California’s Broken Long Term Care System

In November, CANHR released a white paper summarizing some of the major problems in long term care in California and offering recommendations for change to improve California’s long term care system. The paper titled “California’s Broken Long Term Care System,” outlines the problems in oversight, enforcement and funding in nursing homes, residential care, home and community based services and elder abuse prevention and prosecution and offers recommendations for improvement. These include:

Nursing Home Reform

There is a pressing need to replace the leadership at the Department of Public Health and the Center for Health Care Quality with visionary consumer protection leaders who will reform the Department and directly address the crisis in care nursing home residents are facing. Recent investigations found that residents’ lives are jeopardized by sexual abuse, life-threatening infections, abusive use of mind altering drugs, neglect, chronic understaffing, illegal evictions, unfit operators, placement in dangerous facilities, nursing home closures, chemical restraint, kickbacks, dumping, self-dealing by operators, profiteering and more. The Department’s notorious Licensing and Certification Division remains dysfunctional despite having added an army of new positions since 2015.

Residential Care and DSS

The Department of Social Services’ (DSS) Community Care Licensing Division is responsible for regulatory oversight of over 74,000 different facilities statewide, 7,240+ of which are RCFEs. Although DSS, CCL is clearly dedicated to its mission of consumer protections, the DSS budget was cut to the point that inspections had to occur only once every five years. DSS lacks the funds to meaningfully inspect and oversee California’s RCFEs which house over 152,000 frail elders, with another 30,000 residents in Continuing Care Retirement Communities. DSS is required to go to annual inspections in 2019. Residents deserve a fully funded and comprehensive regulatory oversight system to ensure compliance with the rules designed to protect them, and DSS deserves to have the funding needed to do its job.

Home and Community Based Services

California offers a limited number of Home and Community-Based Service (HCBS) programs, which provide long-term services in the community as an alternative to nursing homes. Countless studies show that when states invest in HCBS, they reduce overall long-term care spending. Yet, California consistently fails to take advantage of the potential cost savings, due to its failure to meaningfully shift resources to HCBS. Instead, HCBS programs are often difficult to access due to limited slots, strict enrollment caps, and waitlists that are several years long.
CANHR News

- CANHR’s ED Named as AARP Well-Being Champion

Patricia McGinnis, CANHR’s Executive Director, has been selected as an AARP Well-Being Champion as part of AARP’s Public Policy Institute’s Culture of Health Initiative. According to AARP, the AARP Well-Being Champions is a group of 10 leaders, all of whom are 50+, who saw a challenge before them—in their own communities—and responded. They have highlighted these “Champions” and their solutions to help spread good ideas, and to inspire people to generate new solutions for their communities. AARP has officially launched a website and is promoting a video (also viewable on Twitter and Facebook) featuring these solutions to promote health and well-being, along with a program booklet.

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Thank you for your support in 2018

We want to thank everyone who generously contributed money, time and/or resources to CANHR throughout 2018. 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!

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In Memory of Elizabeth Boileau

CANHR mourns the loss of Elizabeth Boileau, who died on October 31, 2018, after a brief illness. Elizabeth was our friend and colleague and an integral part of CANHR’s family. She worked at CANHR for many years, taking on various roles as publications manager, office manager, and long term care advocate. Elizabeth was also a long time member of CANHR’s LRS Advisory Committee. Elizabeth’s heart and smile could warm a room, and words could never express how much we will miss her. Goodbye dear friend.

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About CANHR

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

CANHR
650 Harrison Street, 2nd Floor
San Francisco, CA 94107
Tel: (415) 974-5171
Fax: (415) 777-2904

Consumer Hotline:
(800) 474-1116

www.canhr.org
canhrmail@canhr.org
Institutional & Financial Elder Abuse

Elderly and disabled victims of abuse and neglect in nursing homes and of financial abuse deserve to be fully compensated for their injuries. Curbing the right to sue, limiting damages or suppressing evidence of abuse and neglect won’t solve the problem of a mismanaged and manipulated insurance market, nor will it decrease liability premiums or improve quality of care. We support reforms that will address the systemic problems of abuse and neglect of elders and persons with disabilities, and that will improve the quality of care for all of California’s nursing home residents, act as deterrents to abuse and compensate victims of abuse.

CLICK HERE to read a copy of the full report and CANHR’s recommendations or go to www.canhr.org.

Meanwhile, CANHR calls on the new Governor and legislators to address this crisis in long term care and to create new models of care where the health and safety of residents takes priority and where elder abuse becomes a distant memory.

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.

Planned giving can include:

- 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.
Beware of Risky Home Improvement Loans Tied with Green Ribbon

*By: Lisa Sitkin, Senior Staff Attorney, National Housing Law Project*

Property Assessed Clean Energy (PACE) programs offer financing for “green” home improvements, such as HVAC system upgrades, energy efficient windows and solar panels. PACE loans are generally sold through home improvement contractors and their agents, often via in-home solicitations. PACE loans are secured by a property tax lien and repaid through assessments added to a homeowner’s annual property tax bill. Although PACE programs are authorized by state and local governments, they are actually run by private, profit-making enterprises called PACE administrators that, until recently, have operated with little to no government oversight.

While the stated purpose of PACE programs is to increase access to home improvements that can increase energy efficiency and reduce energy costs, in practice, PACE has operated much like the predatory lending operations of the early 2000’s, and has resulted in frequent abuses, particularly with respect to low-income, LEP and senior homeowners.

PACE loans pose a particularly serious risk to senior homeowners who have equity in their homes but live on limited fixed incomes. Advocates who work with senior homeowners need to be aware of this relatively new – and relatively expensive – loan product and should, when possible, advise their clients to be extremely cautious when considering using a PACE loan. If a particular improvement is critical, homeowners should check first to see if there are any government programs, such as California’s Low Income Weatherization Program (LIWP) or lower cost financing alternatives.

