 10/22/2015</td>
<td>A male resident with health conditions that led to significant choking risks, died after choking on food on 12/6/14. The resident had at least three prior choking incidents in 2014, including at least two that required the Heimlich maneuver. On 11/12/14 doctor’s order for a swallow evaluation was not implemented. The facility was cited for failing to review and revise its careplan related to the resident’s swallowing problems which led to the resident’s death due to aspiration. Citation # 110011473.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Seaview Rehabilitation &amp; Wellness Center, LP</th>
<th>6400 Purdue Dr, Eureka</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B</strong> $20000</td>
<td>Mandated Reporting Patient Care Sexual Abuse 09/09/2015</td>
</tr>
<tr>
<td>Seaview Rehabilitation &amp; Wellness Center failed to report an allegation of physical abuse to the Department of Public Health, State Licensing and Certification agency within 24 hours of the incident. In the report, Resident 1 stated that an Unlicensed staff B touched her breasts inappropriately during a shower. The reported abuse caused psychological stress to the resident. Citation # 110011594.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Lake County</th>
<th>Rocky Point Care Center</th>
<th>625 16th. Street, Lakeport</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B</strong> $20000</td>
<td>Mental Abuse Patient Care Verbal Abuse 08/11/2015</td>
<td></td>
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<tr>
<td>The facility failed to ensure Resident 1’s right to be free from verbal abuse when a certified nursing assistant (Staff A) used derogatory language toward Resident 1. This subjected Resident 1 to verbal abuse and psychosocial distress. Resident 1 stated the incident made him feel, “not very good.” Citation # 110011542.</td>
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<thead>
<tr>
<th>Marin County</th>
<th>The Redwoods, a Community of Seniors</th>
<th>40 Camino Alto, Mill Valley</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> $20000</td>
<td>Fall 08/27/2015</td>
<td>A 93 year old female resident with a high risk of falls, fell from her wheelchair while being pushed on 8/10/13. She suffered a broken neck and died six days later. The resident's careplan called for foot rests and a wedge cushion to prevent falls but neither were used on the day of the fall. The facility was cited for failing to implement the resident's careplan which contributed to her fall and death. Citation # 110011426.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Napa County</th>
<th>Napa Valley Care Center</th>
<th>3275 Villa Lane, Napa</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B</strong> $2000</td>
<td>Infection Patient Care 10/27/2015</td>
<td></td>
</tr>
<tr>
<td>Between 1/1/15 and 5/14/15, 23 residents tested positive for C diff (a bacterial infection that causes severe diarrhea) and one resident had been treated for nine urinary tract infections in that same time period. The facility was cited for failure to implement infection control policy; care plan or report the recurring urinary tract infection and, disinfect rooms and surfaces contaminated by C diff. Citation # 110011771.</td>
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<table>
<thead>
<tr>
<th>Santa Clara County</th>
<th>San Jose Healthcare &amp; Wellness Center</th>
<th>75 N. 13th Street, San Jose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B</strong> $2000</td>
<td>Elopement 11/13/2015</td>
<td></td>
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<tr>
<td>On October 7, 2015, a resident with dementia was assessed for risk of elopement and wandering, left the facility in her wheelchair by herself, and was hit by a car in the facility’s back parking lot. The resident sustained abrasions and skin tears to the right temporal area, right elbow and right hand. The resident’s care plan dated April 29, 2015, indicated that she loved to go to the back parking lot to enjoy fresh air which was not safe due to her cognitive deficit. As a result, a WanderGuard was obtained for her safety. Nursing staff were to check for placement and function every shift. The facility was cited for failing to provide adequate supervision and a well-functioning WanderGuard. Citation # 070011840.</td>
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<thead>
<tr>
<th>Sonoma County</th>
<th>Sonoma Valley Hospital D/P SNF</th>
<th>347 Andrieux St, Sonoma</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> $20000</td>
<td>Careplan Fall Patient Care Supervision 08/25/2015</td>
<td></td>
</tr>
<tr>
<td>Sonoma Valley Hospital violated Resident 1’s Fall Risk Evaluation by failing to provide adequate supervision for Resident 1 who was left alone in the bathroom. Resident 1 got up unassisted and fell. The fall resulted in a right hip fracture which required surgical repair. Citation # 110011509.</td>
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</table>
### Fresno County

