In an open letter to the Department of Public Health last summer, CANHR asked the Department why it is putting the interests of Shlomo Rechnitz, a nursing home operator with a disturbing record of poor care, above the rights of residents to receive high quality care. At year’s end, it appears the answer to that question is that DPH’s leaders have completely abandoned their duty to protect residents from unfit operators. There seems to be no end to scandals involving Mr. Rechnitz’s nursing homes. To name a few recent ones: the U.S Department of Justice settled charges against Brius (a holding company owned by Mr. Rechnitz) nursing homes for illegal kickbacks for patient referrals and false claims to government health care programs; the California Legislature ordered an audit of Brius Healthcare transactions; the California attorney general’s office is prosecuting the administrator of a Rechnitz-affiliated nursing home for elder abuse in wrongfully discharging residents who could not care for themselves; the National Union of Healthcare Workers (NUHW) filed a complaint with the Department of Public Health that Rechnitz falsely described his compliance history in nearly two dozen nursing home licensure applications; multiple wrongful death cases have been filed against his nursing homes; and the NUHW published a report, “Brius Healthcare’s Insider Transactions,” on how Rechnitz may be profiting at nursing home residents’ expense by steering millions of dollars in taxpayer funds to a web of companies he created to service his nursing homes. Evidence that residents are being neglected and exploited goes on and on and on.

CANHR’s open letter took DPH to task for allowing Rechnitz and his companies to continue operating over 20 nursing homes for which they do not have licenses. In several cases, the DPH had denied licenses sought by Rechnitz; while 18 other skilled nursing facility licensing applications he submitted to DPH have been pending for nearly two years. Many hundreds of residents live in these facilities. California laws do not give operators squatters’ rights to occupy and run nursing homes without a license. Yet DPH is not only allowing chain operators to run nursing homes without a license, it continues to certify them so they will get paid by Medicare and Medi-Cal while doing so, even in instances where license applications have been denied and appeals lost. DPH’s leaders offer no justification for these actions and identify no laws to support them.

One such instance involves the Riverside Convalescent Hospital, a Chico skilled nursing facility Rechnitz acquired in 2014. DPH denied a Rechnitz change-of-ownership licensing application on September 16, 2014, citing poor care in other facilities, and Rechnitz appealed. The appeals dragged on for three years until

DPh Fiddles: ..................... (continued on page 3)
Welcome CANHR Babies!

Two CANHR staff welcomed new baby girls over the past few months. Avi Tucker, CANHR’s Web/Design Coordinator, welcomed baby Hannah on October 7, 2017. Armando Rafailan, our Office Manager/LRS Assistant, welcomed baby Jocelyn, on November 10, 2017. Jocelyn joins her big brother, Julian, in the Rafailan family. Although neither Avi, nor Armando, are getting much sleep right now – they are thrilled to have these new girls in their families.

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.

Thank you for your Support

We want to thank everyone who generously contributed money, time and/or resources to CANHR throughout 2017. A very special thank-you goes to those of you who volunteered to teach at our trainings and to write articles for our newsletters; thank you to those of you who wrote letters to legislators in support of our bills; and a special thank you to those who advocated on behalf of your family members and friends in long term care to make their lives better. We could not do our work without your support!

Donate to CANHR When You Shop on Amazon.com

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

Happy Holidays!

Warmest wishes for a happy holiday season and a great new year from the staff at CANHR!
his attorneys withdrew the appeal on September 18, 2017. Throughout this period, DPH allowed Rechnitz-affiliated companies to run Riverside Convalescent Hospital, and is still allowing them to do so today.

Since 2015, Riverside Convalescent Hospital has been cited for more than 100 deficiencies and currently has a 1-star rating from the Centers for Medicare & Medicaid Services. A DPH complaint investigation completed on July 7, 2017 found the facility did not have enough nursing staff to meet residents’ needs. Residents’ call lights were not promptly answered; a family member reported a resident was in tears due to lack of help; nursing assistants stated no one wanted to work at the facility; and the Director of Nursing reported that “when he first started working 5/2017 at the facility, at one point 100 percent of the staff were from the nursing registry.”

Although this finding is just one of many violations that have occurred at Riverside Convalescent, it speaks to the fundamental betrayal of the public trust by DPH. The Department’s findings suggest that Riverside Convalescent has a toxic reputation and cannot hire and retain enough staff to provide even the most basic of care. Why did DPH allow Rechnitz and his companies to continue operating the facility in this condition for years after declaring him unfit for a license to run this facility in 2014?

When operators are denied licenses and lose appeals, why is it that only residents face any consequences?

While years go by with unfit, unlicensed operators running nursing homes, the public is left with only one conclusion as to why: DPH does not care enough to do anything. Time is not on the side of DPH’s leaders, however, who are under increasing scrutiny for their shocking indifference to the suffering of residents who are increasingly being abused, neglected and mistreated.

As the 2018 Governor’s race heats up, candidates are already talking about cleaning house at DPH and banning unfit nursing home operators. The top four leading Democratic candidates engaged in an eye-opening debate on this subject at an October 22, 2017 forum hosted by NUHW. During the eleven minute exchange, State Treasurer John Chiang promised to “identify those bad actors so they can’t create subsequent companies,” Lt. Gov. Gavin Newsom stated he would call out bad actors and make sure “the folks appointed to oversight are doing their jobs,” and former Los Angeles Mayor Antonio Villaraigosa vowed to ensure our laws have teeth and that operators “don’t get away with murder.”

Former State Superintendent of Public Instruction Delaine Eastin said it best, declaring “We need to make sure that those agencies that do the oversight over your hospitals and your nursing homes have people on fire to do the right things for all of you but especially for all those patients who are not getting the kind of care they deserve in California.”

Take note, bad actors, squatters and indifferent DPH leaders: questions are accumulating, concern is growing, and the spotlight is intensifying.

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**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.
In 2012, the Centers for Medicare and Medicaid Services (CMS) announced the Partnership to Improve Dementia Care in Nursing Homes following a withering Office of Inspector General (OIG) report finding rampant misuse of antipsychotic drugs in nursing homes throughout the country. A centerpiece of the Partnership was a series of antipsychotic reduction goals, which ultimately called for a 30% reduction in antipsychotic use in nursing homes by the end of 2016.

In its latest report on antipsychotic use in nursing homes, the Centers for Medicare and Medicaid Services (CMS) states that antipsychotic use has declined 35% nationally since 2011. That sounds impressive but a close look behind the numbers demonstrates that epidemic misuse of psychotropic drugs has continued - albeit better hidden from the public.

Hiding Antipsychotics in a Phony Diagnosis

The CMS measure for antipsychotic use excludes residents with certain diagnoses, like schizophrenia. This measure shows a 35% reduction in antipsychotic use but the actual reduction in antipsychotic use in nursing homes is only 23%. Why the difference? Nursing homes are using fake schizophrenia diagnoses so antipsychotics are “not counted.”