The residential PACE model has a number of inherent flaws from a consumer protection perspective that make it especially dangerous for elderly homeowners. First, PACE lending was originally designed to be equity-based, with underwriting decisions that rely on property value and homeowner equity rather than on a homeowner’s creditworthiness or ability to repay the loan. As a result, homeowners with relatively high equity but low income can get approved but often struggle to make payments on PACE assessments. Although California recently started requiring PACE administrators to actually assess whether a given homeowner will be able to repay a PACE loan, the rules remain fairly lax and leave a lot of room for error and abuse.

PACE was also designed to evade Truth-in-Lending disclosure rules, so many homeowners have been talked into taking out unaffordable PACE loans whose terms were never disclosed or explained to them. These shortcomings are exacerbated by the frequent use of electronic versions of key PACE documents on tablets with small screens that are difficult for many homeowners to review.

In addition, PACE financing relies on door-to-door sales by contractors who, until recently, have barely been regulated with respect to their PACE solicitation activity. These contractors – known as PACE solicitors – have every incentive to maximize projects and project costs, misrepresent the terms and implications of PACE transactions and pressure homeowners into signing often inaccurate project completion certificates so they can get paid with PACE funds. Again and again, homeowners have found themselves facing unaffordable increases in their property tax bills for often shoddy or incomplete work. While these transactions are consummated at lightning speed, they have proven very difficult – if not impossible – for homeowners to untangle once problems come to light.

If you have questions or concerns about PACE or about a specific client’s PACE transaction, please contact Lisa Sitkin (*lsitkin@nhlp.org*) for more information. Additional information is also available from the National Consumer Law Center at [https://www.nclc.org/images/pdf/energy_utility_telecom/pace/ib-pace-stories.pdf](https://www.nclc.org/images/pdf/energy_utility_telecom/pace/ib-pace-stories.pdf).
Wildfires and Medi-Cal

Our hearts go out to all of those who suffered losses in the recent wildfires, and particularly to those in Paradise who lost loved ones. Consumers who are on Medi-Cal -- either traditional Medi-Cal or MAGI, the adult Medicaid expansion program through the Affordable Care Act -- who were impacted by the recent fires should be aware of their rights regarding receipt of disaster assistance and insurance payments, as well as what assistance is available for those wishing to apply or recertify for Medi-Cal.

Traditional Medi-Cal: Treatment of Insurance & Disaster Relief Payments

- Insurance payments, (including funds received for the purchase of temporary housing) received for the purpose of replacing or repairing exempt property that is lost, damaged or stolen is exempt property in the month of receipt and is exempt property for nine months from the date of receipt. The initial nine month period shall be extended for a reasonable period up to nine months where the county finds that the individual has good cause for not repairing, replacing or contracting for the repair or replacement of exempt property. Note: Given the circumstances with the Paradise fires, we were informed that the Department will build in great flexibility with this policy since it is likely to be some time before residents can rebuild – if they can rebuild. Please let CANHR know if you have any problems with extensions being granted.

- For those on traditional Medi-Cal, either in the community or in a nursing home, receipt of disaster assistance funds from federal, state or local government agencies, or disaster assistance organizations, are permanently exempt and shall not be counted as income or property. Note: Gift cards of any amount are also exempt as income and as property.

MAGI Eligibility – Treatment of Disaster Relief Payments

- Under MAGI, most disaster assistance received by victims of federally recognized disasters are exempt as income. Whether the payments are exempt depends on the source of the payment. Payments individuals receive from charitable organizations (not employer sponsored) as a result of a disaster or emergency hardships are considered gifts and are excluded from the gross income of the tax household. Note: Gift cards of any amount are also exempt as income and as property. Payments from insurance in federally declared disaster areas are exempt as income.

- Please contact the CANHR office at (800) 474-1116 if you have questions and see this alert for more information: http://www.canhr.org/factsheets/misc_fs/PDFs/FS_TreatmentofDisasterAssistance.pdf

New Study: Money Motivates Nursing Home Discharge Decisions

We’re sure that no one would be surprised to learn that A new study reviewing nursing home occupancy rates (census) and resident discharge rates finds that financial incentives significantly influence how aggressively nursing homes discharge residents. When facilities have a low census and less overall revenue, they discharge residents at much lower rates than facilities with a high census and few empty beds. The effort to maximize profit leads facilities with a high census to push out residents whose stay is paid for, in part, by Medicaid (Medi-Cal) in favor of other, higher-paying, residents. The reviewed data shows that when a facility’s census reaches about 90% of capacity, residents on Medicaid are suddenly discharged much more often, due to more “positive discharge effort” from the facility. The study provides good data backup for what we have long known: it’s not residents’ conditions that prompt nursing home discharges, it is the revenue they bring.
Did You Know?

… Home for the Holidays

As the holidays approach, nursing facility residents and their family members often worry about losing their rooms, or their Medicare or Medi-Cal status, if they leave a nursing facility for brief periods of time. While the rules for Medicare and Medi-Cal differ, both programs will permit, and reimburse the facility for, short leaves – depending on how long the leave is.

The Medicare Policy Manual, Chapter 8 §30.7.3, states that residents who are having their nursing home stay paid by Medicare can leave the facility for an “outside pass or short leave of absence for the purpose of attending a special religious service, holiday meal, family occasion, going on a car ride, or trial visit home” can do so without losing their coverage. If they return by midnight, the facility can bill Medicare for the day. If the resident is gone overnight (past midnight) and returns the next day, this is considered a leave of absence and the facility can bill the beneficiary to hold the bed during the absence. The facility must inform the resident of the option to make bed-hold payments, and the amount of the bedhold payments, prior to the leave of absence. Make sure you discuss this with the facility and are clear about cost, since the daily rate at a nursing home can be high.

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

Suggested Gifts for Long Term Care Residents

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

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

Happy Holidays!
Resident Rights and Practice Tips

In 2014, CANHR sponsored landmark legislation (AB 2171, Wieckowski) which created a statutory comprehensive bill of rights for RCFE residents. The rights became effective on January 1, 2015, but the regulations implementing the rights were only recently completed and became effective as of October 1, 2018.