**Horizon Health And Subacute Center**  
3034 East Herndon / 2020 North Weber Avenue, Fresno  

<table>
<thead>
<tr>
<th>Citation #</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>120011910</td>
<td>A female resident fell to the ground outside of the facility while unattended in her wheelchair on 6/14/15. The resident exited through an exit patio door in her wheelchair and due to unlevel ground on the side walk the wheel of the chair tipped over the edge of the side walk, causing the resident to fall to the ground with her wheelchair. Due to the fall the resident suffered a fractured left arm. A call light and audible alarm system was not present on the patio doors prior to the resident's fall. The facility failed to identify residents who are at risk of falling and to prevent accidents by providing an environment free from hazards. Citation # 040011885.</td>
</tr>
</tbody>
</table>

**NorthPointe Healthcare Centre**  
668 E. Bullard Ave, Fresno  

<table>
<thead>
<tr>
<th>Citation #</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>120011910</td>
<td>On September 2, 2015, a resident with a pressure ulcer, and a swallowing disorder requiring a pureed diet, was transferred to a board and care facility. On September 3, the resident exhibited signs of choking and was transferred from the board and care to the hospital emergency department, and subsequently transferred to a skilled nursing facility. The facility was cited for failing to allow the resident to remain in the facility, to provide medical justification for transfer to a lower level of care, and to prevent an unsafe transfer and discharge when the resident needed skilled nursing care for his swallowing disorder and a pressure ulcer. Citation # 040011866.</td>
</tr>
</tbody>
</table>

### Kern County

**Evergreen Bakersfield Post Acute Care**  
6212 Tudor Way, Bakersfield  

<table>
<thead>
<tr>
<th>Citation #</th>
<th>Description</th>
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<tbody>
<tr>
<td>120011910</td>
<td>On 10/3/15, a 92 year old female was transferred to the hospital after a fall from her bed. The resident's daughter believed the resident may have fallen while a staff member was turning her, and reported the incident of alleged abuse to the hospital staff herself. The facility was cited for failure to report the incident of suspected abuse to the Department. Citation # 120011795.</td>
</tr>
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</table>

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

<table>
<thead>
<tr>
<th>Citation #</th>
<th>Description</th>
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<tbody>
<tr>
<td>120011910</td>
<td>On 10/29/15, a 74 year old female resident was subject to verbal abuse by a CNA, in the presence of the resident's family member. The CNA put her face directly in front of the resident's face and began yelling, intimidating the resident. The facility was cited for failure to prevent abuse. Citation # 120011910.</td>
</tr>
</tbody>
</table>
Ridgecrest Regional Transitional Care and Rehabilitation Unit
1081 N China Lake Blvd, Ridgecrest
A $20000  12/28/2015
On 10/22/2015, The resident fell from the wrong lift and fractured her shoulder. The facility failed to use adequate mechanical lift and personnel required to transfer the resident from chair to bed when the CNA decided to transfer the resident alone using the wrong mechanical lift. Citation # 120011906.

The Rehabilitation Center Of Bakersfield
2211 Mount Vernon Avenue, Bakersfield
B $2000  Careplan Dietary Services Nutrition Patient Care  12/17/2015
The facility was fined for failing to appropriately address resident's significant weight loss in a timely manner. This resulted in the resident losing additional weight which had the potential for a decline in the health and wellness of the resident. Citation # 120011906.

Allen Care Convalescent Hospital Corporation
201 Allen Ave., Glendale
B $2000  Bed Hold  10/31/2015
On 8/26/15, a resident who had schizophrenia and behavioral symptoms that included episodes of agitation and physical aggression towards residents was sent to the hospital for an evaluation. On 9/4/15, the hospital declared that she was ready for discharge back to the facility. The facility refused to readmit her. The resident had to remain in the hospital and was upset because she wanted to go back to the facility. On 9/14/15, a Refusal to Readmit Appeal was conducted where it was determined that the facility failed to give the required written bed-hold notice and readmit the resident. Citation # 920011918.

Los Angeles County

Bay Crest Care Center
3750 Garnet Avenue, Torrance
B $1000  Physical Environment  12/24/2015
On 9/14/15, the facility was cited for failing to provide comfortable and safe temperature levels between 71-81 degrees. The ambient temperature in the area including the entrance lounge, nursing station and six resident rooms ranged from 82-83 degrees, placing the residents at risk of heat exhaustion and hydration. The maintenance supervisor stated that the facility had been waiting a couple of years for a replacement air conditioning unit. Citation # 910011918.

