Absolutely not! - According to most long term care advocates in California. What California really needs is more affordable access to alternatives to nursing homes, such as home care services, residential care, the assisted living waiver program, adult day care and adult day health care, more mental health services and special treatment programs, and accompanying Medicaid waiver services like those in effect in Washington state and Oregon, where residential care and assisted living services are available under their Medicaid programs. Alternative housing programs and moving residents out of nursing homes was the subject of a recent New York Times cover story. (www.nytimes.com/2016/05/14/us/nursing-homes-medicaid.html)

Unfortunately, the nursing home industry is peddling the myth that California will need at least 10,000 more beds by the year 2020 to “keep up with demand” as occupancy rates and the demand for beds in nursing homes keep increasing. In fact, no one is demanding more nursing home beds and study after study has shown that:

- nursing home occupancy rates are declining or remaining flat due to consumer demand for alternatives;
- consumers are not “demanding” nursing home beds, but demanding home and community based alternatives such as in-home care and assisted living; and
- in 26 years, the demand for nursing home beds has not risen significantly and is unlikely to rise significantly in the future, as elders seek alternatives to long term nursing home stays.

There are approximately 1,250 licensed nursing homes in California with about 120,000 beds, and over 300,000 Californians are cared for annually in licensed long-term care facilities. However, 83% of nursing home residents are discharged after a stay of three months or less, and only 6% of all residents remain in the facility for one year or more. Nursing facility occupancy rates in California are approximately 87%, which means that 13% of nursing home beds or 15,600+ beds are available on any given day.

Corporate Grab

Despite these facts, the for-profit nursing home industry is sponsoring AB 2104 which would expand the California Health Facilities Financing Authority and the California Health Facility Construction Loan Insurance Fund to include for-profit corporations that operate skilled nursing facilities in California, allowing them to acquire or build new facilities or expand current facilities. Remarkably, they even sold their misinformation to the legislature. AB 2104, authored by Assemblyman Matthew Dababneh (D-Encino), passed the Assembly Health Committee by a vote of 18-0!

Does CA Need More Nursing Home Beds (cont. on page 3)
CANHR News

CANHR Board of Directors

CANHR is pleased to welcome a new member, Terry Donnelly, to its Board of Directors. Terry is known by many long term care advocates in California as a former long term care ombudsman coordinator, as a former Deputy Director at CANHR and as a consultant on numerous issues, including RCFE and CCRC policy issues. His knowledge and expertise will be greatly appreciated. Welcome Terry.

CANHR Staff

CANHR would like to thank Rehena Shakya and Sahana Kiron Magal for their wonderful work as interns this year at CANHR and to congratulate them on their graduation and receipt of their Masters in Gerontology at San Francisco State University. We know they will go on to do great work for elders and long term care.

CANHR will also say goodbye this month to long time Program Operations Manager, Robert Martien, who is leaving to pursue other career opportunities. Robert has been our friend and colleague and an invaluable member of CANHR’s family for over 14 years. While he will remain our friend and colleague, we will miss his presence at CANHR.

Leave a Legacy

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

In Memory

CANHR, the CANHR family, and advocates against elder abuse throughout the state are grieving after learning of the death of Kevin Kane.

Kevin was a long-time prolific member of CANHR’s Lawyer Referral Service panel, a trainer and mentor during CANHR Elder Law Conferences, and a bright light among elder abuse litigators in California. His enthusiasm, smile, warmth, and infectious optimism will be missed by his friends and colleagues. His creative, intelligent, and tireless work to protect the victims of elder abuse and seek justice on their behalf will be missed by everyone. Kevin was a true gentleman and hero.

About CANHR

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

CANHR

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These for-profit corporate entities want access to two programs set aside specifically to help eligible and credit worthy nonprofit and public health facilities reduce their cost of capital, and promote important California health access, health care improvement and cost containment objectives by providing cost-effective tax-exempt bond, low-cost loan, and direct grant programs. In other words, they want the taxpayers of California to fund the expansion of their companies.

Note that 88 percent of California’s nursing homes are for-profit and 12 percent are non-profit. The for-profit corporations and real estate investment trusts that own and operate skilled nursing facilities in California are some of the most profitable entities in the country, bringing in hundreds of millions of Medicare, private pay and Medi-Cal dollars every year. Without even taking into account the inflated corporate salaries and the numerous ways in which profits are “hidden” in administrative, lease back and management costs, their profit margins are more than ten times that of the non-profit margin.

Allowing these programs intended for public and not-for-profit health care entities to be raided by for-profit nursing home corporations is not only a travesty, but also a betrayal of the taxpayers of California and of the mission of both programs.

AB 2104 is currently held under submission in the Assembly Appropriations Committee, which means that the author and the committee members might want to work on or discuss the bill further. This does not preclude the bill from being set for another hearing.

AB 2104 should die a quick death and the Legislature should focus on providing the citizens of California with real long term care remedies and alternatives—not more substandard, unaffordable and unwanted corporate nursing home care.
New Nursing Home Complaint Investigation Deadlines Take Effect on July 1, 2016

July 1, 2016 will bring some welcome news for nursing home residents due to a new law that will begin phasing in complaint investigation deadlines for the California Department of Public Health (CDPH) on that date. The new deadlines apply to complaints filed by nursing home residents or others on their behalf. Complaints typically involve understaffing, abuse, neglect, mistreatment, injuries, deaths, restraint, illegal evictions and other dangerous violations of laws and rights that require rapid response by CDPH.

Existing law requires CDPH to make onsite investigations of nursing homes within 24 hours of complaints involving a threat of imminent danger of death or serious bodily harm and within 10 working days for all other complaints. Until now, the law has not set specific deadlines for CDPH to complete its investigations.

A 2015 budget bill (SB 75) established the new deadlines, which initially requires CDPH to complete investigations within 90 days of complaints involving a threat of imminent danger of death or serious bodily harm that are received on or after July 1, 2016. In extenuating circumstances, the Department may extend the deadline by up to an additional 60 days upon written notification to the complainant and facility.

The following additional requirements are phased in over the next two years:

- Investigations of complaints filed from July 1, 2017 through June 30, 2018 that do not involve threats of imminent danger of death or serious bodily harm must be completed within 90 days of receipt, with the possibility of an extension of up to 90 days due to extenuating circumstances.

- Investigations of all types of complaints filed on or after July 1, 2018 must be completed within 60 days of receipt, with the possibility of an extension of up to 60 days under extenuating circumstances.

Additionally, the law now sets a new timeline for CDPH to issue state citations (fines) associated with complaint investigation findings. For complaints subject to the new deadlines, CDPH must issue any citations resulting from its investigative findings within 30 days of the completion of the complaint investigation.

The need for CDPH to protect nursing home residents from mistreatment is greater than ever with complaints skyrocketing during the last two years. CDPH data shows that the number of nursing home complaints jumped from 6,510 in fiscal year 2013/14 to 7,609 in FY 2014/15, an increase of over 16 percent. In the first half of FY 2015/16, the number of complaints continued to rise along with CDPH’s growing backlog of open complaints.

It is an open question whether CDPH will obey the law. The Department has defied the existing investigation timelines for many years and fought those that are now taking effect. It has not been shamed by countless audits, oversight hearings, federal investigations, lawsuits and media stories that showed it has routinely turned its back on nursing home residents who have suffered abuse and neglect. The Department certainly has no more excuses since it sought and received funding last year to add hundreds of new inspectors.

The complaint investigation deadlines discussed above are found in section 1420 of the California Health and Safety Code.

New Nursing Home Complaint Investigation Deadlines Take Effect on July 1, 2016

Nursing Home Chain Ownership Changes are Linked to Poor Quality of Care

A fascinating research article published in the May issue of Health Affairs reports that nursing homes that are frequently bought and sold by nursing home chains are plagued by low quality. Researchers from several distinguished universities came to this not too surprising conclusion after tracking nursing home transactions, such as mergers and acquisitions, throughout the nation between 1993 and 2010. The analyses and findings are described as the first comprehensive picture of how chain involvement in the nursing home sector has evolved.

The picture it paints is that nursing home residents throughout the nation are poorly served by the chaotic behaviors of nursing home chains. Here are some of the key findings:

- Two defining features of the nursing home industry are the tremendous churn in chain ownership and the perception of low-quality care at many facilities.

- On average, about 1,500 nursing homes annually experienced a change related to chain ownership in the period 1993-2010.

- The proportion of chain owned nursing homes increased substantially during the study period, growing from...
Under both state and federal law, nursing homes are required to have activities programs tailored to residents’ interests and to enhance their quality of life. Facilities’ compliance with this requirement can vary significantly. Some facilities pay little to no attention to their resident activities program. The result can be a joyless wasteland of bingo and summer camp arts and crafts, as was the case described in a recent Department of Public Health survey at Courtyard Health Care Center in Davis (“Courtyard”). (To see the deficiency issued against Courtyard, go to http://canhr.org/citations/2016.04/courtyard-healthcare-center-citation.pdf)

The DPH investigators compared the Courtyard activities calendar with the actual activities taking place in the facility’s activity room. They found barely any residents participating in any activities and barely any life to the activities that were scheduled throughout the day.