The majority of RCFE resident rights are now set forth in California Health & Safety Code (HSC) section 1569.269 and California Code of Regulations (CCR), Title 22, sections 87468-87468.2. Below are descriptions of a few resident rights, and related practice tips.

Resident Records Rights

RCFE records and personal information are confidential, and cannot be released without resident approval. [HSC 1569.269(a)(3); 22 CCR 87468.2(a)(2).] However, residents have the right to review their own records and purchase photocopies. [HSC 1569.269(a)(21); 22 CCR 87468.2(a)(19).] With respect to timing, the facility must provide prompt access to the records, and copies within two business days. With respect to cost, the facility can charge for copying the records, but cannot charge more than the “community standard.” The community standard is not defined, but should not exceed 25 cents per page as that is the cap for health care providers. [HSC 123110(k)(2).]

TIP: To avoid paying copying costs to the RCFE, consider taking photographs with a phone or digital camera, or bringing in a copying machine to the facility.

Room & Roommate Rights

RCFE residents have the right to reasonable accommodation of their preferences concerning rooms and roommates, including the right to share a room with their spouse, domestic partner or person of their choice. [HSC 1569.269(a)(17), (19); 22 CCR 87468.2(a)(15), (17)] For transgender residents, the facility must assign rooms according to the resident’s gender identity. [HSC 1439.51(a)(3); 22 CCR 87468.1(b)(3)] If an RCFE wants to make any room changes, it must give at least 30 days advance written notice, unless the change is agreed to by the resident, required to fill a vacant bed, or necessary due to an emergency. [HSC 1569.269(a)(18); 22 CCR 87468.2(a)(16)]

TIP: Refuse to move if the facility wants to put you into a less desirable room. Refusing a room change is not one of the five legal reasons for eviction.

Visitation Rights

RCFE residents have the right to visit privately with persons of their choice. [HSC 1569.269(a)(24); 22 CCR 87468.1(a)(11)] The key to visitation rights is that they lie with the resident, and no one but the resident can legally control a resident’s visitation. Third parties, including family members, RCFE administrators, and agents under powers of attorney for health care and finances, are not authorized to limit the visitation of RCFE residents. Even court-appointed conservators may not control a conservatee’s visitation without special court authorization. [Probate Code 2351(a)]

TIP: For more information about visitation rights, see CANHR’s Visitation Rights guide at http://canhr.org/reports/VisitationRightsGuide.pdf.

Right to Refuse Medical Care or Other Treatment

RCFE residents are entitled to fully participate in planning their care, and must be provided with sufficient information and support to make informed decisions and choices. [HSC 1569.269(a)(9); 22 CCR 87468.2(a)(7).] A resident’s right to make choices about care includes the right to receive or reject medical care or other services. [22 CCR 87468.1(a)(16).] For example, an RCFE resident is entitled to receive or reject assistance with personal care, or assistance with the self-administration of medications.

TIP: If an RCFE recommends a service that you do not wish to receive, such as a “higher level of care,” advise the facility in writing that you do not want the service. Do not pay for any services that you have refused.

Right to Notice of Retention Limitations

RCFEs are required to disclose in writing, at or before the time of admission, any limitations or restrictions on their ability to meet residents’ needs. [HSC 1569.269(a)(15); 22 CCR 87468.2(a)(13).] For example, if an RCFE does not have a hoyer lift or cannot provide one on one supervision, it would need to disclose this information to residents in its admission agreement or other pre-admission documents.

TIP: If an RCFE tells a resident that he/she must leave because it is not able to provide a particular service, check to see whether the admission agreement or another document states that the RCFE cannot provide that service. If it does not, challenge the RCFE’s refusal to provide the service.


CANHR on the Move...

Past Speaking Engagements,
Panel Discussions and Training Sessions

• **September 14:** Prescott Cole was the moderator for the Closing the Gap on Elder Abuse training in Anaheim for law enforcement, APS and civil litigators co-sponsored with the California District Attorneys Association.

• **September 17:** Jody Spiegel and Tony Chicotel ventured to San Diego to provide training on long-term care facility evictions to the staff of the Legal Aid Society of San Diego.

• **September 18:** Prescott Cole participated in the quarterly Veteran’s Benefits Protection Project meeting in San Francisco.

• **September 18:** Jody Spiegel and Tony Chicotel reprised the training on long-term care facility evictions in Bakersfield for Greater Bakersfield Legal Assistance.

• **September 18:** Prescott Cole presented a proposal to renovate the California Partnership Program at the Department of Health Care Services Long-Term Care Task Force meeting in Sacramento.

• **September 14:** Prescott Cole was the moderator for the Closing the Gap on Elder Abuse training in Anaheim for law enforcement, APS and civil litigators co-sponsored with the California District Attorneys Association.

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• **September 18:** Prescott Cole presented a proposal to renovate the California Partnership Program at the Department of Health Care Services Long-Term Care Task Force meeting in Sacramento.

CANHR staff attorneys, Tony Chicotel and Jody Spiegel, at the Wild World of Long Term Care Evictions trainings for legal services programs. The two trainings were hosted by Legal Aid Society of San Diego and by Greater Bakersfield Legal Assistance.

• **September 20:** Efrain Gutierrez hosted an information table at the 18th Annual Senior Fair in Los Angeles, courtesy of Councilman Curren D. Price, Jr.

• **September 28:** Prescott Cole presented the CANHR Restitution Project to the US Attorney General’s Elder Justice Task Force meeting for the Northern District of California.

• **October 3:** Tony Chicotel participated in a panel discussion on homelessness and long-term care at the state Ombudsman conference in Folsom.

• **October 6:** CANHR hosted an information table at El Shaddai Prayer and Deliverance Center.

• **October 8:** Prescott Cole was a guest lecturer at Hastings’s Law School Medical-Legal Partnership for Seniors Class.

• **October 17:** Efrain Gutierrez gave a SCAM presentation on elder financial abuse at the Estelle Van Meter Senior Center.