Brentwood Health Care Center
1321 Franklin Street, Santa Monica
B $ Bed Hold  12/24/2015
On 9/17/15, a Psychiatric Emergency Team was called to transport a resident to the hospital for psychiatric evaluation. Prior to the call, the resident had been screaming in the hallway because he hadn't been served a hot dog at dinner, yelling about his new roommate, and had been verbally abusive to others, including staff and visitors. On 9/21 the hospital determined that he was stable and doing well and ready to be discharged back to the nursing home. The facility administrator did not feel readmission appropriate. The resident subsequently was discharged to an alternate facility which upset the resident. The facility was cited for failing to provide the resident with the proper bed-hold notification upon being transferred to the hospital. Citation # 910011924.

Brookfield Healthcare Center
9300 Telegraph Rd., Downey
B $2000  Elopement Notification Other Patient Care Security Supervision  10/30/2015
On 7/18/2014, a non-ambulatory resident went missing for three days after he requested his debit card to go shopping. During this time, his whereabouts were unknown and he went without needed medications, food and supervision. The police returned him to the facility on 7/21/2014 after finding him wandering around another local city. The facility was cited for failing to: supervise the resident after he reported he was going shopping; have a physician's order to go out on pass; and report the missing resident to the Department of Public Health. Citation # 940011766.

Burbank Healthcare And Rehabilitation Center
1041 S Main St, Burbank
A $10000  Fall  12/22/2015

On 9/14/15, a Refusal to Readmit Appeal was conducted where the MS stated that the doors were broken and needed to be fixed. He stated that he was in the process of changing the door frames and "tore the door down" the day before the elopement. A test of the facility security was conducted where the MS exited a door that was supposed to be alarmed and waited seven minutes to see if facility staff would respond to the alarm. There was no response from staff. The investigation noted that the facility's list of residents noted residents with dementia, some requiring Wanderguard bracelets, two of the residents were assessed as high risk for wandering out of the facility and seven were at high risk for eloping. The facility was cited for failing to provide adequate supervision and a secure environment. Citation # 920011721.
On 7/29/15, a resident, with poor balance, poor safety awareness, a history of falls, and in need of extensive assistance with transfers, toilet use and personal hygiene was wheeled into a bathroom and left unattended for several minutes. The resident was found lying on the bathroom floor by a visiting hospice nurse. The fall fractured the resident's back. The facility was cited for failure to ensure that the resident was supervised and assisted while sitting on the toilet. Citation # 920011898.

Colonial Gardens Nursing Home
7246 S Rosemead Blvd, Pico Rivera
AA $100000 10/15/2015
A 76 year old female resident choked on an uncut hot dog and died on 4/22/14. The resident had Parkinson's disease, required supervision with eating and was missing half of her teeth. She also had a tendency to eat her food very quickly unless told to slow down. Despite that, the facility did not monitor the resident's diet or ability to chew her food. On 4/22/14, another resident alerted two CNAs that the resident was choking in the dining room. Staff members were not able to dislodge the food. The facility was cited for failing to: provide food the resident could eat and chew without difficulty, provide adequate supervision during dining, and call 911 immediately after the resident started choking. Citation # 940011712.

Country Villa South Convalescent Center
3515 Overland Ave, Los Angeles
A $180000 Careplan Medication Notification Patient Care Patient Records 02/26/2015
On 1/29/12, a 75-year-old resident died hanging from a rod in a closet in his room. Based on his interview and record review, the resident verbalized he was depressed upon his initial admission assessment. Prior to his death, the Nursing Admission Assessment indicated under the narrative notes that the patient stated he was depressed and he needed someone to talk to. The physician's order indicated Librium for alcohol withdrawal, and Ativan for anxiety. The facility policy and procedure is to ensure that when a patient displays mental or psycho-social adjustment difficulties, the resident receives appropriate treatment and services to correct the identified problems in order to obtain or maintain the highest practicable physical, mental, and psycho-social well-being. The facility failed to ensure the resident, who verbalized he was depressed upon initial admission assessment, was continuously monitored for signs and symptoms of depression, and referred to a behavioral specialist to identify his level of depression. Citation # 910011225.