Other nursing homes have robust activities that are vibrant, entertaining, and rich. These programs not only keep residents active and engaged, they can be restorative – helping them recover skills and purpose and enabling them to transition to a home and community based setting. In fact, activities programs are critical to what is supposed to differentiate nursing homes from short-term health care centers: a focus on psycho-social well-being, connectedness, vitality, and well-being beyond mere physical health.

A good activities program includes group activities, such as outings, religious worship, classes, and exercise, but also provides one-to-one time such as reading, music, and simple conversation. Nursing homes and their residents are often characterized by limitations (physical and cognitive) and lack of meaningful choice and control. An individualized activities program is a perfect vehicle for providing choice and control and for eradicating limitations.

If a prospective resident or his or her family members want to know whether a particular nursing home is “good or bad,” one quick rule of thumb is to attend a facility activity. Do a lot of residents participate? Is the activity fun and engaging? Is it dignified, recognizing that the residents are adults with individualized tastes? Chances are decent that if a facility has well-planned, animated activities, it has an overall caring environment where residents can best thrive.

A good activities program is more about facility culture and staff effort than it is about resources; after all, staff energy and attention to a resident’s likes and dislikes are the two key components. A facility management team that stresses activities is likely thinking about the overall well-being of its residents and is more likely to initiate and maintain better outcomes.

Residential Care Facilities for the Elderly are also required to have “planned activities” programs that keep residents entertained, engaged, and active. (22 Cal. Code Regs. Section 87219) As in nursing homes, some facilities fulfill the requirement quite well while others are completely deficient.

When assessing a long-term care facility’s performance, be sure to spend some time investigating and observing its activities program. Activities can be representative of overall care.
CANHR is sponsoring, supporting, and/or closely following the following pieces of legislation this session. Please check www.canhr.org for updated details on legislation, and www.leginfo.ca.gov for information of specific bills.

### CANHR Sponsored

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

This bill would limit Medi-Cal recovery for those who are 55+ years of age to only what is required by federal law; 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:** Included in the proposed budgets submitted by the Assembly and Senate Budget Committees. Should be included in budget trailer bill language.

**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. 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:** Hearing in Assembly Insurance on June 22.

**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 before a court can approve the use of psychotropic drugs for a conservatee with dementia. **Status:** Senate floor.

**SB 1065 (Monning): Dismissal or Denial of Petitions to Compel Arbitration: Appeals**

This bill will help elders who are sick and dying and have received a trial preference in an elder abuse case to get their day in court quickly, rather than being delayed by an appellate process that can take three years or more. **Status:** Assembly Judiciary.

### CANHR Support


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:** Died in Assembly Appropriations.

**AB 1797 (Lackey): In-Home Supportive Services: Application**

This bill would improve the In-Home Supportive Services (IHSS) application process by requiring that individuals applying electronically receive a confirmation number and require the county to process an application within 30 days. **Status:** Hearing in Senate Human Services on June 14.

**AB 2231 (Calderon): Care Facilities: Civil Penalties**

This bill would improve the penalty system in Residential Care Facilities for the Elderly (RCFEs). In 2014, Governor Brown signed into law AB 2236, which increased civil penalties for incidents resulting in death or serious bodily injury of residents. However, AB 2236 did not address penalties for the myriad of other injuries and violations that harm residents in RCFEs. This bill would increase the amount of civil penalties imposed for a licensing violation under those provisions, and would impose civil penalties for repeat violations. **Status:** Assembly floor.

**AB 2394 (Garcia): Medi-Cal: Nonmedical Transportation**

This bill would clarify that nonmedical transportation is a benefit for all beneficiaries under the Medi-Cal program. Currently, the benefit is only offered to children on Medi-Cal and to Cal MediConnect beneficiaries. **Status:** Assembly floor.

**SB 939 (Monning): CCRC Refunds**

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:** Assembly Human Services.

**Oppose**

**AB 2104 (Dababneh): Public Financing of For-Profit Nursing Homes Chains**

This bill would make low-cost financing and loan guarantees available to for-profit nursing homes through the California Health Facilities Financing Authority Fund and the Health Facility Construction Loan Insurance Fund. These actions would betray the mission of these programs to help nonprofit and public health facilities reduce their cost of capital and would enable the expansion of for-profit nursing home chains that are providing poor quality of care to their residents. **Status:** Assembly Appropriations – held under submission – hopefully dead.

**AB 2341 (Lackey): Health Facilities: Special Services**

This bill would allow skilled nursing facilities to deliver unregulated “special services” (dialysis, peritoneal, and infusion services) to outpatients. This bill would deregulate oversight of these services, allowing nursing homes to create “special services” of their own design and establish standards of care for their delivery. **Status:** Gutted and amended to a bill about vacant judgeships.

**AB 2661 (Burke): Continuing Care Retirement Communities: Refundable Contracts**

Elderly residents often expend a significant portion of their life savings in order to purchase care in a continuing care retirement community (CCRC). Existing law requires a CCRC offering a refundable contract to maintain a refund reserve in trust for residents of the community. This bill would eliminate certain refund reserve protections for residents of CCRCs in California. **Status:** Pulled by the author.

**SB 929 (Vidak): Compensation for Guardians and Conservators**

This bill would eliminate one of the very few remaining financial disincentives for filing for conservatorship in California, by permitting compensation to third parties who neither want nor will take a role in the conservatorship. **Status:** Assembly Judiciary.

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

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**Consumer Scams Alert**

**Annuity Scams Alert:** If you’ve purchased an annuity within the last four years to qualify for a government benefit, chances are the insurance agent has broken the law and you may be entitled to collect damages. In California, it is absolutely illegal for an insurance agent or broker to sell annuities to qualify for the Veteran’s Aid and Attendance Benefit and illegal in most instances to sell annuities to qualify for Medi-Cal.

**Annuities and Veteran’s Aid And Attendance Benefits:** California Insurance Code § 785.5 states that an agent or broker cannot sell an annuity to obtain Veteran’s benefits for a senior, nor can they charge a fee for service for assisting a senior to qualify for the benefit. It’s extremely important for seniors to be aware of this because the Veteran’s Administration has become very aggressive against seniors who are moving their assets into annuities or irrevocable trusts in the hopes of appearing “impoverished” in order to gain access to the VA benefit. The Veterans Affairs Administration has proposed new rules that would deny eligibility to senior veterans who transfer assets in this way, and it is uncertain as to whether these rules, once enacted, will apply retroactively. So beware.

**Annuities and Medi-Cal:** Another area of concern regards annuities being sold to qualify for Medi-Cal. It is illegal for an insurance agent to sell an annuity to a senior if that senior (1) would already have qualified for Medi-Cal without purchasing the annuity or (2) would not qualify after having purchased the annuity (Insurance Code § 789.9). The Insurance Code forbids agents to sell annuities to seniors with liquid assets totaling less than the annual Community Spouse Resource Allowance ($119,220 in 2016). This applies to all seniors, whether or not they are married or single. Nor does the law allow annuities to be sold to “prepare to qualify” a senior for Medi-Cal at some future time. Since a senior’s financial situation is subject to change, there can be no absolute guarantee that the senior will qualify when the time comes. Regardless of what an agent may promise, it is illegal. An illegal sale also occurs when the insurance agent has the senior using money from his or her exempt IRA, pension or 401(k). Non work-related annuities also run the risk of being subject to a Medi-Cal recovery claim, whereas funds in work-related pensions are not subject to Medi-Cal recovery as long as there is a named beneficiary on the account.

**Call CANHR** If you or your loved one has purchased an annuity within the last four years to gain access to a government benefit, give CANHR a call and we can tell you if you are entitled to receive money back for any damages you might have incurred because of that purchase.
Consumers often contact us for assistance in selecting a long term care facility. CANHR does not provide referrals to specific RCFEs or other long term care facilities, but there are several resources to assist consumers in searching for an RCFE.*

**1. Recommendations From Family, Friends And Professionals**

Consumers should seek information about facilities from people they trust. Relatives, friends, clergy, local senior groups, Alzheimer’s support groups, elder law attorneys, hospital discharge planners, doctors and other professionals may have recent experiences with RCFEs, or know someone else who has helpful information.

**2. Community Care Licensing Facility Search Website**

Consumers can search online for information regarding RCFEs on the Facility Search website of Community Care Licensing (CCL), the division of the Department of Social Services (DSS) that regulates assisted living facilities. The website can generate a list of all facilities within a particular city, county or zip code, or provide facility-specific information. Consumers can view inspection reports created after April 16, 2015, and complaint investigation reports approved after January 11, 2016. Unfortunately, to review inspection and complaint reports generated prior to these dates, consumers will have to contact DSS regional offices to review a facility’s paper file, or request that the report be sent to them via fax or mail. Click here for a list of DSS regional offices - [http://ccld.ca.gov/res/pdf/ASC.pdf](http://ccld.ca.gov/res/pdf/ASC.pdf).

