Are California Nursing Homes Prepared for Emergencies?

If the recent tragedies that unfolded following hurricanes Irma and Harvey are any indication, the answer is undoubtedly no.

In Florida, eleven residents of The Rehabilitation Center at Hollywood Hills died shortly after Hurricane Irma swept through the state, knocking out a transformer that powered the nursing home’s air conditioning system. On September 13, eight residents died after suffering there in sweltering conditions, with body temperatures reaching as high as 109.9 degrees. At least three more residents of the facility died during the following days and many more needed intensive care after emergency responders evacuated over 140 of them to local hospitals. Crime scene tape now drapes the nursing home as investigators ponder why so many critically ill residents were left in extremely dangerous conditions when a fully functioning hospital was just yards away. The nation is justly horrified by this tragedy.

In Texas, a photo of several residents sitting in waist deep water went viral on August 27 after Hurricane Harvey brought record flooding to Southeast Texas.

Why were these facilities and many others not better prepared to keep their residents safe? On September 20, 2017, the Senate Special Committee on Aging held a hearing to consider this question and hear from experts. At the outset of the hearing, Susan Collins, the committee chair, held up a voluminous report that contained recommendations made following Hurricane Katrina in 2005. Lessons have already been learned, over and over again in other disasters, but they are falling on deaf ears in too many nursing homes.

California nursing home and assisted living residents are at high risk from disasters. Although hurricanes are not a threat here, California is prone to wildfires, earthquakes, floods, mudslides and other types of natural disasters. Man-made disasters, such as fire, are another threat, and residents are increasingly at risk from extreme weather. During the recent prolonged heat wave, CANHR received reports that some nursing home residents were evacuated to San Francisco hospitals due to temperatures reaching 100 degrees inside of a facility. Not all California nursing homes have air conditioning. Over the Labor Day weekend, a 95-year old Millbrae resident at the St. Francis Pavilion assisted living facility died of heat stroke.

On September 19, NPR published an article titled, Many Nursing Homes Aren’t Prepared For Even Basic Emergencies. It reported that 53 percent of California nursing homes have been cited in the last four years for at least one of two deficiencies related to emergency preparation: training employees what to do in an emergency and carrying out unannounced staff drills; or having a detailed written plan for disasters and emergencies, such as fire, severe weather and missing...
Thank you Summer Interns!

CANHR would like to thank web development interns Dinesh Yallah and Soumithri, Chilakamarri, Computer Science graduate students for their excellent coding and web design work this summer at CANHR and to wish them well in their future endeavors.

CANHR also had the benefit of the services of Michele Cole, a U.C. Santa Cruz student, who assisted CANHR staff with a number of projects this summer. Thank you Dinesh, Soumithri, and Michele – we’ll miss you.

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.

Fall Workplace Giving

California Advocates for Nursing Home Reform is participating as a “non-affiliated beneficiary agency” in the United Way Work Place Giving Campaign for 2017. As A Certified Community Campaign Agency we are participating in:

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

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

Send Us Your Feedback and Your Support!

We would like to hear from you. If you have questions you would like answered, comments on our web site or on services you recently received, you can contact CANHR through our new feedback form. Visit our web page at www.cahnr.org, click on “contact us” and tell us what you think. You may also make a secure online donation to CANHR through our website by clicking the “Donate Now” button and following the simple instructions.
residents. A third of U.S. nursing homes have been cited for failing to inspect their generators each week or to test them monthly. Nursing homes usually face no consequences for flaunting these most basic safety requirements because inspectors treat the violations as minor deficiencies.

Regulations will not help residents in facilities that pay no heed to them or if state officials do not enforce them, but there are regulatory changes that should be made. In the wake of Hurricane Irma, Florida’s Governor rushed to establish emergency rules that require each nursing home and assisted living facility to have sufficient generator capacity and fuel to cool the facility to 80 degree or less for at least four days if electrical power is lost. The Florida nursing home industry helped kill proposed legislation following a 2005 hurricane that would have established similar requirements.

California officials should review and strengthen its emergency preparedness requirements and oversight now, rather than wait for disaster to strike.

CANHR has called on the Department of Public Health to establish comparable regulations on generator capacity and emergency preparedness for California nursing homes and to reexamine its methods of ensuring compliance with State and federal requirements.

Facility Responsibility for Resident Safety During Heat Waves

The suffering is preventable and should not occur. Nursing homes and assisted living facilities (known in California as “Residential Care Facilities for the Elderly” or RCFEs) are obligated to protect their residents from the heat.

Nursing Homes

The California Department of Public Health (DPH) is the state agency responsible for enforcing California and federal nursing home laws. In recent years, DPH has issued advisories to nursing home about their duties to protect residents during hot weather. The advisories suggest certain measures, such as using fans, monitoring resident conditions and offering frozen treats between meals. [AFL 17-15, Level II Excessive Heat Warning (9/1/17)]

To protect residents, nursing homes must take all possible measures to maintain their air conditioning and electrical systems in full working order during adverse conditions.

Comfortable and Safe Temperatures

To prevent illness, suffering and death caused by excessive heat, nursing homes are required to be well ventilated and to maintain comfortable and safe temperature levels at all times. Nursing homes that were certified for Medicare and/or Medi-Cal after October 1, 1990 must maintain a temperature between 71-82 degrees. [Title 42, Code of Federal Regulations, Section 483.10(i)(6)]

Air Conditioning

Although the law does not specifically require nursing homes to be air conditioned, nursing homes in many areas of the state must have air conditioning to comply with their legal mandate to maintain comfortable and safe temperature levels. Air-conditioned nursing homes must maintain their systems in normal operating condition to provide a comfortable temperature. [Title 22, California Code of Regulations, Section 72657]

Emergency Generators

Nursing homes are required to maintain emergency electrical systems in safe operating condition. Emergency generators must be tested at least every 14 days under full load condition for at least 30 minutes. [Title 22, California Code of Regulations, Section 72641; Title 42, Code of Federal Regulations, Section 483.90]

Residential Care Facilities for the Elderly (RCFEs)

The California Department of Social Services (DSS) is the state agency responsible for enforcing the laws governing RCFEs. DSS issues periodic heat advisories to remind operators that they must have contingency plans in place to deal with the loss of air conditioning, and an evacuation plan in case residents need to be moved to a cooler location. [PIN 17-08, Notice Regarding Extreme Heat in California (6/22/17)]

Comfortable and Safe Temperatures

RCFE residents have the right to safe, healthful and comfortable accommodations. [California Health and California’s Nursing Homes ...... (continued on page 4)
California’s Nursing Homes ................ (cont from page 3)

Safety Code, Section 1569.269(a)(5)] Additionally, RCFEs are required to maintain comfortable temperatures for residents in all areas of the facility, and to cool rooms to a comfortable range, between 78-85 degrees. [Title 22, CCR, Section 87303(b)]

Air Conditioning
California law does not require RCFEs to be air conditioned, but facilities in warmer areas of the state must have air conditioning because California law requires all facilities to maintain comfortable and safe temperature levels. [California Health and Safety Code, Section 1569.269(a)(5); Title 22, CCR, Section 87303(b)]

Emergency Generators
Although California law does not specifically require RCFEs to have emergency generators, it does require facilities to be safe and in good repair at all times. [Title 22, California Code of Regulations, Section 87303(a)] Since heat waves may cause power outages that threaten the welfare of residents, facilities should have emergency generators to comply with their legal mandate to keep residents safe and comfortable.

What Can You Do If Conditions Become Unsafe?
Conditions can grow dangerous quickly, so it is important to notify authorities immediately when temperatures become unsafe. Contact these offices:

State Regulatory Agencies:
Nursing Homes - California Department of Public Health (DPH): Call DPH immediately and file a complaint. If conditions are dangerous, tell DPH that residents are endangered and seek an immediate investigation. Contact information for DPH District Offices is available on the DPH website. If DPH does not respond, contact CANHR for further assistance.

RCFEs – California Department of Social Services (DSS): Call DSS’ toll-free complaint hotline at 844-LET-US-NO [844-538-8766] and file a complaint. If conditions are dangerous, tell DSS that residents are endangered and seek an immediate investigation. Contact information for DSS Regional Offices is available at the DSS website. If DSS does not respond, contact CANHR for further assistance.

Long Term Care Ombudsman: Ombudsman staff and volunteers assist residents of long term care facilities throughout California, advise residents about their rights, and investigate complaints. The CA Department of Aging website lists local Ombudsman programs.

California Attorney General’s Bureau of Medi-Cal Fraud and Elder Abuse: (800-722-0432; website: https://oag.ca.gov/bmfea/reporting): If one or more residents have died or suffered serious harm due to a facility’s failure to provide safe conditions, notify the Attorney General and request an investigation. You can also contact CANHR for referral to an attorney specializing in elder abuse and neglect (see http://www.canhr.org/LRS/index.html).

In addition, consider contacting your local media as there is often great interest about unsafe conditions during heat waves. And make sure you inform your California legislators about your concerns.

GET YOUR COPY NOW!
THE NEW MEDI-CAL RECOVERY LAWS
Provides guidance on the new Medi-Cal Recovery laws that are effective for those individuals who die on or after January 1, 2017.

Download your free copy at canhr.org/medcal/medcal_recoveryinfo.htm or call the CANHR office to purchase multiple copies. Available in multiple languages.
**Families and Residents Win!**

**Defeat Sutter’s Attempt to Close St. Luke’s Sub-acute Unit**

California hospitals are finding that some families and residents are prepared to fight back when they try to close sub-acute units. Such was the case at St. Luke’s sub-acute unit in San Francisco after the California Pacific Medical Center (CPMC) announced in June 2017 that it would close the unit. The 24 residents — many whom have lived at St. Luke’s for years and depend on various medical devices and specialized nursing care to keep them alive — were threatened with transfers to facilities as far away as Sacramento and Los Angeles. Instead of accepting the trauma, isolation and likely death that would accompany such evictions, the families chose to fight back.

The families organized a family council; connected with city, union and activist leaders; held press conferences and protests; and repeatedly testified at public hearings about the need to stop the closure of San Francisco’s last remaining sub-acute unit. Their eloquent protests attracted widespread media attention in the Bay Area and earned strong support from the Board of Supervisors. On September 11, CPMC (an affiliate of Sutter Health) surrendered, *issuing an announcement that the sub-acute unit would remain open* for now and that all of the remaining residents would be relocated to a different CPMC campus in San Francisco sometime next year.

On September 21, 2017, KALW, a public radio station in San Francisco, *aired a report on the impact of disappearing sub-acute beds in California hospitals,* citing a 17.8 percent drop in hospital-based skilled nursing facilities. As hospitals close more of these specialized units, there is increasing danger that the evicted residents will be exiled to very distant facilities, separating them from everyone and everything they care about. Death often follows.

In San Francisco, the families and residents did not accept this fate. Their successful campaign against the closure sends a strong message to California hospitals with sub-acute units that each of their residents deserves to be treated with the utmost care and respect and they will pay a heavy price if they decide to treat any of them as a disposable product.

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**Inspector General Warns Nursing Home Residents Are at Risk of Abuse**

On August 24, 2017, Daniel Levinson, the Inspector General for the HHS Office of Inspector General (OIG), *called on the Centers for Medicare and Medicaid Services (CMS) to take immediate action to protect nursing home residents from abuse* following a remarkable investigation that found CMS is not enforcing abuse reporting requirements in the Affordable Care Act that took effect in 2011. The investigation, like many before it, shows that nursing homes and public officials are often apathetic when residents suffer sexual assaults and other serious crimes.

The ongoing OIG investigation identified 134 Medicare beneficiaries who appear to have been victims of rape and other mostly sexual crimes. Eight of them lived in California nursing homes. OIG used emergency room records to identify victims and evaluate the response. More than one-quarter of the cases were not reported to law enforcement as required. State survey agencies that are responsible for investigating nursing home abuse have substantiated only 7 of the 134 incidents.

Inspector General Levinson urged CMS to enforce the law and to follow OIG’s lead in using emergency room records involving nursing home residents to identify potential cases of abuse and neglect.

The OIG alert closely follows CNN’s most recent report in its ongoing investigation of sexual abuse in U.S. nursing homes.

