In May of 2011, the U.S. Health and Human Services’ Inspector General released a long awaited report on the misuse of antipsychotic drugs in nursing homes throughout the country. Concurrent with the report, the Inspector General testified before the Senate Committee on Aging about the massive use of deadly antipsychotic drugs on nursing home residents with dementia:

"Government, taxpayers, nursing home residents, as well as their families and caregivers should be outraged — and seek solutions."

Eight years have elapsed since Inspector General Levinson’s testimony. Have we found solutions to the insidious drugging of elderly nursing home residents? Was anybody actually outraged? The sad answer to both questions is probably not.

The Campaign to Reduce the Use of Antipsychotics

To great fanfare, the Centers for Medicare and Medicaid Services (CMS) announced a campaign to reduce the inappropriate use of antipsychotics in nursing homes in March 2012. Despite pleas from resident advocates, the campaign focused on educating facilities on good dementia care rather than penalizing the inappropriate use of antipsychotics. Consequently, nursing homes that inappropriately drug residents to sedate them are perhaps even LESS likely to be punished than they were in 2011. Recent CMS enforcement data shows when nursing homes are cited for inappropriately drugging residents, zero percent of the citations are identified as causing harm to the resident and fines are rarely issued.

CMS and resident advocates did agree that measuring and tracking inappropriate drugging would be important for the campaign. Regrettably, however, CMS chose to measure antipsychotic use only, ignoring other classes of harmful and misused psychotropic drugs. In addition, CMS based its measure on facilities’ self-reported data and then agreed to exclude antipsychotic use for residents diagnosed with schizophrenia, ensuring the antipsychotic measure would not accurately count antipsychotic use.

False Drugging Reductions Touted as Success

Since CMS created its antipsychotic drug “quality measure,” the reported use of antipsychotics in nursing homes has dropped a remarkable 39%, from 23.9% of residents in 2011 to 14.6% in 2018. The nursing home industry states its care is “dramatically better,” and touts that only one in seven residents “receive an antipsychotic drug,” down from one in four.

The truth is we don’t know how many nursing home residents are receiving an antipsychotic. We do know it is a lot more than 14.6%:

No Outrage ......................... (continued on page 3)
CANHR News

CANHR celebrates 35 Years of Advocacy!

California Advocates for Nursing Home Reform cordially invites you to join us for our 35th Anniversary Fundraising Gala on Saturday, May 4th, 2019 at San Francisco State University, the Towers Conference Center. Former Senator Mark Leno, who authored a number of CANHR bills and has been an ardent advocate for the aged and disabled, will be the keynote speaker. Festivities begin at 6:00 pm and include a cocktail reception, a silent and live auction and dinner. Tickets and sponsorship opportunities are available now. Click for more information.

CANHR’s White Paper on Long Term Care Issues

In November 2018, CANHR released a white paper summarizing major problems in long term care in California and offering recommendations as to what needs to be done to improve nursing home and residential care; create more affordable and accessible home and community based services; and hold predators and abusers accountable for elder abuse. CANHR had hoped to use the report to convince policymakers to invest more funds into oversight of long term care facilities and into alternatives to institutionalization. With many new legislators, the results remain to be seen. CLICK HERE to download the report.

Leave a Legacy

Planned giving leaves a legacy to honor your memory or that of someone you love 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 take a number of forms, including gifts by will, gifts of life insurance or annuities or gifts via 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.

This quarter, CANHR would like to thank the Demski Trust and the Lorraine M. Jones Revocable Trust for their generous bequests.

If You Want to Receive Alerts and the Advocate by E-mail

Please make sure that CANHR has your correct e-mail address in order to send you our monthly News & Notes electronic newsletter, updates on legislation, Medi-Cal regulations and other policy issues throughout the year. Send your correct e-mail address to amber@canhr.org

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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.

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Data reported by nursing homes shows 20.1% of residents are getting an antipsychotic. While this demonstrates that the CMS measure significantly underreports antipsychotic use, the number of residents who receive an antipsychotic is likely even higher. Nursing homes can lie by claiming a resident who received an antipsychotic did not receive an antipsychotic. Nursing homes can also simply not report whether a resident receives an antipsychotic. In 2018, antipsychotic use was not reported at all for approximately 5 – 10% of residents nationwide.

A recent study in the journal Aging & Mental Health found that nursing homes’ self-reported antipsychotic use rates were lower than their actual rates as determined by Medicare Part D drug prescription data. When the CMS campaign started, underreporting increased.

When CMS conducted audits of nursing homes’ self-reported data, it identified misreported antipsychotic use as a “most common error.”

Phony Schizophrenia Diagnoses to Hide Drugging

When nursing homes accurately report their antipsychotic use, they can nonetheless avoid scrutiny by misdiagnosing residents as having schizophrenia. Antipsychotic use by residents with schizophrenia is not counted in the CMS measure. Since 2011, schizophrenia diagnoses in nursing homes are up a whopping 42%. During that same time, symptoms of schizophrenia are down. The desire to hide antipsychotic drug use, not resident symptoms, is driving the massive increase in schizophrenia diagnoses. The increase in schizophrenia diagnoses erases thirty percent of the alleged drop in antipsychotic use in nursing homes. In other words, had schizophrenia diagnoses been stable, the decrease in antipsychotic use would be thirty percent smaller.

Switching to Other Drugs to Evade Scrutiny.

When CMS elected to focus exclusively on antipsychotic usage as its proxy for dementia care, it was predictable that some nursing homes would switch to other drugs to chemically restrain residents. Since 2011, the use of other drugs that sedate or restrain residents has not fallen, and in some cases, has likely increased dramatically. Depakote, an anti-convulsant that sedates nursing home residents, has become favored because its use is not counted and it comes in a sprinkle form that can be added to residents’ food without their knowledge. Depakote has become so popular it is often referred to in nursing homes as “Vitamin D.” Despite all of the fanfare about reducing antipsychotics and about improving dementia care, the depressing fact is that at least 62% of all nursing home residents still receive a psychotropic drug and many of them receive multiple psychotropic drugs. Residents are drugged for the convenience of staff who are unwilling or unable to address underlying causes of resident distress or discomfort.

It’s Time to Get to Work

The CMS Campaign to reduce inappropriate use of antipsychotics is mostly a failure. Eight years after Inspector General Levinson’s call to arms, one in five residents still receive an antipsychotic drug while nearly two in three receive a psychotropic drug. Nursing homes that use drugs to chemically restrain residents are not punished, dementia care remains deficient and CMS is still asking instead of telling. In order to ensure residents are not inappropriately drugged, we need real outrage and the following policy measures:

1. Reform or scrap the CMS antipsychotic quality measure. The current measure gives the public a very inaccurate picture of antipsychotic use in nursing homes and may be doing more harm than good.

2. Require written informed consent from the resident or the resident’s representative for all psychotropic drugs used in nursing homes. The best guardians against inappropriate drugging are residents and their loved ones. We need to ensure they are told about risks and alternatives and given the chance to reject bad prescriptions.

3. Adopt a rebuttable presumption of resident harm whenever a nursing home is cited for inappropriate drugging. This will lead to consequences (financial penalties) for drugging that currently just do not exist. When CMS treats resident drugging as a minimal concern, so do nursing homes.

If CMS wanted to end the misuse of psychotropic drugs, it could. Physical restraint use, which once plagued nursing homes, is almost non-existent because it was stigmatized as unhelpful and barbaric. Using drugs to impair residents’ brains and quiet them down, however, remains a standard practice and is considered “treatment.” The culture shift we need is flagging, the outrage to fuel it is nowhere to be seen.
Senate Hearing a Missed Opportunity to Address Mistreatment of Nursing Home Residents

On March 6, 2019, the U.S. Senate Finance Committee held a hearing with the misleading title, Not Forgotten: Protecting Americans from Abuse and Neglect in Nursing Homes. Forgotten or not, the hearing gave nursing home residents little reason to believe the Senate is preparing to protect them from abuse or neglect. The hearing opened with a heartbreaking testimony from the daughters of two nursing home residents, one of whom died from neglect and the other who was raped by a caregiver. It then quickly turned into a forum for the nursing home industry to lobby for its interests and for the Trump Administration to defend the continuing rollbacks of public protections it has initiated on behalf of the industry.

Issues that matter to residents—such as illegal evictions, drugging and dangerous owners—were mostly ignored. CANHR and its advocacy partners issued a joint written statement to the Committee urging it to give attention to these issues.

Hundreds of Nursing Homes Receive Staffing Waivers from DPH

The Department of Public Health has approved hundreds of waivers that allow California nursing homes to staff below the California minimum staffing requirements that took effect on July 1, 2018 under SB 97. Nursing homes with approved waivers are allowed to staff below the daily minimum of 3.5 direct care service hours per resident or provide less than 2.4 CNA hours per resident each day, or both.

More than half of California nursing homes sought staffing waivers. DPH has created two types of waivers: the workforce shortage waiver and the patient needs waiver.

As of January 31, 2019, DPH had granted workforce shortage waivers to 117 nursing homes. DPH has not posted any information on the nursing homes that were denied waivers, but 344 skilled nursing facilities originally applied for this waiver.

As of March 1, 2019, DPH had granted patient needs waivers to 245 nursing homes. 391 facilities applied for this waiver, which CANHR has challenged because it is not legislatively authorized.

CANHR remains concerned that DPH’s excessive focus on waiving California’s minimum staffing requirements is harming residents’ ability to receive needed care.

Another Rechnitz Nursing Home Repeatedly Cited for Endangering Residents

In February 2019, the Department of Public Health (DPH) issued ten citations to Lakewood Healthcare Center, a skilled nursing facility in Downey owned and operated by Shlomo Rechnitz and his affiliates. The citations included six Class A citations and four Class B citations with fines totaling $156,000.

Four of the Class A violations involved residents who suffered serious harm due to falls. The other two Class A citations concerned residents on pureed or mechanical soft diets who choked on solid food (honey buns) provided by the activity staff. One resident died and the other nearly did, requiring CPR and hospitalization for intubation.

The facility was also cited for actively impeding the DPH investigations.

Since 2016, the DPH has received 315 complaints and facility reported incidents on Lakewood Healthcare Center while issuing it 164 deficiencies and 29 citations (state fines), according to the DPH Cal Health Find website.

Rechnitz owns California’s largest nursing home chain. His facilities have often been cited for harming and mistreating residents and three of them were decertified following the deaths of residents due to neglect. Yet the Department of Public Health has allowed him and his companies to continue to operate over 20 nursing homes for years while it dickers over whether or not to approve their license requests.

Lakeview Terrace Settles Wrongful Discharge Case for $600,000

On February 8, 2019, Los Angeles City Attorney Mike Feuer announced that Lakeview Terrace, an L.A. nursing home, has agreed to pay $600,000 for fines and services to settle a case alleging unlawful and unsafe discharge of residents. The settlement terms require...
the facility to assist homeless residents find safe and suitable placement and services when they no longer need nursing home care. The settlement even includes modest funds to pay residents’ housing costs for those who do not have appropriate housing available.

Congratulations to the L.A. City Attorney and his staff, who have successfully fought against resident and patient dumping for the last several years, and the WISE & Health Aging Long Term Care Ombudsman program, which was integral to the development and prosecution of the case.