Country Villa Terrace Nursing Center
6070 West Pico Blvd, Los Angeles
AA $80000 Patient Care 02/26/2015
A resident with a jejunum ("j-tube") feeding tube died from an intestinal blockage due to leakage from the tube. On 1/15/12, the resident pulled out her feeding tube. Two nurses replaced the tube with an indwelling catheter tube with a balloon. Balloons are used in gastrostomy ("g-tubes") to help secure placement but was not needed in the resident's jejunum site. The balloon was overinflated, causing an intestinal blockage. No physician was notified of the tube change and reinsertion. The resident began vomiting bile on 1/16/12 and was hospitalized. She developed pneumonia from aspirating the bile and died on 1/24/12. Citation # 910011245.

Goldstar Healthcare Center of Inglewood
515 Centinela Ave., Inglewood
B $18000 Patient Care Patient Rights Transfer 11/04/2015
The facility was cited for failing to readmit Resident 12, on two separate occasions; September 30, 2014, and October 3, 2014, when an attempt was made to have her readmitted to the facility. This resulted in resident 12 being transferred from general acute care hospital (GACH) 1 to GACH 2 unnecessarily, placing the resident in a community where access to the resident was inconvenient for the resident's responsible party. Citation # 910011657.

Holiday Manor Care Center
20554 Roscoe Blvd, Canoga Park
AA $100000 Careplan Fall Patient Care Patient Rights 12/01/2015
On 9/8/14, a female resident fell in her room near her bed, sustaining a head injury. She was found moaning on the floor in the seated position. She later developed an intracranial hemorrhage (bleeding in the brain), and died on 9/17/14. The immediate cause of death was blunt force head trauma. The resident was considered high risk for falls/ injuries due to her diagnoses of dementia, psychosis, anxiety, and depression. She was prescribed psychotropic medications due to psychosis. The nurse that found her on the floor stated that the resident routinely went to the bathroom by herself unassisted. Another CNA explained that the CNAs were to document the level of assistance provided and her mobility status, but the forms were incomplete. The facility failed to ensure the resident was monitored for unassisted transfers and walking, ensure the nursing staff was aware of her assistance requirements, implement and reevaluate the plan of care when needed, and implement the facility's policy and procedure on Falls, Risk for and Actual Fall. Citation # 920011776.

Imperial Crest Health Care Center
11834 Inglewood Ave, Hawthorne
B $2000 Administration Bed Hold Transfer 05/26/2015
A male resident was living at a Board and Care prior to admission to the SNF on November 29, 2012. On December 4th it was discovered that he had a right hip fracture. On December 10, 2012, a resident was ready to leave the General Acute Care Hospital following surgical repair of the right hip. The facility refused to accept the resident's return after a 7-day bed hold. The facility failed to follow its policy regarding the seven-day bed hold. The facility failed to re-admit the resident to the facility within the seven-day bed hold, after receiving treatment at the GACH. Citation # 910011505.
On 4/10/15 around 4 p.m., a male resident and female resident were observed in a hallway and appeared to be separating from each other. The male resident appeared to be zipping his pants up. A CNA that witnessed the two mentioned the female resident had tears running down her face. This incident was not reported to the Department of Public Health immediately or within 24 hours of the incident. The facility failed to report an allegation of sexual abuse in a timely manner. Citation # 940011958.

Joyce Eisenberg Keefer Medical Center

7150 Tampa Ave., Reseda
B $2000 Patient Care Patient Rights Supervision 10/16/2015

The facility was cited for failure to protect a resident with severe cognitive impairment from abuse after the private companion of another resident slapped her on the hand, causing a bruise. Citation # 930011726.

Lakewood Healthcare Center

12023 S. Lakewood Blvd, Downey
B $2000 Mandated Reporting Physical Abuse 10/02/2015

On 5/9/14, a resident called the police and reported that he had been physically assaulted by someone in his room with a hammer. The police reportedly did not substantiate the allegation. In the following days, the resident continued to report he had been assaulted but the facility did not report the alleged abuse to the Department of Public Health within 24 hours or investigate the alleged abuse immediately. Citation # 940011768.

Lighthouse Healthcare Center

2222 Santa Ana Blvd, Los Angeles
B $2000 Physical Abuse 12/02/2015

On 5/17/15, two CNAs dragged a 67 year old resident by her legs from the dining room after she became agitated, knocked trays off the table and fell to the floor. As a result of the fall and subsequent pulling and dragging on the floor by nursing staff, the resident sustained a skin tear to her left forearm requiring treatment. The facility was cited for failing to ensure that the resident was free from physical abuse, and failing to follow its policy regarding combative and agitated residents. Citation # 940011876.