**CMS Launches Jimmo Settlement Agreement Webpage**

In accordance with a February 1, 2017 court order, the Centers for Medicare and Medicaid Services (CMS) *launched a website in late August with information and resources on the Jimmo Settlement.* Jimmo is a landmark case brought on behalf of a nationwide class of Medicare beneficiaries who were illegally denied coverage and access to skilled nursing home or home health services because they did not show sufficient potential for improvement. The Jimmo Settlement Agreement clarifies that Medicare coverage of skilled nursing and skilled therapy services does not turn on the presence or absence of a beneficiary’s potential for...
Good News for Married Couples Seeking Nursing Home Alternatives Covered by Medi-Cal

In 2014 the Federal Government issued guidance to the states about a new law under the Affordable Care Act, expanding “Spousal Impoverishment Protections” to Medi-Cal applicants eligible for Home and Community-Based Services (HCBS). California failed to implement this new law until advocacy groups filed a lawsuit asking the court to force California to apply the expanded protections immediately and retroactively apply benefits to those who would have been eligible during that period. As a result, the California Department of Health Care Services (DHCS) released (All County Welfare Director’s Letter 17-25) implementing the expansion. The expansion will allow spouses to keep their loved ones at home and avoid institutionalization without exhausting all their financial resources.

How does Spousal Impoverishment work?
Under California law, Spousal Impoverishment Protections allow the spouse of a Medi-Cal beneficiary receiving HCBS to retain additional assets, i.e., a “Community Spouse Resource Allowance (CSRA)” of up to $120,900. The Community Spouse may also keep all income in his/her name, without it going towards Share of Cost. And, if his/her income is less than $3,023, he/she may receive an allocation from the Medi-Cal spouse’s income to reach $3,023.

Example: Barbara and Fred are married; Fred has Multiple Sclerosis and needs HCBS services. Barbara is still working and earning a monthly income of $2,000. Fred only receives Social Security of $1,368. Combined they have a savings of about $50,000. Fred will be eligible for Medi-Cal, because the $50,000 is under the asset threshold for Spousal Impoverishment. Barbara will be able to keep all her income. Fred will be able to keep a $600 maintenance needs allowance and give Barbara the remaining income as a monthly allocation. For more examples see ACWDL 17-25.

What are Home and Community-Based Services (HCBS)?
Medi-Cal HCBS programs/waivers are alternatives to nursing homes, for individuals who would otherwise require care in a skilled nursing facility or hospital. For more information about individual programs visit http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalWaiversList.aspx

How does someone apply for HCBS with Spousal Impoverishment protections?
To access Spousal Impoverishment under the HCBS programs/waivers, the applicant must:

- Already be on Medi-Cal or applying for Medi-Cal
- Notify Medi-Cal that they need HCBS or be in the process of applying for an HCBS waiver
- Prove they meet the clinical criteria for skilled nursing care by a) approved assessment from an HCBS program or b) submit a completed Doctors Verification Form (Form included on ACWDL 17-25)

I am an IHSS recipient, is that considered a Home and Community Based Service program?
Community First Choice Option (CFCO) is an HCBS program offered through IHSS. A large percentage of IHSS recipients are enrolled in CFCO. IHSS recipients can verify with the Medi-Cal office whether they are on CFCO. To apply for CFCO, the individual must contact IHSS to request an assessment. There is no waitlist and it is available in all 58 counties in California.

What if the desired HCBS program has a waitlist?
Spousal Impoverishment provisions apply to HCBS applicants on waitlists, regardless if the wait is two months, two years or more.

More questions?
Call CANHR’s Toll-Free Hotline 1-800-474-1116 and ask to speak to an Advocate.
Did You Know?

Nursing home residents have the right to a 7-day bed hold when hospitalized

Upon admission to a skilled nursing facility, among the many documents that a resident has to read and sign should be an official document informing the resident of the facility’s bed-hold policy. The facility’s particular bed-hold policy should correspond with the state and federal regulations that give residents the right to have their own bed held for seven days while they are in the hospital. This applies to both Medi-Cal and private pay residents, the only difference being that private pay residents are responsible for paying for those seven days that they are out of the facility. The days are counted from the day the resident leaves the facility and signs a bed-hold notice. The day the resident returns to the facility is not counted as a bed-hold day (Cal. Code of Regulations, Title 22 § 51535.1(c)(3)).

After seven days, the facility may give that resident’s bed away to a new resident in need. However, Medi-Cal residents have the right to the first available bed in the facility when they are ready to return. Private pay residents also have this right if the facility fails to notify them of their bed-hold rights. Facilities will often try to get away with refusing readmission to Medi-Cal residents. This is informally called “hospital dumping” and is against the law. All residents have the right to appeal when readmission is denied.

In addition to including information about bed-hold policies in the admissions agreement, the facility must give a written bed-hold notice to the resident and/or the resident’s family upon being transferred to the hospital, as is required by both federal law and state regulations (CCR Title 22 § 72520(b) & 42 C.F.R. §483.15(d) & (e)(1)(i)) If the resident returns to the facility within the seven days, he/she should return to the same room and same bed, without having to sign new admission agreements. Signing new contracts or rules should never be a condition of readmission for the resident.

Dear Advocate,

Both my parents are World War II veterans. My dad has Parkinson’s and my mom is in the beginning stages of Alzheimer’s. I’ve been caring for both of them at home, 24 hours a day, 7 days a week, for two years. I’m exhausted! and I don’t know what to do anymore. Is there any help for me from the VA? I don’t want to put them in a home, but I don’t think I can do this much longer without a break.

Sincerely,
Respite Needed NOW

Dear Respite Needed,

Your parents would likely qualify for some VA home care benefits. The Veteran’s Affairs (VA) has a “VA Caregiver Support” Program. Their helpline operates Monday-Friday 8am-11pm ET and Saturday 10:30am-6:00 ET. The helpline offers information about services available to your parents from the VA, such as VA Aid and Attendance benefits that can help pay for home care. They can also put you in contact with a Caregiver Support Coordinator. The VA’s Caregiver Support Line’s toll free phone number is 1-855-260-3274 or visit them on the web at: http://www.caregiver.va.gov/
In 2000, I entered the CCRC where I currently reside. I paid a monthly fee of $1,777 per month. Today, I am paying a monthly fee just shy of $6,000 per month ($67,000 per year). When I explained to the executive director that the amount I was paying exceeded my income, he suggested I move into a studio apartment to reduce my monthly care fee. At my age of 92, a move of this type would result in the following:

- I would have to give up my office where I produce my columns and my special equipment design for visually impaired people.
- I would probably, due to my frail condition, become ill.
- I would have to get rid of most of my possessions, which would affect my identity.
- For the administration, it would free up my apartment to be sold to a couple resulting in a huge sum of money for the administration in excess of what I am paying.

For 16 of the 17 years I have resided in the CCRC, my food needs were challenged because I would not move into a skilled nursing facility in order to get my pureed food. I have a condition called cricopharyngeal spasms, which requires special preparation of my food. The first administration reaction was that I was to move out of my apartment into the skilled nursing facility in order to obtain pureed food. I refused and insisted that my pureed food be given to me in my apartment. I had to resort to the legal system to get what I needed despite the fact that my contract stated that if a special diet were required, the CCRC would have to provide it. There is no mention in the contract as to where it should be provided.

I prevailed. Sixteen years later I’m still in my apartment and living a normal life. However, the management met my food needs grudgingly. I was made to feel like a criminal because I had this condition.

I began to write my columns and covered many issues of the violation of CCRC residents’ rights. I became involved in helping to pass legislation that protected residents from abusive administrations. Increasingly, efforts to intimidate and silence me were encouraged. Key employees participated in this effort. Methods were always used to deny my polite request so that I would become strident and could be accused of being controversial.

My triumph was when a bill legislating the establishment of a family council was passed into law. In 2016, at the facility where I reside, there is an active and effective family council, which meets regularly. I was put on the agenda at the July 13, 2017 family council meeting. The topic I covered at the meeting was “How a CCRC Resident Can Run Out of Money.”

A CCRC resident can make all the right and logical financial decisions, but under CCRC rules that can absolve the CCRC management forever being responsible for such a resident financially. Many family council committees are working on issues long overdue for attention in the facility, including the issue addressed in this column.

I am considered controversial because I continue to be outspoken about these issues and write about them. It is my hope that by informing my readers they will be saved from unpleasant surprises after they have signed a contract with the CCRC facility. It is urgent for marketing directors to be very specific and truthful when informing CCRC prospective residents of exactly how their financial structure will affect the way CCRC administrators will deal with their particular financial structure.

The question that should be asked. “Will they truly be responsible for that resident’s life care without bankrupting the resident?”

Professor Hyatt is an AARP California policy advisor. Professor Hyatt can be seen on YOUTUBE on the USC School of Social Work website at https://www.youtube.com/watch?v=CMrC6o6Rm04
Legislation Update, September 2017

CANHR supported or opposed the following pieces of legislation this session. A number of the bills died in committee and the successful ones are now on the Governor’s desk. Governor Brown has until October 15 to sign, not sign or veto bills. Please check www.canhr.org for updated details on legislation, and www.leginfo.ca.gov for information on specific bills.

Support

AB 275 (Wood): Strengthening Closure Protections for Nursing Home Residents

AB 275 would take modest steps to enhance protections for nursing home residents during a facility closure. The bill responds to a 2016 crisis in Eureka when Shlomo Rechnitz – who owns all five freestanding facilities in Eureka – threatened to close three of them in an effort to obtain higher Medi-Cal payments. **Status: Signed by the Governor.**

AB 286 (Gipson): To Allow Medi-Cal Beneficiaries to Return Home

Under current law, Medi-Cal beneficiaries in nursing homes may retain a “home upkeep allowance” of $209 per month if a doctor certifies they are likely to return home within 6 months. AB 286 would base the allowance on the actual cost of maintaining the home. **Status: DEAD.**

AB 550 (Reyes): Restoring Funding for Long Term Care Ombudsman Programs

In 2008, the 35 local Long Term Care Ombudsman programs had all state funding cut, leading to enormous reductions in staff and services for residents of long term care facilities. AB 550 partially remedies this problem, by boosting the base funding allocation and adding $2.25M in total funding. **Status: DEAD.**

AB 859 (Eggman): Protecting Seniors Abused by Nursing Homes

This bill will protect seniors and dependent adults abused in nursing homes and discourage facilities from intentionally destroying evidence in violation of the law. AB 859 provides that when a judge or arbitrator finds the nursing home has illegally destroyed evidence, the standard of proof is reduced from clear and convincing to preponderance of the evidence. **Status: Vetoed by Governor.**

AB 937 (Eggman): Requests Regarding Resuscitative Measures

Since the adoption of the Physician Order for Life-Sustaining Treatment (POLST) law in 2008, third party “representatives” may override a patient’s prior expressions of treatment preferences by executing a POLST. AB 937 would re-establish patients’ control over their own health decisions by ensuring that in any conflict among instructions, the patient’s most recent expression is given primacy. **Status: Vetoed.**

AB 940 (Weber): Transfer and Discharge Notices to Long Term Care Ombudsman

This bill codifies a federal regulation that requires nursing homes to send copies of resident transfer or discharge notices to the local long-term care Ombudsman. **Status: Signed by the Governor.**

SB 202 (Dodd): Medi-Cal Personal Needs Allowance

This bill would increase the personal needs allowance for residents of long term care facilities on Medi-Cal from $35 per month to $80 per month. **Status: DEAD.**

SB 218 (Dodd): The Qualified ABLE Program

This bill will prohibit the state from filing a claim against a beneficiary’s CalABLE account for recovery of medical assistance paid under Medi-Cal. **Status: On the Governor’s desk.**

SB 219 (Weiner): LGBT Senior Bill of Rights

SB 219 prohibits long term care facilities from taking discriminatory actions based on a resident’s actual or perceived sexual orientation, gender identity, gender expression, or HIV status. **Status: Signed into law.**

SB 416 (Anderson): Elder abuse: Isolation

This bill would make it a crime for a caretaker of an elder or dependent adult to willfully isolate that adult. **Status: DEAD.**

Legislation Update .................. (continued on page 11)
Five Hot Topics in RCFEs

Every day, CANHR receives calls and emails from residents of Residential Care Facilities for the Elderly (RCFEs) seeking help. These calls and emails are critical as they inform our advocacy efforts! Over the last year, we have heard from a number of people with common complaints. Here, in a nutshell is a description of the complaints and a short summary of how to resolve them.