**When Hospice Care Goes Wrong**

Steve Lopez, a Los Angeles Times columnist, is shining a spotlight on problems with hospice care in California through an ongoing series of articles inspired by the poor end of life care for his parents. While recognizing the noble work of hospice caregivers, the columns explore a wide array of troubling issues: the explosive growth of hospice agencies; the rise of corporate hospices; conflicts of interest between hospitals and hospices; layers of fraud; poor staffing; broken care promises; avoidable suffering by hospice patients; lack of oversight and no accountability. The columns also illustrate the challenges families often face in choosing a hospice agency due to aggressive marketing, pressure by hospital staff, lack of comparative information to distinguish good hospice agencies from bad ones and imminent discharge deadlines.

**House Committee Calls Out Fading Antipsychotic Campaign**

On January 22, 2019, Richard E. Neal, the Chairperson of the Ways and Means Committee of the House of Representatives, took aim at the Centers for Medicare & Medicaid Services’ nursing home antipsychotic reduction campaign—calling the recent data on antipsychotic use “extremely disappointing.” Representative Neal’s letter is remarkable not only for its clear disapproval of the campaign’s lack of progress, but also for its insightful understanding of why the campaign is failing.

The letter begins by pointing out that progress in reducing the use of antipsychotics in nursing homes has stalled. Drugging data back that up: in 2016 approximately 20.6% of nursing home residents received an antipsychotic drug. Two years later, the percentage is approximately 20.1%. As Representative Neal states, drugging remains a “major problem.” Additional data are equally troubling. When nursing homes are cited for inappropriately administering psychotropic drugs to residents, less than one percent of the issued deficiencies are identified as causing harm to the resident. In fiscal year 2019, 503 nursing home deficiencies have been issued nationwide for inappropriate psychotropic drug use (F758) and only one of them was identified as causing harm. In California, enforcement is even worse: of the 408 deficiencies since fiscal year 2018, zero were cited for harm. Representative Neal flatly explains the data mean “nursing homes are getting away with this practice.” Perhaps the most alarming data indicate nursing homes are falsely diagnosing residents as having schizophrenia in order to conceal antipsychotic use from CMS’s antipsychotic quality measure. When CMS started its campaign, it made the poor choice to exclude some antipsychotic use by diagnosis (like schizophrenia), which has resulted in a predictable increase in residents with excluded diagnoses. For example, the percentage of residents “with” schizophrenia has increased by 42% since the national campaign began in 2012.

Representative Neal’s letter ends with a number of requests for CMS to explain its choices and describe its future plans for the campaign. Among the requests is for CMS to describe how state surveyors will more effectively identify when antipsychotics lead to resident harm. The answer to this is simple. CMS needs to take the position that antipsychotic use for people with dementia is presumptively harmful and force nursing homes to explain why it’s not harmful in each case. This presumption is justified by the psychopharmacology of antipsychotics and their insidious impact on the lives of people with dementia. In order for the antipsychotic reduction campaign to move forward, CMS needs to try some real enforcement.
Did You Know?

Bad Placement Decisions Can Be a Crime

An increasing number of nursing homes, hospitals, and family members are turning to placement agencies to find housing for older adults who need care. Placement agencies can be government or private agencies. They act as brokers, connecting housing and care providers with persons who need housing and care. But they are rarely contacted by persons who need housing and care – they are usually contacted by a third party who needs to get a person moved. Increasingly, that third party is a nursing home or hospital. The quality and ethical concerns of placement agencies vary a great deal. Many agencies are only interested in getting residents into houses or facilities so they can collect their commission with little regard for whether the house or facility is suitable and provides adequate care to meet the needs of its new resident.

To counter the financial pressure to make bad placements, California criminalizes placing individuals in Residential Care Facilities for the Elderly (RCFEs) that are not equipped to meet the needs of the individual or placing individuals in facilities providing care or supervision that are unlicensed and not exempt from licensing. (Health and Safety Code Section 1569.47) Moving residents to such unsafe places is a misdemeanor. The law applies to all placement agencies, notably including hospital discharge planners, who increasingly send patients to inappropriate facilities to save money. If you have a case where an inappropriate placement is made through a placement agency or hospital discharge planner, you can report this as a crime to your local district attorney’s office.

Dear Vexed in Ventura:

The California Department of Public Health (CDPH) has two public websites that provide information on every licensed nursing home, including Medicare and Medi-Cal status, and the history of complaints, deficiencies (violations) and citations (financial penalties). It is best to avoid nursing homes that have many complaints, deficiencies or citations. These websites are Cal Health Find and The Health Facilities Consumer Information System (which Cal Health Find was intended to replace). Each of these websites has their own strengths and weaknesses.

ProPublica’s Nursing Home Inspect site also provides access to nursing home inspection histories, with advanced search features. There are also two popular websites that use nursing home rating systems. These are Nursing Home Compare (operated by Medicare) and CalQualityCare (managed by the University of California, San Francisco and the Institute for Health and Aging). Although the ratings have serious limitations, they can be useful in narrowing your choice.

One can also look on Yelp or other web-based review sites, which offer a more personal perspective. Use your best judgement when considering online reviews.

Ask detailed questions, seek references and try for a nursing home that is close to the individual who will be visiting the resident most often. Additionally, use CANHR’s Nursing Home Evaluation Checklist to help you evaluate facilities under consideration.

For additional information on this subject, visit our factsheet How to Choose a Nursing Home.
Legislation Update - March, 2019

CANHR is supporting, opposing and/or closely following the following pieces of legislation this session. This list is subject to change. Please check www.canhr.org for updated details on legislation, and www.leginfo.ca.gov for information on specific bills.

**Sponsor**

AB 737 (Eggman) – Residential Care Facilities for the Elderly: Licensing and Regulation
This bill improves the information available to the Department of Social Services’ Community Care Licensing Division (CCLD) when deciding whether to approve or deny an application to operate a Residential Care Facility for the Elderly (RCFE). Often, CCLD cannot identify the individuals who want to own or operate an RCFE, whether they have operated other facilities, and their operational or regulatory compliance history.

**Status:** Assembly Human Services Committee - Hearing on 4/9/19

SB 314 (Dodd) – Elders and Dependent Adults: Abandonment
This would add “abandonment of an elder or dependent adult” as a cause of action under the Elder and Dependent Adult Civil Protection Act of the Welfare and Institutions Code (EADACPA). Currently, EADACPA can only be used in instances where there has been physical abuse, neglect, or financial abuse.

**Status:** Senate Judiciary Committee - In Floor Process

**Support**

AB 50 (Kalra) – Assisted Living Waiver
This bill would improve the Assisted Living Waiver (ALW) Program by increasing the number of participant slots, expanding the geographic service area, and requiring the state to state minimum wage increases are reflected in the provider reimbursement rate.

**Status:** Assembly Health Committee - Hearing Postponed

AB 506 (Kalra) – Long Term Health Facilities
This bill greatly enhances the state nursing home enforcement system by: 1) increasing the penalties for state citations issued against nursing homes and indexing the penalties to inflation for future years, 2) requiring a citation be issued for each victim when more than one victim is affected, and 3) updating the criteria for AA citations (those that cause the death of a resident) from the old “direct proximate cause of death’ standard to the more clear “substantial factor” standard.

**Status:** Assembly Health Committee Hearing on 4/2/19

AB 715 (Arambula) – Medi-Cal: End the Senior Penalty
This bill would ensure that seniors are treated fairly and can afford to access medical care. The bill would decrease the number of low-income seniors losing free Medi-Cal by increasing the Medi-Cal income eligibility limit for seniors to 138% of the federal poverty level, an amount equivalent to other Medi-Cal income levels for younger adults.

**Status:** Assembly Health Committee Hearing on 4/2/19

AB 1042 (Wood) – Home Upkeep Allowance
Maintaining a residence outside of a nursing home is a major obstacle for Medi-Cal beneficiaries in nursing homes who want to return home. Under current law, beneficiaries are permitted to retain a Home Upkeep Allowance of $209 per month, and the rest of their income must be applied to Share of Cost for nursing home care. This bill would base the Home Upkeep Allowance on the actual cost of maintaining the home, up to 100 percent of the federal poverty level.

**Status:** Assembly Health Committee Hearing on 4/2/19

SB 214 (Dodd) – California Community Transitions Program
This bill would require California to continue to administer the California Community Transitions program under the federal Money Follows the Person Rebalancing Demonstration. If federal matching funds are unavailable, the bill would require the department to fund the program.

**Status:** Senate Health Committee - In Committee Process
**SB 440 (Pan) – Cognitive Impairment Safety Net System Task**
Force This bill would convene a task force to study and assess the need for a cognitive impairment safety net system, which could bring some long-range thinking and cohesion to the way we support Californians with cognitive impairment.

**Status:** Senate Huan Services Committee - Hearing on 4/18/2019

**Oppose**

**AB 999 (Patterson) – Disability Access: statutory damages**
AB 999 is an erosion of mandated public accommodation protections for disabled adults. This bill would change the definition of what constitutes an exempted small business from one that employs twenty-five employees to fifty employees. This substantial change will interfere with thousands of handicapped individuals’ ability to access facilities.

**Status:** Assembly Judiciary Committee - In Committee Process

**AB 1709 (Jones-Sawyer) – Nursing homes: staff**
This nursing home industry sponsored bill would reduce the minimum number of in-service training hours certified nursing assistants (CNAs) must complete every two years from 48 to 30 hours and allow all of the training to be obtained through an online training program. It would also modify nursing home administrator qualifications.

**Status:** Assembly Healthy Committee - Hearing on 04/23/19

**SB 40 (Weiner) – Conservatorship: serious mental illness and substance abuse disorders**
This bill would permit a temporary conservatorship process in San Diego, Los Angeles, and San Francisco counties without notice to the proposed conservatee or an opportunity to contest. SB 40 is clearly unconstitutional.

**Status:** Senate Judiciary Committee - Hearing on 4/09/19

**CANHR Watch**

**AB 683 (Carillo) – Medi-Cal: Eligibility**
This bill increases and simplifies the asset eligibility limit for Medi-Cal and eliminates those limits for Medicare Savings Programs, which makes Medicare more affordable.

**Status:** Assembly Health Committee - Hearing on 4/2/19

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**Planned Giving Leaves**

**A Legacy to Honor Your Memory and Helps to Ensure the Future of CANHR.**

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

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- gifts by will
- gifts of life insurance
- gifts by a revocable living trust or charitable remainder trust.

Call the CANHR office or email patm@canhr.org to get more information and a free booklet on planned giving.
Past Speaking Engagements, Panel Discussions and Training Sessions

- **December 4:** Prescott Cole presented a one hour webinar on Criminal Restitution and Civil Financial Elder Abuse litigation.

- **December 7:** Prescott Cole participated in the Legal Aid Association of California Support Center Meeting in Oakland.


- **December 20:** CANHR staff along with CANHR’s mascots Fozzy & Chloe visited Chaparral House in Berkeley (a skilled nursing facility) to deliver holiday cheer and cards to residents.