**3. Long Term Care Ombudsman Program**

The Ombudsman Program provides free advocacy services for residents of RCFEs and other long term care facilities, and assists residents in resolving concerns about care and resident rights. Ombudsman Programs cannot provide referrals to specific facilities. However, some Ombudsman Programs have listings of local facilities, information about specific facilities based on personal observation and public records, and copies of CCL inspection and complaint reports. Click here for a list of local ombudsman programs - [http://www.aging.ca.gov/Programs/LTCOP/Contacts](http://www.aging.ca.gov/Programs/LTCOP/Contacts).

**4. Care Managers/Social Workers**

Consumers can hire trained professionals to assist in finding long term care facilities. Care Managers and Social Workers specializing in elder care can provide assistance with assessing level of care, searching for facilities to meet resident needs, and completing necessary paperwork. The cost for these services is generally based on an hourly rate. Some organizations offer sliding scale fee arrangements.

**5. Private Referral/Placement Agencies**

Private referral or placement agencies also assist consumers in finding RCFEs, but these agencies should be used with caution. Most offer consumers their services for free, because they are paid a commission by RCFEs and other facilities for any placement. The agencies may steer prospective residents to facilities with whom they contract, although other facilities may provide better care. Consequently, prospective residents should not automatically rely on a referral or placement service.

**6. Personal Visits**

Once you have identified an RCFE that seems to be affordable and has the necessary services, visit the facility. Ask to see the entire facility, not just the nicely decorated lobby or a designated unit. Try to get a feel for the quality of care and how residents are treated by the staff. Resident appearance, residents’ rooms, quality of food and activities are all important factors in evaluating an RCFE. However, nothing is more important than the proximity of the facility to the resident’s family, friends and health care professionals, and the quality and quantity of staff. Do comparative shopping. Use CANHR’s RCFE Evaluation Checklist and Dementia Care Checklist to help you evaluate facilities under consideration.

*In general, consumers can use the above resources in searching for any type of long term care facility, including nursing homes. Note, the internet search tools specific to nursing homes differ from RCFEs. For information on choosing a nursing home, including websites with nursing home ratings, see CANHR’s fact sheet at [http://canhr.org/factsheets/nh_fs/html/fs_howtochoose.htm](http://canhr.org/factsheets/nh_fs/html/fs_howtochoose.htm). Additionally, private referral agencies do not generally assist Medi-Cal beneficiaries with nursing home placement.*
A lot is happening on the Continuing Care Retirement Community front. Continuing Care Retirement Communities (CCRCs) usually provide independent living and access to a continuum of care including assisted living, increasingly specialized dementia care, and nursing home care. The distinguishing feature of CCRCs is their promise of care for at least one year and usually for life and charging substantial entrance fees for this promise and access to care. Most CCRCs require substantial entrance fees, along with monthly fees. Entrance fees can range from $50,000 to more than $2 million.

**CCRC Refunds:** SB 939 (Monning) would require the CCRC 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. This is an important bill for those residents who wish to move or for those whose estates are awaiting probate, as residents, and/or their heirs, have experienced significant delays in receiving their lump-sum payments from entrance fees that are conditioned upon resale of their CCRC unit. SB 939 passed the Senate and is now in the Assembly Human Services Committee.

**Erickson Living:** In a push to establish a base in California and to avoid refund requirements as required by law, Erickson Living sponsored AB 2661, which would have eliminated certain refund reserve protections for residents of CCRCs in California. Thankfully, the author pulled the bill, but Erickson continues to vigorously oppose SB 939 on the basis that repayment to the estates of seniors would cause “financial instability.” It should be noted that, although Erickson Living has no CCRCs in California, they have spent an enormous amount of funds lobbying in California - funds that should go for the financial stability of their own CCRCs in other states. Redwood Capital Investments LLC bought Erickson Retirement Communities for $365 million after it filed for bankruptcy in 2010. Now called Erickson Living, it is headquartered in Baltimore and has facilities in 10 other states, but not in California.

**Family Councils and Resident Councils in CCRCs:** Effective January 1, 2015, new, comprehensive laws governing resident and family councils in RCFEs went into effect. AB 1572 (Eggman) was sponsored by CANHR. All of these new laws apply to CCRCs, which are licensed as Residential Care Facilities for the Elderly (RCFEs). Resident councils and family councils are particularly powerful tools in CCRCs where the management tries to control much of the decision-making. Several CCRCs have already organized resident councils and family councils and this is only the beginning. CANHR’s fact sheet on Family Councils in RCFEs explains the new laws and copies can be downloaded for free from our website at www.canhr.org.

More information about CCRCs in California can be found at our CCRC page http://www.canhr.org/CCRC/. This includes the CANHR consumer guide, *Continuing Care Retirement Communities: Is One Right for You?* a 14-page consumer’s guide that provides essential information to make an informed decision regarding whether a CCRC is right for you.

**Long Term Care News ................ (continued from page 4)**

- 44% in 1993 to 51% in 2010.
- The proportion of large chains nearly doubled while the number and proportion of small chains decreased.
- Only two of the top ten chains in 1993 were still in operation under the same ownership structure by 2010.
- Nursing homes owned by chains had many more deficiencies than independent nursing homes did.
- Chains targeted the worst-quality nursing homes for acquisition and poor quality of care persisted in these facilities after they were acquired.

The authors present a range of thoughtful recommendations, including regulating chains, surveying nursing homes as a group within a particular chain, rating and reporting the performance of chains, improving scrutiny of ownership transactions, requiring public notification of impending sales, and giving the public more useful and accurate information on chain ownership on state and federal websites.

The article, *Low-Quality Nursing Homes Were More Likely Than Other Nursing Homes To Be Bought Or Sold By Chains In 1993–2010,* is available from Health Affairs.
February 25: Staff Attorney Tony Chicotel gave a presentation to the San Francisco Bioethics Forum about decision-making for unrepresented health care consumers.

February 25: Efrain Gutierrez assisted Senior Staff Attorney Prescott Cole with CANHR’s training for Adult Protective Services and Civil Litigators on financial elder abuse issues in Los Angeles.

March 1: Prescott Cole directed a class at the University of California Hastings College of the Law on Medi-Cal for Long Term Care.

March 4: Prescott Cole attended a CANELA informational luncheon discussion on Transfer on Death Deed information in San Francisco.

March 15: CANHR staff visited Sacramento for the annual CANHR Leg Day – to meet with various key legislators and their staff members and to discuss a variety of important policy and legislative issues such as Medi-Cal recovery, conservatorship reforms and nursing home and RCFE resident rights.

March 16: Staff Attorney Jody Spiegel spoke to members of One LA regarding long term care issues at the San Gabriel Mission.

March 22: Julie Pollock and Pauline Mosher attended the 2016 Aging in America Conference in Washington, DC, where they received the 2015 Rosalinde Gilbert Award on behalf of CANHR. CANHR won the award for our efforts to eliminate chemical restraints in nursing homes.

March 23: Tony Chicotel and Jody Spiegel presented a webinar on long term care facility evictions: “Rights, Rules, and Remedies” as part of CANHR free legal services webinar series.

March 23: Prescott Cole gave a presentation on Reverse Mortgage suitability, Transfer on Death Deeds and Medi-Cal recovery at Horizons Foundation.

March 29: Jody Spiegel presented on Medi-Cal Eligibility & Recovery at the Center for Healthcare Rights in Los Angeles.

April 1: Efrain Gutierrez visited Bell Gardens Senior Center for outreach on Medi-Cal Recovery.

April 4: CANHR Staff attorneys Prescott Cole and Tony Chicotel, along with CANHR Executive Director, Pat McGinnis, presented a workshop on Elder Abuse Prevention through San Francisco State University’s Gerontology Program.

April 6: Prescott Cole participated in the Veteran’s Aid and Attendance Benefit Taskforce at the Department of Insurance Offices in San Francisco.

CANHR On The Move ............. (continued on page 11)
• April 9th: Long Term Care Advocate Pauline Mosher presented about Long Term Care, Medi-Cal Recovery and Reverse Mortgages at the 3rd Annual Alzheimer’s Latino Conference held at the Mayfair Community Center.

• April 11: Prescott Cole conducted a session at San Francisco State College on financial elder abuse.

• April 15: Jody Spiegel participated in the RCFE Advocates Quarterly Meeting with Community Care Licensing.

• April 20: Prescott Cole conducted a seminar on civil financial abuse litigation, reverse mortgages, Transfer on Death Deeds, and Medi-Cal recovery at the Law Foundation of Silicone Valley.

• April 20: Efrain Gutierrez hosted a CANHR information table at the San Gabriel Mission and Executive Director Pat McGinnis presented on Medi-Cal Recovery at a consumer workshop co-sponsored by Neighborhood Legal Services, Inc.

• April 22: Efrain Gutierrez and Executive Director Pat McGinnis presented a three hour continuing education workshop to Social Workers and Discharge Planners on Medi-Cal & Recovery at the Magnolia Place Family Center in Los Angeles.