1. **Monthly Fee Increases.** In some RCFEs, rate increases seem to come fast and furious, often tied to alleged increases in the care the resident needs. Many rate increases imposed on residents are illegal! Primarily, RCFE admission agreements often violate Health and Safety Code Section 1569.884’s requirement that fees be carefully detailed. Residents should know exactly what each dollar they spend is buying them. A lot of agreements don’t have such specificity; instead, they have references to “levels of care” that are only vaguely described. When the fees aren’t detailed, they can be challenged.

   One strategy for assisted living profitability is to give residents a low price when they move in and have them sign an admission agreement that gives the facility complete discretion over the services the resident will get. Once the resident has moved in, the facility is then free to perform a “reassessment” and allege increased needs that come with increased costs. The facility has total control over how much the resident will be charged. Many residents are loathe to move again and feel trapped into paying the additional fees. If you are given a rate increase that seems unfair or otherwise objectionable, take a close look at the admission agreement. If you don’t see a thorough explanation of the services that each dollar buys, call CANHR.

2. **Pharmacy Fees.** The RCFE market is increasingly important to pharmacies and they all seem to be fighting hard for lucrative deals with facilities. As a result, RCFEs are increasingly likely to have a “preferred pharmacy” to which they steer residents. Even more troubling, some facilities impose fees, often several hundred dollars a month, on residents who use a different pharmacy. Health and Safety Code Section 1569.314 prohibits facilities from charging fees for selecting one pharmacy over another and Section 1569.269(a)(20) ensures a resident’s right to choose their pharmacy.

3. **SSI as a Payment Source.** If a resident of an RCFE runs out of money to pay for their care and qualifies for federal Supplemental Security Income (SSI), the facility must accept the SSI board and care rate as payment in full. The 2017 board and care rate is $1158 per month. The resident must be permitted to keep $132 per month for personal needs and the facility is paid the remaining $1026 per month. Many facilities don’t like accepting the board and care rate and often tell residents that the facility “does not take SSI.” But it has to. 22 Cal. Code of Regulations Section 87464(e) provides that “if the resident is an SSI/SSP recipient, then the basic services shall be provided and/or made available at the basic rate at no additional charge to the resident.” The “basic rate” is defined in Section 87101(b)(1) as “the SSI/SSP established rate, which does not include that amount allocated for the recipient’s personal and incidental needs.”

4. **Visitation Rights.** Who controls the residents’ right to visit with friends and family? The residents do. The only time a third person may interfere with a resident’s right to visitation is if that third party is a court-appointed conservator with specially expressed power to control visitation. Agents under powers of attorney do not have the power to control visitation. In cases where a resident is unable to express agreement or objection with a proposed visit, residents should enjoy a presumption that the visits are welcome. For more information about visitation rights see CANHR’s guide “Your Right to Visit.”
5. **Evictions.** There are only five reasons a resident can be evicted from an RCFE – but a great number of admission agreements claim nine, ten, or up to fifteen reasons. Eviction cases are on the rise and residents need to know their rights. They have the right to advance written notice that includes information about their right to an administrative appeal with the Department of Social Services. They have the right to not be evicted unless one of the five legal reasons is satisfied. And they have the right to not only file an administrative appeal but to challenge their eviction in court. For more information about RCFE eviction issues, see [CANHR's eviction fact sheet](#).

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**Long Term Care News** (continued from page 5)

improvement, but rather on the beneficiary’s need for skilled care.

More information is available from the [Center for Medicare Advocacy's press release](#) on the new CMS webpage on *Jimmo*.

**Brius Healthcare’s Insider Transactions**

On August 16, 2017, the National Union of Healthcare Workers (NUHW) released a report describing how Shlomo Rechnitz, the CEO of Brius Healthcare, may be profiting at the expense of residents of his nursing homes by steering millions of dollars in taxpayer funds to a web of companies he created to service his nursing homes. Rechnitz is California’s largest nursing home operator, owning or operating about 80 nursing homes in California.

The NUHW report, *Brius Healthcare’s Insider Transactions*, states that in 2015 Rechnitz companies received $67 million in payments from Brius nursing homes, some of which were in the form of inflated rents. The report concludes that Californians expect nursing home operators to provide quality care, not to devise transactions that divert public funds from resident care.

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**Oppose**

**AB 130 (Assembly Budget Committee): Health and Human Services**

This is a budget bill that would allow skilled nursing facilities that do not meet California’s minimum staffing requirements to qualify for bonus Medi-Cal payments from the Quality Accountability Supplemental Payment Program. **Status: Signed by the Governor.**

**AB 150 (Mathis): Disabled Persons: Rights: Liability**

This bill would prevent a person from filing a complaint under the Disabled Persons Act (DPA) against businesses with fewer than 50 full-time employees, unless the person notifies the business and waits six months to see if the violations continue. **Status: DEAD.**

**AB 1026 (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 enable the expansion of for-profit nursing home chains that are providing poor care to their residents. **Status: DEAD.**

**Federal Proposed Laws**

**H.R. 1215 – OPPOSE**

Congress is considering a bill that will effectively end California’s 20-plus year civil protection system for victims of elder abuse or neglect perpetrated by health care providers. While California already has a $250,000 cap on non-economic damages – the centerpiece of H.R. 1215 - elder and dependent adult abuse cases are rightfully exempt. H.R. 1215 would end this critical exemption. H.R. 1215 inoculates an entire class of professionals and the health care industry from being held liable when their actions fall below, even far below, the acceptable standards or when they intentionally hurt a patient. **Status: U.S. Senate Judiciary.**
Past Speaking Engagements, Panel Discussions and Training Sessions

- **June 20**: Pauline Mosher presented on Transfer Discharge Rights and Long Term Care Medi-Cal to 37 HICAP volunteers at the SOBRATO Conference center in San Jose.

- **June 21**: Tony Chicotel presented with attorney Tom Andrews on RCFE care and cases as part of CANHR’s webinar series for private bar attorneys.

- **July 13**: Yvonne Hernandez Long Term Care Advocate presented to the Contra Costa County Aging & Adult Services Agency about CANHR Services and Resources.

- **July 24**: Pauline Mosher hosted a table featuring CANHR consumer publications at the San Francisco State IAGG Conference Local Educational Trip. 40 attendees representing 14 countries attended.

- **July 26**: CANHR Staff provided CANHR resources and information at the Music on the Main Event in Richmond.

- **July 28**: Jody Spiegel Participated in the RCFE Advocates Quarterly Meeting with Community Care Licensing.

- **August 5**: Prescott Cole participated in the Legal Services State Bar Coordination Meeting conference call.

- **August 8**: Jody Spiegel gave a presentation on Residential Care Facilities for the Elderly to the WISE & Healthy Aging Long Term Care Ombudsman Program as part of its Certification Training Program.

- **August 11**: Efrain Gutierrez hosted a CANHR resource and information booth at the 15th Annual Senior Fair at Cerritos College, courtesy of Congresswoman Linda Sanchez.

- **August 11**: Julie Pollock and Pauline Mosher gave a presentation on Medi-Cal and Home and Community Based Services for social workers in Oakland, CA.

- **August 16-present**: Yvonne Hernandez and CANHR staff supported the St. Luke’s Family Council with their fight against the closure of the Subacute Unit in San Francisco.

- **August 19**: Efrain Gutierrez provided CANHR resources and information at the Super Saturday Senior Fair at the Buena Park Senior Activity Center.

- **August 20**: Prescott Cole testified on long term care insurance issues at the Assembly Committee on Aging’s Information Hearing on Financial Long-Term Care Services and Support.

- **August 21**: Prescott Cole was a participant on a conference call with the Attorney General’s Office about revamping the “Face It It’s a Crime” public awareness campaign.

- **August 30**: Julie Pollock attended a family council meeting at Sagebrook Senior Living / Eden Villa Senior Living in San Francisco.

- **September 27**: Yvonne Hernandez, Long Term Care Advocate provided CANHR resources and information at the SF Department Partnership for Community - Based Care and Support Aging Your Way Resource Fair.
CANHR Advocate Yvonne Hernandez joining families from St. Luke’s Family Council to protest the closure of the San Francisco Subacute Unit.

Pat McGinnis thanks web development interns Dinesh Yalla (l), and Soumithri Chilakamarri (r), along with CANHR’s mascot, Fozzy.

Planned giving leaves a legacy to honor your memory and helps to ensure the future of CANHR.

CANHR has been a not for profit 501(c)(3) corporation since 1983. With careful planning, it is possible to reduce or eliminate income and estate taxes while turning appreciated assets into income for yourself or others.

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- gifts by will
- gifts of life insurance
- gifts 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.
CANHR welcomes memorial and honorary gifts. This is a great way to honor a special person or a loved one, while helping those who are long term care residents. Recent gifts have been made in the names of the following persons:

<table>
<thead>
<tr>
<th>Memorials</th>
<th>In Honor Of</th>
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<tbody>
<tr>
<td>Mary W. Ballantyne</td>
<td>My mother, Alice Scobey and for the wonderful work you do.</td>
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<tr>
<td>Bob Peterson</td>
<td>Mary Webster</td>
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<td>Linda Bradford</td>
<td>Pete Summers</td>
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<td>Donald Freeman</td>
<td>Charlene Harrington</td>
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<td>Ben Frankfield</td>
<td>Lottie Swamis</td>
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<td>Elizabeth Boileau</td>
<td>Judith Betts</td>
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<td>Annabelle Griffith</td>
<td>Vending Thomson</td>
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<td>Ellen Griffith</td>
<td>Lance W. Thomson</td>
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<td>E. Johnson</td>
<td>My Beloved Mother - Rita</td>
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<td>Sandra Tucker</td>
<td>Denise Twomey</td>
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<td>Timothy Millar</td>
<td>Gary Zacher</td>
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<td>Patrick Nakao</td>
<td>Janice Zacher</td>
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<td>Our Parents</td>
<td>Seth Emery</td>
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<td>Mr. &amp; Mrs. Kenneth C. Burchill</td>
<td>Patricia Emery</td>
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**Upcoming Events**

- **October 16:** CANHR Staff will be providing CANHR resources and information at the SF Department of Aging and Adult Services and The SF Interfaith Council Resource Fair for Older Adults and Persons with Disabilities. The event is at St. Mary’s Cathedral from 8:30 a.m. - 12:00 noon.

- **November 3:** CANHR will be hosting a resource and information table at the Nakaoka Community Center Senior Fair, 1670 W. 162nd St., Gardena, CA 90247
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.

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Alameda County

Driftwood Healthcare Center - Hayward

19700 Hesperian Blvd., Hayward

B $2000 Fall Injury Patient Care Physical Environment Supervision 8/17/2017

On 6/12/17, a male resident fell and fractured his rib when the nursing assistant improperly transferred him from his wheelchair to his bed using a Hoyer lift. One of the sling loops came off the mechanical lift’s hook during the transfer. The nursing assistant was transferring him alone, even though she was aware two people were required when using a Hoyer lift. The resident was transferred to the hospital. The facility was cited for failure to ensure that the resident environment remains free from accident hazards and failure to ensure that each resident receives adequate supervision to prevent accidents. Citation # 020013416.

Hayward Springs Care Center

21863 Vallejo St., Hayward

B $2000 Careplan Supervision 3/22/2017

On 11/16/16 Resident 1 with a neurological disorder was left unattended with another resident 2 and an altercation ensued when resident 1 was seen punching resident 2 all over the face and body. Resident 1 sustained multiple bruises on his face, chest, back and was bleeding across the nose bridge. The Licensed Vocational Nurse stated that this was not the first time that resident 1 was involved in a altercation with other residents or staff members. The facility failed to supervise resident 1 to prevent harm to resident 2. This violation has a direct relationship to the health, safety, or security of other residents. Citation # 020013072.