- **January 15:** Tony Chicotel traveled to San Mateo to speak to the Institute on Aging’s Community Care Settings Team about ethical dilemmas in long term care advocacy.

- **January 16:** Jody Spiegel gave a presentation to Inland Empire HICAP regarding Long Term Care Medi-Cal Eligibility and Recovery.

- **January 22:** Patricia McGinnis gave a presentation to the California Commission on Aging in Sacramento regarding CANHR’s white paper on California’s Broken LTC System.

- **January 26:** Prescott Cole was a guest lecturer at Hasting’s Law School Medical- Legal Partnership for Seniors class.

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

- **January 29:** Tony Chicotel presented to Community Care Licensing on capacity, surrogate decision making, and RCFE residents’ rights.

- **February 13:** Efrain Gutierrez provided Senior Scams and Medi-Cal Recovery material at the Alhambra Senior Center.

- **February 20:** Patricia McGinnis gave a presentation at the CCRC SF Towers Health Committee on CCRC Rights.

- **March 1:** Tony Chicotel presented at the California NAELA summit in San Francisco about good and bad choices in long term care.

- **March 1:** Prescott Cole presented to RCFE Administrators and Staff, Discharge Planners, APS and Law Enforcement and Estate Planning Attorneys in Chico about Long-Term Care Benefits, Scams and Civil Litigation.

- **March 26:** Tony Chicotel presented to the Asian Network Pacific Home Care in Oakland about capacity and surrogate decision making.

- **March 27:** Tony Chicotel gave a webinar about End-of-Life and Death Decisions for legal services.

- **March 28th:** Pauline Mosher presented about CANHR services to the UCSF Geriatric’s Fellows.

- **March 29:** Tony Chicotel participated in a meeting of elder justice professionals hosted by the US Department of Justice.

- **March 29:** Prescott Cole presented on elder financial abuse restitution at the California Lawyers Association Trust and Estates Section Second Annual Elder Abuse Symposium.

▲ CANHR staff spreading holiday cheer at Chaparral House skilled nursing facility. **Pictured Left to Right:** Pauline Mosher, Tony Chicotel, K.J. Page (Chaparral House administrator) and Armando Rafailan.
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.

In the CANHR Advocate Winter 2018 newsletter, we profiled several resident rights and related practice tips. Below are descriptions of additional resident rights and related practice tips.

**Recipients Of Supplemental Security Income (SSI) Can Pay Reduced Rate**

SSI is a program funded by federal and state governments that pays a minimum monthly income to individuals who are aged (65+), blind or disabled, and have limited income (<$1,194.37 per month as of 1/1/19) and resources (<$2,000 in countable assets). If a RCFE resident receives SSI, California law limits the monthly rate that the facility may charge the SSI recipient for “basic services.” [22 CCR 87464(e). Note, “Basic Services” are defined very broadly in 22 CCR 87101(b)(2)]. Under 2019 SSI payment rates, RCFE residents who are SSI beneficiaries will receive payments to ensure their income is $1,194.37 per month, and must pay the RCFE $1,058.37 per month. This leaves the resident with $136 per month for personal needs ($1,194.37 - $1,058.37 = $136). Additionally, California law prohibits a facility from requiring a resident to waive his/her right to receive SSI benefits in its Admission Agreement. [HSC 1569.269(c); 22 CCR 87468.2(c)]

**TIP:** For more information about RCFEs and SSI, see CANHR’s fact sheets at [www.canhr.org/factsheets/rcfe_fs/html/rcfe_fs.ssi.htm](http://www.canhr.org/factsheets/rcfe_fs/html/rcfe_fs.ssi.htm) and [www.canhr.org/factsheets/rcfe_fs/html/rcfe_fs.RCFEs_and_SSI.htm](http://www.canhr.org/factsheets/rcfe_fs/html/rcfe_fs.RCFEs_and_SSI.htm).

**All Fees Must Be Specified In Admission Agreement**

Generally, RCFEs are free to set their own rates, and the rates will vary depending on the items and services that the resident needs and uses. Some RCFEs charge a fixed rate for all services, but most facilities combine a fixed rate with extra charges for higher levels of service. The admission agreement must include a comprehensive description of all items and services provided under a single rate, and any additional items and services and their corresponding fees. In all cases, the admission agreement must clearly indicate what the charges are, and what items and services are provided for the charges. [HSC 1569.884(a)-(b); 22 CCR 87507(g)(3)] No fee may be charged that is not clearly stated in the admission agreement. [HSC 1569.884(c); 22 CCR 87507(g)(3)]

**TIP:** Check your bill to make sure that the charges are correct, and do not pay any fees for items or services that are not specified in the admission agreement. Charges for additional services are often uncollectible, because they are not adequately described in the admission agreement. For more information about RCFE admission agreement requirements, see CANHR’s fact sheet at [www.canhr.org/factsheets/rcfe_fs/html/rcfe_fs.admission.htm](http://www.canhr.org/factsheets/rcfe_fs/html/rcfe_fs.admission.htm).

**Post-Death Refunds Are Required**

An RCFE must include in the admission agreement its policy concerning refunds, including the conditions under which a refund for advanced monthly fees will be returned in the event of a resident’s death. [HSC 1569.884(h); 22 CCR 87507(g)(5)] RCFEs are prohibited from imposing charges after the death of a resident, beginning on the date after the resident’s personal property has been removed from the living unit. [HSC 1569.652(a)] The facility must refund any fees paid in advance to the individual/s contractually responsible for paying the fees or, if the resident paid the fees, to the resident’s estate. The fees must be refunded within 15 days after the resident’s person property has been removed. [HSC 1569.652(c)]

**TIP:** Check the admission agreement to see whether the facility charges fees after a resident’s death, and
the amount of those fees. If the agreement requires payment of fees after a resident’s death, remove the resident’s personal property as soon as possible to maximize the amount of the refund.

**Medi-Cal Payment For Assisted Living**

In general, Medi-Cal does not pay for assisted living. However, there is one Medi-Cal program called the “Assisted Living Waiver” (ALW) that will pay for individuals who require nursing home level of care to receive services to meet their care needs in an RCFE. Unfortunately, the ALW is currently available only to a limited number of people in a limited number of counties at a limited number of facilities. Additionally, demand for the program has outpaced supply, and there is currently a substantial waitlist. Assemblymember Kalra has introduced legislation to increase the number of ALW participant slots and expand the program geographically. For more information about the ALW, including eligibility requirements and participating counties and facilities, see CANHR’s fact sheet at www.canhr.org/factsheets/rcfe_fs/html/rcfe_fs.alw.htm.

**TIP:** If you would like to enroll in the ALW, contact a Care Coordination Agency (CCA) in your county to complete the one-page Waitlist Request Form. For a list of CCAs, see www.dhcs.ca.gov/services/ltc/Documents/Care-Coordination-Agencies-2018.pdf.

**Pharmacy Fees And Right To Choose Own Pharmacy**

Residents have the right to choose their own pharmacy. [HSC 1569.269(a)(20), 1569.314; 22 CCR 87468.2(a)(18)] RCFEs may not charge residents a fee for using the pharmacy of their choice, unless the fee is set forth in the negotiated admission agreement and is limited to the actual costs incurred by the RCFE in using that pharmacy. [See *Evaluator Manual*, Section 87507(g)(3) at page 110.1] For example, a RCFE may not charge a resident a monthly fee for using a non-preferred pharmacy, nor for staff time performing the same work handling a resident’s medications as it does from any other pharmacy.

**TIP:** If you are charged a fee for using a non-preferred pharmacy, check your admission agreement and billing statement to determine if the fee is specified in the admission agreement, and if it reflects actual, non-ordinary costs incurred by the RCFE. Charges related to using a non-preferred pharmacy are often uncollectible, because they are not adequately described in the admission agreement, nor based on actual costs.
CCRC Corner

CCRCs and the Myth of “Continuing Care”

As more and more Continuing Care Retirement Communities (CCRC’s) opt out of life care contracts and a growing number plan to opt out of providing skilled nursing care at their communities, one has to wonder: what happened to the concept of continuing care?

In a marketing effort to attract younger, wealthier and more active (i.e., healthier) residents, LeadingAge, the membership and lobbying group for CCRCs, joined with Mather LifeWays, a senior living provider, in a 2015 campaign to identify and market a new name for CCRCs. The goal of this renaming and marketing campaign is to phase out the use of the name “continuing care retirement or senior living community”, and replace it with “Life Plan Community” - with an emphasis on overall wellness and a healthy, active lifestyle.

Nothing wrong with that. In fact, as seniors live longer and age better, a healthy, active lifestyle is certainly a good thing. The problem is that the notion of “care” is being suppressed in favor of amenities. One senior living community website, in praising the new name, notes that “continuing care communities are now being referred to as Life Plan Communities, which focuses more on the individual and less about care.”

Sounds nice, but let’s not kid ourselves. The main reason for dumping the SNFs in CCRCs is money. Decreased demand for nursing home beds, combined with the high costs of running a skilled nursing facility and the pending October 1, 2019 changes in Medicare reimbursement for rehabilitation under the Patient-Driven Payment Model (PDPM) are all factors in the reduction of skilled nursing beds at CCRCs.

However, when prospective residents are expected to pay a buy-in of $300,000 to $1 million+ with the intention of aging in place and receiving “care” when and if they need it, they may be facing a major problem when there is no skilled nursing care on site.

The type of contract you sign with a CCRC is most important. Life Care contracts or Type A contracts, are all inclusive. You pay a one-time entry fee, part or all of which may be refundable, plus a monthly rent. In return you get unlimited access to health care services in the facility for the rest of your life. Type C contracts are less expensive up front, and you pay for health services as you need them, at market rates. Type Bs are hybrids of these two. A fourth option: month-to-month rentals have no entry fee.

Under California law (Health & Safety Code §1771(l)), “…care shall be provided under a life care contract in a continuing care retirement community having a comprehensive continuum of care, including a skilled nursing facility, under the ownership and supervision of the provider on or adjacent to the provider. A change shall not be made in the monthly fee based on the level of care. A life care contract shall also include provisions to subsidize residents who become financially unable to pay their monthly care fees.”

Thus, those CCRCs that have residents with life care contracts must have a skilled nursing facility under the ownership and supervision of the provider on or adjacent to the provider.

This statute was particularly useful when the Covia-run San Francisco Towers’ COO announced their intention to close their on-site skilled nursing facility. When he realized that many of the residents had life care contracts (and that there was actually a law preventing the closure), he wrote to the residents: “…we will not consider closing the SNF at San Francisco Towers while there are contracts with residents that stipulate otherwise.” Obviously, the intention is not to enter into further life care contracts, and, when the current life care residents move or die, to get rid of the skilled nursing facility.

Another example is The Canterbury, a Rancho Palos Verdes CCRC run by Episcopal Communities & Services for Seniors who filed a notice of intention to close their skilled nursing facility with the Department of Public Health on January 2, 2019, with the intention to finalize the closure by October 31, 2019. According to the CCRC Branch, if there are no life care contracts involved, the Canterbury would be within its rights to close the facility, despite the Canterbury’s advertising “skilled nursing and medical care right on campus.”

Regardless of the type of contract signed, the real question is: how many residents moved to the Canterbury because they advertised “continuing care,” including skilled nursing and medical care right on campus.”