• April 23: Executive Director Pat McGinnis presented a session on Elder Abuse Prevention at the first annual Kasem Cares Conference on Aging in Costa Mesa.

• April 29: The California Association of Long Term Care Medicine (CALTCM) welcomed Tony Chicotel to talk about informed consent as part of its annual conference in Los Angeles.

• May 3: Tony Chicotel spoke at the California Association of Superior Court Investigator conference about dementia care without drugs.

• May 4: As part of CANHR’s social worker webinar series, Tony Chicotel presented about capacity, decision-making, and conservatorships.

• May 4: Office Manager Armando Rafailan attended the Blaze a Trail / Older Americans Event and information faire at the Oakland City Hall.

• May 10: Prescott Cole gave a presentation on financial abuse issues for the Kiwanis Club of Greater San Mateo.

• May 11: Tony Chicotel and Pauline Mosher discussed hospital and nursing home discharge issues as part of CANHR’s social worker webinar series.

• May 11: Armando Rafailan hosted a CANHR information desk at the Richmond Memorial Auditorium and Convention Center.

• May 18: Prescott Cole participated in the Veteran’s Aid and Attendance Benefit Taskforce at the Department of Insurance Offices in San Francisco.

• May 20: Julie Pollock gave a lecture at Palo Alto Medical Foundation on long-term care preparedness.

• May 23: Armando Rafailan hosted a CANHR information desk at the Richmond Memorial Auditorium and Convention Center.

• May 24: Prescott Cole and Tony Chicotel presented a webinar on Long-Term Care Issues spotting for the Legal Aid Association of California.
Did You Know?

Medicare Will Not Pay for a Nursing Home if You’re Under Outpatient Hospital Status

A patient can be in a hospital receiving medical care, tests, medications, overnight accommodations and meals, but may still be considered an outpatient as far as Medicare is concerned. The classification between outpatient/observation status versus inpatient status may not be obvious in regards to patient care, but the distinction will determine whether or not Medicare will pay for rehabilitation in a skilled nursing facility following the hospital stay. In order for Medicare to cover post-hospital nursing home care, there is a three-day hospital inpatient requirement.

If a patient is unsure about their inpatient/outpatient status, they should ask their physician or a member of the care team. The Notice Act, effective August 6, 2016, requires hospitals to provide written and oral notice within 36 hours to patients who have observation/outpatient status for more than 24 hours. To read more about how the Centers for Medicare and Medicaid Services (CMS) will implement the act, go to www.medicareadvocacy.org.

Dear Advocate,

My dad has a living trust stating that it will become irrevocable on death of the trustor. Once my dad passes away and the trust becomes irrevocable, is it subject to Medi-Cal estate recovery?

Sincerely,

Trustworthy in Tracy

Dear Trustworthy in Tracy,

Yes, it would be subject to recovery. In your dad’s case, the trust only became irrevocable upon the trustor’s (your dad’s) death, but, during his life, he retained the right to amend or terminate the trust. As a result, it is not an irrevocable trust since your dad could make changes to or revoke the trust until the time of his death. An irrevocable trust is one that cannot be amended or changed, or even terminated, during the trustor’s lifetime. Assets in irrevocable trusts are exempt from Medi-Cal recovery. However, your dad’s living trust is a simple living trust and it is subject to Medi-Cal recovery. Any such transactions should always be discussed with a qualified estate-planning attorney who is knowledgeable of Medi-Cal recovery rules.

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:

**Memorials**

Robert D. Barker  
Virginia Barker  

Donna Smith and Luther B. Denson  
Ruth Holland  

In memory of my beloved mother,  
Rosamond L. Edeline  
Gail L. Bean  

Oscar M. Guerrero  
Michael D. White  

Kevin Kane  
Robert Boucher  

Kevin Kane  
Judith Carlin  

Kevin Kane  
Ramon Lewis  

Kevin Kane  
Michael Moran  

Kevin Peter Kane  
Marcia Noone  

Kevin Peter Kane  
Ruth Shari  

Kevin P. Kane, Esq.  
Maren Stenseth  

Thelma Ousborn  
Mary Woolfolk  

Our Parents  
Mr. & Mrs. K. Burchill  

Jerry LaMonte Rogers  
Gerri Rogers  

David Rosenkrantz  
Larry Ross  

LaVerne Schwacher  
Debra Vogler  

Vondina Thomson  
Lance Thomson  

My beloved mother - Rita Twomey  
Denise Twomey  

Betty Josephine Wallace  
David Wallace  

Frances Williams  
Jackie Johnson  

**In Honor Of**

Jean Bjorkman  
Debra Halvarson Groh  

Tony Chicotel  
KJ Page  

Betty Soreide  
Nancy Lukens
Give To CANHR

How Your Gift Helps

Your contributions help CANHR grow and thrive, so we can extend our services and support to ever more long term care consumers and their family members.

Why Donate?

CANHR is not a government agency. We are funded by membership donations, foundation grants, and publication sales. To continue our work, we need the support of people like you who are unwilling to ignore the abuse and loss that the elderly and disabled in this state suffer in long term care facilities.

What You Get When You Donate

• 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.

Donate Online  https://www.gifttool.com/donations/Donate?ID=1325

Mail-in Donation Form

To mail in your donation, please fill out the form and return it with your donation to:

CANHR, 650 Harrison Street, 2nd Floor, San Francisco, CA 94107.

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

This gift is in memory of: __________________________________________
(or) in honor of: __________________________________________

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

Name: __________________________
Address: __________________________
City/State: __________________________ Zip: __________________________
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Facility Name: __________________________
CANHR’s Lawyer Referral Service (LRS)

The only statewide bar certified lawyer referral service specializing in Elder Law

- Elder Adult And Dependent Abuse And Neglect In Care Homes
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CANHR prohibits the use of its name for the purpose of advertisement by attorneys, financial planners or any other organization or entity.
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.nursinghomguide.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.

### Alameda County

**Baypoint Healthcare Center**  
442 Sunset Blvd., Hayward  
**B $1000 Careplan Patient Care Supervision 01/13/2016**  
The facility violated a resident's right to considerate and respectful care when the resident was left on a floor mattress all night after rolling out of bed. The facility did not provide services necessary for the resident's special needs as an individual with a bariatric condition. The facility lacked adequate staff, the proper lift equipment and did not call for guidance or emergency assistance. Resident 1 stated that she felt abandoned, depressed and angry as she lay on the floor all night. Citation # 020011961.

**B $1000 Fall Injury Patient Care 01/13/2016**  
At 1:30 a.m. on 10/20/15, an obese female resident fell off her bed while being turned by a nursing assistant. The resident was a high risk for falls, and was supposed to be turned by at least two staff members. The resident was left on the floor for the entire night after the fall, because the nursing staff was unable to lift her. Rather than call 911 or check her skin for injuries, the nurse offered the patient Ativan (anxiety medication.) The resident was transferred to the hospital the next morning. The facility was cited for failure to ensure the environment remains free of accident hazards and failure to provide adequate supervision to prevent accidents. Citation # 020011957.

**Castro Valley Healthcare and Rehabilitation Center**  
20259 Lake Chabot Rd., Castro Valley  
**B $2000 Medication Patient Care 11/19/2015**  
A terminally ill resident on hospice who had end stage congestive heart failure and cancer suffered unrelieved pain when the facility failed to assess his pain or give him his prn dose of morphine sulfate as ordered for breakthrough pain between 7/1/15 and 7/10/15. On 7/10/15, the resident told the inspector, "I am hurting so much, this people don't care." Citation # 020011859.

**Windsor Healthcare Center of Oakland**  
2919 Fruitvale Ave., Oakland  
**B $2000 Careplan Medication Patient Care 12/22/2015**  
The facility failed to ensure that residents are free from any significant medication errors by failing to administer doses of ordered antibiotic and anti viral medications to two residents. The first resident missed six doses of (Rocephin) to treat his bone infection. The second resident missed 5 doses of (Triumeq) for treatment of his HIV. Citation # 020011915.

**B $2000 Medication 12/22/2015**  
During a 5/6/15 interview with a resident with lung disease and chronic pain, a state investigator was told by the resident that the pain she was experiencing impacted her ability to move. Her care plan called for pain medication every four hours or as needed, but when she asked for pills she was denied. When a LVN was asked to describe the resident's pain, the LVN stated that the resident, "Has pain all the time. I think her anxiety contributes to her pain. I suggest that she get up out of bed and go to activities." When asked if her anxiety caused the pain the resident stated, "My anxiety does not cause my pain. I fell at a previous facility and fractured my ribs and had 3 staples in my head. The pain medication takes the edge off but I need it by the third hour and the staff tells me to wait." The facility was cited for failure to properly assess and monitor the resident's pain levels. Citation # 020011912.