B $2000 Injury Mandated Reporting Patient Rights 3/22/2017

On 2/20/17, a female resident told the Director of Nursing that she had been hit on the head by a male nursing assistant. The resident stated this was not the first time the male nursing assistant hit her. A licensed nurse was stated that she had observed red marks on this resident’s face on more than one occasion. Another nursing assistant stated that whenever the accused male nursing assistant would shower or care for a resident, the resident would have red marks on their bodies. She stated that the female resident in question had gone to the activities room with red cheeks several months ago, and screamed that the same male nursing assistant had hit her. Two other staff members observed bruising on the resident’s right thigh on 12/31/16, after a shower with the accused nursing assistant. The facility was cited for failure to implement abuse prevention policies and procedures, and failure to report or investigate allegations of abuse. Citation # 020013076.

B $2000 Mandated Reporting Mental Abuse Patient Care Physical Abuse 3/22/2017

A resident stated that on or around 9/23/16, a male nursing assistant intentionally put his finger in the resident’s anus while changing him, in order to cause pain. The resident yelled, “Stop doing that!” and the nursing assistant replied “I’m not hurting you.” Another nursing assistant reported that during a night shift (couldn’t remember the date) the resident told her that the male nursing assistant put his finger in the resident’s anus. The nursing assistant reported it to the charge nurse, who told her to put it in the “grievance book” and took no other action. The facility failed to investigate the allegation of abuse and failed to report the abuse to the police, ombudsman, and the Department. The accused nursing assistant continued to provide hands on care to residents. Citation # 020013073.

Kindred Nursing and Rehabilitation - Medical Hill

475 29th Street, Oakland

B $1200 Careplan Fall Injury Patient Care Supervision 07/07/2017

A resident known for falls and with a care plan that requires 2 people to assist in using the bathroom was left unattended in the bathroom and later found laying down on the floor. The resident was sent to the hospital for evaluation. The resident suffered a fractured left tibia and fibula. The resident was discharged with a cast on the left lower leg. The facility failed to provide the assistance of two staff members to prevent the fall. This violation has direct relationship to the health, safety, or security of the resident. Citation # 020013332.

B $1200 Careplan Injury Neglect Patient Care Supervision 5/02/2017

A resident diagnosed with dementia and behavioral disturbances was served hot tea in a lightweight foam cup, and left unattended. The resident spilled hot tea on herself and sustained a second degree burn on the side of her elbow. The resident’s physician
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Lake Merritt HealthCare Center LLC

309 MacArthur Blvd., Oakland

B $2000  Bed Hold  5/15/2017
On 4/21/17, the facility denied re-admission to a resident who was hospitalized the prior day. The facility stated there were safety issues for not taking him back. However, the hospital reported the resident was pleasant and did not have any behavioral problems. He remained in the hospital for at least 20 days due to the facility’s refusal to readmit him. The administrator acknowledged the duty to readmit the resident but stated: “I’d rather you (State Evaluator) write me up than to receive (Patient 1) back!” The facility was cited because its failure to readmit the resident violated his right to return and resulted in his “continued, medically unnecessary stay at the acute care hospital with no place to be discharged.” Citation # 020013197.

B $2000  Careplan Fall Injury Patient Care Supervision  Staff (Inservice) Training  Staffing  08/01/2017
Resident was transferred from wheelchair to bed without an assistive device or without the assistance of another staff member. During the interview the CNA stated since everyone else was busy; she decided to transfer the resident by herself. The CNA was not able to hold the resident’s weight and the resident fell over on the floor with the wheelchair on top of her. The resident’s eye hit the side of the bed table in the process. The CNA also stated that she never used a mechanical lift to transfer the resident. The facility failed to ensure resident safety during transfer to and from a wheelchair. This violation has a direct effect on the health, and safety of the resident. Citation # 020013393.

Morton Bakar Center

494 Blossom Way, Hayward

B $2000  Mandated Reporting  Physical Abuse  3/27/2017
Facility surveillance video showed that a certified nursing assistant (CNA) pushed a resident in the face and pulled on her shirt on 5/30/16. Another CNA witnessed the abuse but did not report it as required. The facility allowed the witness to continue to provide resident care despite her failure to report the abuse as required. The facility later removed the abuse witness from providing care on 6/21/16. The facility was cited because it failed to protect the residents from further abuse. Citation # 020013082.

Contra Costa County

Kindred Transitional Care and Rehabilitation-Walnut Creek

1224 Rossmoor Parkway, Walnut Creek

AA $100000  Neglect  Patient Care  08/07/2017
A resident died on 10/28/15 following a scheduled tracheostomy tube change at the facility. Prior to the procedure, the resident did not have any respiratory issues and her vital signs were stable. After the tracheostomy change, the resident’s oxygen saturation level dropped, her skin changed to an ashy color, and she experienced acute respiratory failure. The Director of Respiratory Therapy who helped perform the procedure stated the facility did not have emergency protocols in an event like this, only to call 911. She was transported to the emergency room where she died a short time later. The Coroner issued a report stating that the cause of death was acute respiratory failure, with bilateral collapsed lungs, due to improper placement of tracheostomy tube, with tracheal and esophageal perforation. The facility was cited because it failed to ensure staff hyperextended the resident’s neck prior to changing her tracheostomy tube and failed to use an oral bag mask to ventilate when she experienced respiratory difficulty after the new tracheostomy tube was inserted, resulting in her death. Citation # 020013410.

B $1500  Injury Supervision  8/23/2017
On 5/16/17, a resident whose diagnoses included multiple sclerosis suffered a second degree burn on her abdomen when she spilled hot tea while drinking from a foam cup with a lid that did not fit the cup. The resident described the burn as painful. The facility was cited for failing to provide the resident with necessary supervision and assistance. Citation # 020013446.

Lafayette Care Center

1010 First Street, Lafayette

B $1000  Careplan  Decubiti (Bedsores)  Patient Care  3/22/2017
A male resident with paraplegia was admitted to the facility on 11/18/16. By 2/16/17, he had developed severe bedsores on the right hip and right toe and advanced bedsores on the right and left heels. The facility was cited for failure to prevent bedsores for one of three sampled residents. Citation # 020013062.

B $1800  Infection Injury  Physical Environment  3/22/2017
In March of 2017, the facility was cited for failure to prevent rodent and insect infestation for 4 of 21 resident rooms. Two residents had a dead rodent removed from their room, and there was extensive evidence of rats in the kitchen. Another resident was bitten by a “deadly spider” on 12/23/16 and was prescribed antibiotics for the bite. Citation # 020013061.

Lone Tree Convalescent Hospital

4001 Lone Tree Way, Antioch

B $1500  Careplan Fall Injury Patient Care Staff (Inservice) Training  8/25/2017
A resident known for falls and diagnosed with dementia required extensive assistance from two staff members for transfer to and from a wheelchair. The CNA attempted to transfer the resident alone and the resident fell to the floor. Two days after the fall, the resident indicated pain in the right leg with swelling of the thigh and knee. The resident was transferred to the hospital where it was noted a sharp piece of bone just under the skin was rotated inwardly. The resident was treated for a femoral stress fracture and small femur fracture. The resident underwent surgery and a cast was placed on the right leg. The resident was then discharged from the hospital to have hospice care. Citation # 020013450.

Madera County

Golden Living Center - Chowchilla
A female resident was wheelchair bound and known to have behaviors of wandering into other residents rooms. A male resident was known to have inappropriate sexual behaviors towards other residents and required direct visual monitoring of his whereabouts within the facility every 15 minutes. On 11/23/16, the female resident wandered unsupervised into the male resident’s room. Sometime after she wandered in, the female resident was observed sitting on his bed next to him, her hand was inside his brief and his finger inserted into her vagina. The facility failed to prevent her from wandering unsupervised and failed to monitor her whereabouts every 15 minutes. The facility also failed to ensure that the female resident was free of sexual abuse. Citation # 040013181.

Monterey County

Cypress Ridge Care Center
1501 Skyline Drive, Monterey
B $2000 Careplan Patient Care Patient Rights Transfer 6/1/2017
The facility sent three residents, one of whom had lived in the facility for nearly four years to a different nursing home over 200 miles away with hardly any notice. At least two of the residents were told they would otherwise end up “on the street.” The facility was cited for improperly transferring the residents, failing to notify them in writing at least 30 days prior to the transfer, and failing to advise the residents of their rights to appeal. Citation # 070013241.

Monterey County

Kindred Nursing and Transitional Care-Pacific Coast
720 East Romie Lane, Salinas
B $2000 Patient Care 7/18/2017
CNA failed to transfer the resident safely from the wheelchair to the bed. The resident required a two person transfer, however CNA attempted to transfer resident by himself. CNA placed the wheelchair with resident’s weaker side against the bed, and in the process of the transfer resident’s prosthetic leg did not pivot, causing pain and his right hip to fracture. Citation # 070013346.

Windsor Skyline Care Center
348 Iris Drive, Salinas
B $2000 Decubiti (Bedsores) 6/14/2017
On 5/19/17, the facility discontinued treatment to prevent a pressure ulcer for a resident who was at risk due to impaired mobility, incontinence and other behaviors. Resident’s left heel had no treatment and no pressure relieving device. These failures resulted in the resident sustaining a left heel deep tissue injury, and a pressure sore. The facility was cited for failing to ensure appropriate care and treatment to prevent the pressure ulcer. Citation # 070013289.

Sacramento County

Mission Carmichael Healthcare Center
3630 Mission Avenue, Carmichael
A $20000 Infection Patient Care 2/2/2017
On 3/4/2015, Resident A was diagnosed with cardiovascular disease, hypertension, chronic kidney disease, and congestive heart failure. Resident A developed a stage 2 pressure ulcer on his left ankle and due to the lack of care progressed to a stage 4. In resident A’s “Skin-Weekly Pressure Ulcer Record,” dated 5/14/2017 indicated that he developed a “new” stage 2 ulcer while at the facility. The Department determined that the facility failed to ensure Resident A did not develop an avoidable pressure ulcer. Citation # 030012930.

Sacramento County

Sacramento Post-Acute
5255 Hemlock Street, Sacramento
A $20000 Decubiti (Bedsores) 2/9/2017
The facility was cited for failing to properly assess and monitor a resident who was a quadriplegic at risk for developing bedsores. The resident’s records revealed that during the resident’s first seven days at the facility, from January 2nd through 9th 2014, there was no record of the resident’s skin condition being assessed or monitored for skin breakdown. By 1/23/14, the resident had developed decubitus ulcers ranging in severity from Stage IIIs to unstageable (full thickness pressure ulcer, tunneled deep tissue wound, unable to get exact measurements) on the buttocks, heel, coccyx, and foot. Citation # 030012928.

Saylor Lane Healthcare Center
3500 Folsom Blvd., Sacramento
B $2000 Infection 3/24/2017
On 11/28/2016, and 12/8/2016 an investigation into the allegation of a respiratory outbreak. The investigation was carried out by the department and determined the facility failed to report the outbreak of flu like symptoms. A tour of the facility was conducted and all patients were in their room and there was no any indication that protective measures against the spread of infection had been initiated by the staff members. In an interview with the Administrator on 12/8/2016 he/she agreed the outbreak had occurred around 11/24/2016. When asked if the facility had responded to the outbreak promptly, he stated, “No.” As a result of the outbreak, a total fifteen patients developed symptoms of respiratory infection, four were hospitalized, and three died. Citation # 030013081.

San Joaquin County

Golden Living Center - Hy-Pana
4545 Shelley Court, Stockton
B $2000 Dignity Mandated Reporting Verbal Abuse 4/14/2017
The facility was cited for failing to investigate and report an allegation of abuse for a resident. A resident said she had been verbally treated inappropriately by a CNA who cursed at her and scared her. There was no documented evidence the alleged incident had been investigated and reported to the authorities as required by law although a physician had recorded a progress note dated 12/28/16 indicated complaints of difficulty with staff.
San Mateo County

Seton Medical Center
1900 Sullivan Ave., Daly City
B $2000 Administration Bed Hold Patient Rights Transfer 3/09/2017
On 1/3/2017 a resident diagnosed with dementia was refused readmission to the facility after being discharged from acute care facility. The Director of Nursing stated that “behaviors of the resident posed a danger to staff and other residents. The Director of Nursing stated the decision not to readmit the resident was a combined decision of Administrator, Medical Director, and Senior Management. The facility failed to readmit a resident after being hospitalized. This violation caused likely significant humiliation, indignity, anxiety, or other emotional trauma. Citation # 220013024.