Next issue: Where does the CCRC money go? Buildings, Bonuses and Bankruptcies
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

**Lake Merritt Healthcare Center Llc**  
309 Macarthur Boulevard, Oakland  
**B $2000 Physical Environment**  
08/01/2018

The facility was cited for failing to provide an environment free from accident hazards for a resident when an electrical wire below the bed sparked and caused a burn on the floor as a result of faulty and exposed wiring. During a concurrent observation and interview with a licensed electrician (LE), who had been called by the facility, the LE stated, if the exposed, sparking wiring had been lying next to combustible materials, (for example sheets and blankets), the incident could have started a fire. Citation # 020013395.

**Parkview Healthcare Center**  
27350 Tampa Avenue, Hayward  
**B $1500 Patient Care Physical Environment**  
10/26/2016

The facility was cited for failing to ensure a safe environment for a resident resulting in him ingesting a toxic substance (liquid soap) which was left in a hydration cup on his bedside table. As a result the resident experienced vomiting, respiratory distress with low oxygen saturation levels (low amounts of oxygen in the blood) and required emergency medical treatment and hospitalization at a general acute care hospital. Citation # 020012677.

### Amador County

**Kit Carson Nursing & Rehabilitation Center**  
811 Court Street, Jackson  
**B $2000 Mandated Reporting Physical Abuse Verbal Abuse**  
01/11/2019

On 3/28/17, an allegation that a CNA was yelling, cursing and pushing residents was reported to the Assistant Administrator “a couple of days after it happened.” The allegation was not reported to the Department. The facility was cited for failing to report the incident of alleged abuse to the Department Citation # 030014663.

### Contra Costa County

**Shields Richmond Nursing Center**  
1919 Cutting Boulevard, Richmond  
**B $2000 Bed Hold Evictions**  
10/18/2018

On 8/21/18, a male resident was hospitalized following a fall. On 9/8/18, the resident was cleared to return to the nursing home but a representative claimed there was no available bed. A review of the facility census showed there were two available male beds. The facility marketing director stated the facility had decided not to readmit the resident. The facility was cited for failing to readmit the resident after hospitalization. Citation # 020014507.
Fresno County
Fresno Postacute Care
1233 A St, Fresno

B $2000 Careplan Neglect Patient Care
09/26/2018
On 5/18/18, a resident was interviewed about her level of care. She stated tearfully, “I feel that I am getting depressed. I try not to think about my situation. It makes me sad.” The facility’s MDS Coordinator reviewed the resident’s medical record and stated “The resident has limited physical mobility related to morbid obesity.” The Occupational Therapist stated “Rehab goals was to sit up on a wheelchair. No wheelchair was delivered.” The resident was not able to take showers because a replacement sling had not been delivered to the facility. The facility failed to ensure freedom from neglect when resident was not provided with a bed, wheelchair, shower chair or sling able to safely and comfortably accommodate her size. Citation # 040014433.

Inyo County
Bishop Care Center
151 Pioneer Ln, Bishop

B $100 Evictions Transfer 10/22/2018
The facility failed to send copies of resident transfer and discharge notices to the long term care Ombudsman office for all three residents who were transferred or discharged during May 2018. The facility staff stated they were not aware of the legal requirement to send copies of notices to the Ombudsman despite the local Ombudsman telling them. The facility was cited for its failures, which placed the residents at risk for unsafe discharges. Citation # 240014490.

B $100 Evictions Transfer 10/22/2018
The facility failed to send copies of resident transfer and discharge notices to the long term care Ombudsman office for all six residents who were transferred or discharged during April 2018. The facility staff stated they were not aware of the legal requirement to send copies of notices to the Ombudsman despite the local Ombudsman telling them. The facility was cited for its failures, which placed the residents at risk for unsafe discharges. Citation # 240014489.

B $100 Evictions Transfer 10/22/2018
The facility failed to send copies of resident transfer and discharge notices to the long term care Ombudsman office for all six residents who were transferred or discharged during March 2018. The facility staff stated they were not aware of the legal requirement to send copies of notices to the Ombudsman despite the local Ombudsman telling them. The facility was cited for its failures, which placed the residents at risk for unsafe discharges. Citation # 240014477.

B $100 Evictions Transfer 10/22/2018
The facility failed to send copies of resident transfer and discharge notices to the long term care Ombudsman office for all five residents who were discharged during June 2018. The facility staff stated they were not aware of the legal requirement to send copies of notices to the Ombudsman despite the local Ombudsman telling them. The facility was cited for its failures, which placed the residents at risk for unsafe discharges. Citation # 240014489.

B $100 Evictions Transfer 10/22/2018
The facility failed to send copies of resident transfer and discharge notices to the long term care Ombudsman office for all four residents who were transferred or discharged during February 2018. The facility staff stated they were not aware of the legal requirement to send copies of notices to the Ombudsman despite the local Ombudsman telling them. The facility was cited for its failures, which placed the residents at risk for unsafe discharges. Citation # 240014474.

B $100 Evictions Transfer 10/22/2018
The facility failed to send copies of resident transfer and discharge notices to the long term care Ombudsman office for all six residents who were transferred or discharged during January 2018. The facility staff stated they were not aware of the legal requirement to send copies of notices to the Ombudsman despite the local Ombudsman telling them. The facility was cited for its failures, which placed the residents at risk for unsafe discharges. Citation # 240014495.

B $100 Evictions Transfer 10/22/2018
The facility failed to send copies of resident transfer and discharge notices to the long term care Ombudsman office for all five residents who were discharged during July 2018. The facility staff stated they were not aware of the legal requirement to send copies of notices to the Ombudsman despite the local Ombudsman telling them. The facility was cited for its failures, which placed the residents at risk for unsafe discharges. Citation # 240014491.

Kern County
Ridgecrest Regional Transitional Care and Rehabilitation Unit
1081 N China Lake Blvd, Ridgecrest

B $100 Evictions Transfer 10/22/2018
The facility failed to send copies of resident transfer and discharge notices to the long term care Ombudsman office for all six residents who were transferred or discharged during April 2018. The facility staff stated they were not aware of the legal requirement to send copies of notices to the Ombudsman despite the local Ombudsman telling them. The facility was cited for its failures, which placed the residents at risk for unsafe discharges. Citation # 240014490.

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B $100 Evictions Transfer 10/22/2018
The facility failed to send copies of resident transfer and discharge notices to the long term care Ombudsman office for all three residents who were transferred or discharged during July 2018. The facility staff stated they were not aware of the legal requirement to send copies of notices to the Ombudsman despite the local Ombudsman telling them. The facility was cited for its failures, which placed the residents at risk for unsafe discharges. Citation # 240014491.

Kern County
Ridgecrest Regional Transitional Care and Rehabilitation Unit
1081 N China Lake Blvd, Ridgecrest

B $100 Evictions Transfer 10/22/2018
The facility failed to send copies of resident transfer and discharge notices to the long term care Ombudsman office for all six residents who were transferred or discharged during April 2018. The facility staff stated they were not aware of the legal requirement to send copies of notices to the Ombudsman despite the local Ombudsman telling them. The facility was cited for its failures, which placed the residents at risk for unsafe discharges. Citation # 240014490.

A $20000 Decubiti (Bedsores) Infection Neglect
01/25/2019
On 4/9/18, an 80 year old resident required extensive surgery to repair a contracture of her left hand. The hand injury developed when her contracted fingers continually pressed her untrimmed fingernails into the palm of her left hand, causing a painful 2.5 centimeter pressure injury. The
resident’s nails of the left hand were very long and dirty, had not been cleaned in months, and had a strong, foul smelling odor. Her daughter complained for a year that her mother needed treatment for the clenched hand but the facility never responded. The facility was cited because its failures resulted in a pressure injury requiring surgical intervention which had a substantial probability of death or serious physical harm to the resident. Citation # 120014697.

Kern County
The Rehabilitation Center Of Bakersfield
2211 Mount Vernon Ave, Bakersfield

B $2000 Notification Patient Rights Physical Abuse 10/22/2018
On 9/5/2018 a family member of the resident reported to the Department of Public Health a staff member was hurting the resident. It was reported that a CNA had pulled the resident’s arm. The resident stated “They don’t treat me right.” The CNA’s room assignment was changed, but she was not sent home or suspended. The Director of Nursing was not aware of the abuse allegations. The facility failed to report all incidents of alleged abuse or suspected abuse of a resident of the facility to the department immediately. Citation # 120014486.

Lake County
Evergreen Lakeport Healthcare
1291 Craig Avenue, Lakeport

B $2000 Fall Injury Mandated Reporting Patient Care Physical Abuse 07/19/2018
On 2/9/17, a nursing assistant pulled a 90 year old wheelchair-bound resident by his ankles for 20 feet, after the resident told the nursing assistant he was not ready for bed. The resident fell out of his wheelchair onto his right shoulder and face, which “sounded like a bowling ball hitting the concrete.” The resident began profusely bleeding and required steri-strips on his head. When the Assistant Director of Nursing documented the “occurrence,” she failed to include a witness’ observation that the nursing assistant pulled the resident by his feet for 20 feet. The facility was cited for failure to report an allegation of abuse to the Department of Public Health. Citation # 110013517.

Los Angeles County
Alexandria Care Center
1515 N Alexandria Ave, Los Angeles

B $2000 Careplan Dignity Infection Injury Neglect Patient Care Staff (Inservice) Training Staffing 10/05/2018
The resident was admitted to the facility on 9/10/2018 with a pressure injury that needed to be free from signs and symptoms of infection for 14 days. In addition to the resident’s care he needed incontinence care by staff to maintain dignity and comfort and to prevent incontinence related complications. The resident stated that the nursing staff did not want to change his wound dressing. The wound dressing would be saturated with drainage and the drainage would irritate the surrounding skin. The resident would change his own incontinence brief because it would become saturated with drainage. The Administrator of the facility, stated that he told the LVN to change his wound dressing four times, but the LVN kept saying she was too busy. The facility failed to ensure the nursing staff would attend to the resident’s needs. This violation had a direct impact to the resident’s health and safety. Citation # 920014591.

B $2000 Neglect 11/17/2018
On 10/2/18, a resident with multiple comorbidities was observed lying in bed awake, alert and oriented, crying and wiping tears from his eyes. The resident stated the nursing staff did not change his incontinence brief, wound dressing and did not empty his colostomy bag. He stated that his complaints about his care went unanswered. He further stated that he was tired of asking the nursing staff to perform those tasks because it made him feel like a child, and sometimes he emptied his colostomy bag because some nursing staff did not want to do it. The facility was cited for failing to investigate allegations of neglect, not taking corrective actions and not resolving grievances voiced by a resident. Citation # 920014580.
Antelope Valley Care Center  
44567 15th St W, Lancaster

B $2000 Careplan Deterioration Neglect Patient Care 01/07/2019

A female resident died after collapsing during her physical therapy session on 8/14/18. The resident had congestive heart failure and lung disease, requiring close monitoring of her oxygen levels, shortness of breath and vital signs. The facility was cited for failing to monitor vital signs on multiple days, failing to administer oxygen as ordered by the resident’s physician and failing to address and create a careplan for the resident’s poor oxygen levels. Citation # 920014703.