• **October 17:** Jody Spiegel gave an In-Service Training on Long Term Care Services and Medi-Cal to the Care Management Team at Adventist Hospital in Glendale.

• **October 25:** Prescott Cole presented an “Issues in Long-Term Care” training for the San Mateo County Ombudsmen.

(Left): Stacey Wood, Prescott Cole, Joel R. Bryant, and Sherri Adams at the CDAA training in Los Angeles

CANHR On The Move .................. (continued on page 9)
- **October 26:** Prescott Cole, Pat McGinnis and Efrain Gutierrez participated in the “Closing the Gap on Elder Financial Abuse” Multi-disciplinary education training at the Magnolia Place Family Center in Los Angeles for law enforcement, APS, Ombudsmen, and Legal Services providers, co-sponsored by the California District Attorneys Association.

- **November 1:** Julie Pollock conducted a webinar in-service training for Kaiser Sacramento social workers on “Advocating for Your Clients on Medi-Cal”.

- **November 7:** Jody Spiegel gave a presentation on Fall Awareness & Prevention in RCFEs for Community Care Licensing staff at a Clinical Symposium in Riverside.

- **November 7:** Prescott Cole participated in the State Bar Legal Services Bimonthly Coordination Teleconference.

- **November 8:** Tony Chicotel provided a training session on representing clients with impaired cognitive capacity at LAAC’s Traveling Training in Sacramento.

- **November 14:** Prescott Cole presented a training to San Francisco Adult Protective Services Financial Abuse Virtual Unit (FAVU) on the Restitution Guide, HEPP, and Medi-Cal long-term care issues.

- **November 17 & 18:** CANHR hosted its 22nd annual Elder Law Conference at the Monterey Plaza Hotel with a capacity crowd of over 300 private bar and legal services attorneys.

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**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:

### IN MEMORY OF

- Sherry O. McIlwain
  - Gloria McIlwain and Sharon Roberts-Cagle
- Tim Millar
  - Mary Gerber
- In Loving Memory Ronald Randolph
  - Brenda Williams
- Alice and Tom Riley
  - Barbara B. Riley
- Ed J. Toohey
  - Jeannette D. Santage
- In Memory of My Friend
  - Barney Unck, a WWII Pilot
  - John Williams
- Yu-Fa Wu and Helen C. Wu
  - Hsinmei Wu
- Tim Millar
  - Anonymous

### IN HONOR OF

- Tony Chicotel
  - Mary Ballin
- Patricia McGinnis and
  - Tony Chicotel
  - Flora Calem
- All Unfortunate Consumers In Nursing Homes and/or Residential Facilities
  - Barbara Yorganjian
- Mr. and Mrs. H
  - Lisa Edwards
- Jody Spiegel
  - Omir Perez

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(Left) Executive Director of the California’s Women’s Law Center, Betsy Butler, and Efrain Gutierrez of CANHR pose at the CANHR/CDAA training in Los Angeles.
Citation Watch - Consumer Report

The following citation summaries are compiled from the citations issued by the California Department of Public Health to California skilled nursing facilities and received by CANHR as of the publication of this issue of the Advocate. CANHR makes every effort to ensure that consumers are provided with accurate information. CANHR welcomes comments and suggestions or notice of errors. Please direct such comments to mis@canhr.org or by calling the CANHR office at (800) 474-1116.

Citations without summaries will be reprinted with summaries once received by the CANHR office. Citations from earlier months are included if a description was not printed in a previous issue. Appeals of citations and collection of fines can take up to three years.

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

Alameda County

Alameda County Medical Center D/P SNF
15400 Foothill Boulevard, San Leandro
B $1000 Elopement Physical Environment
1/16/2018
The facility failed to monitor the functionality of a resident’s WanderGuard signaling band and left a resident whose careplan stated he required supervision, unsupervised on 10/29/17. The resident’s WanderGuard was not activated at three locations, and when a CNA saw the resident unsupervised off the unit, she asked if he wanted to go upstairs and he said no. When she went to check on him again, he was gone. Citation # 020013736.

Alameda Healthcare & Wellness Center
430 Willow Street, Alameda
B $2000 Physical Abuse Verbal Abuse
12/08/2016
On 10/6/16, an elderly resident who suffered from stroke and partial paralysis tearfully reported that a certified nursing assistant (CNA) slammed her into bed and told her it was too early to get up when she pushed her call light early in the morning. The same CNA punched her on the forehead, leaving a purplish bruise, when the resident later pushed her call light again. The facility was cited because it did not immediately suspend and remove the accused CNA from the resident’s care in accordance with its policy on investigating abuse. Citation # 020012796.

Kyakameena Care Center
2131 Carleton Street, Berkeley
B $2000 Physical Environment 10/04/2018
From 5/14/18-7/9/18, the nursing home did not have a working call system, and asked residents to use their personal cell phones or a manual call bell to call facility staff for assistance. Facility staff were inconsistent in responding to at least two residents who used their cell phones and the manual call bells. The facility was cited for failing to maintain a nurses’ signal system in operating order. Citation # 020014454.

Oakland Heights Nursing and Rehabilitation
2361 East 29th Street, Oakland
B $1000 Neglect 04/16/2018
A resident with impaired respiratory function was to be provided breathing treatments as ordered and the staff was to observe and report signs of respiratory distress. On 12/18/17, the resident was reported screaming for help because she was having problems breathing. She called 911 because no one was coming to help her. According to the ER notes, the resident was suffering from shortness of breath which was worsening. The facility was cited for failing to provide the resident with breathing medications as ordered by the physician and not answering calls of distress from the resident. Citation # 020014000.
Parkview Healthcare Center
27350 Tampa Avenue, Hayward
B $1500 Neglect Supervision 03/29/2018
On 6/18/17, a resident suffered acute heat exhaustion requiring emergency treatment at the hospital after she was left unattended outside on a patio on a day that reached 105°. A family member discovered her passed out on the smoking patio, where she was bleeding from the nose and confused. The facility was cited for failing to provide sufficient supervision when it left the resident unattended in the extreme heat. Citation # 020013932.