Santa Clara County

Canyon Springs Post-Acute
180 North Jackson Avenue, San Jose
AA $100000 Careplan Other 6/14/2016
On 3/18/17, a female resident with COPD and on oxygen died from extensive burns when she caught on fire while smoking in her room. After shouting for help, the resident was seen with her legs on fire. As staff rushed to obtain extinguishers, the fire engulfed the resident. A month before, the resident had been found smoking in her room, which was not permitted by facility rules. The resident’s smoking and behavioral plans were not updated to address her frequent violations of safe smoking protocols. The facility was cited for failing to provide adequate supervision and failure to revise the resident’s care plan in light of her unsafe smoking behavior. Citation # 070013229.

Herman Health Care Center
2295 Plummer Avenue, San Jose
B $2000 Fall 7/11/2017
Staff did not supervise resident while she was sitting in a wheelchair without footrests, resulting in a fall that caused forehead lacerations and rib fractures. The resident has dementia, and is totally dependent for all activities of daily living, and was assessed as being a high risk for falls. The resident needed footrests and for her wheelchair to be tilted back, precautions that were not in place at the time of her fall. Citation # 070013235.

Los Gatos Oaks Convalescent Hospital
16605 Lark Avenue, Los Gatos
B $2000 Other 7/17/2017
During an observation and record review with the Registered Dietitian (RD) the emergency food supplies were not separated from the kitchen food supplies. The emergency food supplies meant to provide for residents, staff, and visitors for three days in the event of an emergency were unavailable. The emergency disaster kit was also inspected, and two of the First Aid Kits contained expired antibiotic ointments. Citation # 070013344.

Palo Alto Sub-Acute And Rehabilitation Center
911 Bryant Street, Palo Alto
B $2000 Physical Abuse 7/14/2017
A resident stated that CNA went to change another resident, then grabbed her breasts. The resident resisted, and CNA threw her on a bed, then picked her up and threw her into a wheelchair. CNA then took resident to another room and returned about an hour later and threw resident onto a bed. The resident suffered some bruising, and the facility terminated CNA. Citation # 070013341.

Valley House Rehabilitation Center
991 Clyde Avenue, Santa Clara
B $2000 Patient Care 5/31/2017
The facility was cited for failure to provide appropriate treatment and assistive devices after staff did not provide a resident with hearing loss with his hearing aids. Upon investigation staff reported they could not find the hearing aids. As a result the resident was not able to talk to other residents or participate in activities of interest Citation # 070013236.

Santa Clara County

Garden City Healthcare Center
1310 West Granger Ave, Modesto
A $20000 Careplan Elopement Fall Injury Patient Care Supervision 9/07/2017
A resident known for elopement and known to wander around the facility was left unsupervised. The resident left the facility unattended, fell, sustained a right hip and right arm fracture. The resident suffered a decline in in physical mobility and required extensive post operative physical and occupational therapy as a result of the fall. The facility failed to monitor the resident and personal alarm system function. These violations placed the resident in imminent danger. Citation # 070013208.

Riverbank Nursing Center
2649 West Topeka, Riverbank
B $2000 Administration Bed Hold Careplan Infection Medication Neglect Notification Patient Care Transfer 5/25/2017
On 1/18/2017, a resident with difficulty walking due to a stage 4 pressure wound on her heal and with very limited coping skills was discharged from the facility and sent to a woman’s center on her own via taxi and bus. Adult Protective Services was called in to assist when the resident arrived to the woman’s center. No one from the facility contacted the center for availability and confirm the resident’s arrival. One of the licensed nurses at the facility stated “I don’t think she is capable of taking care of herself because of her schizophrenic personality and her wound. The facility failed to provide sufficient preparation to ensure a safe an orderly discharge for the resident. Citation # 040013225.
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Fresno County

Alice Manor Convalescent Hospital

8448 E. Adams Avenue, Fowler

B $2000 Administration Bed Hold Notification Patient Rights Transfer 5/30/2017

On 9/22/2016, a resident with psychiatric and mental illness was discharged from the facility without proper notice. This resulted in an unsafe discharge to the resident’s home where he did not receive medically prescribed services. The resident became agitated at home and left after one day to wander the streets. Police transferred the resident to a treatment center. The facility failed to provide sufficient preparation to ensure a safe discharge for the resident. Citation # 040013232.

B $2000 Dietary Services Patient Care 8/8/2017

Staff failed to follow a resident’s physician-ordered diet plan of soft foods (pureed, finely chopped, etc.). The resident’s meal tray was not reviewed to ensure food served complied with his individual care plan. The resident was served chunks of meat too large for him to swallow. As a result he choked, was given the Heimlich Maneuver to restore normal breathing and required transfer to a hospital for further evaluation. Citation # 040013417.

Manning Gardens Care Center, Inc.

2113 E. Manning Ave., Fresno

A $20000 Evictions 7/26/2017

A 78 year old female resident was illegally evicted from the facility on 11/7/2016 when the staff called 911 and left her at the sidewalk of her former home when the police and fire departments arrived. In May of 2016, the resident had been living at home and lying on the floor for an unknown number of days with feces in her hair, cockroaches on her, and maggots in a wound on her foot. Emergency medical services called the house “not livable.” After a brief hospitalization, the resident was transferred to the facility but her son was using her income and her Medi-Cal share of cost went unpaid. On 10/6/2016, the facility issued a defective discharge notice that was missing, among other things, required information about the resident’s right to appeal. The facility management decided to send the resident back to her former home, with no assurances the resident would be safe and receive the extensive care she needed, including postoperative care for the wound on her foot. A physician’s orders for home care and equipment were unfulfilled. Upon interview, an assistant administrator stated she was unaware of any regulatory requirement for safe resident discharges. The facility administrator claimed the discharge “was never not safe;” in fact, the resident “was actually discharged to the hospital with a visit in between to see her home.” Citation # 040013363.

B $2000 Evictions Transfer 7/26/2017

A 92 year old male resident who had been at the facility since 2013 was discharged to an unlicensed boarding home on 2/4/17. The resident had extensive needs for care and supervision due to cognitive impairments and just one month prior to his discharge had been assessed as needing long term care. Nonetheless, he was sent to a home that was unequipped to provide any of the care he needed. The resident was given no discharge notice and the facility had no real idea of what level of care he would receive at his new home, stating “we didn’t do out homework.” Citation # 040013361.

Twilight Haven

1717 S. Winery Ave., Fresno

A $20000 Physical Abuse 9/13/2017

On 4/19/2017, at about 1:30 am, a certified nurse assistant repeatedly stabbed a 90 year old resident in the head with a ball point pen. A licensed nurse who witnessed the stabbing heard the resident yell, “OW! OW! Why are you doing this to me? What did I do to deserve this?” The nurse pushed the CNA away from the resident, who was sitting in her wheelchair with both hands held over the top of her head. Blood was seeping through the resident’s fingers. The police were called and took the CNA from the building. The resident was taken to the hospital where she underwent a CT scan examination of her brain and treatment of a superficial wound to the head. The facility was cited for failing to ensure the resident was free from abuse. Citation # 040013483.
Kern County

Bakersfield Healthcare Center
730 34th Street, Bakersfield

A $20000 Injury 3/15/2017
On 1/10/2017, an unannounced visit was made to the facility to look into a incident where a resident received burns while smoking. The care plan for Resident 1 revised 12/6/2016 stated that she was able to smoke independently. Resident 1 was outside smoking when CNA 1 heard someone yell for help as The CNA 1 was assisting a resident at the facility and saw resident 1 catch fire on the patio. Prior to the incident with Resident 1, the Director of Nursing stated that she was included in the “CARE PLAN CONFERENCE” for Resident 1, however could not recall if the interdisciplinary team discussed the unsafe smoking behavior. In conclusion, several staff members were aware of Resident 1’s unsafe smoking behavior, but failed to attend to her needs as a resident. Citation # 120013008.

Delano District Skilled Nursing Facility
1509 Tokay Street, Delano

B $2000 Administration Careplan Fall Medication Neglect Notification Patient Care Supervision 8/07/2017
On 6/6/2017 a resident was observed to have an empty bottle of vodka in her room. The resident admitted to drinking the bottle and taking her medications with it. She was informed that the combination of alcohol and medications could be fatal. The resident admitted that she was drinking alcohol and taking her medications for the last two months and the nurses at the facility did not use clinical judgment when administering medication to the resident. The facility failed to follow policy and procedures to notify a physician promptly to alter treatment significantly. Citation # 120013405.

Golden Living Center - Bakersfield
3601 San Dimas St., Bakersfield

A $20000 Careplan Injury Patient Care 6/27/2017
The facility failed to safely transfer a resident from her wheelchair to her bed. Only one CNA transferred the resident, although assessment tools indicated the resident needed two or more person’s to physically assist with transfers. The resident complained of extreme severe pain and stated that during the transfer her legs got tangled and when staff put her to bed she heard both legs pop. As a result, the facility transferred the resident to an acute hospital where they were informed the resident sustained fractures to both of her legs. Citation # 120013271.

The Rehabilitation Center Of Bakersfield
2211 Mount Vernon Avenue, Bakersfield

B $2000 Neglect Patient Care 3/07/2017
On 1/18/2017, the Director of Staff Development was interviewed and could not recollect the time when he/she was informed that CNA 1 was placing towels under the residents. The reason for placing a towels underneath the residents to refrain from changing the residents twice during her shift. Soon after, the Assistant Director of Nursing (ADON) was interviewed as well and stated that she was not fully aware of the occurring incidents with CNA 1, and insisted that Registered Nurse (RN) was aware of the situation. Citation # 120012980.

Valley Convalescent Hospital
1205 Eighth Street, Bakersfield

AA $100000 Fall Injury Neglect 7/07/2017
On 2/21/2017, an 80 year old resident suffered a fatal cervical spine fracture when he fell out of bed while his bed rails were down. His physician had ordered the bed rail and his care plan stated it was needed for safety reasons. Upon hospitalization, it was determined the resident’s fracture was unstable and unlikely to heal. The resident was admitted to hospice at the facility and died on March 1, 2017, eight days after he fell. The facility was cited because its failure to ensure the resident’s bed side-rail was in the up position was a direct proximate cause of his death. Citation # 120013119.

Los Angeles County

Atlantic Memorial Healthcare Center
2750 Atlantic Ave., Long Beach

A $16000 Patient Care 4/28/2017
On 3/14/17, a resident was found having difficulty breathing and was visibly discomforted due to increased secretions from his tracheostomy site. The inner cannulas had not been changed since his admission on 3/12/17. The necessary equipment the Resident’s care was not found by his bedside, and full tracheostomy supplies were not found in the central supply room. The facility was cited for its failure to provide the resident with the proper treatment for his special needs of tracheostomy care, and failure to provide care and services that ensure the highest well being of their residents. Citation # 940013132.

B $20000 Patient Care 4/28/2017
On 3/14/17 the call lights were tested, and it was observed that in some cases the light did not illuminate, and that the calls were not audible in the hallway. During a quality of life meeting on 3/15/17 residents complained that the call lights were not being answered quickly, sometimes taking almost an hour before staff members responded. The facility failed to ensure all resident call lights were audible upon activation, and failed to ensure all call lights were functioning. This resulted in call lights not being answered, and the resident’s needs not being met. Citation # 940013131.
A 73 year old male resident with Parkinson’s disease and an implanted deep brain stimulator (DBS) was not monitored for possible complications or side effects. Some or most of the staff was unaware of the device and had not observed a protruding area under the resident’s skin on his chest where the DBS battery was located. The facility was cited for failing to perform a thorough initial assessment of the resident and for failing to develop a comprehensive plan of care related to the DBS. Citation # 940013133.

B $1000 Administration 4/28/2017
During an inspection on 3/14/17 it was noted that the facility failed to provide CNA 1 after an interview on 12/15/2014. The facility failed to ensure Resident 1 had a bank gift. In result, CNA 1 was transported and booked at the police station on 12/24/2014. In an interview secretions. The resident's medical records indicated the regular assessment of breathing sounds and suction of respiratory secretions. The resident's medical records indicated the assessment and suction was not performed. A family member who visited every day reported suction was not done and the suction machine was always empty. The facility was cited for failing to provide proper respiratory care. Citation # 940013427.