<table>
<thead>
<tr>
<th>Year</th>
<th>CMS Antipsychotic Measure</th>
<th>Full Antipsychotic Measure</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>23.90%</td>
<td>26.20%</td>
<td>-2.30%</td>
</tr>
<tr>
<td>2012</td>
<td>22.30%</td>
<td>25.00%</td>
<td>-2.70%</td>
</tr>
<tr>
<td>2013</td>
<td>22.30%</td>
<td>23.30%</td>
<td>-3.00%</td>
</tr>
<tr>
<td>2014</td>
<td>19.10%</td>
<td>22.40%</td>
<td>-3.30%</td>
</tr>
<tr>
<td>2015</td>
<td>17.00%</td>
<td>21.10%</td>
<td>-4.10%</td>
</tr>
<tr>
<td>2016</td>
<td>16.00%</td>
<td>20.50%</td>
<td>-4.50%</td>
</tr>
<tr>
<td>2017</td>
<td>15.50%</td>
<td>20.19%</td>
<td>-4.69%</td>
</tr>
</tbody>
</table>

Antipsychotic use that is hidden from the CMS measure has more than doubled since 2011, primarily because the percentage of nursing home residents with schizophrenia has gone from 6.5% to 8.5% (a 31% increase). However, reported symptoms of schizophrenia in nursing homes have decreased (reported resident hallucinations, delusions, and psychosis are all significantly down since 2011). Thus, it appears there is a large increase in bogus schizophrenia diagnoses to prevent antipsychotic use being counted by CMS. Many health care providers have noticed a suspicious increase in schizophrenia diagnoses.

Switching to Other Drugs.

The inappropriate use of chemical restraints to sedate and subdue “problem” residents is not limited to just antipsychotics. Anti-anxiety drugs, which used to be referred to as tranquilizers, are also commonly used to control nursing home residents. Since CMS’s campaign to improve dementia care, the use of anti-anxiety drugs has barely budged, trickling down from 21.4% in 2011 to 20.4% in 2017, an overall reduction of 5%. And that doesn’t account for the rise in use of drugs that are not reported to CMS at all: Depakote (an anti-seizure drug) and Nuedexta (the new kid on the block for central nervous system drugs). A recent study found that 14.3% of elderly nursing home residents were receiving an anti-seizure drug while other reports suggest use is on the rise because these drugs are “not counted” by CMS.

CMS’s approach to reducing the misuse of psych drugs in nursing homes has been disproportionately focused on education - asking, rather than compelling - facilities to improve their care. Very little has been done to enforce the law and ensure residents are not chemically restrained. As a result, good nursing homes have gotten better but bad nursing homes could care less. In California alone, 78 nursing homes drug at least half of their residents with antipsychotics and 54 drug one-third or more residents with anti-anxiety drugs.
Trump Administration Scaling Back Nursing Home Fines and Requirements

California On December 24, 2017, the New York Times reported that the Trump Administration has scaled back the use of fines against nursing homes that harm residents or place them in grave risk of injury. The Times article, Trump Administration Eases Nursing Home Fines in Victory for Industry, described the reduced use of fines as part of a broader relaxation of regulations under the president at the behest of the nursing home industry.

One of the restrictions bars fines for violations of new federal nursing home requirements. On November 24, 2017 – just four days before new federal nursing home requirements took effect – the Centers for Medicare & Medicaid Services (CMS) imposed an 18-month moratorium on enforcing almost all of the new requirements. This capitulation to nursing home industry demands will prevent state inspection agencies from issuing civil money penalties and most other sanctions to nursing homes that violate the new requirements.

The moratorium is just the most recent sign that CMS is leading an attack on federal nursing home standards. CMS is actively working with the nursing home industry and other provider organizations through its deceptively named “Patients Over Paperwork” initiative to roll back standards and undermine any type of accountability. Many critical rights and standards, along with the entire federal inspection system, are being labeled as regulatory burdens and targeted for elimination.

Infection Lapses Are Rampant in Nursing Homes but Punishment is Rare

So says a Los Angeles Times and Kaiser Health News headline for an article published on December 21, 2017. The article reports that 74 percent of the nation’s nursing homes have been cited for infection control violations during the last four years. In California, nearly 90 percent of nursing homes have been cited.

The life threatening nature of infections in nursing homes is unquestioned. The government has estimated that as many as 380,000 nursing home residents die each year due to infections. Despite the deadly consequences, the article states inspectors labeled infection control violations as serious for only 161 of the 12,056 nursing homes they have cited since 2014. Treating these violations as minor problems allows nursing homes to avoid any penalties even when they violate the requirements year after year.

Scandal-Ridden Brius to Pay up to $6.9 Million for Illegal Kickback Scheme

On November 16, 2017, The U. S. Department of Justice announced that four Brius-owned nursing homes in the San Diego area will pay up to $6.9 million dollars to resolve a whistleblower lawsuit involving illegal kickbacks for patient referrals and false claims to government health care programs. Brius is a nursing home chain owned by Shlomo Rechnitz.

Nursing home employees used corporate credit cards to pay for gift cards, massages, tickets to sporting events, and a cruise on the Inspiration Hornblower that were given to discharge planners at Scripps Mercy Hospital San Diego to induce patient referrals to the four nursing homes: Point Loma Convalescent Hospital, Brighton Place-San Diego, Brighton Place-Spring Valley, and Amaya Springs Health Care Center. The four nursing homes have also entered into Corporate Integrity Agreements with the Department of Health and Human Services.

CMS Agrees: Something Stinks About Nursing Home Discharges

Following more national news stories (from Forbes and the Washington Post) about illegal and inappropriate nursing home discharges, the Centers for Medicare and Medicaid Services released a Survey and Certification memo announcing an initiative to address them.

The new initiative is focused on “encouraging states to pursue” projects to reduce illegal discharges and requiring state survey agencies to transfer discharge cases to the federal regional office for review. While
An unfortunately common situation in long term care is depleting funds when living in a Residential Care Facility for the Elderly (RCFE), as all assisted living or board and care facilities in California are known. RCFE costs are expensive, with even small board and care homes regularly costing more than $4,000 a month. For most residents, the costs exceed their monthly income, forcing them to rely on whatever savings they have. And after years of paying for care, those savings are often exhausted. While these situations can be grim, there are options that typically go unexplored.

**A Way to Stay**

The first group of options is focused on staying in the RCFE, minimizing disruption to the resident. Perhaps the best route in this regard is SSI (Supplemental Security Income). If an RCFE resident is out of savings and makes less than $1,173 per month, they will qualify for SSI at the board and care rate. The facility will receive $1,039, which it must accept as payment in full for basic services, and the resident will receive $134, which they may use for personal needs.