### Butte County

**Windsor Chico Creek Care and Rehabilitation Center**  
587 Rio Lindo Ave., Chico  
**A $10000 Neglect 04/22/2016**  
On 4/19/13, a resident died after the facility failed to keep the resident's oxygen level greater or equal to 90% per his physician's order. Multiple nurses failed to evaluate or report the resident's acute respiratory emergency and rapid deterioration to a physician and registered nurse (RN). One licensed vocational nurse documented life threatening oxygen saturation levels for an hour-long period but did not notify the RN, claiming to be more capable than the RN. A second licensed nurse found the resident unresponsive and without movement but did not evaluate the resident or initiate CPR. The nurse left the room to check on other residents. The resident had been admitted for short-term therapy with plans to return home and had signed a Physician Order for Life Sustaining Treatment (POLST) seeking full treatment and resuscitation in such an event. When EMS was finally contacted and arrived, the resident was without signs of life. EMS responders documented that the staff was not aware that the resident had stopped breathing. He was transported to the hospital where he was pronounced dead upon arrival. Citation # 23010255.

### Contra Costa County

**Stonebrook Healthcare Center**  
4367 Concord Blvd., Concord  
**B $1000 Fall Injury Patient Care Supervision 11/05/2015**  
On 11/19/14, a male resident fell out of his wheelchair and fractured his skull and elbow. The resident was considered a high risk for falls, and used a reclining wheelchair. However, a physical therapist left the resident unattended in his wheelchair, at a ninety degree angle instead of a reclining angle. The facility was cited for failure to ensure an environment free of accident hazards and failure to provide supervision to prevent accidents. Citation # 020011831.

### Humboldt County

**Jerold Phelps Community Hospital D/P SNF**  
735 Cedar St, Garberville  
**B $2000 Mandated Reporting Mental Abuse Patient Care Retaliation Against Resident Verbal Abuse 01/20/2016**  
The facility failed to report an incident of abuse to the Department of Public Health. In retaliation to a resident, a licensed nurse began
to behave aggressively and "vicious" towards a resident after the resident had made a comment about the nurse's girlfriend. The resident no longer felt safe around the nurse and was afraid the licensed nurse would "poison" him. This had a direct effect on the overall health and safety of the resident. Citation # 110011925.

Marin County
Professional Post Acute Center
81 Professional Center Parkway, San Rafael
A $20000 Elopement 03/08/2016
On five separate dates in June, July and August 2014, a resident who exhibited mental decompensation and dangerous behaviors, eloped from the facility. The elopements included walking down a steep hill, heavily trafficked roads, freeway on-ramps and exit ramps, and a bridge overpass of the freeway. On 7/19/14, the resident was caught smoking outside of the designated smoking area. Approximately 12 hours later, he was again smoking outside of the designated smoking area, and threw a cigarette into the grass area behind the building causing a fire and creating a fire hazard for the other residents. Five days later, he was treated for second or third degree burns to both thumbs from a cigarette lighter. The facility was cited for failing to provide adequate supervision and developing an effective plan of care resulting in repeated elopements and unsafe smoking behaviors. Citation # 110011956.
A $20000 Injury Physical Abuse Verbal Abuse 03/08/2016
The facility failed to protect a resident from physical harm, verbal abuse and mental anguish when he was twice assaulted by another resident in July 2014. In the first incident, on 7/8/14, the other resident, who was described in facility records as a "bully," grabbed the victim's arm, hit him several times in the chest and pushed the over-bed table into him, causing several scratches and significant bruising to his forearm. Seventeen days later on 7/25/14, the same resident punched him on the shoulder and swore at him while they were both in the Activity Room. The same resident also verbally abused him before, during, and after the two physical altercations, continually "giving him the finger" and mouthing profanities that caused him anxiety and made him unable to sleep at night. Citation # 110011954.

Monterey County
Windsor The Ridge Rehabilitation Center
350 Iris Drive, Salinas
B $2000 Fall 03/16/2016
On 12/28/15, while preparing a totally dependent resident for a transfer from his bed to a wheelchair the CNA exited the room looking for a second staff person to assist in the transfer. When the staff returned the resident was found on the floor with a broken leg and head injury. The fractures to his tibia/fibula resulted in his right lower leg being amputated. The resident's record showed him to be a fall risk with poor safety awareness. The facility was cited for failing to ensure that the resident was free from an avoidable accident. Citation # 070012119.

San Mateo County
Devonshire Oaks Nursing Center
3635 Jefferson Ave., Redwood City
B $20000 Injury Patient Care Patient Records Physical Environment 03/29/2016
A female resident was sent to the hospital for x-rays on 12/30/15 after complaining of left arm pain. The x-rays revealed she had a left arm fracture, although her medical chart contained no documentation related to the injury. A charge nurse stated that the resident most likely fractured her arm on the side rails of her bed, which were not padded. During the course of the Department's investigation of the incident, the Director of Nursing willfully falsified the resident's records, adding a note that the staff attempted to add padding to the side rails, but the resident refused. The facility was cited for willful falsification of patient health records. Citation # 220012152.

Santa Clara County
Children's Recovery Ctr Of Northern Cal. D/P SNF
3777 South Bascom Avenue, Campbell
B $1200 Bed Hold 05/13/2014
On 3/18/14, an adolescent was admitted into the facility. The youth had seizure disorder, persistent vegetative state, spasticity and chronic respiratory failure due to a head injury. He had a tracheostomy tube, a gastrostomy tube, and was on a ventilator. On 4/28/14, the facility transferred him to a hospital for medical evaluation and treatment, then refused to readmit him. There was no documentation that the facility's director of nursing explained to the resident's representatives that he had a right to a seven day bed-hold. The facility was cited for its failure to provide a written bed-hold notice and refused to readmit the resident. Citation # 070010713.

Shasta County
Marquis Care at Shasta
3550 Churn Creek Road, Redding
B $2000 Mental Abuse Physical Abuse 04/01/2016
On 11/6/15, a Certified Nursing Assistant (CNA) physically and mentally abused a resident who suffered from Parkinson’s Disease when he needed to use the bathroom at 4 am. The aide roughly shoved him into the bathroom, refused to clean feces off the toilet, pried his fingers from a grab bar and forced him down onto the dirty toilet, causing him pain that he said felt like “scalding hot water.” After leaving the bathroom, the CNA wadded up and threw a blanket at the resident. He stated the CNA "has been rough with me before but this was the first time that he had tried to manhandle me. I was scared of him...but I’m 80 years old so what am I supposed to do." Citation # 230012151.

Solano County
Orchard Post Acute Care
101 S. Orchard Street, Vacaville
B $1000 Mandated Reporting Physical Abuse 11/10/2015
On 10/3/15, a 60 year old female resident was kissed and groped by a visitor while she sat in her wheelchair. The incident happened twice and was reported to CDPH on 10/6/15. The facility failed to report an allegation of physical abuse to the Department of Public Health within 24 hours. This failure resulted in the Department's inability to independently investigate the abuse allegation without delay, and had the potential for the resident and other residents to be exposed to further abuse. Citation # 110011788.

Paradise Valley Estates
2800 Estates Drive, Fairfield
B $2000 Patient Care 11/09/2015
On 5/28/13, a resident was found on his hands and knees by a housekeeper. On 5/31/13, he was found on the floor next to the mat near his bed. The facility failed to revise the resident's nursing plan of care to prevent further falls with effective interventions specific to his known behaviors of getting out of bed and the wheelchair unassisted. The resident again fell on 8/8/13 and sustained a fractured right hip requiring surgery. Citation # 110011827.
A $20000 Careplan Fall Patient Care 12/23/2015
The facility was cited for failure to develop a care plan to include transfers for a resident who was diagnosed with a condition which left her unable to grasp with the right hand or bear weight on her right leg. The developed care plan did not specify instructions on what type of lift to use to transfer her out of bed. When transferring out of bed, staff incorrectly used a stand up lift, which requires the ability to bear weight on both legs. The resident fell and fractured her right arm as a result. Citation # 110011877.

Sonoma County
EmpRes Post Acute Rehabilitation
300 Douglas Street, Petaluma
The facility was cited for failure to protect a resident from verbal abuse when a second resident yelled profanity and threatened to kill her in the hallway. The second resident had a history of behavior issues and a history of lashing out at staff. Citation # 11001830.

**Healdsburg Senior Living Community**
725 Grove Street, Healdsburg

**B $2000 Patient Care Verbal Abuse 11/24/2015**
The facility was cited for failure to protect a resident from verbal abuse when a second resident yelled profanity and threatened to kill her in the hallway. The second resident had a history of behavior issues and a history of lashing out at staff. Citation # 11001830.

**Spring Lake Village**
5555 Montgomery Drive, Santa Rosa

**A $18000 Fall Injury Patient Care Supervision 12/18/2015**
A female resident who was a high risk for falls was admitted to the facility on 12/29/12. Over the six month period she lived in the facility, she fell at least four times, resulting in two hospitalizations, and fractures to her right hip and neck. She died on 7/9/13. A physician noted that it was the falls that led to her decline. The facility was cited for failure to keep the resident free from injury and failure to provide a care plan that addressed the resident’s high risk for falls. Citation # 11001872.