The Rehabilitation Center of Oakland
210 40th Street Way, Oakland
B $1200 Fall Injury Patient Care 05/01/2017
On 9/28/16 a CNA helped a resident who was a quadriplegic get out of bed and ready for wound care. The CNA who was there to support the resident attended to another resident who had called out for her, which resulted in the resident falling out of the bed. The resident suffered an unstable and broken left elbow. Citation # 020013173.

Calaveras County
Avalon Health Care - San Andreas
900 Mountain Ranch Road, San Andreas
B $1000 Notification Transfer 09/12/2018
The facility failed to provide copies of resident transfer notices to the long term care Ombudsman office. From January to July of 2018, several residents were transferred to the hospital for acute care but no notice was sent to the Ombudsman. The facility was cited for failing to follow the legal requirements and its own policy regarding the provision of notices. Citation # 030014371.

Moraga Post Acute
348 Rheem Boulevard, Moraga
B $1200 Fall 03/23/2018
On 2/3/18, a quadriplegic resident who suffered from Multiple Sclerosis was admitted into the ER with blunt head trauma after falling head first from a Hoyer Lift while being transferred from the bed to a wheelchair. The CNA who attempted the transfer stated that she called for help but staff were busy assisting other residents, and while waiting for help she tried to position him in front of the wheelchair. She stated that she called for assistance from staff again and tried to catch the resident before he hit the floor, but he was too heavy. The facility was cited for not having at least two staff present while the resident was being transferred. Citation # 020013929.

Orinda Care Center, Llc
11 Altarinda Road, Orinda
B $1500 Bed Hold 04/03/2018
On 9/5/17, a resident was sent to the hospital for a pressure ulcer surgery and was anticipated to return to the facility. The resident stated she wanted to go back to the facility because it had been her home for a few years. On 9/27/17, she was ready to be discharged back to the nursing home but they wouldn’t readmit her claiming that there was no available bed. On 1/26/18 the resident’s Case Worker (CW) called the facility’s Admissions Coordinator who informed the CW that there were no available beds, even though there were two female beds vacant at that time. A review of the facility’s daily census sheet stated that from 1/27/18 to 2/1/18 there were a number of available beds. The facility was cited for failing to permit the resident to return to the facility after hospitalization. Citation # 020013953.

B $2000 Fall 10/04/2018
On 7/30/18, the facility driver who was taking resident back to the facility after their dialysis treatment left one resident outside on the curb by herself in a wheelchair while going back into the building to get another resident. The driver had not affixed the wheelchair’s break and the wheelchair started to roll, and the resident slid out falling to the pavement. The fall caused abrasions to the forehead and a fractured femur. The facility was cited for failing to ensure that the resident received adequate supervision to prevent an accident. Citation # 020014448.
**Fresno County**

Dycora Transitional Health - Manchester  
3408 E Shields Ave, Fresno  
B $2000 Physical Environment 10/24/2018  
On 7/2/18, during a transfer from the bed onto a wheelchair, the resident’s leg was sliced by the jagged metal on the end portion of the bed’s side rail slicing his calf and requiring a transfer to the hospital and 17 staples to close the wound. A plastic cap would normally cover the exposed metal. When interviewed, the maintenance supervisor stated he had been aware for over a month and a half that plastic side rail caps were missing on resident beds leaving rough metal edges exposed. The facility was fined for failing to ensure the residents’ environment was free of accident hazards. Citation # 040014527.

**Kern County**

Golden Living Center - Shafter  
140 E Tulare Ave, Shafter  
B $2000 Mandated Reporting Physical Abuse 10/16/2018  
On 8/20/18, an 88 year old resident told her daughter that someone in the facility had slapped her left hand, and the daughter reported the incident to the Social Services Designee (SSD). The SSD stated nothing was done because she had determined that the resident was making false allegations. The facility was cited for failing to report an allegation of abuse to the Department within 24 hours. Citation # 120014455.

Kern Valley Healthcare District D/P SNF  
6412 Laurel Ave, Lake Isabella  
B $2000 Mandated Reporting Physical Abuse 10/30/2018  
On 6/15/18, a 66 year old resident complained that a CNA was rough and abused her giving care. The facility did not report the alleged abuse to the Department until over two months later on 8/17/18. The facility was cited for failing to report an abuse allegation in a timely manner. Citation # 120014512.

**Los Angeles County**

Berkley East Convalescent Hospital  
2021 Arizona Ave, Santa Monica  
B $2000 Fall 08/01/2018  
On 5/16/18, a 56 year old female was admitted into the facility for rehab and recovery from a hip replacement surgery. At 1 am on 5/22/18, the resident needed to go to the bathroom and pressed her call light. There was no response to the call and she wet the bed. After waiting some more, she got out of bed because she didn’t want to lie in her urine. There was urine on the floor and she slipped and fractured her leg. The resident stated she was depressed about the prospect of being in bed for three to four months when she had been told she’d be walking in one week and back to normal in six from her hip replacement. The facility was cited for failure to provide adequate supervision by not having enough staff to answer the call light and provide care to the resident. Citation # 910014307.

Country Villa Wilshire Convalescent Center  
855 N Fairfax Ave, Los Angeles  
A $20000 Patient Care Supervision 09/28/2018  
On 12/15/15 a resident who required use of a BiPAP machine was found unresponsive. At 11 pm on 11/14/15 the resident was without this machine, and his oxygen saturation levels were below the normal range. The resident was restless, and was recorded once again taking off his mask. There was no further documented evidence that the resident’s oxygen saturation levels were rechecked. The resident was pronounced dead at 4:49 am from a heart attack. Citation # 910014447.