Another alternative for staying in place for military veterans who have run out of money is using the Veterans’ Aid and Attendance benefit. This gives qualifying veterans a modest monthly benefit to help pay for RCFE (or other types of) care. For more on the Aid and Attendance program, see CANHR’s fact sheet at [http://canhr.org/factsheets/misc_fs/html/fs_aid&_attendance.htm](http://canhr.org/factsheets/misc_fs/html/fs_aid&_attendance.htm)

If the RCFE participates in the Assisted Living Waiver (ALW) program, the resident who has run out of money and qualifies for Medi-Cal benefits should definitely apply. The ALW program is designed to keep RCFE residents out of more expensive nursing homes and pays the facility a range from approximately $50 to $200 per day. The problem is that not many RCFEs participate in the ALW program and there is currently a substantial waitlist to receive the benefit. For more on the ALW program, see CANHR’s fact sheet at [http://canhr.org/factsheets/rcfe_fs/html/fs_alw.htm](http://canhr.org/factsheets/rcfe_fs/html/fs_alw.htm)

If there is no benefit or program that will enable the resident to stay in their RCFE, a final option is to simply negotiate with the management for a lower rate. Some facilities may have occupancy shortages and prefer the resident stay at a lower rate than leave altogether.

**Moving On**

If the resident cannot stay in the facility despite the foregoing options, they should, of course, consider moving to a less expensive RCFE. This may be a viable alternative for a resident of a high end assisted living facility with a healthy income.

Residents with lower incomes who don’t qualify for SSI have few options. For some residents less dependent on care, they may be able to return to an independent living arrangement by cobbling their care together through family and friends, In-Home Supportive Services, adult day care, or another Medi-Cal-funded Home and Community Based Service (HCBS) program that offers long term services to individuals living at home. For more on eligibility for these programs, see CANHR’s fact sheet at [http://www.canhr.org/factsheets/medi-cal_fs/PDFs/FS_Spousal_Impoverishment_HCBS.pdf](http://www.canhr.org/factsheets/medi-cal_fs/PDFs/FS_Spousal_Impoverishment_HCBS.pdf)

For residents who require a great deal of care and cannot go to an independent living arrangement, their only option may be a nursing home, paid for primarily through Medi-Cal. The big problem for these residents is that nursing homes are very reluctant to admit anyone when Medi-Cal is their primary payment source. Their chances of nursing home admission are much better if they can trigger Medicare coverage through a 3-day qualifying hospital stay - so the only option for an increasing number of RCFE residents is to try to get into a hospital. This is extremely unfortunate for residents and for public policy.

**A Growing and Vexing Problem**

The state and federal governments offer little in the way of benefits programs to RCFE residents who have run out of money. For generations, those governments
have favored spending on institutional (nursing home) care. In 1999, the U.S. Supreme Court found the bias in favor of institutional spending violated disability discrimination law, which should have ushered a new era of community based alternatives. (Olmstead v. L.C.) While there have been efforts to expand home and community based programs since then, they have not kept pace with the increased demand as the population continues to age. Public spending in California continues to shamefully favor institutional care.

Until major changes occur in our policies, RCFE residents who run out of money will continue to have limited options for future care and will often remain precariously unsure of what to do.

In October 2017, CMS doubled down on its weak approach to the misuse of psychotropic drugs. In announcing its new goals for antipsychotic reduction CMS stated:

Nursing homes with low rates of antipsychotic medication use are encouraged to continue their efforts and maintain their success, while those with high rates of use are to work to decrease antipsychotic medication use by 15 percent . . . by the end of 2019.

This announcement is tantamount to a eulogy for the National Partnership, which has coasted for years on tepid commitment from CMS. The announcement tells most nursing homes the job of reducing antipsychotic use is largely done. For the other nursing homes that have done nothing, CMS is saying “please try again to slightly reduce your extreme levels of drugging by the end of the decade. Beware, if you ignore us again, we might ask you drug offenders to try again in 2020.”

Misuse of antipsychotics, and several other psychotropic drugs, continues to be one of the most pernicious problems in nursing homes and deserves a real campaign marked by enforcement of our laws and improvement of our care standards. While CMS declares progress, a closer look reveals that much of this progress is illusory. The numbers it uses are hype - don’t believe them.

1 National Partnership to Improve Dementia Care in Nursing Homes: Antipsychotic Medication Use Data Report (October 2017)

2 The full antipsychotic measure comes from CMS’s Minimum Data Set (MDS) 3.0 Frequency Reports compiled quarterly. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report.html
Dear Curious,

I have great news for you - Medi-Cal cannot make a claim against your parents’ home. The Medi-Cal estate recovery laws changed dramatically on January 1, 2017, and the new laws are much more favorable to consumers. After January 1, 2017, if a Medi-Cal recipient is survived by a spouse or registered domestic partner, the Medi-Cal estate claim is prohibited and forever barred. Even though your mother passed away in 2015, because your father did not pass away until after January 1, 2017, the new Medi-Cal recovery laws apply and the Medi-Cal estate claim for your mother’s nursing home expenses is barred.

For more information on the new Medi-Cal recovery laws, see CANHR’s consumer guide at [http://canhr.org/publications/PDFs/Medi-Cal_Recovery.pdf](http://canhr.org/publications/PDFs/Medi-Cal_Recovery.pdf).

Sincerely,
Curious in Canton
Year 2018 Rate and Cost of Living Adjustments

Rate and Cost Increases Effective 1/1/2018

There will be a 2% Cost of Living Increase (COLA) in 2018.

2018 Medicare Rate Increases: See Medicare website: www.medicare.gov

MEDICARE PART A
Hospital Deductible (Day 1-60): $1,340.00 (up from $1,316.00)
Coinsurance per day:
Day 61-90: $335.00 (up from $329.00)
Day 91-150: $670.00 (up from $658.00)
All cost for each day beyond 150 days.

MEDICARE PART B
Premium per month: $130.00-$428.60 (based on income)
Deductible per year: $183.00 (up from $166.00)

2018 Medi-Cal Resources Rates:
Community Spouse Resource Allowance (CSRA): $123,600.00
Minimum Monthly Maintenance Needs Allowance (MMMNA): $3,090.00
Average Private Pay Rate (APPR): $8,515.00 (subject to change April 2018)

Supplemental Security Income (SSI) & State Supplemental Program Rates (SSP):

<table>
<thead>
<tr>
<th></th>
<th>Single</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged and Disabled:</td>
<td>$910.72</td>
<td>$1,532.14</td>
</tr>
<tr>
<td>Blind:</td>
<td>$967.23</td>
<td>$1,683.19</td>
</tr>
<tr>
<td>One is Blind, One is Aged or Disabled</td>
<td>$1,625.65</td>
<td></td>
</tr>
</tbody>
</table>

** Rates noted are for independent living only.

SSI Non-Medical Board and Care Rate:
Total Payment: $1,173.37 (up from $1,158.37)
Amount Payable to RCFE for Basic Services: $1039.37 (up from $1026.37)
Personal and Incidental Needs Allowance: $134 (up from $132)

Aged and Disabled Federal Poverty Level Program: Effective 4/1/2017:

Individual: $1,235.00 (up from $1,220.00)
Couple: $1,664.00 (up from $1,645.00)
CCRC Corner

CCRCs: Family Councils and Resident Councils

The Department of Social Services, Community Care Licensing Division recently released a Policy Information Notice (PIN 17-11-ASC) to inform all CCRC providers and RCFE licensees of their obligations regarding family councils and resident councils. Too many CCRC providers don’t seem to understand that they are also RCFE licensees and, as such, are required to comply with the laws relating to the formation, maintenance and promotion of resident councils and family councils. CANHR has received numerous complaints from CCRC residents about providers interfering with the organizing of family councils, not permitting the posting of information, and not responding to family council concerns, among other violations.