**Stanislaus County**
Avalon Care Center - Modesto
515 E. Orangeburg Avenue, Modesto

**A $20000 Evictions 03/16/2016**
In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. A male resident was discharged on 12/22/15 to another nursing home with no advance planning and only one hour. No advance notice was given other than to call him the day of the transfer and tell him that his mother was being moved to a facility 49 miles away. He was told that if he objected, his mother would be sent to his home to live with him. Many of the resident’s objects were lost in the move. The facility was cited for violating the resident’s transfer and discharge rights. Citation # 040012108.

**B $2000 Evictions 03/16/2016**
In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. On 12/8/15, the facility transferred a female resident who had been in the facility for over one year. No advance notice was given other than to call her son the day of the transfer and tell him that his mother was being moved to a facility 375 miles away. He was told that if he objected, his mother would be sent to his home to live with him. Many of the resident’s objects were lost in the move. The facility was cited for violating the resident’s transfer and discharge rights. Citation # 040012109.

**Spring Lake Village**
5555 Montgomery Drive, Santa Rosa

**B $2000 Evictions 03/16/2016**
In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. On 12/8/15, the facility sent her to a facility that was 375 miles from San Diego. The resident stated "one day they just picked me up and moved me here." The facility was cited for violating the resident’s transfer and discharge rights. Citation # 040012109.
not have legal justification for any of the discharges. A female resident was discharged on 12/3/15 to another nursing home with no advance planning and little advance notice. The facility was cited for violating the resident's transfer and discharge rights. Citation # 040012078.

B $2000 Evictions 03/16/2016

In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. In August 2015, the responsible party of a resident with severe cognitive impairment and who required extensive assistance requested the resident be transferred because the resident was nervous and anxious and intermittently tearful about what would happen to her when the facility closed. The resident moved to another nursing home but missed her friends. The facility was cited for violating the resident's transfer and discharge rights and failing to ensure her medical and welfare needs would be met. Citation # 040012079.

B $20000 Evictions 03/16/2016

In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. On 10/29/15, a male resident with physical disabilities was transferred to another nursing home with one day's notice. He did not want to move but felt he had no choice. The facility was cited for violating the resident's transfer and discharge rights and failing to ensure his medical and welfare needs would be met. Citation # 040012081.

A $20000 Evictions 03/16/2016

In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. A male resident was discharged on 10/20/15 to his pregnant daughter's mobile home. He had multiple physical disabilities which required two people to assist him with many activities of daily living. On 1/15/16, the resident had declined, was riddled with bedsores, and his daughter was overwhelmed, stating "we can't do this anymore." The facility failed to ensure the resident was discharged to a safe environment with prepared caregivers and was cited for violating the resident's transfer and discharge rights and for failing to provide adequate preparation and planning prior to discharge. Citation # 040012118.

B $2000 Evictions 03/16/2016

In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. On 10/5/15, the facility transferred a female resident who had lived there for 12 years to a different nursing home. Despite her long residency and significant care needs, she was not given any preparation or orientation prior to transfer. She stated that she felt she "didn't have a choice" and had to leave. Upon arriving at the new nursing home, she became depressed and "did nothing but cry." She even engaged in a hunger strike, losing nine percent of her body weight in one month. Eventually she was readmitted to the facility. The facility was cited for violating the resident's transfer and discharge rights and for sending her out against her will. Citation # 040012117.

B $2000 Evictions 03/16/2016

In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. A resident with schizophrenia and a feeding tube who was totally dependent on staff for mobility, nutrition, and hygiene was transferred to another nursing home on 8/24/15. His public guardian agreed to the transfer because of worries about what would happen to the resident due to the ownership change. The facility was cited for violating the resident's transfer and discharge rights and failing to ensure his medical and welfare needs would be met. Citation # 040012087.

B $2000 Evictions 03/16/2016

In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. A female resident who required extensive assistance was sent to the hospital on 9/7/15. When she was ready to return to the facility, her responsible party was informed that the resident could not return to her bed because the facility had been sold and all of the residents had to move out. When the responsible party balked, he was told the resident could go to a different nursing home now "or take your chances later." The resident was sent to the new nursing home on 9/11/15. The facility was cited for violating the resident's transfer and discharge rights and failing to ensure his medical and welfare needs would be met. Citation # 040012088.

B $20000 Evictions 03/16/2016

In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. On 6/18/15, a resident with paraplegia was transferred to a hospital due to pressure sores that ultimately required surgery. When the resident's hospitalization was complete on 7/11/15, the facility refused to readmit him stating it was "no longer caring for long term residents." The resident was sent to a different nursing home that was farther from his family. The facility was cited for violating the resident's transfer and discharge rights and failing to ensure his medical and welfare needs would be met. Citation # 040012082.

B $2000 Evictions 03/16/2016

In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. A resident with mild cognitive impairment and a feeding tube was sent to a different nursing home on 11/11/15. The facility had no documentation that the resident was notified before the transfer nor was there any evidence the facility staff considered whether the transfer was safe and appropriate. The facility was cited for violating the resident's transfer and discharge rights and failing to ensure his medical and welfare needs would be met. Citation # 040012089.

B $20000 Evictions 03/16/2016

In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. A female resident with severe cognitive impairment was transferred to another nursing home on 12/8/15. Her responsible party stated he felt the resident was "kicked out" and was "doing much worse" since the move. The facility was cited for violating the resident's transfer and discharge rights and failing to ensure her medical and welfare needs would be met. Citation # 040012090.

B $20000 Evictions 03/16/2016

In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. A resident was hospitalized on 9/16/15 for chest pain and shortness of breath and returned to the facility on 9/22. The resident
was made aware of "changes" in the facility and was transferred to another nursing home on 9/25/15. The resident was told that she had to leave because the facility was shutting down. She had lived there for six years. The facility was cited for violating the resident's transfer and discharge rights and failing to ensure her medical and welfare needs would be met. Citation # 040012091.

B $2000 Evictions 03/16/2016
In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. A resident with severe cognitive impairment was transferred to another nursing home on 11/11/15. He had trouble adjusting, was lonely, and his condition declined. The facility was cited for violating the resident's transfer and discharge rights and failing to ensure his medical and welfare needs would be met. Citation # 040012092.

B $2000 Evictions 03/16/2016
In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. A male resident with heart disease and extensive care needs was transferred to another nursing home on 10/23/15. He agreed to the transfer because he was told the facility was closing and he had no choice to stay. The resident's records indicated the resident's responsible party asked for the transfer but the responsible party stated the facility told him the resident had to move. The facility was cited for violating the resident's transfer and discharge rights and failing to ensure his medical and welfare needs would be met. Citation # 040012094.

B $2000 Evictions 03/16/2016
In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. A female resident with chronic pain and depression was transferred to another nursing home on 9/10/15 with one day's notice. The facility was cited for violating the resident's transfer and discharge rights and failing to ensure her medical and welfare needs would be met. Citation # 040012095.

B $2000 Evictions 03/16/2016
In April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. On 10/29/15, a female resident with a severe cognitive impairment was transferred to another nursing home. Her son stated she moved because the facility's pending closure was a "scary situation." The resident experienced multiple difficulties due to the transfer. The facility was cited for violating the resident's transfer and discharge rights and failing to ensure her medical and welfare needs would be met. Citation # 040012097.

B $2000 Evictions 03/16/2016
On April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to a sub-acute setting" and "didn't want long-term care residents." No written discharge notices were provided to any residents and the facility did not have legal justification for any of the discharges. On 10/22/15, a female resident with encephalopathy and COPD was notified that she would be transferred to another nursing home the next day. No advance discharge planning was done and the resident experienced a great deal of anxiety. The facility was cited for violating the resident's transfer and discharge rights. Citation # 040012098.

B $2000 Evictions 03/16/2016
On April 2015 the facility began discharging all of its residents to make way for a new owner who wanted to "convert the facility to
The following citation summaries are compiled from the citations issued by the California Department of Public Health to Southern California skilled nursing facilities and received by CANHR as of the publication of this 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 Advocate. Appeals of citations and collection of fines can take up to three years. For up-to-date information on any citation or facility, visit the Nursing Home Guide through CANHR’s web site: www.canhr.org, or call the CANHR office.

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

Fresno County

Community Subacute And Transitional Care Center
3003 N. Mariposa Street, Fresno

B $1500 Patient Rights Physical Restraints 02/24/2016
A physician's order dated 2/26/15 indicated "Bilateral soft wrist restraint at all times to prevent falls and to prevent pulling of life sustaining devices..." Physical restraints were used for six months without documentation that alternative and least restrictive methods had been attempted. An abrasion to the wrist occurred under the restraint. In addition, a nursing care plan was not developed and implemented to include a method to reduce the use of physical restraints. This failure resulted in psychosocial and physical harm to the resident, evidenced by restlessness and behaviors which led to multiple falls to the floor in an attempt to be free from the physical restraints. Citation # 040012044.