Marina Care Center

5240 Sepulveda Blvd, Culver City
B $1800 Mandated Reporting Physical Abuse 10/30/2015

On 7/5/2015, a 76 year old resident suffered bruising to both arms and hands, which she reported was caused when a nursing assistant grabbed her very hard after the resident asked her to come back later to weigh her. The facility was cited because it failed to suspend the perpetrator pending the investigation results. The facility did not conduct a thorough investigation, did not report the incident to the Department of Public Health and failed to ensure that the resident was cared for gently. Citation # 910011809.

Motion Picture & Television Hospital D/P SNF

23388 Mulholland Dr., Woodland Hills
A $20000 Fall Injury 9/24/2015

Due to lack of proper supervision, a resident of the facility suffered injuries in two falls from his wheelchair. On 4/10/10, the resident wheeled himself out of the activity room patio door, went through an unlocked gate and fell off a curb into the street. The resident suffered a closed head injury, cuts to his face and knees, and a facial laceration above his left eye. The second fall took place on 11/16/2010 when the resident wheeled himself through the doors leading to an emergency exit stairwell and fell down the staircase, landing on his face. The stairway door was not equipped with a door alarm. He sustained a broken nose, subdural hematoma and facial lacerations that were treated at a local hospital. The resident's care plan called for a wheelchair alarm that was not in use at the time of either fall. The facility was cited because it failed to provide close supervision and a safe environment. Citation # 930011723.

Mountain View Convalescent Hospital

13333 Fenton Avenue, Sylmar
B $2000 Medication 11/12/2015

On 7/17/15, the Department received a complaint that the facility was giving a resident blood thinner medication without properly monitoring for adverse effects of the medication. This resulted in high laboratory results. Based on record review and interviews, the Department cited the facility for among other things, failure to accurately document and maintain records related to the administration of a blood thinner, timely submitting a request for acquiring medication ordered by a physician, and improper use of a flow sheet to monitor doses. Citation # 920011837.

Pacific Palms Healthcare

1020 Termino Avenue, Long Beach
A $20000 Fall Injury 9/24/2015

On 1/18/15, a 71 year-old a bed-bound resident who required two CNAs for transfers and had poor safety awareness was asked by a CNA to turn over on her left side. When she did she fell off of the bed breaking her leg. The facility was cited for failing to adequately assist a resident who was at high risk for falls. Citation # 940011818.

Pacific Villa, Inc.

3501 Cedar Avenue, Long Beach
A $20000 Neglect 12/02/2015

On 2/20/15, a GI physician recommended that a resident have a colonoscopy and EGD due to abnormal findings from a CT scan of the resident's abdomen. The facility failed to follow-up on these recommendations over an eight month period. Its failure to do so resulted in the resident having severe abdominal pain and requiring narcotic pain medication of 130 tablets over an eight month period without a definitive diagnosis and treatment plan. Citation # 940011864.

A $20000 Fall Supervision 12/02/2015
On 6/30/15, a 76 year old resident, who had a history of falls and was assessed as being at high risk of falls, fell while smoking unsupervised on the patio. The resident suffered blunt head trauma with a hematoma and abrasion that required hospitalization for seven days. The facility was cited for not providing supervision in accordance with her care plan and failing to implement its policy and plan of care to prevent the resident's many unsupervised falls. Citation # 940011862.

**Palos Verdes Health Care Center**

26303 S. Western Ave, Lomita

B $1000 Patient Care Physical Abuse Retaliation Against Resident 08/31/2015

The facility was cited for failing to intervene between residents before an incident of abuse occurred. Resident 1 and Resident 2 were caught in an instance of physical abuse when resident 1 had swung his wooden cane at Resident 2, making Resident 2 bleed from his earlobe, where he got hit. There were no preventative measures taken to avoid this issue, which resulted in a fine for the facility. Citation # 910011665.

**Santa Monica Convalescent Center II**

2250 29th Street, Santa Monica

B $1800 Mandated Reporting Patient Care Physical Abuse Retaliation Against Resident 05/26/2015

The facility failed to report allegations of abuse to the department of public health (DPH) in a timely manner, after bruises were found on the resident's right chin and right arm. The facility was cited for failing to investigate the claim of the abuse between Resident 1 and a CNA, where the CNA allegedly hit resident 1 on her chin and arm. Citation # 910011439.