AB 1572 (Eggman) which was effective January 1, 2015, strengthened the laws regarding both resident and family councils, adding rights for family members and penalties for those providers and licensees who violate the provisions of Health & Safety Code §§1569.157 and 1569.158. This includes the following provision: A violation of the resident council (and family council) section shall constitute a violation of resident rights which shall be subject to a daily civil penalty of two hundred fifty dollars ($250) until the violation is corrected. CCRC residents and their family members whose rights are violated are urged to file complaints with the CCRC Branch:

Continuing Care Branch  
CCLD Complaint Hotline  
File a Complaint  
1-844-LET-US-NO

For more information about the rights of resident and family councils and the responsibilities and obligations of the providers, see CANHR’s fact sheet: http://www.canhr.org/factsheets/rcfe_fs/PDFs/FS_RCFE_Family_Councils.pdf

CCRC Legislation in 2018 – Oppose AB 853

CANHR is gearing up to once again to oppose AB 853 (Choi) – a bill solely intended to pave the way for Erickson Living, a senior housing developer, that is not yet even an operator in the CCRC industry in California. Their goal is to avoid current statutory requirements regarding Continuing Care Retirement Communities in California. AB 853 does little to ensure solvency or responsible care by CCRC providers. Instead, several provisions of the CCRC statutes intended to protect consumers are weakened and, in the case of changing the definition of repayable contracts, simply unnecessary.

Ultimate Advocate – Lillian Hyatt

Professor Lillian Hyatt is CANHR’s Advocate Correspondent for CCRC issues and an AARP Public Policy Specialist on CCRC issues. She is a resident of a CCRC, a fierce advocate and has been writing columns about CCRCs and resident rights for the past 14 years for CANHR and for the newsletter of the National Association of Social Workers–California Chapter.

Professor Hyatt can be seen on Youtube on the USC School of Social Work website at https://www.youtube.com/watch?v=CMrC6o6Rm04

CANHR’s Executive Director, Pat McGinnis, Deputy Director, Pauline Mosher, and Office Manager, Armando Rafailan, visited with Lillian recently at her residence in San Francisco.
CANHR welcomes memorial and honorary gifts. This is a great way to honor a special person or a loved one, while helping those who are long term care residents. Recent gifts have been made in the names of the following persons:

**Memorials**

- Mary W. Ballantyne  
  Bob Peterson
- Sybil A. Alznauer  
  R. Ruth Linden, Ph.D.
- Linda Bradford  
  Donald Freeman
- Ethel Christensen  
  Ron Christensen
- Pat Coleman  
  H. L. Coleman
- Victoria Delas  
  Anthony Delas
- Beryl DuBois  
  Candie Brady
- In memory of my mother, Rosamond Edeline, who passed on March 29, 2005  
  Gail L. Bean
- Michele Lynn Galla  
  Geraldine Eckner
- Faith Geer  
  Martin Schiffenbauer
- Margaret Mizner Glidden  
  Nancie Glidden
- Marion S. John  
  George & Carolyn John
- Jane Kristiansen  
  Gerry Murphy
- Ursula & Edmund Kroll  
  Christopher Kroll
- Sherry O. McIlwain  
  Gloria McIlwain & Sharon Roberts-Cagle
- Patti Medlin  
  Michael Medlin
- Tim Millar  
  Raymond James
- Tim Millar  
  Daniel Rossi
- Denis Powell  
  Argene R. Powell
- Ronald Randolph  
  Brenda Williams
- Laverne Schwacher  
  Debra Vogler
- Alice Scobey  
  Mary Webster
- Therese Serezlis  
  Leslie and Debra Stein
- Therese Serezlis  
  Kelsi Moore
- Therese Serezlis  
  Kathi Silverman
- Therese Serezlis  
  Nola Serezlis-Slattery & Carl Slattery

**In Honor Of**

- Sharron Evans  
  Robert & Beverly Lyman
- Jean Buysse  
  Pauline Sherman
- Mike Connors, Tony Chicotel, and Janet Wells  
  Toby Edelman
- Terry & Angela Donnelly  
  Donna Ambrogi
- Judy Ghilarducci  
  Chuck Berry
- Sabita Goswami  
  Subrata Goswami
- Bessie W. Harris  
  Bobbie Williams
- The Tim Millar Family  
  Catherine Hofman
- Julius Schnall  
  Jean Schnall
- Therese Serezlis  
  Terrence D. & Stana L Slattery
- Therese Serezlis  
  Dr. Michael A. & Ione B. Slattery
- Therese G. Serezlis  
  Joanne M. Wierzbicki
- Hagop Jack Shadoian  
  Barbara Yorganjian
- Thomas Speer Walther  
  Anthony Moy
- Betty Jane Sprague  
  Sally Sprague
- Warren T. Stewart  
  Elizabeth Boileau
- Peter R. Summers  
  Agnes G. Summers
- Doris Turrill  
  Jo Oliver
- Rita M. Twomey, my beloved mother  
  Denise Twomey
- Bruno and Evelyn Wartman  
  Patricia Moran
- Joseph Wong  
  Timothy Wong
- Joan Young  
  Martin Young
- Nursing Home Social Service Staff  
  Tracy Greene
- In honor of CANHR staff, remembering how Michael Connors, Julie Pollock and Tony Chicotel helped me and my father.  
  Virginia Barker
- Robert Wendland  
  Brian Johnston
Past Speaking Engagements, Panel Discussions and Training Sessions

- **October 6:** Yvonne Hernandez, Long Term Care Advocate provided CANHR resources and information at the Zuckerberg San Francisco General Wellness Center for the Latino Heritage Month celebration.

- **October 10:** Prescott Cole, CANHR Senior Staff member taught a class on Long-Term Care Medi-Cal at UC Hastings’s Law School Medical-Legal Partnership for Seniors.

- **October 11:** Prescott Cole taught a class on Long-Term Care Medi-Cal and Nursing Home Abuse at UC Berkeley Extension Geriatric Studies Class.