B $2000 Physical Restraints 03/02/2016
On 12/18/15, the Department made a series of unannounced visits that resulted in a fine against the facility for improperly restraining one of its residents. The resident's restraint was causing a skin abrasion of the left wrist. The facility was keeping the resident in restraints to prevent him from pulling out his catheter and feeding tube. Investigators noted that they observed the resident was grimacing as he pulled, turned and twisted his left wrist under the wrist restraint, and that there was scarred skin tissue in the area where the restraint came into contact with his skin. The resident's care plan called for a check on the restraints every thirty minutes and a release of restraints every two hours. Citation # 040012057.

Kern County

Bakersfield Healthcare Center
730 34th Street, Bakersfield

A $20000 Neglect Patient Care 03/01/2016
On 12/18/15, an 83 year old resident died after the facility neglected to promptly respond when she had a severe change of condition. The facility was preparing to discharge the resident to a board and care facility when her son protested that she was unresponsive, slumped over in her chair and needed to go to the emergency room. The staff told him that he had to take the resident to the hospital or go to the doctor's office as she was already discharged. The son went to the doctor's office, found the doctor was on vacation, returned to the facility and found his mother's possessions all packed up. He told the staff to call 911 because she was having trouble breathing and they told him she was already discharged. There was no indication that a nurse assessed the resident or took her vital signs after her family notified the facility of her change of condition. A physician assistant directed the facility to send the resident to the hospital after her family called her office about the situation. The resident died about three hours after being sent to the emergency room, which found that she was suffering from sepsis, respiratory distress and severely low blood pressure. Citation # 120012036.

B $2000 Administration Bed Hold Notification Other Patient Records Patient Rights Retaliation Against Resident 03/16/2016
The facility failed to notify the resident in writing of the right to exercise a 7 day hold provision. The Administrator stated that the resident was transferred to a acute hospital because of the residents behavior, and was not offered a seven day bed hold and the facility decided not to readmit the resident back to the facility. The House Manager at the acute hospital was interviewed and she stated that the resident was medically stable, but was still at the hospital because the facility was refusing to readmit the resident. Citation # 120012086.

Delano District Skilled Nursing Facility
1509 Tokay Street, Delano

B $2000 Mandated Reporting 04/18/2016
On 2/16/2016, family members of a resident discovered that his arms were bruised and there was a big piece of skin peeled off his leg. One of them told the investigator that it appeared he had been held down and kicked. The facility was cited for not reporting the incident within 24 hours to the Department of Public Health. Citation # 120012162.

Evergreen Arvin Healthcare
323 Campus Drive, Arvin

B $2000 Mandated Reporting 02/29/2016
On 11/28/15, a resident hit another resident on his head with a wooden cane. The facility did not report the incident to the Department of Public Health until 9 days later. The facility was cited for failing to notify the Department of an abuse allegation within 24 hours. Citation # 120012203.
On 1/12/16, after repeatedly verbalizing suicidal thoughts to staff, a resident attempted suicide by placing a plastic bag over his head and tying it around his neck. After the resident’s sister came in and called for help, a CNA ripped open the plastic bag, and the resident was transferred to the hospital. The resident, admitted with a history of major depressive disorder, told staff two weeks prior to the incident that he would get a gun and shoot himself, was crying and upset most of the time, and refused to eat. There was no care plan, interventions or IDT review regarding the resident’s expression of suicidal thoughts. The facility was cited for failing to take necessary actions which resulted in the resident attempting suicide. Citation # 120012055.

Golden Living Center - Shafter

140 E Tulare Ave, Shafter

B $2000 Bed Hold 03/14/2016

On 2/10/16, the facility transferred a resident on Medi-Cal to the hospital for behavior reasons. The facility was cited because it failed to offer a seven day bed hold, failed to offer the first available bed to the resident and did not readmit the resident even after the hospital reported she was medically stable. Citation # 120012066.

Parkview Healthcare Center

329 North Real Road, Bakersfield

B $2000 Mandated Reporting Physical Abuse 02/22/2016

A 73 year old female resident with multiple health conditions had her face grabbed forcefully by a CNA who then told the resident “you are evil and mean.” The resident explained that she was trying to make conversation with the CNA and her violent response was unprovoked. The facility was cited for failing to protect its resident from mental and physical abuse. Citation # 120012022.

B $2000 Dignity Mental Abuse Neglect Patient Care Patient Rights 1/29/2016

On 12/5/2015 an 81 year old female resident used the call light for assistance. The resident was incontinent and needed assistance cleaning up. The resident called for the CNA 3 times for assistance and was advised by the CNA to soil herself while in bed. Based on observation, interview, and record review, the facility failed to protect the resident from neglect, when the CNA refused and delayed to provide a bed pan when the resident requested it. This failure caused the resident to soil herself, suffer from mental anguish, humiliation, indignity, anxiety, and emotional trauma. Citation # 120011967.

B $2000 Administration Dignity Mandated Reporting Mental Abuse Verbal Abuse 1/29/2016

On 12/12/2015 a female resident filled out a Concern / Grievance form at the facility. She reported that the CNA refused to take her to the bathroom and stated, “I don’t have time, I have other residents to tend to.” When the CNA finally took her to the bathroom, the CNA kept rushing her stating, “Are you done yet? I have other residents to take care of.” During an interview with the Director of Nursing and the Licensed Vocational Nurse it was determined that the incident was reported to the California Department of Public Health 3 days after the incident. The facility failed to report an allegation of abuse to the Department within 24 hours. Citation # 120011977.

A $20000 Fall Injury 02/22/2016

An 86 year old female resident with a cognitive impairment fell from her wheelchair while traveling over some flooring that was being replaced and was uneven. The resident suffered a very bad head wound requiring sutures to repair. The facility was cited for failing to ensure the environment was free of unreasonable accident hazards. Citation # 120012021.

Ridgcrest Regional Transitional Care and Rehabilitation Unit

1081 N China Lake Blvd, Ridgecrest

B $2000 Physical Abuse Verbal Abuse 03/21/2016

On 1/7/2016, a licensed nurse witnessed a certified nursing assistant (CNA) hit a 76 year old resident in the head with a pillow while telling her to "shut up." The assault caused distress to the resident, who was in bed at the time and was hit hard enough that her head moved towards her shoulder. The facility was cited for failing to protect the resident from physical and verbal abuse. Citation # 120012123.

The Rehabilitation Center Of Bakersfield

2211 Mount Vernon Avenue, Bakersfield

B $2000 Administration Bed Hold Notification Patient Rights Transfer 03/16/2016

The facility failed to notify the resident in writing of the right to exercise a 7 day bed hold provision. The facility failed to provide written notice that should include information that a non Medi-Cal resident will be liable for the cost of the bed hold days, and their primary insurance may or may not cover such costs. The facility refused to readmit the resident back to the facility due to the residents primary insurance not paying for the residents stay. The facility Administrator stated he would not accept the resident for free. This violation likely caused significant humiliation, indignity, anxiety, or emotional trauma to the resident. Citation # 120012085.

Los Angeles County

Allen Care Convalescent Hospital Corporation

201 Allen Ave., Glendale

B $2000 12/31/2015

On 3/30/14, a resident with an extensive history of wandering eloped and was later returned to the facility by the police department. The resident had diagnoses that included schizoaffective and bipolar disorder that can lead to risky behavior and suicidal tendencies. The resident's care plan indicated she was at risk for elopement and that she did not have the capacity to understand and make decisions. The CNA who last saw her before she eloped saw her all dressed up in the lobby around 5 am. When the CNA asked where she was going she said she had to get out of the facility. The CNA said he tried to talk her into going back to her room but left her in the lobby when he went to answer a call light. The facility was cited for failure to provide a safe environment, adequate supervision and assertive devices to prevent the resident from leaving the facility unassisted. Citation # 920011927.

B $2000 Elopement Patient Care Supervision 12/31/2015

On 12/3/13, a female resident with schizophrenia left the facility unsupervised, and was never found. The resident was at high risk for elopement, and staff were supposed to conduct periodic checks on the resident. The facility was cited for failing to provide adequate supervision to prevent a resident from leaving the facility unassisted. Citation # 920011926.

Glendora Grand, Inc.

805 West Arrow Highway, Glendora

AA $100000 Supervision 6/19/2015

On 5/25/2014, a resident choked on food and died at the facility. The resident was on a pureed diet and required close supervision during meals because of a history of choking incidents. The facility reported that, during lunch time, the resident choked on a hot dog she took from her roommate’s tray in their room where
they had been served. The assigned certified nursing assistant (CNA) had left her unsupervised and found her gasping for air on the floor of her room when he returned. Life saving efforts by facility staff and paramedics were unsuccessful and she died at the facility within the hour. The coroner autopsy report indicated that choking was the cause of death. The facility was cited because its failure to provide adequate supervision to the resident was a direct cause of her death. Citation # 950011518.

B $2000 Patient Care Verbal Abuse 03/18/2016
A resident at Glendora Grand Inc. was subject to a verbal threat by another resident and feared for his safety. A resident stated to the other resident that he would get his friends from the outside to come beat up the threatened resident. Another resident overheard this threat and also feared for his safety. The issue was brought to the attention of the Registered Nurse, but no investigation was set in place. The facility failed to investigate an allegation of a verbal threat, which put the residents at risk for abuse. Citation # 950012127.