855 N Fairfax Ave, Los Angeles  
A $20000 Fall 09/28/2018  
On 3/15/16 a 94 year old wheelchair-bound resident who had poor safety awareness was found at the back of the facility. The resident had an unobserved fall down six flights of stairs resulting in traumatic brain injury, multiple skin tears and a fractured spine. On 4/18/18, during an interview, the administrator stated there was no investigation as to why the resident was outside the facility without supervision. The facility was cited for failing to ensure that a resident who was identified to have poor safety awareness was provided with adequate supervision. Citation # 910014446.
La Brea Rehabilitation Center
505 N La Brea Ave, Los Angeles
A $20000 Patient Care 09/10/2018
On 4/8/16, a resident with acute edema died from a blood clot leading to cardiac arrest. Based on interviews and record review it was determined that the facility failed to ensure the resident received treatment and care based on professional standards of practice. The findings included, but were limited to the following: 1 Failure to elevate the resident’s legs pursuant to the resident’s careplan; 2. Failure to assess and monitor for symptoms of edema; 3. Failure to apply and remove compression stockings as ordered by the physician. Citation # 940014399.

Mountain View Convalescent Hospital
13333 Fenton Ave, Sylmar
B $2000 Medication 10/10/2018
On 8/18/18 a resident experienced abdominal pain at the site of his G tube. The resident had impaired cognitive skills, yet during an interview with a nurse on 8/21/18, the nurse stated the resident was able to make his needs known. The Nurses Notes from 8/18/18-8/20/18 did not indicate that the resident’s pain was addressed. Following these dates, regardless of the residents crying, groaning, face grimacing and other signs of physical pain the resident was given pain medication for mild pain inconsistently. After a physician’s order on 8/22/18 for a pain medication for moderate to severe pain, the resident did not receive the medication until the following morning. This resulted in the resident experiencing unnecessary pain. Citation # 920014481.

San Fernando Post Acute Hospital
12260 Foothill Blvd, Sylmar
B $2000 Bed Hold Evictions 08/23/2018
A resident was hospitalized on 4/19/18 but was not given his mandatory bed hold “due to aggressive behavior.” The resident was refused readmission when he was ready to come back to the facility and the facility was cited for failing to offer a bed hold and refusing to readmit the resident. Citation # 920014359.

Valley Palms Care Center
13400 Sherman Way, North Hollywood
B $2000 Evictions Notification 09/06/2018
Three residents were discharged to board and care homes without appropriate notice and without sending notice to the long term care Ombudsman in February and March 2018. The board and care homes were unlicensed and identified by an outside placement agency, as the social services director did not know that verifying the facility’s license was necessary. The facility was cited for failing to notify the Ombudsman and failing to ensure a safe and orderly discharge for the three residents. Citation # 920014393.

Valley Vista Nursing And Transitional Care Llc
6120 Vineland Ave, North Hollywood
A $18000 Elopement Fall Patient Care Supervision 09/21/2018
On 1/22/18 a nursing home resident who was high risk for falls and required supervision was left unmonitored, regardless of the fact that just three days earlier she was found wandering into another resident’s room and going through her belongings. This resulted in the resident wandering into another resident’s room, squatting, urinating on the floor and falling backward, sustaining a broken wrist. Citation # 920014423.

Mariposa County
Avalon Care Center - Sonora
19929 Greenley Road, Sonora
B $2000 Patient Care 10/19/2018
A resident’s breathing machine exhaust port was intentionally blocked with a cotton swab by a nurse who was unaware of how the machine worked, and thought it would help keep oxygen in the machine. Instead, the blockage caused the buildup of carbon dioxide which would have normally exited through the exhaust valve, causing harm to the resident, who was admitted to the hospital with an altered state of consciousness, low tissue oxygen levels and high carbon dioxide blood levels. Citation # 030014487.
Monterey County

Cypress Ridge Care Center
1501 Skyline Dr, Monterey
B $2000 Patient Care 10/10/2018
Multiple residents did not receive scheduled showers on 9/27/18 and 9/28/18 when the hot water supply was interrupted during construction at the facility. No one checked to make sure the hot water was turned back on after the work ended, causing several residents to go without showers or be subjected to bed baths with cold water. One of the residents said he felt dirty. Another said she “felt like a cold rag” during a bed bath. The family member of a third resident said she had only one shower since admission on 8/25/18, more than a month earlier. Citation # 070014472.

Windsor Gardens Rehabilitation Center of Salinas
637 E Romie Ln, Salinas
B $2000 Infection Neglect Patient Care 10/05/2018
On 9/8/18, a resident was observed to have chills and a temperature of 104.5. The resident’s physician ordered antibiotics and a urine culture. The culture tested positive for a urinary tract infection (UTI) on 9/9/18, but the physician never followed up after receiving the lab results, and the nurses did not make any effort to reach the physician or change the resident’s careplan for ten days, until 9/19/18, when the resident was sent to the hospital with sepsis. At that time, the resident was nauseous, with a swollen stomach. The facility was cited for failure to provide quality care. Citation # 070014461.

Napa County

Napa Valley Care Center
3275 Villa Ln, Napa
A $20000 Infection Neglect Patient Care 09/14/2018
A 78-year-old male resident was admitted to the facility on 12/8/16 following abdominal surgery. The resident had a wound on his right groin, which required nursing care and a “wound VAC” which is a suctioning device for wound treatment. The nurse failed to change the resident’s wound VAC as required, even though she documented that she did so in the resident’s record. This resulted in a severe infection and re-hospitalization for the resident. Citation # 110013194.

A $20000 Careplan Patient Care 09/14/2018
A 69 year old male resident was admitted to the facility on 12/31/16 with sepsis, kidney failure and diabetes. On 1/5/17, the resident was sent to the hospital after attempting to stab himself with a fork. The resident had severely low blood glucose levels at the time of hospitalization. He died on 1/8/17. The facility was cited for failure to clarify incomplete physician orders related to the diabetes, and failure to assess the resident’s blood glucose when he acted irrationally by attempting to stab himself. Citation # 110013195.