**Seacrest Convalescent Hospital**

1416 W. 6th Street, San Pedro

B $1800 Patient Care 10/29/2015

On 5/13/15, a CNA noticed that a resident was experiencing pain while being turned. The resident suffered from dementia and osteoporosis and required two staff for bed mobility and transfers. According to the nurse's notes, the resident was yelling and moaning, swinging his hand, and there was swelling from his left hip to his left foot. An x-ray was ordered, which came back negative for fracture. On 5/14, the resident who was still exhibiting signs of pain was sent to the hospital for another x-ray, which came back positive for a fracture. The fracture was determined to be an injury of unknown origin. Citation # 910011802.

**Tarzana Health And Rehabilitation Center**

5650 RESEDA BOULEVARD, Tarzana

A $20000 Careplan Fall Injury 11/16/2015

The facility was cited for failure to accurately assess the resident's safety risk factors and hazards, failure to develop an initial plan of care with interventions, and failure to revise the care plan with an identified change in mental status prior to her fall. This resulted in the resident falling on 07/25/15 when transferring from her bed to the bathroom unassisted, sustaining a fracture to her hip, requiring surgery on 7/28/15. Ultimately she developed complications while hospitalized and died on 08/20/15. Citation # 920011814.

**The Earlwood**

20820 Earl Street, Torrance

A $14000 Patient Care 07/21/2015

On 1/9/10, a resident fell during the transfer process from a wheelchair to a bed with a mechanical lift. The resident was transferred to an acute care hospital and diagnosed with a fractured arm. The same thing happened again after the resident was readmitted to the facility with the fractured arm. The facility failed to provide two-person physical assistance during the resident's transfer from the wheelchair to the bed by using a Sabina II EE mechanical lift. The facility also failed to assess the resident to determine lifting equipment and transfer needs in accordance with the facility's policy and procedure. Citation # 910011598.

**The Rehabilitation Center on La Brea**

505 N. La Brea Ave, Los Angeles

A $2000 Careplan Decubiti (Bedsores) 10/23/2015

A female resident with dry gangrene on her feet was not monitored and evaluated for wound care as prescribed. The resident's medical records were missing critical nursing assessments and updates of her treatment. Additionally, the findings of additional skin problems by a podiatrist were not reported to the resident's physician as of eleven days later and were not timely treated. The facility was cited for failing to monitor the resident's gangrenous feet and failing to report skin breakdowns and seek needed treatment orders from her physician. Citation # 940011781.

**University Park Healthcare Center**

230 E Adams Blvd, Los Angeles

B $2000 Notification Sexual Abuse 09/30/2015

On 2/17/15, the Department received a complaint that a resident who suffered from dementia had been sexually abused by a CNA. The incident occurred on 2/13/15 and, while the resident recanted, the facility did not report the incident to the department as required by law and its own policy. The facility was cited for failure to report the allegation to the department within 24 hours as required. Citation # 940011762.

**Verdugo Valley Skilled Nursing & Wellness Centre**

2635 Honolulu Avenue, Montrose

A $20000 Patient Care 08/19/2015

A resident developed labored breathing on 5/25/15. A psychiatric technician left the resident's room to page a registered nurse because her walkie talkie battery had not been charged. She then waited for the nurse to call her back. When the technician finally returned to the resident's room, he was no longer responsive but she did not initiate CPR because she was scared. A CNA present in the room also failed to provide CPR. The resident died. Fifty of the 85 staff who required CPR certification either had certifications that had expired or were missing. The facility was cited for failing to respond to a life-threatening emergency in a timely and effective manner. Citation # 920011675.

B $2000 Careplan 10/16/2015

The facility was cited for failing to ensure that they monitored a resident who was at risk for smoking related injuries due to impaired cognition skills. This resulted in a
fire that started in the resident's bathroom trash can placing others a risk for serious injury, burns or smoke inhalation. Citation # 920011785.

**WMF $10000 Patient Records 12/14/2015**

From June 2013 to June 2014, the facility staff willfully falsified a resident's medical records by documenting physicians' orders from a physician who did not give the orders or serve as the resident's physician. The facility record falsely reflected the care and services to this resident, documenting numerous communications with and medical orders from this physician that never took place. The physician never visited the resident in the facility and never wrote or called orders for the resident's care. The physician told the investigator that the resident was not his patient and that he had never been to the facility. The orders could not be traced to any other physician and the resident was not under the care of a primary physician for over a year. The facility was cited for willfully falsifying the resident's records. Citation # 920011838.