California Post-Acute Care  
3615 E Imperial Hwy, Lynwood

B $2000 Bed Hold Evictions 08/02/2018

A 63 year old male resident was hospitalized on 3/25/18. When the resident’s hospital physician determined the resident was ready to return to the facility on 3/30/18, the facility refused readmission. The facility failed to follow its bed hold policy. Citation # 940014311.

Catered Manor Nursing Center  
4010 N Virginia Rd, Long Beach

A $20000 Care plan Neglect Notification Patient Care 02/01/2019

From 10/31/18-11/4/18, the facility gave daily insulin injections to a 94 year old resident who had diabetes and had altered mental status, without monitoring his blood sugar levels or poor food consumption. On 11/4/18, the resident’s family member noticed that the resident was “not normal” and called the paramedics after the facility staff delayed in doing so. The resident was admitted to the hospital in severe respiratory distress with hypoglycemia and a very low blood glucose level. The resident died five days later on 11/9/18. The resident’s physician stated that ideally the resident’s blood glucose should have been checked before meals and at bedtime, and closely monitored due to his poor oral intake. The facility was cited for failing to monitor, document and report the resident’s blood sugar levels, signs and symptoms of hypoglycemia, and dietary compliance. It was also cited for failing to develop policies and procedures on insulin use to provide adequate blood sugar monitoring. Citation # 940014769.

Country Villa Los Feliz Nursing Center  
3002 Rowena Ave, Los Angeles

B $2000 Administration Careplan Elopement Fall Injury Supervision 01/11/2019

On 10/3/18 a resident diagnosed with Alzheimer’s and dementia wandered out of the facility through the emergency exit door in his wheelchair. The resident rolled down the facility’s steep parking lot ramp to the street curb, causing the resident to fall out of his wheelchair. The resident was found on the floor with a facial laceration that required staples and fractured his right ribs. During an interview with the Administrator he stated, “there was nothing we could do to prevent the fall.” The Administrator stated that he did not have a wander guard because the facility did not feel like the resident needed one at the time. The facility failed to ensure the resident was free from accidents, failed to implement a careplan and failed to maintain an accident free environment. Citation # 920014719.

Country Villa Wilshire Convalescent Center  
855 N Fairfax Ave, Los Angeles

B $2000 Feeding Injury Neglect Notification Patient Care 9/28/2018

On 4/18/2016 a resident was served hot tea during dinner. The resident took a sip of tea and spit out scalding tea onto her chest causing a burn that became a blister. The administrator stated “I do not remember the resident sustaining a burn to the chest area.” He also stated there was no investigation done regarding the incident. The facility failed to ensure a resident remain free of accident hazards by checking the food temperature including hot tea as indicated in the facility policy. Citation # 910014449.

Eisenberg Village  
18855 Victory Blvd, Reseda

A $20000 Fall Injury 08/31/2018

A resident died on 2/20/15, about a week after suffering an un-witnessed fall on the facility patio on 2/12/15. The resident suffered knee injuries and, seven hours after the fall, right facial redness was observed, an indicator of possible head injury. The resident, who was on the blood thinner, Coumadin, began vomiting coffee ground color emesis the day after the fall and had several more vomiting episodes in the following days. Tests for internal bleeding problems revealed critically high results after the fall. The resident’s family refused transfer to the hospital, she began receiving hospice services on 2/19/15 and died the next day at the facility. The facility was cited for failing to adequately supervise the resident to prevent falls, failing to provide or arrange immediate medical evaluations and interventions in the presence of right side facial redness, and several other failures to meet her needs. Citation # 920014374.
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A $15000 Nutrition 02/01/2019
On 12/12/18, an investigation into the care being provided to a resident with a swallowing disorder, muscle wasting contractures and respiratory disease and who needed assistance in eating determined that the resident had sustained a severe progressive weight loss. The resident had moderate memory problems and required extensive assistance with one-person assist with transfers, personal hygiene and bed mobility. During a six week period, the resident went from 176 to 150 pounds. When interviewed on 12/14/18, the resident said that he did not eat breakfast that day or the day before that. The facility was cited for failing to provide appropriate care and services for the resident. Citation # 950014782.

Grand Valley Health Care Center
13524 Sherman Way, Van Nuys
B $2000 Dietary Services Physical Environment 10/25/2018
The facility’s kitchen had a cockroach infestation, which was discovered by the Department on 9/4/18. The kitchen also contained cracks in the walls, broken grouts between floor tiles, three floor drains directly connected to a sewer line, and other conditions necessary to harbor pests. The facility was cited for failure to ensure food was stored in accordance with professional standards. Citation # 920014531.

Lakeview Terrace
831 S Lake Street, Los Angeles
B $1500 Fall Injury Patient Care 12/21/2018
A 77 year old male resident was admitted to the facility on 10/5/18 with cognitive impairment, kidney failure and a high risk for falls. On 10/10/18, the resident slid out of his wheelchair in an unwitnessed fall. The resident was sent to the hospital on 10/15/18 with a left-thumb abrasion and general weakness. The facility was cited for failure to report the resident’s scalp abrasion and left thumb fracture following the unwitnessed fall. Citation # 9100014754.

Lakewood Healthcare Center
12023 Lakewood Blvd, Downey
B $2000 Careplan Fall Patient Care 02/05/2019
The facility failed to follow the careplan for a resident with a history of falls with injury, and staff failed to follow facility policies on reporting falls with injury. As a result, the resident had an unwitnessed fall resulting in skin abrasions to the head and arm. Citation # 940014795.

B $2000 Other Patient Care Patient Records 02/05/2019
On 11/5/18, the Department received a complaint regarding many unreported falls with injury and neglect in the facility and went to the facility to investigate. During an initial tour, the floors were observed with black stains, call lights were ringing without staff responding, a foul strong ammonia odor permeated throughout the hallways, residents were yelling, and there were no staff members around. An RN stated that the facility was having multiple issues, including: 1) Recurrent falls not reported timely to the physician and care not provided; 2) Nurse-patient ratio did not meet the criteria to care for residents’ needs; 3) Reports of incidents, body assessments, and nurses notes being removed from clinical records by the DON; and 4) DON asking the licensed nurses to change their documentation because she did not want to get into trouble with the Department. The RN also stated that the DON sent a mass message to the staff informing them to not talk to the Department team and not answer any telephone calls from the Department.

A review of police call reports from 8/19/18-10/30/18 indicated that the facility called 911 three times for elder abuse, one death, and three missing person reports. A review of paramedics call log from January-October 2018 indicated that the facility called the paramedics four times for bleeding caused by residents’ cuts, 13 times for difficulty in breathing episodes, 11 seizures, two falls with injury, five cardiac arrests resulting in death, one heart attack and one choking episode. A review of 10 residents’ clinical records indicated numerous missing documents, and the DON stated she did not know why all the residents’ incidents/accidents were occurring in the facility or why the nurses’ documentation was missing. The DON stated that she would not provide staff files as per the Vice-President Officer orders, and then provided partial staff files over 24 hours later.

The facility was cited for failing to allow the Department team access to resident clinical records and facility staff files, and for failing to keep residents’ records readily available in the clinical charts. Citation # 940014788.

A $20000 Fall Injury Supervision 02/05/2019
On 10/1/18, an 86 year old resident who was at high risk of falls suffered a fractured hip when she fell out of her wheelchair at 5 am after being wheeled to the nurses’ station. Her doctor ordered an x-ray at 7 am, but it wasn’t done until several hours later because the nurse stated she was busy with other residents and forgot to follow-up. The resident was hospitalized for eight days and endured a two-part surgery to repair her hip. The facility did not report the incident to the Department of Public Health as required and failed to follow its careplan to prevent falls even after the resident was readmitted to the facility. It was cited for failing to provide adequate supervision and other violations. Citation # 940014793.
B $2000 Injury Mandated Reporting 02/08/2019
On 8/23/18, an 80 year old resident became agitated when staff attempted to get him up from bed. The resident swung his hand and hit the head of the bed resulting in a broken arm. The facility did not report the incident to the Department. The facility was cited for failing to provide an environment free of hazards for the resident, and for not reporting the resident’s injury pursuant to facility policy. Citation # 940014801.

B $2000 Fall Patient Care 02/08/2019
The facility was cited after it failed to provide adequate supervision for a resident who was at a high risk for falls, and failed to properly report falls with injuries for a resident, resulting in the resident falling in the hallway of the facility, sustaining a nosebleed and a swollen eye. Citation # 940014802.

A $20000 Careplan Feeding Supervision 02/08/2019
A 72 year old male resident choked on solid food and had to be resuscitated via CPR. The resident had difficulty swallowing and was supposed to be receiving pureed food. On 10/14/18, the resident was found unresponsive, revived with CPR after the food was removed from his throat, and sent to the hospital. The resident had to be intubated and receive mechanical ventilation. The facility was cited for failing to follow the resident’s doctor-prescribed diet, provide adequate supervision during eating and ensure all staff members were aware of the resident’s plan of care. Citation # 940014809.

A $20000 Feeding Neglect Supervision 02/08/2019
On 6/7/18, a 59 year old resident who had difficulties with swallowing and was on a mechanical soft diet choked to death on a honey bun provided by the activities director. A CNA who responded to the choking episode stated she removed a honey bun from the resident’s mouth but that no equipment was available to remove and dislodge the part was in his throat. There was a delay in CPR and resuscitation while the resident was moved to his room. Paramedics arrived at the facility and pronounced the resident dead after unsuccessful resuscitation efforts. Although the resident did not have pneumonia and had not been treated for it, his physician (who was the facility’s Medical Director) listed pneumonia as a cause of death on his death certificate. He later changed the cause of death to dementia. The facility did not initiate an investigation or incident report. The facility was cited for allowing the resident access to food that was not on his diet and for failing to initiate CPR timely, follow physician diet orders and provide necessary supervision. Citation # 940014808.

A $16000 Fall Injury Supervision 02/08/2019
On 11/3/18, a 76 year old resident who was at high risk for falls suffered a fall and three fractured ribs while attempting to get up from the toilet while unsupervised. The facility was cited for failing to provide adequate supervision and for failing to report the resident’s injury. Citation # 940014799.

Leisure Glen Post Acute Care Center
330 Mission Rd, Glendale

B $2000 Mandated Reporting Physical Abuse 02/22/2019
On 11/22/18 a resident complained that another resident entered her room and began moving her belongings and the linen from her bed and that his hand had hit her left ear. The facility was cited for failing to follow its abuse policy of reporting abuse immediately or no later than 24 hours. Citation # 920014832.

Long Beach Care Center
2615 Grand Ave, Long Beach

B $2000 Mandated Reporting 02/22/2019
On 11/22/18 a resident complained that another resident entered her room and began moving her belongings and the linen from her bed and that his hand had hit her left ear. The facility was cited for failing to follow its abuse policy of reporting abuse immediately or no later than 24 hours. Citation # 920014832.