Piner’s Nursing Home
1800 Pueblo Ave, Napa
B $2000 Evictions Mandated Reporting Patient Rights 10/22/2018
On 4/25/18, the facility was cited for failure to notify the Ombudsman of a resident’s discharge, which prevented the Ombudsman from advocating for the resident. The resident was admitted to the facility on 4/16/18 for swelling in the left knee, and was discharged on 4/25/18. According to the Social Services Director, the resident was discharged because she “completed her therapy,” which is not a valid reason for discharge. The Ombudsman stated the facility had not been informing her office of resident discharges. Citation # 110014306.

Placer County

Roseville Point Health & Wellness Center
600 Sunrise Avenue, Roseville
B $2000 Evictions 07/14/2017
On 10/4/16, a female resident who could not walk or ambulate and was totally dependent on staff for dressing, toileting, hygiene, and transferring from bed to chair was sent to an independent “room and board” home identified by a placement agency. The room and board was completely unequipped to provide care to the resident. She could not even get through the front door of the home so she was placed in the garage where she defecated on herself and could not get up from the floor. Within two hours, she had to be transferred to a hospital. The facility was cited for failing to ensure a safe discharge, creating risk of injury or neglect. Citation # 030013349.
<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Date</th>
<th>Reason</th>
<th>Result</th>
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<tbody>
<tr>
<td>B S2000 Bed Hold Evictions 04/26/2018</td>
<td>A male resident with paraplegia was hospitalized on 1/25/18 for a urinary tract infection. On 1/29/18, the resident was medically stable and ready to return to the facility. The facility refused readmission, claiming it had discharged the resident despite having no documentation the resident was given a written discharge notice. The facility was cited for failing to readmit the resident after his hospitalization was no longer necessary. Citation # 030014015.</td>
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<td>Riverside County</td>
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<td>Brookdale Rancho Mirage</td>
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<td>B S2000 Evictions Transfer 09/20/2018</td>
<td>During the investigation of a discharge complaint, it was discovered the facility failed to send a copy of a resident’s discharge notice to the local long term care Ombudsman program. The failure may have led to the resident being discharged on 4/20/18 without having an advocate to ensure a safe discharge or without a clear understanding of his appeal rights. Citation # 250014398.</td>
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<td>Corona Post Acute Center</td>
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<td>B S2000 Administration Supervision Theft &amp; Loss 10/02/2018</td>
<td>The facility failed to thoroughly screen staff through background checks, resulting in a staff member, with a previous criminal conviction for theft, pressuring a resident, who repeatedly gave the employee money, from $40 up to $1,000, over the course of 2 years. When abuse allegations surfaced, the facility failed to prevent the employee’s wife, also an employee, from having direct access to the resident, or interview other residents cared for by the accused employee, possibly exposing them to financial abuse. Citation # 250014429.</td>
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<td>Palm Grove Healthcare</td>
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<td>B S2000 Mandated Reporting Patient Care Physical Abuse 10/02/2018</td>
<td>A Laundry Aide at the facility witnessed a CNA grab a resident by the hair and shake her head back and forth. The Laundry Aide did not tell anyone until 8/8/17, two months after the incident, in fear of being fired. This abuse was not immediately reported to the state agency, which put other residents at risk for abuse. Citation # 250014361.</td>
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<td>Premier Care Center For Palm Springs</td>
<td>2990 E Ramon Rd, Palm Springs</td>
<td>B S500 Notification Transfer 09/20/2018</td>
<td>On 3/28/18, the facility failed to ensure that a written notification of transfer was provided to the resident, the resident’s representative or local long-term care ombudsman when the resident was transferred to an acute hospital. The facility was cited for failing to provide the required notice. Citation # 250014312.</td>
</tr>
<tr>
<td>Riverwalk Post Acute</td>
<td>4000 Harrison St, Riverside</td>
<td>B S2000 Mandated Reporting Verbal Abuse 10/04/2018</td>
<td>On 5/25/18, a resident told the Operations Manager that another resident had threatened him because he had reported a previous incident to him involving the same resident. The resident allegedly said: “You know what happens to people who snitch where I come from? They get stabbed.” The facility did not report the alleged verbal abuse to the DPH until 41 days after the incident. The facility was cited for failing to report to the DPH within 24 hours. Citation # 250014378.</td>
</tr>
<tr>
<td>Sacramento County</td>
<td>Double Tree Post-Acute Care Center</td>
<td>7400 24th Street, Sacramento</td>
<td>B S2000 Mandated Reporting Physical Abuse 10/02/2018</td>
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Eskaton Care Center Greenhaven  
455 Florin Road, Sacramento  
B $2000 Notification 10/27/2017  
On 10/13/15, a CNA informed the LN in charge of a female resident of the resident’s unresponsiveness, but the LN failed to respond to and notify a physician of the change in condition. The facility was cited for the failure of the LN to respond to the resident’s change in condition which may have contributed to the resident’s death. Citation # 030013565.
B $2000 Mandated Reporting Verbal Abuse 09/05/2018  
Facility administrators reported an alleged incident of abuse 5 days after a resident alleged verbal abuse against a staff member, instead of within 24 hours, as required by law. Citation # 030014381.

Pioneer House  
415 P Street, Sacramento  
B $2000 Bed Hold Evictions 10/19/2017  
On 3/23/17, a female resident was sent to the hospital for a “behavioral episode” where she threw silverware during lunch time. The hospital made several attempts to have the resident readmitted but the facility refused, despite the resident’s bed hold rights and a “court order” to take her back. The facility was cited for failing to readmit the resident. Citation # 030013512.

Saylor Lane Healthcare Center  
3500 Folsom Boulevard, Sacramento  
B $2000 Bed Hold Evictions 8/30/2017  
A female resident was hospitalized on 12/21/16. She was not given a bed hold notice. On 1/13/17, she was cleared to return to the facility but the facility refused to readmit her despite having many available beds. The facility was cited for failing to readmit the resident. Citation # 030013459.