**Madera County**

**Avalon Care Center-Chowchilla, L.L.C.**

1010 Ventura Avenue, Chowchilla

A $20000 Fall Patient Care Supervision 10/27/2015

On 6/8/15, a 70 year old female resident fell out of her wheelchair while on the facility's smoking patio, and lay unconscious on the hot cement, unnoticed by staff, for likely over an hour. That day, the temperature was 104 degrees Fahrenheit at 5:50 p.m. By the time the resident was found at 6:00 p.m., she had sustained 2nd and 3rd degree burns to her right knee and both feet. She was hospitalized for over three months while both feet were amputated, and she was ultimately placed on hospice. The facility was cited for failure to prevent accidents. Citation # 040011799.

**Orange County**

**Fountain Care Center**

1835 W. La Veta Avenue, Orange

B $1500 Mandated Reporting Notification Patient Care Physical Abuse 11/16/2015

The facility was cited after a CNA falsified a report of an incident in which a resident fell from a shower chair and fractured her knee. Instead of seeking assistance or assessment of the patient's injuries, the CNA returned the resident to her bed, told her not to report what happened and reported to the LVN that the resident had a headache. Because of this falsification, the resident was not provided medical care for her fractured knee or given appropriate pain relief until a family member arrived and called for further medical intervention. Citation # 060011842.

**Leisure Court Nursing Center**

1135 Leisure Court, Anaheim

B $10000 Chemical Restraints Patient Care 11/05/2015

On 7/21/15, an 82 year old female resident with dementia was observed in her bed screaming, "Help me! Hurry!" and "Oh my god it hurts!" The resident frequently complained of pain, but rather than assess her verbal and nonverbal pain indicators, the staff requested an increase in Depakote, a psychotherapeutic medication, on 7/21/15, for "agitation manifested by yelling without provocation." On 7/23/15, the physical therapist indicated he was not aware that the resident had a hairline left hip fracture. The facility failed to document the resident's hydration status or assess her pain indicators prior to prescribing increased psychotherapeutic medications. Citation # 060011825.

**Riverside County**

**Alta Vista Healthcare & Wellness Centre**

9020 Garfield Ave., Riverside

B $1500 Verbal Abuse 11/24/2015

Beginning 3/11/15, a 64 year-old male diagnosed with paranoid schizophrenia and confined to a wheelchair was being belligerent and hostile towards staff, which caused emotional distress and altercations with other residents. He used his wheelchair to block people's way and would bang on doors. He would yell at staff and call them names and intimidate visitors. The investigators learned that the staff tried to avoid him and the residents were afraid of him. The facility was cited for failure to investigate a complaint of a resident verbally abusing and harassing other residents. Citation # 250011865.

**Corona Health Care Center**

1400 Circle City Drive, Corona

B $2000 Fiduciary Mandated Reporting Patient Records Theft & Loss 1/07/2016

The facility failed to clearly identify all banking records including deposits for a patient trust fund account, resulting in an inability to locate $47,992 in the residents account. On August 4, 2015, Auditors found the licensee's patient trust fund account was identified as "Debtor in Possession,, however the checks for that account were identified as a patient trust account. In addition, the auditors were unable to determine where the licensee deposited $47,992 in patient trust funds that were not deposited in the account. The facility failed to safeguard the patients funds, which resulted in a fine and citation. Citation # 250011942.

**B $2000 Fiduciary Theft & Loss 1/07/2016**

A financial audit of the facility showed that in May 2014, the facility transferred $50,000 from the patient trust account to the facility corporate account. During September and October 2014, $35,000 in patient funds were transferred to the facility corporate account. The facility was cited for failure to ensure that patient funds were not commingled with the facility corporate account. Citation # 250011934.

**B $2000 Administration Fiduciary 1/07/2016**

In April 2014, the facility failed to deposit $914 from two patients' pension checks into its patient trust account. It was cited because it did not maintain an accurate record of patients' funds. Citation # 250011940.