Maclay Healthcare Center
12831 Maclay St, Sylmar

A $20000 Medication 12/14/2019
On 9/5/18, a resident with congestive heart therapy was prescribed a diuretic medication with instructions to discontinue a different diuretic the resident had been taking before. Nonetheless, the resident was given both medications and suffered a severe loss of blood pressure and had to be hospitalized. The facility had not been closely monitoring the resident’s blood pressure. The facility was cited for failing to prevent a significant medication error. Citation # 920014659.
Marycrest Manor  
10664 Saint James Dr, Culver City  
A  $16000 Careplan Fall 02/27/2019  
On 9/7/18 a CNA placed a resident who had osteoporosis, a history of falls and a tendency to get up without assistance, alone in her room for breakfast. When the nurse came back, the resident had fallen and sustained a left hip fracture. The nurse stated that she should have taken the resident to the dining room for close monitoring during breakfast. The facility was cited for failing to provide necessary care for the resident. Citation # 910014836.

Montebello Care Center  
1035 W Beverly Blvd, Montebello  
A  $20000 Careplan Deterioration Patient Care 1/23/2019  
The facility failed to properly provide care and treatment to a resident who had a skin ulcer. After staff noticed the ulcer, located on the resident's back at the base of the spine, increasing in size and severity, they did not properly notify a physician, failed to follow treatment prescribed by a physician and failed to ensure that the resident did not put additional pressure on the wound, instead allowing the resident to sit upright in a wheelchair for 3 hours. Citation # 950014755.

Mountain View Convalescent Hospital  
13333 Fenton Ave, Sylmar  
B  $1800 Mandated Reporting Sexual Abuse 10/12/2018  
A male resident was admitted to the facility on 10/4/17 with a schizoaffective disorder and respiratory failure. On 10/6/18, he reported to a nursing assistant that a female nursing assistant raped him. The nursing assistant failed to report this to her supervisor or the Department, so the alleged abuse was not investigated promptly, and the suspected abuser was not removed from the resident's care areas. The facility was cited for failure to report. Citation # 920014493.

Palos Verdes Health Care Center  
26303 Western Ave, Lomita  
B  $2000 Mandated Reporting Mental Abuse Physical Abuse 02/15/2019  
On 11/15/18, a CNA yelled at a resident, snatched the diaper off of her and left her naked. This incident was part of a pattern of abuse that was witnessed by another CNA. The resident described the abusive CNA as “mean, evil” and stated she would tell her to urinate in her diaper so that she did not have to help her use the toilet. The facility failed to report the abuse to the Department of Public Health, did not investigate the situation and continued to assign the abusive CNA to the resident’s care after she reported the abuse. Citation # 910014824.

Stoney Point Healthcare Center  
21820 Craggy View St., Chatsworth  
AA  $100000 Neglect Patient Care Supervision 08/25/2018  
On 4/25/18, a resident who was mentally ill and had severely impaired cognitive abilities died of asphyxia after being left unattended in the facility's courtyard where he had been rummaging through the trash cans. He was found with a brown substance that looked like feces on his hands, mouth and face. The resident appeared to be eating the brown substance. A certified nursing assistant (CNA) placed him in the shower after the administrator directed him to clean the resident off. At 3:50 pm, the CNA notified the Registered Nurse Supervisor that the resident was slumped over and unresponsive but the RN supervisor did not go into the shower room to assess him. The licensed staff did not check the resident’s airway, breathing and pulse for at least eight minutes despite his expressed wish for CPR in that circumstance. The facility called 911 at 4 pm, about 10 minutes after the resident became unresponsive. Paramedics arrived at 4:15 pm and declared him dead within a minute. An autopsy report stated foreign material was found in the resident's trachea, lung airways and stomach. The facility was cited for failing to supervise the resident, failing to assess his condition, failing to initiate CPR in a timely manner and multiple other failures that were a direct, proximate cause of the resident’s death. Citation # 920014365.

Tarzana Health And Rehabilitation Center  
5650 Reseda Blvd, Tarzana  
B  $1800 Careplan Patient Care 9/24/2018  
A 59 year old male resident was admitted to the facility on 5/17/18 with chronic inflammation of the pancreas and left hip repair. He was sent to the hospital in excruciating pain on 5/25/18 after three days of ineffective pain management. The facility was cited for failure to monitor and assess pain, failure to notify the physician after the resident experienced excruciating pain and failure to revise the care plan with additional pain interventions. Citation # 920014431.

The Orchard - Post Acute Care  
12385 Washington Blvd, Whittier  
WMF  $1000 Patient Records 2/6/2019  
On 11/12/18, a physician ordered treatment for a resident with a pressure sore. On every shift, the resident was to have been cleansed with a wound cleanser, patted dry, and covered with hydrocolloid patch. On 12/17/18, during a Recertification Survey, it was determined that the resident hadn't received the prescribed care on several occasions and that the resident's record of care had been falsified. This determination was based on observations, interview and record review. The facility was cited for willful material falsification of the resident’s medical records. Citation # 940014807.
CanHR Advocate Spring 2019

Woodland Care Center
7120 Corbin Ave, Reseda
B $2000 Patient Care 12/07/2019
On 11/2/18, a CNA found a resident lying in bed, unresponsive with an abnormal breathing pattern. The resident had a fever, low blood pressure and elevated blood sugar. The resident was placed on comfort care per the Resident’s Representative’s request and expired on 11/3/18. A review of the records indicated that the facility had been failing to notify the physician when the resident’s blood sugar levels were too high, had failed to monitor the resident’s blood sugar after administration on insulin and failed to ensure that the resident received meals within 5 to 15 minutes of receiving insulin. The facility was cited for failing to follow professional standards of practice necessary to adequately manage and control the blood glucose levels of one of their residents. Citation # 920014641.

Marin County
Kindred Transitional Care & Rehab - Smith Ranch
1550 Silveira Pkwy, San Rafael
B $2000 Mandated Reporting Patient Care
Patient Rights Physical Abuse Supervision
12/11/2018
On 2/1/17 a resident reported physical abuse from a staff member to the facility administrator. The administrator did not interview other residents under the care of the staff member accused of abuse. Other licensed staff members had complained about that accused staff member of being rude and rough with residents. The facility failed to report staff to resident abuse to the Department within 24 hours, when the resident reported a staff member for rough handling. Citation # 110014363.

Smith Ranch Skilled Nursing & Rehabilitation Center
1550 Silveira Pkwy, San Rafael
A $20000 Fall 01/29/2019
On 5/18/16, a severely cognitively impaired 90 year old resident with a history of falls got out of bed to go to the bathroom and fell to the floor. Although the resident required a hands-on staff assist for ambulating, staff had observed her on several prior occasions walking to the bathroom without the assistance of staff or a walker. The resident was taken to the ER with a femoral and neck fracture. She underwent unsuccessful hip surgery, was placed on hospice and died on 5/23/16. The facility was cited for failing to provide adequate assistance and supervision for the resident. Citation # 110014366.

Merced County
Los Banos Nursing & Rehabilitation Center
931 Idaho Ave, Los Banos
A $20000 Fall Injury 12/17/2018
On 4/21/18, a 95 year old resident broke her hip when the sling from a mechanical lift ripped apart while she was being transferred from her wheelchair to her bed, dropping her on the floor from a height of two feet. The damaged sling used by the facility was at least 8-9 months beyond the manufacturer’s suggested usable lifetime. It had no system to track the age or condition of its slings. The resident was hospitalized in severe pain, sent to the operating room and underwent general anesthesia before the surgery was canceled due to complications. She remained in the hospital for seven days, where she received intensive care and was put in traction. Upon return to the nursing home, the resident was no longer able to feed herself or attend activities, as she became bed-bound and required narcotic pain relievers. Citation # 040014653.

Forest Hill Manor Health Center
551 Gibson Ave, Pacific Grove
B $2000 Verbal Abuse 1/24/2019
On 1/2/19, a resident and housekeeper had a verbal argument which resulted in the housekeeper calling the resident a profanity. The facility was cited for failing to protect a resident from verbal abuse. Citation # 070014728.

Windsor Gardens Rehabilitation Center of Salinas
637 E Romie Ln, Salinas
B $2000 Verbal Abuse 1/24/2019
On 1/2/19, a resident and housekeeper had a verbal argument which resulted in the housekeeper calling the resident a profanity. The facility was cited for failing to protect a resident from verbal abuse. Citation # 070014728.

Windsor Monterey Care Center
1575 Skyline Dr, Monterey
A $20000 Careplan Dietary Services Feeding Hydration Neglect Nutrition Patient Care 10/19/2018
The facility was cited for failing to provide care and treatment for a resident when the resident was identified as having lost weight. The Resident’s February 2018 careplan interventions of added snacks were not implemented. A clinical review of the resident’s records indicated an order for snacks to be given three times a day. The report documented the resident was not offered additional snacks 69 out of 77 days. After weight loss in June 2018, the careplan was not revised. The resident lost a total of 28.7 pounds between...
February and June. The resident did not have a hydration plan in place after weight loss and his daily fluid intake was not assessed by the nurse to ensure the resident’s hydration status met his assessed fluid requirements. These failures resulted in the resident becoming severely malnourished and dehydrated leading to death. Citation # 070014326.

**Windsor Skyline Care Center**
348 Iris Dr, Salinas

**B $2000 Careplan Evictions Notification 01/08/2019**

The facility was cited for failure to properly discharge a resident when they only gave a three day notice, instead of the 30 days as required by law. Additionally, the facility failed to provide proper 30 day notice to the resident’s son and local Ombudsman, and failed to develop a discharge plan to properly assess and prepare the resident and ensure she would receive appropriate supports once discharged. The 80 year old, partially blind resident, with dementia and a history of falls, was discharged to her home where she lived alone. Within two weeks, the woman was brought to the emergency room, after her son found her in her apartment, laying in her own feces and urine, speaking incoherently. Citation # 070014669.

**Orange County**

**Newport Subacute Healthcare Center**
2570 Newport Blvd, Costa Mesa

**B $2000 Careplan Mandated Reporting Neglect Patient Care Sexual Abuse 03/19/2019**

On 12/14/18, a LVN found a male resident in the bed of a female resident with his hands in her pants. The male resident had no cognitive impairment. The female resident did not have the capacity to make decisions, nor give consent, and was a functional quadriplegic. On other occasions, the male resident was observed to grab the female resident’s hand and place it on his crotch, make inappropriate comments and flick his tongue at her in a sexual manner. The facility was cited for failing to prevent sexual abuse against the female resident by failing to identify the resident’s behaviors as abuse, monitor him and implement interventions to keep the female resident safe. Citation # 060014887.

**Placer County**

**Pine Creek Care Center**
1139 Cirby Way, Roseville

**B $2000 Fall Injury Patient Care 10/29/2018**

A resident who had dementia, traumatic brain injury and had a history of falls was brought into the dining room on 8/2/18 and left there alone. It was known not to leave this resident unattended. This resulted in an avoidable fall with injuries including, facial bruising and abrasions, a skin tear on her right hand and a wound on her left second finger. The facility failed to supervise the resident to prevent accidents adequately. Citation # 030014529.