Sherwood Healthcare Center  
4700 Elvas Avenue, Sacramento  
B $2000 Medication 12/06/2018  
On 8/6/17-8/7/17 the facility failed to give a resident her medication as ordered. These medications included both the resident’s blood pressure and pain medication. Although the pain medication could be found in the emergency drug kit, the nurse instructed the resident to practice deep breathing for the pain. The failure to administer this medication resulted in unrelieved severe pain, anxiety and elevated blood pressure. Citation # 030013675.

Windsor Care Center of Sacramento  
501 Jessie Avenue, Sacramento  
B $2000 Evictions 10/30/2018  
On 10/1/16, Windsor Care Center of Sacramento transferred a resident with dementia to a local hospital for striking out at other residents. Ten days later, he was cleared for readmission by the hospital doctors but he was not readmitted. On 2/23/17, an administrative hearing was held and Windsor was ordered to readmit the resident. It ignored the order. The facility claimed it had no available bed for the resident but that was untrue. As of mid-2018, the resident had still not been readmitted. The facility was cited for failing to readmit the resident and fined a total of $2,000. Citation # 030014525.

San Diego County  
Villa Coronado D/P SNF  
233 Prospect Place, Coronado  
B $2000 Fall Injury Patient Care 10/24/2018  
On 4/28/17, a resident fell from a gurney onto the floor while being transferred from the gurney into his bed. As a result of the fall, the resident sustained bleeding inside his skull, and broken bones in his jaw, nose and eye socket, and was hospitalized for two weeks. The facility was cited for failing to ensure that two CNAs secured the side rails on the gurney when transferring the resident into his bed. Citation # 090014511.

San Joaquin County  
Crestwood Manor  
1130 Monaco Court, Stockton  
A $12000 Patient Care 10/18/2018  
On 12/8/15, a resident was found unresponsive on the bathroom floor. The resident, who suffered from severe psychotic symptoms was being treated with antipsychotic medications, had been left on the toilet for 45 minutes. In the days preceding the fall, the staff had known he was having trouble breathing, had a fever of 103 F and was resistive to care but did not notify the treating physician about his condition. The facility nurse stated that she did not ask for labs, x-rays or oxygen because she thought his medications were causing his fever. The facility was cited for failure to meet professional standards for nursing care. Citation # 030014484.
Golden Living Center-Chateau
1221 Rosemarie Lane, Stockton
B $2000 Bed Hold Evictions 10/09/2018
A male resident who had lived at the facility for eight years was hospitalized on 4/26/17 after striking another resident. The hospital doctor found the resident had no acute care need and ordered readmission but the facility refused. The facility claimed it could no longer care for the resident but did not perform a legal discharge. The facility was cited for failing to readmit the resident after he was medically cleared for readmission. Citation # 030013532.

Kindred Transitional Care & Rehabilitation - Valley Gardens
1517 Knickerbocker Drive, Stockton
B $2000 Bed Hold Evictions 10/05/2017
A resident was sent to the hospital on 7/14/17. When he was cleared by the hospital doctors to return to the facility on 7/25/17, the facility refused to readmit him. The facility was under the mistaken belief that it did not need to readmit residents after their 7-day bed hold expired, even if they had available beds. The facility was cited for failing to timely readmit the resident. Citation # 030013526.

Wine Country Care Center
321 W. Turner Road, Lodi
B $2000 Mandated Reporting 08/09/2018
On 6/7/18, a CNA witnessed another CNA punching a female resident in the face, but failed to notify the staff immediately. The facility was thus cited for failing to report the alleged abuse to the Department of Health Services within the required 24 hours. Citation # 030013415.

Santa Clara County
Webster House
437 Webster St, Palo Alto
B $2000 Fall Supervision 11/16/2018
On 10/16/18, a 94 year old resident with severe cognitive impairment who required supervision while walking, tripped and fell in the hallway while pushing another resident in a wheelchair. The resident broke bones in both of her wrists, and was transferred to the emergency room. The resident had four previous falls on 5/21/18, 5/30/18, 6/2/18 and 9/30/18, and corresponding fall assessments indicating she was a high risk for falls. The facility was cited for failing to provide adequate supervision. Citation # 070014584.
Stanislaus County

Modesto Post Acute Center
159 E Orangeburg Ave, Modesto
A $20000 Evictions 10/1/2018
An 87 year old female resident with severe dementia who had lived at the facility for nearly three years went out to lunch with a family member on 2/14/18. When the resident had not returned the next morning, she was “discharged.” Multiple calls to the family member were not answered but eventually he told the facility he was keeping the resident for 14 days. After being reminded the resident needed her medications, the family member brought the resident back to the facility on 2/16/18. The facility refused to take her back, prompting a 911 call and transfer to a hospital, where she was treated for bronchitis. The resident was readmitted from the hospital on 2/26/18. The facility was cited for failing to follow its own procedures for resident discharge. It did not inform the resident’s physician, develop and communicate a post-discharge plan of care, or enlist the police to ensure the resident’s safety. Citation # 040014444.

Tulare County

Kaweah Delta Skilled Nursing Center
1633 S. Court St., Visalia
B $2000 Mandated Reporting Physical Abuse 11/19/2018
The facility failed to properly report an alleged incident of abuse to proper law enforcement and state agencies within a 24 hour period, as required by law, after a resident stated that a staff member pulled her leg and told her to “shut up” when she cried. Citation # 120014571.

Yolo County

Alderson Convalescent Hospital
124 Walnut Street, Woodland
B $2000 Mandated Reporting Physical Abuse Verbal Abuse 11/09/2018
Facility staff failed to properly report a witnessed incident of abuse to proper law enforcement and state agencies within a 24 hour period, as required by law, after a CNA witnessed another staff member push a resident into her bed and yell at her, when the resident refused to get into bed. Citation # 030013604.

Cottonwood Post-Acute Rehab
625 Cottonwood Street, Woodland
B $2000 Mandated Reporting 10/20/2017
The facility was cited for failing to report an alleged instance of physical abuse of a female resident by her assigned CNA that occurred sometime in February 2017, despite the resident having reported the incident to management in early February. There was no documented evidence of the report and investigation of the incident. Citation # 030013560.
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