A $20000 Neglect 8/15/2017
A resident with severe swallowing problems was hospitalized on 1/1/2015 for emergency intubation when he developed a thick semi-solid blockage to his airway while at the facility for five days. The resident had significant cognitive problems and difficulty swallowing following a stroke. His careplan called for regular assessment of breathing sounds and suction of respiratory secretions. The resident's medical records indicated the assessment and suction was not performed. A family member who visited every day reported suction was not done and the suction machine was always empty. The facility was cited for failing to provide proper respiratory care. Citation # 940013427.

Avalon Villa Care Center
12029 S Avalon Blvd, Los Angeles

B $2000 Theft & Loss 1/06/2017
On 12/01/14, Resident 1 was admitted into a facility with diagnoses that included bronchitis, diabetes, and depression. During an interview on 7/24/2014 the Director of Nurses (DON) stated Resident 1 received a call from her bank stating that a fraudulent check had been cashed from her account. Resident 1 had gone to the bank and received a copy of the check and the check was made out to a CNA 1 that worked at the facility. In an interview of the local police's incident report on 8/25/2015, CNA 1 stated that Resident 1 gave CNA 1 the check as a Christmas gift. In result, CNA 1 was transported and booked at the police station on 12/15/2014. The facility failed to ensure Resident 1 was free from financial abuse by a facility staff member had a direct or immediate relationship to the health, safety or security of Resident 1. Citation # 940012864.

B $2000 Fall Injury Patient Care 2/24/2017
On 6/30/16, the resident was found on the floor with a cut near the left outer corner of his eye with swelling and redness. Before this incident, despite orders by the physician, the facility failed to provide an additional mattress by the resident’s bed, who had a habit of crawling or rolling from the bed to the floor. On 4/28/16, a review indicated that the resident was high risk for falling. The facility was found in violation of making sure that the resident’s environment remained as free from hazards as possible and that the resident was given inadequate supervision and assistance to prevent accidents. Citation # 940013001.

Bell Convalescent Hospital
4900 E. Florence Ave, Bell

A $20000 3/23/2017
CitationWatch description will be published once citation is received. Citation # 940012870.

California Post-Acute Care
3615 Imperial Hwy, Lynwood

B $2000 Mandated Reporting Physical Abuse 3/15/2017
On 9/4/16, a resident stated that a CNA, in lieu of answering his call light, threw water on him while he was lying in bed. The facility was cited for failing to investigate the resident’s abuse allegation, and failing to notify the Department within 24 hours. Citation # 940013046.

Casa Bonita Convalescent Hospital
535 E Bonita Ave., San Dimas

A $14000 Fall Injury Patient Care 4/07/2016
A 98 year old resident experienced a fall on 7/30/15 after a CNA transferred her between a bed to the shower chair using a lifting device without any assistance from a second staff member. The fall resulted in a laceration to the right side of the head and the resident was transferred to the acute emergency hospital and received 5 staples to the head. The facility was cited for failing to ensure the resident was free of accident hazards. Citation # 950012150.

College Vista Convalescent Hospital
4681 Eagle Rock Bl., Los Angeles

A $18000 Medication 07/07/2017
On 5/20/17, there was a health status investigation for a resident who was receiving wound treatment for gangrene. The resident had impaired cognition, a GT inserted through her abdomen for nutrition and medication, and was totally dependent on staff for mobility. The physician's order for treating the gangrene was wound debridement (removal of dead tissue). The plan also called for the resident to receive pain medication thirty minutes before the start of treatments. A review of the resident's record
noted that the resident did not receive pain medication prior to the procedure and would groan, grimace and flinch during the debridings. The facility was cited for failing administer pain medication as proscribed by the physician Citation # 920013323.

Del Rio Convalescent Center
7002 E Gage Avenue, Bell Gardens

A $10000 Careplan Physical Restraints 5/26/2017
Three residents with cognitive impairments were poorly managed and entered into other resident rooms uninvited. Upon investigation, DPH found one resident was purposely pinned in his wheelchair between two benches so he could not move. Some residents complained that staff were very slow to respond to their need for assistance in asking the other residents to leave their rooms. The facility was cited for failing to properly address the needs of the three residents who entered into other residents’ rooms. Citation # 940013210.

Del Rio Gardens Care Center
7004 E Gage Avenue, Bell Gardens

B $2000 Patient Care Verbal Abuse 2/22/2017
On 9/20/2017, in an interview with CNA 1 stated that she was approaching CNA 2 and heard CNA 2 refer to Resident 1 as an “Asshole.” In review of CNA 2’s employee file indicated that a written warning due to the use of bad words in the previous month. It is safe to claim that CNA 2 has a history of using bad words in front of residents. The facility failed to ensure that Resident 1 was free from verbal abuse when CNA 2 referred to Resident 1 as an “Asshole.” Citation # 940012979.

A $20000 Injury Patient Care 3/29/2017
An 87-year-old non-ambulatory male resident with Alzheimer’s disease was found with a swollen, purple left ankle on 12/18/16 by a nursing assistant. The physician ordered x-rays, which revealed the resident had sustained multiple fractures. The day before, a nursing assistant had transferred the resident from the wheelchair to the bed by herself, and failed to report an injury related to the transfer. The facility was cited for failure to ensure that nursing assistants were provided training regarding transferring the resident, and failure to transfer the resident using a two-person assist or mechanical lift. Citation # 940013058.

B $2000 Administration Careplan Injury Mandated Reporting Notification Patient Care Physical Abuse 7/27/2017
On 6/2/2017 a resident with a stage 4 pressure sore on the coccyx area was rough handled by a CNA. The CNA was changing the draw sheet from underneath the resident roughly. The resident told the CNA “Stop, don’t hurt me, don’t hurt me, ouch.” The administrator was notified and stated that he did not believe that rough handling was an act of abuse and that he did not investigate or send a final conclusion letter to the Department. The facility failed to implement its policy and procedure for abuse prevention. Citation # 940013391.

B $2000 Mandated Reporting 7/27/2017
On 5/18/17, the facility sent a report to the Department of Public Health about an alleged abuse incident involving a resident to resident altercation which occurred on 5/17/17. The incident involved one resident hitting another resident in the face. The Department received the final investigation report on 5/23/17, but it did not contain a root cause analysis of why the resident attacked the other resident. The facility was cited for failing to thoroughly investigate the alleged physical abuse; and revise its abuse reporting policy to include the mandated reporting timeframes set forth in state law. Citation # 940013385.

B $2000 Mandated Reporting 7/27/2017
On 11/11/16, the facility sent a report to the Department of Public Health about an alleged abuse incident involving a resident to resident altercation which occurred on 11/11/16. Facility staff witnessed one resident hit another resident on his arm. The Department did not receive the result of the facility’s investigation. The facility was cited for failing to thoroughly investigate the alleged physical abuse; report the investigation results to the Department within 5 days; and revise its abuse reporting policy to include the mandated reporting timeframes set forth in state law. Citation # 940013392.

A $20000 Supervision 7/27/2017
On 5/28/2017, a male resident had to be hospitalized for a sustained subarachnoid hemorrhage after being struck by his roommate. The assaultive resident had a number of cognitive impairments and a careplan calling for one to one supervision. However, he was left unsupervised in his room and hit the other resident multiple times. A nurse reported he was left unsupervised because the facility was “short of staff.” The facility was cited for failing to provide adequate supervision. Citation # 940013375.

B $2000 Mandated Reporting 7/27/2017
On 9/24/16, the facility sent a report to the Department of Public Health about an alleged abuse incident involving a resident to resident altercation which occurred on 9/23/16. The incident involved one resident scratching the chin and neck of another resident. The Department did not receive the result of the facility’s investigation. The facility was cited for failing to thoroughly investigate the alleged physical abuse; report the investigation results to the Department within 5 days; and revise its abuse reporting policy to include the mandated reporting timeframes set forth in state law. Citation # 940013377.

B $2000 Administration Fall Injury Mandated Reporting 7/27/2017
On 4/1/2017 the facility sent a report to the Department that fall has occurred and a resident suffered a left hip fracture. The facility did not report on how the resident fractured the left hip. The facility’s Administrator stated that he did not complete the investigation in the final report to the Department. The facility failed to implement its policy and procedure for investigating unknown falls. This violation had direct relationship to the health
and safety of the resident. Citation # 940013381.

B $2000 Administration Patient Care Physical Abuse Supervision 7/27/2017

On 10/14/2017 resident 1 at the facility locked resident 2 in the restroom. Resident 1 stated that resident 2 was locked in the bathroom because he was “yelling.” The administrator of the facility did not send notification to the Department and stated that the incident was not investigated properly. The facility failed to implement its policy for abuse prevention, and investigation. This violation is a direct relationship to the health and safety of resident 2. Citation # 940013380.

B $2000 Physical Abuse 7/27/2017

The facility was cited for failing to implement its policy and procedure for abuse prevention, investigation and reporting. The facility failed to investigate an alleged physical abuse involving an altercation between two residents, failed to report the results of the investigation to the Department within five working days and failed to revise the facility’s policy to include the time frames for mandated reporting. Citation # 940013378.

B $2000 Injury Mandated Reporting 7/27/2017

The facility failed to implement its policy and procedure for investigating and reporting injuries of unknown origin by failing to investigate how the resident sustained a bruise on left inner knee and left upper hip discovered on 7/10/16, and a dark purple discoloration to his abdomen discovered on 9/23/16. Citation # 940013383.

B $2000 Injury Mandated Reporting 7/27/2017

The facility was cited for failing to implement its policy and procedure for investigation and reporting injuries of unknown origin by failing to investigate how a 75 year-old male resident sustained a bruise to the right rib cage and the surrounding area of his eye, the bruising was discovered during a shower. The facility was also cited for failure to report the results of the investigation to the department within five working days. Citation # 940013400.

B $2000 Mandated Reporting 7/27/2017

On 5/27/17, the facility sent a report to the Department of Public Health about an alleged abuse incident involving a resident to resident altercation which occurred on 5/26/17. One resident reported that another resident hit him on the side of his mouth. The Department did not receive the result of the facility’s investigation. The facility was cited for failing to: thoroughly investigate the alleged physical abuse; report the investigation results to the Department within 5 days; and revise its abuse reporting policy to include the mandated reporting timeframes set forth in state law. Citation # 940013394.

Downey Care Center

13007 South Paramount, Downey

A $20000 Medication Neglect Notification Patient Care 6/23/2017

A 64 year old resident with severe kidney disease was given a narcotic and another medication not recommended for people with kidney failure at the facility who failed to monitor the resident for medicinal adverse consequences. When transportation staff arrived to pick up the resident to transport her to the dialysis center he became worried, as the resident did not look normal. He asked the facility LVN multiple times if the resident was okay to transport and the facility LVN said she was “okay to go” to the dialysis center. Upon arrival to the dialysis center, the registered nurse noticed the resident looked “drugged” and was sleepy, she immediately called 911 and the resident was taken to the hospital where she arrived with altered mental status, poor responsiveness, hypotension, acute distress, and was unable to verbalize what was wrong and died the same date. Citation # 940013309.

Downey Community Health Center

8425 Iowa Street, Downey

A $16000 Decubiti (Bedsores) 3/24/2017

On 2/14/17, during a facility tour, it was observed that a 65 y/o resident was lying unpositioned for on his back five hours in an elevated bed while connected to a nasogastic tube (inserted through the nose passing the throat and down into the stomach for feeding and hydration). On 2/16/17, the resident was assessed by a wound care specialist that indicated the resident had Stage II, III, and unstageable pressure ulcers. When the resident was admitted into the facility he had only a single Stage I pressure ulcer. The facility was cited for failure to accurately assess and care for the resident’s ulcers. Citation # 940013044.

El Rancho Vista Health Care Center

8925 Mines Avenue, Pico Rivera

A $20000 Careplan Fall Injury Patient Care Supervision 7/12/2017

On 3/5/2017 a resident with a history of falling was placed in a wheelchair left unsupervised in the the nursing station and fell. The resident was found on the floor with blood coming out of his nose. This resulted in the resident being transferred to the hospital and diagnosed to have a subdural hematoma and a left hip fracture. The resident was released to hospice care on 3/19/2017 and the discharge summary indicated the resident’s prognosis as poor. The facility failed to provide an effective care plan for falls and provide adequate supervision. Citation # 940013306.