**Rock Creek Care Center**
260 Racetrack Street, Auburn

**B $2000 Mandated Reporting Physical Abuse Verbal Abuse 10/05/2018**

A resident told family members of her roommate that a certified nursing assistant (CNA) touched her roommate inappropriately while putting her to bed. On 1/28/17, the CNA verbally attacked the resident in her room, yelling and shouting at her for speaking up about the abuse. The family of the roommate witnessed the verbal abuse, complaining to a nurse that “he’s bullying her! She’s helpless!” The facility was cited for the verbal abuse and failing to report it in a timely manner. Citation # 030014457.

**Riverside County**

**Banning Healthcare**
3476 W Wilson St, Banning

**B $2000 Mandated Reporting Sexual Abuse 12/17/2018**

During an investigation on 10/5/18 for an abuse allegation against a licensed nurse in the facility, it was revealed that the nurse in question had previously been found guilty of abuse and was on probation for multiple allegations, including verbal and sexual abuse. The facility failed to protect its residents from abuse when they knowingly employed him on 5/7/15 without implementing their policies for screening new employees. Citation # 030014816.

**Riverside County**

**Banning Healthcare**
3476 W Wilson St, Banning

**B $2000 Mandated Reporting Sexual Abuse 12/17/2018**

On 5/27/18 a resident’s daughter told an LVN that her mother stated that she had been raped. The report of the incident was not faxed to the California Department of Public Health until 5/29/18. The facility failed to report to the Department within 24 hours, putting the resident at risk for harm from physical abuse. Citation # 250014521.
California Nursing & Rehabilitation Center
2299 N Indian Canyon Dr, Palm Springs
B $200 Notification Transfer 01/23/2019
A resident was sent to the hospital for an altered level of consciousness and low blood pressure on 10/29/18. The long term care Ombudsman was not notified of the resident’s transfer as required by law. Facility staff stated they were unaware of the notice requirement, which is meant to help ensure a safe and effective transfer. The facility failed to provide required notice to the Ombudsman. Citation # 250014686.

Centinela Grand, Inc.
2225 N Perris Blvd, Perris
B $2000 Physical Abuse 1/31/2019
On 11/13/18, while staff was changing a resident, another resident who was diagnosed with schizoaffective disorder and a history of physical aggression pushed the resident then forcibly ejected the CNA from the room. The police were called, and the resident was transferred to the hospital for evaluation and treatment. The facility was cited for failing to report an instance of abuse to the Department of Public Health. Citation # 250014699.

Community Care And Rehabilitation Center
4070 Jurupa Ave, Riverside
B $200 Evictions 11/20/2018
A resident was admitted to the facility on 8/16/18 with bleeding in the brain, muscle weakness, and confusion. On 8/23/18, the resident was transferred to the hospital. The facility was cited for failure to notify the long term care ombudsman of the resident’s transfer to the hospital. Citation # 250014565.

Corona Post Acute Center
2600 S Main St, Corona
B $200 Notification Transfer 01/23/2019
On 3/6/18, a nursing home resident was transferred to a hospital for evaluation due to a fracture. There was no documented evidence that the ombudsman was notified of the resident’s transfer to the hospital. The facility was cited for failing to ensure that a copy of the notice of transfer was provided to the ombudsman. Citation # 250014613.

Corona Post Acute Center
2600 S Main St, Corona
B $2000 Fall Patient Care Supervision 01/25/2019
For a four-month period beginning on 3/2/18, a 67 year old nursing home resident with epilepsy and an unspecified developmental disability, had ten fall episodes resulting in injury and hospitalizations. The MDS Coordinator stated he “is not able to cognitively retain education on safety, and call light usage…” the “interventions should have been individualized and appropriate” for the patient’s cognitive status, and he “should have been provided more supervision.” The facility was cited for failing to ensure that the resident received adequate supervision to prevent fall accidents, and failing to implement policies and procedures to manage falls and fall risk. Citation # 250014708.

Extended Care Hospital of Riverside
8171 Magnolia Ave, Riverside
B $2000 Dignity 12/13/2018
After the complainant told the facility staff that the resident had not been bathed and that her hair looked greasy, the resident, who usually wore her hair in a braid, had her braid cut off with “jagged edges,” without authorization or notification. There was no documentation of this incident at the facility and the facility was unable to determine who had cut the resident’s hair. The facility failed to ensure self-determination and the respect of dignity for the resident. Citation # 250014599.

Hemet Valley Healthcare Center
371 N. Weston Place, HEMET
B $200 Evictions Transfer 11/19/2018
A resident was transferred to another nursing home on 7/23/18, four days after her admission. The facility failed to send a copy of the resident’s discharge notice to the long term care Ombudsman as required by law to help ensure a safe transfer. The facility case manager said the oversight happened because she was gone the day of the transfer. Citation # 250014519.

Hemet Valley Healthcare Center
371 N. Weston Place, HEMET
B $500 Mandated Reporting Mental Abuse Retaliation Against Resident 11/20/2018
The facility failed to report an incident of alleged abuse to authorities within the 24-hour period required by law, after it was reported that a staff member had attitude with a resident and took the resident’s call light away. Citation # 250014566.
Life Care Center of Menifee
27600 Encanto Dr, Sun City
A $15000 Fall Injury Supervision 1/23/2019
On 9/23/18, a recently admitted resident suffered a fall and serious injuries when she was left unattended on the toilet by a certified nursing assistant (CNA). Due to left-sided body paralysis, the resident was not stable to sit by herself and needed maximum staff assistance with toileting. The therapists did not complete an evaluation, training or safety clearance with toileting. At the time of the fall, she fell face down on the floor, striking her head. She was hospitalized in critical condition with a serious brain bleed and required intensive care treatment for injuries including contusion, abrasion, headache, vomiting, and worsening of intracranial hemorrhage. Citation # 250014710.

Magnolia Rehabilitation & Nursing Center
8133 Magnolia Ave, Riverside
B $2000 Mandated Reporting Physical Abuse 02/20/2019
On the “Nursing Care Notes,” dated 7/2/18, it stated that a resident complained to Social Services that a CNA had hit her in the face and that her entire face was covered in bruises. The facility was cited for failing to report the issue to the California Department of Public Health. Citation # 250014709.

Manorcare Health Services-Hemet
1717 W Stetson Ave, Hemet
B $2000 Mandated Reporting Verbal Abuse 12/20/2018
On 5/16/18, a nursing home resident’s daughter called the facility and reported to the Unit Manager that a licensed vocational nurse verbally abused her mother on a daily basis. The facility was cited because it did not report the abuse within 24 hours to the Department, failed to thoroughly investigate the allegation of abuse and prevent further potential abuse, and allowed the nurse to continue to have access to the resident and be her nurse. 250014615.

Manorcare Health Services-Palm Desert
74350 Country Club Dr, Palm Desert
B $200 Evictions 12/06/2018
A resident was discharged to a board and care home on 9/24/18. The local Ombudsman office was not given a copy of the resident’s discharge notice as required by law. Citation # 250014587.

Miravilla Care Center
9246 Avenida Miravilla, Cherry Valley
B $2000 Mandated Reporting Patient Care Patient Rights Physical Abuse 12/26/2018
On 7/7/18 there was an altercation between two residents, where one resident hit another resident with the front wheel of her walker. A staff member intervened before the resident was hit again. The resident was assessed and the two were separated. The incident was not reported to the administrator and subsequently, it was not reported to the California Department of Public Health. As a result of this the resident remained “fearful” of the other resident. Citation # 250014630.

Riverside Postacute Care
8781 Lakeview Ave, Riverside
B $2000 Fall Injury Mandated Reporting 9/17/2018
On 6/30/18 a blind resident was struck by a moving car in the facility parking lot while in his wheelchair. The resident sustained injuries to his right arm. The Assistant Director of Nursing stated she was unsure why the incident was not reported. “I don’t know. I guess because there were no major injuries.” No police or EMS were called. Only the attending physician was called because there were no major injuries. The facility failed to report this incident to the department within 24 hours. Citation # 250014377.

The Grove Care and Wellness
3401 Lemon St, Riverside
B $200 Notification Patient Rights Transfer 2/6/2019
The facility failed to ensure written notice of transfer was provided to a resident, the resident’s representative, and the local ombudsman when the resident was transferred to a local hospital for care. This resulted in the resident being discharged without an understanding of the appeal process and appeal rights. Citation # 250014757.

B $200 Notification Patient Rights Transfer 2/6/2019
After a resident was transferred to a local hospital for a blood transfusion, the facility failed to properly provide the resident, the resident’s representative or the local ombudsman with written notice of the transfer. This resulted in the resident being discharged without an understanding of the appeal process and appeal rights. Citation # 250014758.
The Village Healthcare Center
2400 W Acacia Ave, Hemet

B $1000 Notification Transfer 10/31/2018
On 5/24/18, a resident with pneumonia and congestive heart failure was transferred to the hospital for further evaluation due to dizziness. There was no documented evidence that a written notice of transfer was provided to the resident, his representative or ombudsman when the resident was transferred, or after the transfer. The facility was cited for failing to ensure that a written notice was provided to the resident or his representative, and the ombudsman. Citation # 250014379.

B $2000 Mandated Reporting Patient Care
12/05/2018
The facility failed to notify a resident’s physician in a timely manner of abnormal laboratory test results of increasing blood urea nitrogen and elevated levels of creatinine, indicators of kidney failure. As a result, the resident did not receive appropriate medical treatment, experienced a change in mental status, becoming disoriented, and falling down. Eventually the resident was transferred to an emergency room for treatment.  250014586.

Sacramento County

Double Tree Post-Acute Care Center
7400 24th Street, Sacramento

B $2000 Evictions Transfer 01/03/2019
A male resident with quadriplegia was hospitalized for a procedure on 9/25/18. When he was cleared to return on 10/2/18, the facility refused to readmit him, claiming it only had beds for “short-term” residents. The facility admissions coordinator stated, “she does not like to mix short-term patients with long-term patients” stating it “would impact their quality of life.” The resident did not return to the facility until 10/18/18 after the hospital paid the facility to accept him back. The facility was cited for failing to readmit the resident to the first available bed. Citation # 030014689.

WINDSOR EL CAMINO CARE CENTER
2540 Carmichael Way, Carmichael

B $2000 Injury Mandated Reporting 02/20/2019
On 10/3/18, a nursing note indicated that a resident had: “bruising/swelling on right side of back of head; [d]ried blood observed at side; injury of unknown cause.” The Director of Nursing stated: “We don’t know the cause of it; I don’t know what happened; We didn’t report it.” The facility was cited for failing to report the resident’s injury to the Department within 24 hours. Citation # 030014818.

San Diego County

Reo Vista Healthcare Center
6061 Banbury St, San Diego

B $2000 Careplan Neglect Patient Records
02/21/2019
On 10/14/15, a resident at the facility went missing for 17 hours, and when he was found the next day, he was lying face-down, unresponsive in a visitor’s bathroom. His cause of death was determined to be methamphetamine and opiate intoxication. When he was found to be missing, staff failed to properly search the facility for the missing resident or to notify any of the necessary authorities of his absence. Prior to this incident, he had been seen moving in and out of the facility without documentation, and two nurses, when interviewed, stated that he was “groggy” and “drunk” upon returning. There was no change to his careplan, and no documentation to show that nurses had discussed the dangers of his behavior with him. Citation # 090013462.