**B $2000 Administration 1/07/2016**

On 3/25/15 an unannounced monitoring visit was made to the facility as part of the ongoing investigation regarding bankruptcy of the facility. The auditors found the facility refunded funds to five discharged residents from 70-376 days after their discharge date. Seven residents were discharged with no refunds totalling $5,990. In addition, the licensee
applied $4,725 of resident funds in Accounts Receivables instead of refunding the amount to the residents. The facility failed to ensure resident funds were returned within three banking days after discharge and failed to ensure the residents received any refunds after discharge. Citation # 250011943.

**Mt. Rubidoux Nursing Center**

6401 33rd Street, Rubidoux

B $2000 Injury Mandated Reporting 1/06/2016

A female resident reported to a nurse that a CNA had pinched her on 4/3/2015. The nurse did not report the allegation to anyone until two days later when she told the facility administrator. The facility was cited for failing to timely report an allegation of abuse. Citation # 250011941.

**Riverside Behavioral Healthcare Center**

4580 Palm Ave., Riverside

B $2000 Mental Abuse Notification Patient Care Sexual Abuse 09/23/2015

An incident of sexual abuse that occurred at the Riverside Behavioral Healthcare Center was not reported to the Department of Public Health within 24 hours of the incident. The abuse was made by CNA 1 in which the CNA asked Resident 1 and 3 uncomfortable and personal questions regarding their sexual orientation. This made the residents feel unsafe with the CNA and feared for any sexual abuse. Citation # 250011835.

**The Grove Care and Wellness**

3401 Lemon Street, Riverside

B $2000 Mandated Reporting Physical Abuse 1/19/2016

On August 12, 2015, a staff member found a female resident in her room, crying and pointing to her head, making gestures that someone had hit her. The staff member suspected that a CNA slapped the resident in the face, but he did not report the incident to the administrator or to the Department. The facility was cited for failure to report an alleged incident of physical abuse. Citation # 250011724.

**San Diego County**

**Las Villas Del Norte Health Center**

1335 Las Villas Way, Escondido

B $2000 Administration Staff (Inservice) Training 12/11/2015

The facility was cited after it failed to verify the professional licenses of 8 nurses, failed to verify the certifications of 12 CNAs, and failed to provide abuse prevention training for 8 direct care staff. Citation # 080011883.

B $2000 Injury Patient Care 12/11/2015

The facility failed to properly assess the ability of staff to use a mechanical lift, and failed to properly inspect or maintain the lift and slings. The facility was cited for these failures after the worn and frayed sling straps on the lift broke, causing the resident sitting in the sling to fall to the floor, fracturing her vertebrae. As a result of the fall, the resident experienced severe pain, wore a back brace for 4 weeks, and lost the ability to eat independently. Citation # 080011884.

**Shea Family Care Mission Hills**

3680 Reynard Way, San Diego

B $2000 Patient Care 11/24/2015

On 10/26/14, a resident was being transferred to a bedside commode post hip surgery. The staff person transferring her was not able to properly transfer her and the resident ended up on the floor. She was humiliated as she was left to urinate on the floor. In addition, she suffered a refractured left hip, which had to be operated on again. The facility failed to review, evaluate and update the resident's care plan according to the resident's medical care needs. Citation # 090011869.

**The Springs At Pacific Regent**

3884 Nobel Drive, San Diego

B $2000 Patient Care Sexual Abuse 11/03/2015

The facility was cited for failing to report to the Department of Public Health within 24 hours after an allegation of sexual abuse had occurred. Resident B (male) walked into resident A's room (female) and told her to be quiet, lifted her gown and placed his head close to her private area. The facility was cited for failing to report an allegation of sexual abuse. Citation # 250011943.

**Vista Healthcare Center**

247 E. Bobier Drive, Vista

B $2000 Dignity Mental Abuse Physical Abuse Sexual Abuse 12/29/2015

The facility was cited after it failed to protect the privacy and dignity of a resident when two CNAs videotaped a female resident, naked from the waist up, who was sitting in her shower chair. The video features the CNAs making fun of the half-naked resident's unwillingness to shower, and the video was posted to a social media website. Citation # 080011922.

**Ventura County**

**Mary Health of the Sick Convalescent & Nursing Hospital**

2929 Theresa Dr, Newbury Park

A $4500 Medication Patient Care 11/03/2015

After a resident received the wrong dosage of insulin, the facility was cited for failure to keep the resident safe from medication errors. Instead of administering the 2 units of insulin as prescribed, staff administered 100 units, resulting