Four Seasons Healthcare & Wellness Center, LP

5335 Laurel Canyon Blvd., North Hollywood

A $20000 4/24/2017

On 1/7/17, a resident was found unresponsive on the floor of the bathroom with a shoelace tightly wrapped around his neck. The facility nurse cut the shoelace, 911 was called, and the resident was pronounced expired. The incident occurred three days after the resident had been discharged from the general acute care
hospital (GACH) psychiatric unit with a severe mental disorder. A review of the GACH assessment indicated the resident had a history of depression, was a danger to self, and increasingly suicidal. According to the physician’s order dated 1/6/17 (two days after the resident was admitted to the facility) the resident was supposed to receive a psychiatry and psychology consult. A review of the record indicated there was no documentation of consults being provided. The facility was cited for failing to properly assess and monitor the resident for suicidal ideation. Citation # 920013129.

**Griffith Park Healthcare Center**
201 Allen Ave., Glendale

A $20000 Physical Restraints 4/26/2017
On 1/23/17, during an unannounced investigation, investigators opened a bedroom door and observed a resident sitting by himself in a Geri-chair with a bed sheet tied around his waist. The resident was wearing an incontinent brief but no other clothing. The resident, who suffered from Alzheimer’s disease, was observed moving his legs up and down as if he was riding a bicycle. During the observation, a CNA walked into the room and said the resident was known for trying to get out of bed, she knew it was wrong to have him tied up with a sheet, and someone from the prior shift must have tied him up. The facility was cited for failing to keep the resident free from physical restraints imposed where the purpose was for convenience and not because it was required to treat the resident’s medical symptoms. Citation # 920013154.

**Huntington Healthcare Center**
4515 Huntington Drive South, Los Angeles

A 58 year old resident who did not have capacity to make decisions was transferred to a general acute care hospital on 05/18/16. The resident’s legal representative was not provided a notice in writing regarding the proposed transfer/discharge, seven day bed hold policy or appeal rights. The facility refused to readmit the resident although a review of the facility’s census indicated the facility had a bed available to permit the readmission. Citation # 920013154.

**Infinity Care Of East Los Angeles**
101 So. Fickett St, Los Angeles

B $2000 Patient Care Verbal Abuse 4/21/2017
On 2/8/17, a 64-year-old female resident pressed her call light to ask for water. A nursing assistant went into her room and stated, “I am busy.” The resident responded, “my mouth is dry” and the nursing assistant then called the resident a “dumb, stupid old lady,” turned off her call light, and left the room without giving her any water. The facility investigated the incident and substantiated the resident’s allegations. The facility was cited for failure to protect the resident from verbal abuse. Citation # 940013148.

**Kei-Ai Los Angeles Healthcare Center**
2221 Lincoln Pk.Ave., Los Angeles
A $10000 Supervision 1/20/2017
After dinner on 1/25/16, a resident hit another resident’s forearm with a metal spoon in the dining room. The resident suffered seven skin tears to her left forearm, three skin tears with bruises on her right forearm, and moderate bleeding. The resident, who had left-sided paralysis, had to undergo skin treatment for two weeks. The facility was cited for failing to provide adequate supervision to residents in the dining room to keep residents safe. Citation # 940012895.

**Kingsley Manor Care Center**
1055 North Kingsley Drive, Los Angeles
A $20000 Injury 5/10/2017
On 5-18-2012, a resident’s paralyzed right arm was fractured while a CNA was dressing her. The CNA said the resident’s shirt was tight and she forced the resident’s arm through the sleeve, causing the fracture. The resident was at risk for fracture due to osteoporosis. The facility was cited for rushing and forcing the resident’s arm through a tight shirt sleeve and for failing to develop a care plan that used loose-fitting clothing and co-worker assistance when getting the resident dressed. Citation # 920013186.

**Lakewood Healthcare Center**
12831 Maclay Street, Sylmar
A $20000 Careplan Fall Injury Patient Care 5/23/2017
A resident experienced two falls on 2/11/17. The falls resulted in a femoral fracture and a deep cut to the eyebrow. The resident was transferred to a general acute care hospital and underwent surgery to repair the left hip. The facility failed to ensure that the resident at risk for falls was provided with adequate supervision to prevent future falls by monitoring the resident as indicated in the care plan. Citation # 940013192.

**Maclay Healthcare Center**
12023 S. Lakewood Blvd, Downey
A $10000 Supervision 1/20/2017
After dinner on 1/25/16, a resident hit another resident’s forearm with a metal spoon in the dining room. The resident suffered seven skin tears to her left forearm, three skin tears with bruises on her right forearm, and moderate bleeding. The resident, who had left-sided paralysis, had to undergo skin treatment for two weeks. The facility was cited for failing to provide adequate supervision to residents in the dining room to keep residents safe. Citation # 940012895.

**Makay Healthcare Center**
12023 S. Lakewood Blvd, Downey
A $20000 Injury 5/10/2017
On 5-18-2012, a resident’s paralyzed right arm was fractured while a CNA was dressing her. The CNA said the resident’s shirt was tight and she forced the resident’s arm through the sleeve, causing the fracture. The resident was at risk for fracture due to osteoporosis. The facility was cited for rushing and forcing the resident’s arm through a tight shirt sleeve and for failing to develop a care plan that used loose-fitting clothing and co-worker assistance when getting the resident dressed. Citation # 940013186.

**Makay Healthcare Center**
12023 S. Lakewood Blvd, Downey
A $20000 Careplan Fall Injury Patient Care 5/23/2017
A resident experienced two falls on 2/11/17. The falls resulted in a femoral fracture and a deep cut to the eyebrow. The resident was transferred to a general acute care hospital and underwent surgery to repair the left hip. The facility failed to ensure that the resident at risk for falls was provided with adequate supervision to prevent future falls by monitoring the resident as indicated in the care plan. Citation # 940013192.

**Maclay Healthcare Center**
12831 Maclay Street, Sylmar
A $20000 Careplan Fall Injury Patient Care 5/23/2017
A resident experienced two falls on 2/11/17. The falls resulted in a femoral fracture and a deep cut to the eyebrow. The resident was transferred to a general acute care hospital and underwent surgery to repair the left hip. The facility failed to ensure that the resident at risk for falls was provided with adequate supervision to prevent future falls by monitoring the resident as indicated in the care plan. Citation # 940013192.

**Maclay Healthcare Center**
12831 Maclay Street, Sylmar
A $10000 Supervision 1/20/2017
After dinner on 1/25/16, a resident hit another resident’s forearm with a metal spoon in the dining room. The resident suffered seven skin tears to her left forearm, three skin tears with bruises on her right forearm, and moderate bleeding. The resident, who had left-sided paralysis, had to undergo skin treatment for two weeks. The facility was cited for failing to provide adequate supervision to residents in the dining room to keep residents safe. Citation # 940012895.

**Maclay Healthcare Center**
12831 Maclay Street, Sylmar
A $20000 Careplan Fall Injury Patient Care 5/23/2017
A resident experienced two falls on 2/11/17. The falls resulted in a femoral fracture and a deep cut to the eyebrow. The resident was transferred to a general acute care hospital and underwent surgery to repair the left hip. The facility failed to ensure that the resident at risk for falls was provided with adequate supervision to prevent future falls by monitoring the resident as indicated in the care plan. Citation # 940013192.
was unable to evaluate the quality of care and quality of life provided to the patient while residing at the facility. Citation # 920013224.

Mountain View Convalescent Hospital
13333 Fenton Avenue, Sylmar
A $20000 Feeding Infection Neglect 07/08/2017
On 7/22/2016, a resident was hospitalized in septic shock due to a displaced gastrostomy tube used to give her feedings and medications. The tube was wrongly placed in her abdominal wall rather than her stomach. She underwent emergency surgery for removal of four liters of pus from the abdominal wall. Following surgery, the resident was placed on hospice care and died on 8/20/2016. The facility was cited because it failed to ensure the gastrostomy tube was properly placed within the resident's stomach, failed to hold the tube feeding water flushes when the resident had episodes of vomiting, failed to check the resident's feeding for residual fluids, and failed to implement its policies on checking the pH level of the feeding residual. Citation # 920013324.

Pacific Care Nursing Center
3355 Pacific Place, Long Beach
A $20000 Injury Patient Care 4/21/2017
A 62 year old male resident experienced second degree burns on 2/12/17 to his eyebrow, nose, cheek, upper lip and fingers. The resident was receiving oxygen therapy in his room when his lighter dropped and suddenly sparked and caused a flame. The facility was cited for failing to ensure that a resident's environment was free from accident hazards as is possible. Citation # 940013141.

A $20000 Careplan Infection Mandated Reporting Notification Patient Care 6/09/2017
The facility failed to provide services needed for a resident who had right and left toe gangrene from 10/30/2016 to 1/4/2017 for a total of more than two months. The facility failed to develop a care plan that was consistent with the resident's specific risks for infection. The facility also failed to refer the resident to a podiatrist for consultation according to the physician's order on 11/18/2016 and 12/28/2016. This resulted in the resident experiencing pain and suffering. The resident was transferred to the intensive care unit under serious condition. The surgeon and podiatrist recommended for below the knee amputation. Citation # 940013261.

Panorama Meadows Nursing Center, LP
14857 Roscoe Blvd., Panorama City
A $20000 Careplan Decubiti (Bedsores) Dietary Services Infection Injury Notification Nutrition Patient Care 06/07/2017
The facility was cited for failing to ensure that a resident who was unable to reposition herself in bed received the necessary care to prevent the development of a pressure ulcer as indicated in her care plan. As a result, the resident developed a stage I pressure ulcer that progressed to unstageable while in the facility. The facility failed to identify the ulcer to ensure monitoring and treatment, to provide the nutritional measures to promote healing of the ulcer, and to notify the physician when the resident's pressure ulcer worsened. Citation # 920013221.

Royal Care Skilled Nursing Center
2725 Pacific Avenue, Long Beach
B $2000 Sexual Abuse 4/28/2017
On 1/9/17, a report was made about an incident which occurred several months prior where an 87 year old female resident, who was diagnosed with dementia, wandered into the room adjacent to hers and engaged in sexual activity with a 66 year old resident diagnosed with with schizophrenia. The female resident's care plan noted that she was known to wander aimless, and significantly intrude on others' privacy and activities. During the investigative interview the Director of Nurses was unable to explain why neither of the residents adjacent rooms were since it was conceivable that their might be further incidents. The facility was cited for failing to prevent and intervene, or properly investigate and report the abuse. Citation # 940013162.

San Fernando Post Acute Hospital
12260 Foothill Blvd, Sylmar
A $15000 Patient Care 6/07/2017
On April 25, 2017 at 8:20 a.m. an investigator went to the facility to observe, interview, and record review. The facility failed to ensure a resident with an indwelling catheter is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary, and resident received appropriate treatment and services to prevent urinary tract infection. In addition, failure to implement a plan of care intervention by not providing Resident 1 with proper incontinent care, to decrease risk of UTI and by not monitoring and reporting to the physician the presence of sediments in the urine. Citation #920013218 Citation # 920013218.

A $15000 Patient Care 06/07/2017
On 3/14/17, a physician ordered exercises to maintain range of motion (ROM) for a resident with diagnoses including multiple sclerosis and paralysis on one side of the body. The facility failed to: ensure that a trained licensed nurse performed a joint mobility assessment; provide the resident with complete ROM exercises as ordered by the physician; and notify the rehabilitation department of the decline in the resident's joint mobility. As a result, the resident has a decline in ROM in multiple joints. The facility was cited for failing to ensure that a resident receives appropriate treatment and services to increase, maintain and/or prevent decline in ROM. Citation # 920013219.
A 48 year old resident died on 2/16/17 after she was found unresponsive, had experienced nausea and vomiting for one week and had refused prescribed meals and nutritional drinks on seven occasions. The facility failed to notify her physician, registered dietitian and conservator of these issues in addition to her having lost a total of 14 lbs since she was admitted on 1/17/17. Citation # 940013389.

A 48 year old resident died on 2/16/17 after a stay of 30 days at the facility and diabetes mellitus was a significant condition that contributed to her death. The facility failed to notify the resident’s physician that the resident refused laboratory tests including blood sugar labs, blood sugar level checks, insulin injections and medication. As a result the resident had irregular blood sugar levels and there was no documentation that a meeting was conducted to address the refusal of treatment and to develop appropriate interventions. Citation # 940013379.