San Joaquin County

Dycora Transitional Health - Quail Lake
1221 Rosemarie Lane, Stockton

B $1000 Notification Transfer 11/16/2018
During a recertification visit on 10/2/18, it was found the facility was not notifying the local long term care Ombudsman program when residents were transferred to the hospital in 2018. The facility was cited for failing to comply with the law requiring notices be sent. Citation # 030014575.

New Hope Post Acute Care
2586 Buthmann Avenue, Tracy

B $1000 Notification Transfer 02/22/2019
During a facility recertification survey on 1/22/19, it was discovered the facility was not notifying the local long term care Ombudsman program when residents were transferred to the hospital. The facility was cited for failing to comply with the law and its own policy requiring notices be sent. Citation # 030014813.

Wagner Heights Nursing And Rehabilitation Center
9289 Branstetter Place, Stockton

B $2000 Mandated Reporting Physical Abuse Supervision Transfer 11/06/2018
A male resident with schizophrenia and bipolar disorder grabbed the wheelchair of another resident and began shaking it on 9/3/17. In response, the facility sent the resident to the hospital on a 5150 (involuntary psychiatric hold). The facility was cited for failure to report an allegation of abuse to the Department within 24 hours. Citation # 030013597.
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Windsor Hampton Care Center
442 E Hampton Street, Stockton
AA $100000 Medication Neglect 09/07/2018
On 1/1/18, a resident died from acute morphine toxicity about 70 hours after admission because the facility gave her the wrong medications. The facility did not administer any of the medications ordered for the resident. Instead, it administered ten medications prescribed for another resident, including several drugs (morphine, temazepam, baclofen, gabapentin, lorazepam, and quetiapine fumarate) that depressed the central nervous system. At admission, the resident was alert and oriented, able to eat independently and walk to the bathroom. She had not been taking morphine or other narcotic medications. Within 55.5 hours after admission, she was confused, within 65.5 hours she was unable to open her mouth or swallow. The facility did not conduct assessments of her deteriorating condition and did not detect the fatal medication errors until the morning of her death. The deputy coroner stated that the resident’s morphine level was 0.27 mg/liter, far beyond a lethal level. The facility was cited because its medication errors were a direct proximate cause of the resident’s death. Citation # 070014848.

Idylwood Care Center
1002 W Fremont Ave, Sunnyvale
B $2000 Evictions 03/05/2019
A female resident with a long history of inability to meet her needs, cognitive impairments and physical ailments was sent home in December 2018 without 24-hour care as recommended by a physical therapist and occupational therapist. The resident had only 13 hours a week of in-home care and some adult day care services. The facility was cited for failing to ensure adequate preparation and assistance was available to the resident after her discharge. Citation # 070014848.

Santa Clara County

Cupertino Healthcare & Wellness Center
22590 Voss Ave, Cupertino
B $2000 Patient Care Patient Rights Sexual Abuse 2/28/2019
The facility failed to protect three residents from unwanted touching from another resident. On 7/3/17 a male resident was accused of touching the breasts of a female resident. He denied the allegation and was advised to stay away from the resident. Another resident reported that on 12/17/18 the same male resident had grabbed her breast and put his hand down her pants. During the investigation in December, it was discovered that he had previously attempted the same behavior with two other residents as well. One incident dated back to February of 2018 and was in the resident’s notes in early December of 2018. Another incident was in November of 2018 where the resident was addressed for injuries, spoke to the police and the male resident was told to “stop.” The facility failed to protect its residents which caused the residents emotional trauma. Citation # 030014385.

Los Altos Sub-Acute And Rehabilitation Center
809 Fremont Ave, Los Altos
B $2000 Careplan Fall 2/13/2019
Facility staff failed to properly follow a resident’s careplan which outlined the need for two staff to physically assist the resident when moving in or out of bed. When one staff member attempted to move the resident without help from a second staff, the resident fell out of bed, suffering a fractured arm. Citation # 070014773.

Mt. Pleasant Nursing Center
1355 Clayton Rd, San Jose
B $2000 Neglect Patient Care 01/18/2019
On 1/2/19, an inspector met with a resident with long, thick, curly, overgrown toenails with calluses on both feet. The resident reported it was very painful to walk or wear shoes due to the condition of his feet. He had asked for podiatry treatment months earlier but the facility did not respond and the visiting podiatrist was not asked to treat him. The facility was cited for failing to provide podiatry services to the resident. Citation # 070014747.

Celebrating 35 Years of Advocacy
Pacific Hills Manor  
370 Noble Ct, Morgan Hill  
B $2000 Infection Neglect Patient Care  
1/24/2019

On 10/30/18, a 73 year old resident was hospitalized for treatment of severe sepsis with acute kidney dysfunction due to a urinary tract infection. The resident had been admitted to Pacific Hills Manor eight days earlier with physician orders to remove an indwelling catheter in two to three days and other instructions related to the catheter. The facility did not carry out the physician’s orders or initiate a careplan for catheter care for the resident. It was cited for these failures, which led to the resident’s emergency hospitalization. Citation # 070014727.

Plum Tree Care Center  
2580 Samaritan Dr, San Jose  
AA $100000 Careplan Medication Neglect Notification Patient Care 12/07/2018

On 7/11/18, an 81 year old woman was admitted to the facility for physical and occupational therapy following back surgery. The resident had rheumatoid arthritis and was on methotrexate, a high risk medication. The resident was taking methotrexate four times a week prior to her admission, but the facility gave her methotrexate every day. On 8/10/18, the resident had three loose bowel movements, and her physician ordered stat lab tests. The lab results reflected a need for prompt medical attention, but the facility failed to follow up on the results and advise the physician of the out of range findings. On 8/20/18, the resident complained of diarrhea and abdominal cramping, and her responsible party requested that she be sent to the hospital for evaluation. She was transferred to the hospital on 8/20/18, and died four days later on 8/24/18. The facility was cited for failure to assess the resident’s elopement risk. Citation # 070014748.

Stonebrook Health And Rehabilitation  
350 De Soto Dr, Los Gatos  
B $2000 Careplan Fall Patient Care 11/30/2018

The facility failed to appropriately prevent falls for two residents by not following their care plans which stated that their beds should be kept in a low position to prevent falls and injury. Both residents fell, one resident suffered a fractured femur, the other suffered a fractured vertebrae. Citation # 070014567.

Saratoga Retirement Community Health Center  
14500 Fruitvale Ave, Saratoga  
AA $100000 Medication Neglect 11/28/2018

On 9/14/18, a resident died as a result of a stroke after the facility failed to administer a vital blood thinning medication for weeks prior to her death. A registered nurse (RN) mistakenly discontinued the blood thinner, Eliquis, indefinitely on 7/25/18, prior to a dental procedure, instead of putting it on hold for a day as per the attending physician’s written order. The facility’s consultant pharmacist failed to identify the discrepancy between the attending physician’s visit notes stating the resident was still on Eliquis, and the electronic record stating it was on indefinite hold. This failure resulted in the resident continuing to miss her daily dose of Eliquis until 8/30/18, when she was hospitalized due to the stroke. It was a direct proximate cause of her death. Citation # 070014543.
Sonoma County

The Oaks Post Acute
450 Hayes Ln, Petaluma

B $2000 Careplan Elopement Patient Care
Physical Environment Security Supervision
11/20/2018

On 7/1/18 a resident with Alzheimer’s and known to wander was able to leave the facility during a power outage. The facility’s door alarm was battery operated during the power outage but did not alert any staff members when the resident opened the door to leave. The facility failed to keep the resident safe when the resident eloped alone without permission and was discovered by a Good Samaritan. Citation # 110014288.

Tulare County

Kaweah Manor Convalescent Hospital
3710 W Tulare Ave, Visalia

A $20000 Careplan Fall Injury Patient Care Supervision Staffing 02/08/2019

A Spanish-speaking 74 year old female resident was admitted to the facility on 9/13/17 with a fractured femur. She was assessed as a high risk for falls, and her care plan indicated she should not be left unattended in the bathroom. On 11/14/18, she was left unattended in the bathroom and fell, sustaining multiple fractures to the face and spine. The nursing assistant assigned to help the resident in the bathroom stated he was the only nursing assistant on the floor at the time, and he left to answer multiple residents’ call lights while he was waiting for her to finish in the bathroom. The facility was cited for failure to ensure that each resident receives adequate supervision. Citation # 120014723.

Providence Sun Villa
350 N Villa St, Porterville

B $2000 Mandated Reporting Notification Theft & Loss 02/22/2019

On 9/27/18 a resident had given his card to a CNA to buy something. On 10/4/18 the resident noticed that his card was missing. The CNA had quit on 10/3/18 and there was $259.15 charged to the account while in the CNA’s possession from 10/3/18 - 10/4/18. The facility failed to report this financial abuse to the State Survey Agency, which had the potential to result in financial abuse of other residents not being reported. Citation # 120014774.

Redwood Springs Healthcare Center
1925 E Houston Ave, Visalia

A $20000 Neglect Supervision 01/18/2019

A 77 year old male resident received second degree burns on his face after smoking with his oxygen tank on while unsupervised. The resident was known for smoking while leaving his oxygen tank on. On 11/19/18, the resident was smoking and other residents heard a pop and “his whole face caught on fire.” The resident put out the fire with his hands but suffered burns to his nose, lip, and cheek. The facility was cited for failing to provide adequate supervision and preventing accidents to residents. Citation # 120014706.

Ventura County

Ojai Health & Rehabilitation
601 N Montgomery St, Ojai

B $1805 Physical Abuse 02/12/2019

On 12/8/18, a 59 year old resident was thrown onto his bed and punched in the eye by a CNA after he complained about not being allowed to smoke a cigarette. On 12/19, the Department received a complaint about the incident and conducted an investigation. During interviews by Department, the facility administrator said he had received a report from a Licensed Nurse about a resident being struck on the right side of his face by a staff member, and the resident said to the interviewer that his eye was black and blue after the punch. The facility was cited for failing to report the incident to the Department within 24 hours. Citation # 050014756.

Thousand Oaks HealthCare Center
93 W Avenida De Los Arboles, Thousand Oaks

A $17100 Decubiti (Bedsores) Neglect 12/13/2018

A 73 year old male resident’s foot was riddled with sores, soaked with urine and infested with maggots due to the facility’s neglect. Wound clinic notes showed the resident was treated for maggots in a foot wound on 8/9/18. On 9/11/18, the resident was again found with maggots in the wound. Medical records did not reflect that required wound care treatments at the facility were completed. On 9/18/18, the resident smelled strongly of urine and was observed with brown seepage coming from his sock. When the sock was removed, maggots fell out of it. The facility was cited for neglecting the resident. Citation # 050014570.

Windsor Terrace Of Westlake Village
250 Fairview Rd, Thousand Oaks

B $1710 Mandated Reporting Physical Abuse 1/15/2019

On 12/2/18, a 73 year old resident was allegedly attacked/assaulted by another resident and sustained cuts and bruises. On 12/5/18, the Administrator and Director of Nursing confirmed that they had not been informed of the abuse, and they had not reported it to the Department. The facility was cited for failing to report an allegation of abuse to the Department within 24 hours. Citation # 050014701.
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