- **October 12:** Julie Pollock, Long Term Care Advocate presented on Medi-Cal Recovery at the Center for Elder’s Independence in downtown Oakland.

- **October 13:** Jody Spiegel, CANHR Staff Attorney participated in the SSI Summit for legal service advocates in Los Angeles.

- **October 16:** CANHR Staff provided 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.

- **October 17:** Yvonne Hernandez, CANHR Long Term Care Advocate conducted a presentation regarding Medi-Cal Recovery for the Central American Resource Center.

- **October 18:** Jody Spiegel participated in the Legal Aid Association of California Directors of Litigation & Advocacy/Support Center Meeting in Los Angeles.

- **October 18:** Tony Chicotel, CANHR Staff Attorney traveled to Folsom to make a presentation about long-term care evictions at the fall Ombudsman Coordinators’ Conference.

- **October 25:** Jody Spiegel participated in the RCFE Advocates Quarterly Meeting with Community Care Licensing.

- **October 27:** Prescott Cole participated in the US Attorney General’s Elder Justice Task Force meeting for the Northern District of California.

- **November 1:** Efrain Gutierrez, Long Term Care Advocate visited Assemblymember Sebastian Ridley-Thomas and provided CANHR resources and information regarding Medi-Cal Recovery.

- **November 2:** Pauline Mosher presented to San Francisco State University Gerontology students about CANHR’s advocacy support role and shaping social policies.

- **November 3:** Efrain Gutierrez, Long Term Care Advocate provided CANHR resources and information at the Gardena Community Center.

- **November 8:** Prescott Cole spoke at the Veteran’s Benefits Protection Project San Francisco City Hall Veteran’s Day Press Conference.

- **November 17 & 18:** CANHR hosted its 21st
annual Elder Law Conference at the Monterey Plaza Hotel with a capacity crowd of legal services and private bar attorneys. The William F. Taylor Memorial Award was presented to Kim Valentine, with the Valentine Law Group in Mission Viejo.

- **November 29:** Prescott Cole was a panelist speaking about abuse and neglect in nursing homes at the California District Attorneys Association Annual Statewide Conference held in Orange County.

- **December 1:** Pauline Mosher presented about CANHR services to the UCSF Geriatric’s Fellows.

- **December 3:** Julie Pollock visited consumer advocate Reverend Seibert at Oakland’s Union Baptist Church.

- **December 11:** Prescott Cole did an Elder Abuse & Financial Abuse training for John Muir Hospital social workers.

- **December 19:** Tony Chicotel presented an overview of important long-term care topics to the Ombudsman staff and volunteers in San Diego County.

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**CANHR Program Manager Julie Pollock and Reverend Seibert of Oakland United Baptist Church.**

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- Transfer on Death Deeds: What You Should Know
- The New Medi-Cal Recovery Laws

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CANHR Staff
Attorney Prescott Cole speaking at the Veteran’s Benefits Protection Project San Francisco City Hall Veteran’s Day Press Conference
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### Monterey County

<table>
<thead>
<tr>
<th>Facility Name</th>
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<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cypress Ridge Care Center</td>
<td>1501 Skyline Drive, Monterey</td>
<td>070013408</td>
<td>8/10/2017</td>
<td>A $2000 Fall Patient Care</td>
<td>A resident reported he was mentally abused on 7/19/17 when a certified nursing assistant laughed at his bowel movement, saying “Oh my God! Look at the size of that,” and purposely did not clean up his bowel movement to make fun of it. The resident was very angry and stated he did not like being laughed at. The facility was cited for failing to report the suspected abuse to state authorities. Citation # 070013408.</td>
</tr>
</tbody>
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### Pacific Grove Convalescent Hospital

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</thead>
<tbody>
<tr>
<td>Pacific Grove Convalescent Hospital</td>
<td>200 Lighthouse Avenue, Pacific Grove</td>
<td>070013422</td>
<td>8/10/2017</td>
<td>B $1000 Elopement Mandated Reporting</td>
<td>After a resident diagnosed with schizophrenia and bipolar disorder left the facility without staff knowledge or permission, staff failed to report the elopement to the CA Department of Public Health or Ombudsman as required by law. Citation # 070013288.</td>
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### Santa Clara County

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<tbody>
<tr>
<td>Canyon Springs Post-Acute</td>
<td>180 North Jackson Avenue, San Jose</td>
<td>070013054</td>
<td>3/16/2017</td>
<td>B $ Fall Patient Care</td>
<td>On 1/17/17, a resident fell backwards in her wheelchair, striking her head and sustaining a scalp laceration that required staples and hospitalization. The facility failed to implement her care plan, which called for use of a wheelchair alarm due to her history of falling. Another resident, who was also at high risk of falling, suffered falls on 10/30/16, 1/4/17, 1/31/17, and 3/17/17. The staff did not use chair and bed alarms to help prevent falls as indicated by her care plan and failed to document plans to prevent future falls. Citation # 070013422.</td>
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### Empress Care Center, LLC

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</tr>
</thead>
<tbody>
<tr>
<td>Empress Care Center, LLC</td>
<td>1299 S. Bascom Avenue, San Jose</td>
<td>070013288</td>
<td>6/15/2017</td>
<td>B $1000 Elopement Mandated Reporting</td>
<td>A resident fell and struck his head on the floor on 5/21/17. The fall resulted in a forehead laceration which required staples and hospitalization. The facility failed to implement the interventions recommended such as placing a mattress on the floor and a sensor pad alarm on the bed to indicate if the resident was getting up from a bed as he was at high risk for falls. Citation # 070013465.</td>
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### Milpitas Care Center

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<tbody>
<tr>
<td>Milpitas Care Center</td>
<td>120 Corning Ave., Milpitas</td>
<td>070013422</td>
<td>8/10/2017</td>
<td>B $2000 Careplan Fall Injury</td>
<td>On 1/17/17, a resident fell backwards in her wheelchair, striking her head and sustaining a scalp laceration that required staples and hospitalization. The facility failed to implement her care plan, which called for use of a wheelchair alarm due to her history of falling. Another resident, who was also at high risk of falling, suffered falls on 10/30/16, 1/4/17, 1/31/17, and 3/17/17. The staff did not use chair and bed alarms to help prevent falls as indicated by her care plan and failed to document plans to prevent future falls. Citation # 070013422.</td>
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### Pacific Hills Manor

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<tbody>
<tr>
<td>Pacific Hills Manor</td>
<td>370 Noble Court, Morgan Hill</td>
<td>070013465</td>
<td>8/30/2017</td>
<td>B $2000 Careplan Fall Injury</td>
<td>A resident fell and struck his head on the floor on 5/21/17. The fall resulted in a forehead laceration which required stitches and a diagnosis of an acute hematoma which required intense neurological surveillance. The facility failed to implement the interventions recommended such as placing a mattress on the floor and a sensor pad alarm on the bed to indicate if the resident was getting up from a bed as he was at high risk for falls. Citation # 070013465.</td>
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### San Tomas Convalescent Hospital

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</tr>
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<tbody>
<tr>
<td>San Tomas Convalescent Hospital</td>
<td>3580 Payne Avenue, San Jose</td>
<td>070013465</td>
<td>8/10/2017</td>
<td>B $2000 Fall Patient Care</td>
<td>A resident fell out of her bed head first while getting</td>
</tr>
</tbody>
</table>

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dressed by an employee on 7/22/17. She was transported to the hospital, scans showed the resident suffered multiple fractures of her cervical spine including a neck fracture, a right facial fracture and a laceration of her right eyebrow. The resident was transferred to a second acute care facility on 7/27/17 and died one day later on 7/28/17. Citation # 070013423.