The facility was cited for failing to exercise a 48 year old resident’s rights. The facility failed to transfer the resident to a suitable facility in order for her to receive the mental health treatment needed in accordance with the Conservatorship Order issued by the Court. Facility failed to obtain an informed consent form from the resident’s conservator regarding vaccinations and use of psychoactive medications. In addition, the facility failed to notify the resident’s conservator of the resident’s refusal to treatment and diet order and change of condition. Citation # 940013390.

A male resident with circulatory problems including deep vein thrombosis began developing signs of poor circulation in his right foot in December 2016. As the resident’s right big toe began to turn gangrenous and slowly die, the facility did not update its careplan. The resident’s physician and responsible party were not informed of the situation until 1/5/17 when the resident had to be transferred to the hospital. The resident was diagnosed with severe right leg artery blockage and underwent an angioplasty in his thigh. Nonetheless, his toe was amputated on 1/10/17. The facility was cited for failing to address the resident’s change in condition. Citation # 940013384.
On 12/1/16, nursing staff reported a palm-sized reddened area on the face of an 82 year old resident. The director of nursing (DON) assumed it was caused by cellulitis and did not investigate or report it to authorities. The redness disappeared in about 3 days without antibiotic treatment, indicating it was not cellulitis. The facility was cited because it did not investigate or report the injury of unknown origin as required. Citation # 940013033.

A 66 year old male resident with alert cognition reported to the Director of Staff Development (DSD) that a nursing assistant called his roommate, a 75 year old male resident, the “N” word and handled him roughly during his care. He stated that the nursing assistant was abusive to the roommate. The 75 year old resident confirmed that the nursing assistant “called him a derogatory name” and that the nursing assistant pushed him against his side rail so that he hit his head. After the resident’s report, the facility failed to investigate the allegations of abuse, failed to report the incident to the Department, law enforcement, and the Ombudsman, failed to check on the State nurse aide registry whether the nursing assistant had prior findings of abuse, and failed to implement the facility’s abuse prevention procedure. Citation # 940013035.

On 10/19/16, a resident was found unresponsive and pronounced dead. The resident had been diagnosed with morbid severe obesity, as well as schizophrenia and a movement disorder. A registered nurse and three certified nursing assistants attempted to manage the resident’s aggressive behavior shortly before her death by holding the resident in a prone position on her bed. A licensed vocational nurse and a certified nurses assistant who took over the care of the resident during the night shift allowed the resident to remain in this prone position until she was found unresponsive. Prior to Resident’s death there were three episodes of unwitnessed falls from her bed, as well as a change in condition of the resident’s behavior which manifested in agitation and screaming, which was not disclosed to her physician. The facility was cited for its failure to provide the resident with the necessary care and proper treatment for mental health disorders and failure to conduct an assessment during a change of condition in the resident’s behavior and inform a physician. The facility also failed to ensure that the staff provided appropriate care and interventions to manage the resident’s aggressive behavior, failed to report all alleged violations involving neglect and mistreatment, failed to thoroughly investigate violations and events leading up to the resident’s death, and failed to implement policy and procedure to protect residents from abuse and neglect. Citation # 940013036.

On 1/24/17, a resident complained that she was not given medication for her pain, and that the LVN told her “You are going to take what I give you or nothing at all.” The facility was cited for failing to thoroughly investigate the resident’s complaints of verbal abuse and not receiving the appropriate pain medication, and for failing to report the complaints immediately to the administrator and the Department. Citation # 940013027.

A 66 year-old male resident with the capacity to understand and make decisions stated that on 1/26/17, a nursing assistant handled him roughly, treating him “like a football” during transfer from wheelchair to bed. The resident notified the Director of Staff Development (DSD) on 1/27/17, but the DSD failed to investigate the incident or report it to the Department. The facility was cited for failure to screen all nursing assistants through the State Nurse Aide registry, failure to investigate all allegations of abuse, failure to report allegations of abuse to the Department, and failure to prevent further potential abuse or mistreatment. Citation # 940013032.

A 57 year old female resident with multiple sclerosis was lifted...
from her motorized wheelchair with a mechanical lift while still buckled in the chair on 2/15/16. As a result the weight of the chair was pinned against the resident’s hip and thigh area, causing a displaced fracture of her right femur. Two months later, a CNA who was assisting the resident at the time was interviewed and said another CNA had been in charge of the mechanical lift but she could not identify her. All 13 CNAs who worked that day were interviewed and none could recall assisting the resident with a mechanical lift. The facility was cited for failing to use two staff members for operating the lift and for failing to unbundle the resident’s wheelchair belt prior to using the lift, causing serious harm to the resident. Citation # 940013164.

Windsor Terrace Healthcare Center

7447 Sepulveda Blvd., Van Nuys

A $150000 Elopement Injury Patient Care Physical Environment Supervision 6/23/2017

A male resident was admitted to the facility on 11/14/16 with major depressive disorder, opioid dependence, anxiety disorder, a brain injury that may have been caused by overdose, and a history of suicidal ideation. Despite a physician’s order to increase the level of supervision over the resident, staff allowed him to elope from the facility with bloody wrists on 11/24/16. The resident tried to jump in front of a car, and had cut himself on his left write and right wrists with a razor blade, creating wounds that required stitches. The facility was cited for failure to increase the level of supervision and provide suicide precautions when the resident was observed to be in a low mood, failure to notify the Director of Nursing and Administrator when the resident was observed to be in a low mood, and failure to conduct a room search to remove potentially dangerous objects from the resident’s room. Citation # 920013281.

Woodruff Convalescent Center

17836 S Woodruff Ave, Bellflower

AA $100000 Administration Chemical Restraints Fall Injury Neglect Physical Restraints Supervision 5/31/2017

An 82 year old resident who was blind and had dementia died on 12/4/16 after suffering five falls over a nine-week period that involved hitting his head. The falls occurred on 8/31/16, 9/29/16, 10/6/16, 10/19/16 and 11/2/16. Prior to the final fall, the facility failed to notify his doctor of abnormal lab results related to blood thinning medications that put him at high risk for bleeding. On 11/2/16, the nursing staff physically restrained the resident in a wheelchair after he awoke at 1:45 am. There was no order for the waist restraint. While he was physically restrained, a nurse gave him Ativan, a psychoactive drug, after he struggled to take off the restraint. At 3:30 am, nursing staff found him lying on the hallway floor, bleeding from a deep cut on his left forehead. Staff called 911 after not being able to stop the bleeding. The resident was hospitalized and required urgent surgery to perform a craniectomy due to traumatic brain injuries caused by the fall. Following surgery, he was put on hospice care at a different facility and died on 12/4/16. Members of the nursing staff expressed concern that someone should have stayed with the resident while he was in the wheelchair and that the facility was not able to meet his needs. The facility failed to adequately monitor the resident; keep him free from physical restraint; inform his physician of lab findings; provide in-service training on dementia to its staff; evaluate and update his care plan after the falls; and carry out his doctor’s order to obtain a psychiatric consultation. The facility was cited because these and other failures by the facility were a direct proximate cause of the resident’s death. Citation # 940013137.

Orange County

New Orange Hills

5017 E. Chapman Avenue, Orange

B $2000 Patient Care 7/17/2017

Two residents were sampled and both developed progressively worse pressure ulcers while under the care of the facility. For resident 1, the facility failed to follow his plan of care to turn him every 2 hours and administer a moisture barrier cream treatment as ordered by the physician. As a result, he developed a Stage II pressure ulcer to his coccyx on 3/1/17, which on 3/14/17 was identified to have deteriorated to a Stage IV pressure ulcer, one with tissue loss so severe it exposes bone, tendon, or muscle. This caused depression and delayed his discharged home. For the second resident, the facility failed to perform treatments as ordered for the skin redness to the coccyx discovered on 4/5/17. On 4/26/17, the resident’s coccyx had worsened to a Stage II pressure ulcer. The facility failed to complete skin assessments performed by licensed staff and chart on a weekly basis. Citation # 060013348.

The Pavilion at Sunny Hills

2222 N. Harbor Blvd., Fullerton

A $10000 Deterioration Fall Injury Notification Patient Care 8/28/2017

on 11/28/16 a resident that required assistance to walk with a walker was found lying on the floor near the bathroom. The resident had recently undergone hip surgery and was recovering at the facility. The resident’s neurological status changed and her physician was not informed. The resident showed a further decline and was transferred to the acute care hospital emergency department. X-ray showed that the resident had a large subdural hemorrhage. The resident expired 48 hours later. The facility failed to inform the resident’s physician of her status as it declined. Citation # 060013455.

Riverside County

Alta Vista Healthcare & Wellness Centre

9020 Garfield Ave., Riverside
On 5/2/16, a female resident was injured on the facility’s bus on her way to the dialysis clinic. The staff member responsible for her safety failed to properly strap her wheelchair to the bus, and as a result, when the bus accelerated she was abruptly pushed backward, her wheelchair tilted and she hit her head on the wall of the bus. She sustained bruising on the back of her head and was transferred to the ER. The Maintenance Supervisor, who was driving the bus, stated he received no training on safe transport of wheelchair-bound patients. The facility was cited for failure to ensure that the resident environment remains free of accident hazards and failure to ensure that each resident receives adequate supervision to prevent accidents. Citation # 250013441.

Desert Springs Healthcare & Wellness Centre
82-262 Valencia Avenue, Indio

On 3/6/16, a resident was abducted by a family member and taken across state lines, where she had to be admitted to an acute care facility. A prior investigation by Adult Protective Services found that the family member had previously neglected the resident. The resident’s conservator authorized the family member to have supervised visits with the resident. However, on the day the resident was taken from the facility, the staff were not familiar with the family member and failed to supervise the visit. The facility was cited for this failure. Citation # 250013252.

Indio Nursing And Rehabilitation Center
47-763 Monroe Avenue, Indio

The facility did not properly report an incident of alleged abuse after a resident accused a staff member of hitting her with a urine cylinder on the hand. The facility did not report the alleged abuse to the Department of Public Health, Ombudsman and law enforcement as required by law. Citation # 250013310.

B $2000 Mandated Reporting Physical Abuse
7/18/2017

The facility did not take necessary steps to prevent a resident from experiencing ongoing verbal and physical abuse over the course of a year. After witnessing multiple incidents of abuse by a resident’s boyfriend, staff did not take any measures to protect the resident from abuse or to prevent the resident’s boyfriend from making unsupervised visits. Citation # 250013268.

Magnolia Rehabilitation & Nursing Center
8133 Magnolia Avenue, Riverside

B $2000 Mandated Reporting Physical Abuse
6/14/2017

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Tulare County

Redwood Springs Healthcare Center

1925 East Houston Avenue, Visalia

A $20000 Patient Care  7/10/2017
The facility failed to provide adequate supervision for a resident diagnosed with dementia and known violent behaviors, resulting in him attacking another resident. That resident was found in the patio, tipped over in her wheelchair, bleeding from her nose and mouth. The male resident was observed with blood on his shirt and told staff that they should call the police because he believed he had killed someone. Citation # 120013313.

A $20000 Medication  7/10/2017
On 2/15/17, a 90 y/o resident who had been assaulted by another resident resident was found strapped into a tipped over wheelchair. She was bleeding from her nose and mouth and had discolored eyes. She was sent to the ER where it was determined that, in addition to the acute nasal bridge lacerations and facial contusions, she had a fracture sternum, five rib fractures to her right chest and six on her left. She returned to the facility to be given appropriate medication for her pain. During a state investigation on 2/24/14, the resident was observed grimacing, moaning, clenching her chest and saying in Spanish that she could not stand the pain. The investigation revealed that the day before, on 2/23/17, the facility had discontinued the resident’s pain assessment without any indication as to why they did so. The facility was cited for failing to provide proper pain management to a resident who required such services. Citation # 120013318.

B $2000 Injury Mandated Reporting  7/10/2017
The facility was cited after staff failed to follow proper procedures under the law for reporting alleged incidents of abuse to the state and local authorities. After a resident was found with severe facial injuries and another resident was observed with blood on his sleeves, the facility did not report the incident, with staff stating that because they were not there to witness the event, they believed they did not need to file a report. Citation # 120013319.