B $2000 Fall Injury Patient Care Physical Abuse 03/18/2016
The facility Glendora Grand, Inc. was cited for failing to protect a resident from a bed fall. This prompted the resident to be transferred to an acute care hospital. According to the emergency physician record, the resident fell out of the bed at the nursing facility and sustained two linear superficial lacerations on the right eyebrow, hematoma under the left eye, acute bilateral nasal bone fractures, and a left orbital wall fracture. A family member of the resident stated she could not believe the extent of the resident's injuries when she saw him at the hospital. Citation # 950012125.

Grand Valley Health Care Center

13524 Sherman Way, Van Nuys

B $2000 Patient Care 04/14/2016
A resident with heart disease and Alzheimer's disease and incontinent of bowel and bladder did not have a bowel movement over a seven day period in June 2015. The facility staff were supposed to monitor the resident for at least one bowel movement every three days. The resident's physician was not informed after day three; in fact, no new care plan interventions were sought or initiated until day day six. The facility was cited for failing to ensure the resident's care plan regarding constipation. Citation # 920012181.

Greenfield Care Center Of Gardena

16530 S Broadway, Gardena

On 12/3/2016 a resident with dementia, Parkinson disease and no known family or friends was transferred from his facility to another facility. This violation is in direct relationship to the resident at least 30 days before the resident was transferred to another facility. The facility was cited because its failure to provide adequate supervision to the resident was a direct cause of her death. Citation # 950011518.

B $2000 Mandated Reporting Physical Abuse 03/23/2016
On 12/3/2016 a resident with dementia, major depression, allergies, and no known family or friends was transferred from his facility to another with no notice to the Department of Public Health. Complaints where made after residents attended a resident council meeting about a construction project and some residents were being transferred to other facilities on the same day. The administrator stated that the facility would be undertaking a major renovation and configuration project. The administrator confirmed that he did not notify the Department of Public Health regarding the facility remodeling project. The facility was cited for failure to provide a written notice to the resident at least 30 days before the resident was transferred to another facility. This violation is in direct relationship to the residents health, safety, and security.Citation # 940012148.

Intercommunity Care Center

2626 Grand Avenue, Long Beach

B $2000 Mandated Reporting Physical Abuse 03/29/2016
On 8/31/15, a resident was subjected to physical and verbal abuse by a certified nursing assistant (CNA) after altercations with her, first in the resident's room and later in the hallway. The hallway incident was captured on video, which showed the CNA chasing the resident down the hallway and throwing juice at her after the resident hit the CNA. The facility was cited for failing to protect the resident from physical and verbal abuse. Citation # 940012148.

Landmark Medical Center

2030 N. Garey Ave., Pomona

B $2000 Mandated Reporting Physical Abuse 04/20/2016
On 11/24/12, a family member of a resident complained to the facility about suspected abuse and called the police. The resident had multiple bruises on her face and some swelling around her eye. Facility records indicated that the injuries may have been sustained during an altercation while in the shower room or may have been self-inflicted. The facility was cited because it failed to immediately report the allegation of physical abuse to the Department of Public Health. Citation # 950012203.

Mountain View Convalescent Hospital

1333 S Fenton Avenue, Sylmar

On 4/27/13, a 59 year old male resident was admitted to the facility with cellulitis (bacterial infection) and abscesses on his legs. On 5/1/13, the resident was transferred to a hospital for evaluation of his legs. That same day, the facility refused to readmit the resident unless he signed a new admission contract with specific conditions regarding his behavior. The resident was discharged from the hospital and on 5/12/13, and lived on the streets until he was finally readmitted to the facility on 5/23/13. Citation # 920012129.
A resident suffered severe pain from 7/23/15 to 7/25/15 due to neglect. On 7/23/15, the resident was in terrible pain, rated 10 out of 10 (worst possible pain), causing her to shake and cry in distress. She complained of severe back pain, where she had newly developed pressure sores that had not been assessed for pain. Her doctor ordered pain medications that did not relieve the pain and on 7/24/15, after examining her, issued new orders for Roxanol, a narcotic pain medication. However, the facility did not obtain and administer this pain medication until early the next morning. Three of her family members stated that she was moaning and crying in severe pain during this period. The facility was cited because it failed to provide necessary care to prevent her suffering, did not assess her pain level, did not evaluate the effectiveness of the pain medication and did not administer ordered pain medication in a timely manner. Citation # 920011985.

On 4/18/12, a high risk for falls resident who needed assistance with care due to a stroke was hospitalized after falling from a mechanical lift while being transferred. The fall resulted in a head injury that required staples and left the resident in a constant state of pain. The CNA who was working the lift said she worked alone, place the resident in the lift's sling, then hoisted her all the way up. One of the four hooks came loose, tilting the resident and causing her to fall to the floor. An interview with the CNA revealed that the lift had not been working properly and there was no documentation to show preventive maintenance had been done on it. The facility was cited form failing to provide adequate supervision to a resident and ensure equipment was maintained in safe operation condition. Citation # 920012029.

The facility did not inform the resident's family about the resident's hospitalization indicated the resident had no pressure sores and its Resident Transfer Form prepared for admission was false. The facility was cited for failing to provide care need to prevent and to treat the pressure sores. Citation # 940011990.

On 1/13/15, the facility was informed by a family member that a relative, who was a former resident of the facility, had tested positive for influenza A after he died the acute care hospital. On 1/14 the facility was instructed by the Public Health Nurse (PHN)to start listing persons who may have been associated with an outbreak. Two residents were tested for influenza and their results were negative. On 1/15 the PHN performed nasal swab test on six resident that had shown symptoms of influence. On 1/18, four of the six tested positive and two of those died. On 1/9 through 1/16 there were 23 episodes of coughing with one complaint of a sore throat. The facilities report to the Department wasn't sent until 1/26. The facility was cited for failing to report the outbreak within 24 hours as require. Citation # 950012179.

A resident who was admitted to the facility on 9/8/15 was transferred to the ER on 9/15 for chest pain and decreased oxygen levels. The facility refused to readmit the resident and
she was transferred to another facility located more than one hundred miles from her home and family. The resident suffered from pneumonia, sepsisemia, anxiety, pain, depressive and bipolar disorder, and an obstructive airway that required use of supplemental oxygen. The facility told investigators that it was their practice to release the bed if the resident didn't request a bed-hold in writing within 24 hours. When interviewed, the hospital Program Manager stated that their request to discharge the resident back to the facility had been sent on 9/17 and the facility response was that there were no available beds. The facility was cited for an improper transfer and discharge Citation # 040012209.

Orange County

Pacific Haven Subacute and Healthcare Center

12072 Trask Avenue, Garden Grove
B $1500 Fall Patient Care 3/7/2016
On 12/4/15, a resident fell to the floor when two CNAs were providing incontinence care to the resident. One CNA left the resident's bedside, leaving the other CNA to care for the resident. As a result, the resident fell to the floor, sustaining an abrasion to his nose and a fracture to his right femur. Citation # 060012053.

Riverside County

AFVW Health Center

17040 Arnold Drive, Riverside
B $2000 Mandated Reporting Physical Abuse 1/27/2016
On 2/22/14, a certified nursing assistant (CNA) witnessed another CNA slap an 86 year old resident on the side of her face during an altercation triggered by the abusive CNA aggressively grabbing the resident's arm while helping her into a wheelchair. The witness did not report the incident to the Director of Nursing until 3/7/14, stating she "did not trust anyone" and did not think anyone would do anything about it. The facility was cited because it failed to report the alleged abuse until 13 days later, potentially exposing the resident to further abuse. Citation # 25001983.

Providence Mt. Rubidoux

6401 33rd Street, Rubidoux
B $2000 Careplan Mandated Reporting Patient Care 1/20/2016
The facility failed to communicate with the dialysis center regarding monitoring blood sugar levels during dialysis, and resident's status and response to dialysis treatments. As a result, a resident experienced two episodes of profound hypoglycemia and became unresponsive. A review of the resident's clinical record revealed no initial care plans for diabetes, dialysis, hypoglycemia or hyperglycemia. Resident 1 died on July 1, 2014 at 7:56 p.m. The facility failed to provide services to ensure Resident 1’s highest practical physical condition was best treated and monitored. Citation # 250011969.

San Diego County

La Paloma Healthcare Center

3232 Thunder Drive, Oceanside
B $2000 Mandated Reporting Sexual Abuse 02/04/2016
The facility was cited for failing to report an allegation of resident abuse within 24 hours. On 9/7/15, a family member called the facility to report that the female resident said a CNA who was cleaning the resident after a bowel movement placed a finger in her vagina. On 9/14/15, the DON was interviewed and stated the Administrator decided the allegation was not abuse and failed to report the allegation to the Department until after the police came to the facility to interview the resident. Citation # 080012010.