**B $2000 Mandated Reporting Verbal Abuse 5/03/2017**

In April 2017, a facility was cited for failing to investigate and report allegations of verbal abuse on behalf of two residents to the ombudsman and Department of Public Health within 24 hours. The first resident was verbally abused by a CNA who said: “Look at you, your fat face, you're putting weight on yourself.” The second resident was verbally abused by a CNA who came into the dining room and yelled at her, because she had reported the CNA for failing to assist another resident with eating. 

Citation # 070013159.

**Willow Glen Center**

1267 Meridian Avenue, San Jose

**B $2000 Mandated Reporting Physical Abuse 4/13/2017**

On 3/21/17, a resident told a CNA that she hit her on the hip while transferring her to the toilet, and that she was going to report her. The CNA did not report the allegation to anyone. The facility was cited for failing to report the alleged abuse of the resident in a timely manner to the immediate supervisor, administrative designee and appropriate agencies.

Citation # 070013116.

**Santa Cruz County**

**Driftwood Healthcare Center - Santa Cruz**

675 24th Avenue, Santa Cruz

**B $2000 Patient Care Transfer 7/27/2017**

Facility failed to appropriately discharge and transfer a patient to her original facility when staff sent the patient, a woman with dementia and who required conservatorship, back to her facility in a taxi. The facility was cited for failure to provide the resident with medical-related social services. Citation # 070013398.

**Watsonville Nursing Center**

535 Auto Center Drive, Watsonville

**B $2000 Mandated Reporting Physical Abuse Verbal Abuse 7/19/2017**

Facility staff failed to appropriately report an incident of alleged abuse, or remove the alleged abuser from duty, after a resident complained that a CNA yelled and hit her. Citation # 070013355.
Citation Watch - Consumer Report

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Fresno County

Sierra Vista Healthcare
1715 S. Cedar Avenue, Fresno

B $2000 Other Patient Rights 9/18/2017
A resident’s bank account was debited $2,280.18 dollars without her permission. The social services director was arrested and charged with identity theft, credit fraud, and three counts of actual use. The facility was cited for failing to ensure that a resident’s personal bank account funds were not withdrawn by the facility social services director without authorization and in violation of facility policy. Citation # 040013500.

Kern County

Kern Valley Healthcare District D/P SNF
6412 Laurel Ave, Lake Isabella

B $2000 Verbal Abuse 11/29/2017
The facility was cited for failing to ensure that a 73 year old resident and a 65 year old resident were not subjected to verbal abuse. The residents were reprimanded and intimidated by a physician who wanted to discuss an incident reported were both residents had called a CNA a “colored girl” while on duty in the SNF. The residents experienced anxiety and distress due to the conversation with the physician. Citation # 120013637.

Los Angeles County

Antelope Valley Care Center
44567 North 15th Street West, Lancaster

A $20000 Patient Care 11/03/2017
On 9/19/17, a resident who was on a regiment of medication that was known to cause constipation developed severe abdominal pain, and on 9/20 she was transferred to the hospital where an x-ray and computerized body image scan revealed a bowel impaction. The resident was a stroke victim and incontinent brief, restless, with his call light out of reach, thick saliva in his mouth. The resident was receiving hospice care and had a physician’s order for no food or fluids via mouth. The facility had no plan for addressing the resident’s nutritional or hydration needs and for six days, he received no food or water. The resident was also not provided prescribed pain medications despite severe abdominal pain. The resident died on 4/29. The facility was cited for neglecting the resident. Citation # 920013217.

Atlantic Memorial Healthcare Center
2750 Atlantic Ave., Long Beach

B $2000 Patient Care 10/05/2017
On 5/29/17, a female resident was transferred to the emergency room due to dangerously low blood pressure (69/40). The resident was admitted to the facility with a diagnosis of dementia, high blood pressure, and an irregular heartbeat. On 5/29/17, the resident was observed to have abnormally low blood pressure, yet the licensed nurse continued to administer medications for high blood pressure and narcotic medications. As a result, the residents blood pressure dropped to dangerously low levels and the resident had to be hospitalized. The facility was cited for failure to notify the physician of the resident’s blood pressure prior to administering the medications, and failure to inform and involve the registered nurse when the resident was having consistently low blood pressure. Citation # 940013530.

Avalon Villa Care Center
12029 S Avalon Blvd, Los Angeles

B $2000 Injury 9/22/2017
On 5/13/17, a 55 year-old wheelchair bound resident was wheeling himself towards the lunch room when two CNAs started a fight with each other. When one CNA hit the other, that CNA fell onto the resident tipping him over and causing injury to his right arm, shoulder and right foot. The facility was cited for failing to ensure the safety of a resident in an area frequented by residents. Citation # 940013478.

Brier Oak On Sunset
5154 Sunset Blvd., Los Angeles

A $20000 Hydration Neglect 7/21/2017
On 4/25/17, a male resident was observed wearing only an incontinence brief, restless, with his call light out of reach, and observable signs of dehydration such as cracked lips and thin saliva in his mouth. The resident was receiving hospice care and had a physician’s order for no food or fluids via mouth. The facility had no plan for addressing the resident’s nutritional or hydration needs and for six days, he received no food or water. The resident was also not provided prescribed pain medications despite severe abdominal pain. The resident died on 4/29. The facility was cited for neglecting the resident. Citation # 920013217.

Brookdale Northridge
17650 Devonshire Street, Northridge

A $15000 Careplan Dietary Services Feeding Hydration Infection Nutrition Patient Care 9/29/2017
The facility was cited for failing to ensure that a resident was provided with sufficient fluids to maintain proper hydration and health. Also, the facility failed to document the residents’ fluid consumption as ordered by her physician. As a result, the resident was transferred to a General Acute Care.
Hospital where she received hydration and antibiotic therapy to treat a urinary tract infection, manage elevated sodium in her blood and an abrupt decrease in her kidney function. Citation # 920013490.

**Del Rio Convalescent Center**

7002 E Gage Avenue, Bell Gardens

B $2000 Mandated Reporting Physical Abuse 10/20/2017

The facility failed to report a resident-to-resident altercation, which occurred on 6/30/17, to the Department within 24 hours. The altercation took place between a 64 year old female resident with schizophrenia, and a 54 year old female resident with dementia and schizophrenia. Citation # 940013552.

B $2000 Patient Care 7/27/2017

On 5/29/2017 Resident 11 assaulted Resident 22 at the facility and Resident 22 had facial trauma in result of the assault. During an interview on 6/2/2017, the administrator stated that he did not conduct a thorough investigation and was unaware that Resident 11 was unsupervised on 5/28/2017. The administrator stated that he should have completed the investigations and sent a final report within 5 days to the Department. The facility failed to implement its policy and procedure for abuse prevention, investigation, and reporting. Citation # 940013401.

B $2000 Injury 7/27/2017

During an interview on 6/7/2017, the facilities administrator stated that his was unaware how Resident 15 sustained a displaced fracture on the right superior pubic ramus. The administrator of the facility admitted to not completing a thorough investigation. In addition, the administrator failed to submit a final report the Department within 5 days. Citation # 940013376.

**Imperial Crest Health Care Center**

11834 Inglewood Ave, Hawthorne

B $2000 Patient Care 10/06/2016

On a state inspection on 8/16/16, a resident who was dependent on staff for grooming, bathing and personal hygiene, was observed continually scratching various areas of her body. It was noted that the resident had a black substance underneath her fingernails and was sliding her head from side to side across he pillow in what appeared to be an attempt to scratch the back of her head. The resident was also observed frowning, grimacing, moaning and groaning. When asked, the resident said the staff did not apply lotion or moisturized her skin. When asked how it felt to shower and have her hair shampooed the resident grabbed and held on to the Evaluator's hand with tears in her eyes. The facility was cited for failing to assess the resident for continuous itching and for failure to apply lotion and medications designed alleviate the discomfort. Citation # 910012633.

**La Paz Geropsychiatric Center**

8835 Vans Avenue, Paramount

B $2000 Elo hemp Mandated Reporting 10/20/2017

The facility was cited for failing to follow their policy and procedures for “Unusual Occurrence Reporting to DPH” to report incidences within 24 hours. The facility noticed the resident was missing at 9 p.m. on 6/25/17, the RN stated when they checked the resident’s room, his roommates were sleeping, and they noticed the bathroom window was hanging from the frame. The RN notified the DON, the resident’s physician, the local police department and the social worker on the same day of the elopement, but failed to report the incident to the department until two days later. Citation # 940013555.

B $2000 Elopement 9/12/2017

On 3/31/17, a resident with schizoaffective disorder went out on a peer pass (a permission to leave the facility with another resident) and did not return. The resident was later found she was admitted into the acute care hospital. On 4/14/17, when she was readmitted to the facility her progress notes indicated that she was uncooperative, severely agitated, and very hard to redirect. The facility was cited for failing to contact the Department within 24 hours of elopement. Citation # 940013491.

**Long Beach Care Center**

2615 Grand Avenue, Long Beach

B $2000 Injury 6/14/2017

On 4/20/2017, Resident 1 kicked CNA 1 due to the lack of attentiveness to the resident’s call light and he needed his diaper changed by CNA 1. CNA 1 reported that Resident 1 kicked her. The LVN for that shift stated that she spoke with Resident 1 and CNA 1 and Resident 1 stated he kicked CNA 1 because CNA was in a rush while completing the activities of daily living care for Resident 1. Resident 1 informed the LVN that CNA 1 slapped him in the face. The facility was cited for not ensuring that Resident 1 had the right to be free from physical abuse when resident 1 kicked CNA 1 because she was not answering the call light when he need to have his diaper changed and CNA subsequently slapped Resident 1 in the face with a open hand. Citation # 940013286.

**Long Beach Healthcare Center**

3401 Cedar Avenue, Long Beach

A $16000 Chemical Restraints 9/22/2017

A 57 year old female resident with multiple sclerosis received sleeping, anti anxiety, and antidepressant drugs. A physician recommended dose reductions but no action was taken. The resident was being given two anti anxiety drugs despite duplication and received “as needed” medication daily. The facility was cited for failing to ensure the resident did not receive unnecessary drugs. Citation # 940013470.

A $16000 Patient Care 9/22/2017

A 57 year old resident diagnosed with multiple sclerosis with an anxiety disorder and who required supervision for locomotion, mobility, and transfers was put on anti-anxiety and antidepressant medications seven days a week and hypnotic medication six days a week. On 7/22/15, It was noted in her care plan that she would leave the facility late at night and return early in the morning smelling of marijuana. Also, she was suspected of smoking dope in her room and once threw a lit cigarette into a linen cart while being told not to smoke in the hallway. The resident refused to use the designated smoking area or to wear a smoking apron. The facility was cited for failing properly supervise the resident and to ensure that her environment remained as free from hazards as possible. Citation # 940013469.

B $2000 Mental Abuse Patient Care Verbal Abuse 9/22/2017

During an unannounced visit on 7/24/17, the Department found that the facility failed to prevent a 57 year old female resident with a history of behavioral issues from yelling at, use profanity towards, verbally abusing, and using threatening and aggressive behaviors towards at least five other residents, including her roommate. Some of the residents stated the abuse had been going on for over five years, without appropriate staff intervention despite resident complaints. Citation # 940013514.
On 5/23/17, at 4:00 p.m., the CNA observed the resident with swelling, discoloration, and pain on the right hip. This failure was cited for failure to conduct an assessment when the resident complained of pain and for failing to notify the Department about the fall within 24 hours of its occurrence. Citation # 920013516.

**Lynwood Healthcare Center**

3611 Imperial Hiway, Lynwood

**B $2000** Mandated Reporting Physical Abuse 10/04/2017

The Department of Public Health (DPH) cited the facility for failing to implement its abuse policies and procedures to investigate and immediately report allegations of staff to resident mistreatment to DPH within 24 hours. On 06/9/17, an unannounced visit was made to the facility to investigate a complaint regarding employee to resident abuse. The 63-year-old male resident stated the incident occurred six months before the investigation when a medication nurse assaulted him during a medication pass. The resident said that the LVN roughly attempted to remove a medicine cup form the resident’s hand, leaving a scratch on the resident’s skin. During the interview, the administrator stated that the resident’s allegation was not reported and investigated as an abuse case because he did not see it as abuse. Citation # 940013527.

**Maclay Healthcare Center**

12831 Maclay Street, Sylmar

**B $2000** Fall 9/22/2017

Nurse’s Notes indicated that on 7/25/17, a resident who was paralyzed on one side of her body, totally dependent on staff for transfers, and unable to make decisions on her own was complaining of pain in her right leg. There was no documentation that the staff attempted to determine the source of the pain or for signs of trauma, such as bruising or swelling. On 7/26, the resident was in acute pain and transferred to a hospital for evaluation. X-rays showed that she had a hip fracture. On 8/10/17, the resident was interviewed and told investigators that she had fallen from her wheelchair and a CNA was with her when it happened. The facility was cited for failure to conduct an assessment when the resident complained of pain and for failing to notify the Department about the fall within 24 hours of its occurrence. Citation # 920013516.

**Regency Oaks Post Acute Care Center**

3850 E. Esther Street, Long Beach

**A $16000** Medication 10/12/2017

Following a complaint about a resident overdosing on pain medication, the facility was cited for failing to ensure the resident was free from unnecessary drugs. The resident was a 53 year old female with COPD. On 6/18/2017, the resident was observed very sleepy and lethargic and had to be hospitalized and treated for an overdose of pain and psychotropic drugs. The facility’s records revealed the staff had failed to document some drug administrations; consequently the resident was given more drugs than had been prescribed by her physician. Citation # 940013541.

**Wellsprings Post-Acute Center**

44445 N.15th St. West, Lancaster

**B $2000** Patient Care Physical Environment 9/10/2017

On 7/25/17 during an annual re-certification survey, the temperature inside the facility was 83 degrees. Two residents were observed lying in bed, sweating, with red, flushed faces. One resident was in bed, still covered with a blanket. The facility was cited for failure to maintain a safe temperature and failure to implement the facility’s policy on Extreme Temperature. Citation # 920013486.

**West Hills Health and Rehabilitation Center**

7940 Topanga Canyon, Canoga Park

**B $2000** Dietary Services Nutrition 9/10/2017

During a tour of the kitchen on 7/24/17, the Department of Public Health observed that the facility failed to refrigerate a pan of pork and roast beef, which was left at dangerous temperatures for longer than six hours, and then served to residents despite the fact that the dietitian requested they be discarded; failure to store food in a safe manner because the refrigerator was not functioning at a proper temperature; failure to have a properly functioning dish washer; failure to ensure the meat thermometers were properly calibrated (some thermometers were observed to be 12 degrees off.) These violations placed all 236 facility residents at risk of food borne illnesses. Citation # 920013485.

**Windsor Convalescent Center of North Long Beach**

260 E Market St, Long Beach

**A $16000** Careplan Fall Injury Medication Patient Care 10/12/2017

A 81 year old resident experienced ten falls within four months. The falls resulted in transfers to a general acute care hospital, lacerations to the head, blunt head trauma and required wound closure, antibiotics and pain medications. The facility failed to adequately monitor and supervise the resident who had a history of multiple falls and was receiving medications with high risk for falls. Citation # 940013539.
Windsor Gardens Healthcare Center Of The Valley
13000 Victory Blvd, North Hollywood
A $20000 Deterioration Neglect 9/22/2017
On 4/13/17, a resident’s family member called the resident’s physician to report the resident was showing signs of lower extremity weakness and an extreme loss of alertness. The physician told the facility staff and a nurse performed a neurological exam but did not report the results back to the physician. A physical therapist noted a significant change in condition that same day which was not reported to the physician either. The resident’s family member later called the facility to report the resident was incoherent but no follow up was performed. On 4/14/17, the resident was found dead in her room. The facility was cited for failing to notify the physician about a change of condition and for responding to the resident’s rapid deterioration. Citation # 920013487.

Orange County
Flagship Healthcare Center
466 Flagship Road, Newport Beach
A $2500 9/27/2017
On 8/11/2017 a medical review for Resident 2 was conducted. Resident 2 was admitted into the facility on 10/24/2017 and diagnosed as paraplegia and contractures. A review of Resident 2’s Minimum Data Set (a standardized assessment tool) as of 7/31/17 notes that the resident had a severe cognitive impairment and requires two people for bed mobility, dressing, toilet use, and personal hygiene. During an investigation CNA 8 was providing care while the resident fell on the floor sustaining a skin tear to the upper lip, right frontal scalp hematoma (abnormal collection of blood outside of a blood vessel), and a fracture of the left distal femoral shaft (thigh bone above the knee joint). The facility failed to provide the necessary care and services to ensure adequate supervision was in place to prevent a fall. Citation # 060013519.

Lake Forest Nursing Center
25652 Old Trabuco Road, Lake Forest
A $10000 Feeding Medication Patient Care 9/22/2017
A resident who is cognitively impaired and not able to make her needs known was administered morphine sulfate in her apple sauce. The resident’s condition was observed to have decreased level of consciousness, not responsive and required administration of oxygen. The resident was then sent to a hospital for emergency evaluation. The methone sulfate dose was later discovered to be intended to another resident. This violation had a direct relationship to the health and safety of the resident. Citation # 060013507.

Seal Beach Health and Rehabilitation Center
3000 N Gate Road, Seal Beach
A $3500 Decubiti (Bedsores) 10/06/2017
On 10/6/17, the facility was cited after a medical record review revealed that the facility failed to ensure that necessary care and services were provided to five residents, all of whom were identified as high risk to develop skin breakdown, to prevent their development of pressure ulcers, and promote treatment for their pressure ulcers. Resident 1 developed a Stage 2 pressure ulcer on the sacrococcyx which deteriorated to a Stage 3, and four additional pressure ulcers on the buttocks area; Resident 2 developed a heel arterial ulcer; Resident 3 developed a Stage 1 heel pressure ulcer which deteriorated to an UTD blood filled blister; Resident 4 developed a Stage 2 heel pressure ulcer; and Resident 5 developed bilateral heel blisters. Citation # 060013535.

Riverside County
Palm Springs Healthcare & Rehabilitation Center
277 S. Sunrise Way, Palm Springs
B $2000 Administration Other Patient Records 8/29/2017
Complaints were made to the department regarding mishandling of funds for a resident. During the investigation it was determined that the facility failed to deposit the residents funds into an interest bearing account and failed to monitor the total amount of funds in the account. This failure cased the resident to lose potential interest on the funds and also to become ineligible for Medi-Cal payment. Citation # 250013436.

Palm Terrace Care Center
11162 Palm Terrace Ln, Riverside
B $2000 Notification Patient Rights Transfer 9/14/2017
The facility failed to ensure a 90 year old residents’ patient rights were not violated when they transferred the resident to another facility without providing adequate notice, medical reason or obtaining consent from the responsible party. Citation # 250013495.

Riverside Behavioral Healthcare Center
4580 Palm Ave., Riverside
B $1000 Administration Other Patient Records 8/29/2017
Complaints were made to the department regarding mishandling of funds for a resident. During the investigation it was determined that the facility failed to deposit the residents funds into an interest bearing account and failed to monitor the total amount of funds in the account. This failure cased the resident to lose potential interest on the funds and also to become ineligible for Medi-Cal payment. Citation # 250013436.