CANHR Celebrates 35 years of Advocacy!

On Saturday, May 4, CANHR’s staff and supporters celebrated CANHR’s 35th Anniversary with a celebratory dinner and live auction Gala held at San Francisco State University’s Towers Conference Center. Over 200 CANHR donors and supporters turned out to celebrate CANHR’s 35 years of advocacy.

Originally founded in 1983 as Bay Area Advocates for Nursing Home Reform, with the goal of improving the quality of care and quality of life for California’s long term care consumers, we quickly realized that long term care is not just about nursing homes, and that the problems faced by consumers went far beyond the Bay Area. In 1990, “BANHR” became “CANHR”, (i.e., California Advocates), and we expanded our services to all of California through our web site, our 800# hotline and our outreach. We also greatly extended our work to focus on legal services support and advocacy around residential care, continuing care, long term care funding, elder abuse and, most importantly, alternatives to institutionalized care.

It has been a remarkable 35 years with CANHR, and we can look back on many accomplishments in the policy, legislative and litigation arenas. Most importantly, we can be proud of the thousands of consumers we have been able to help on a day to day basis – whether helping consumers to steer through the Medi-Cal maze; or assisting with Medi-Cal recovery claims, resident rights, transfer appeals or other concerns. It is the consumers who have informed our work, and it is those consumers whom we were unable to help who keep us working for better care, stronger laws and better enforcement.

CANHR is grateful to the many people who have supported our work over the years by volunteering their time, their financial contributions, and their advocacy. We also thank the many GALA sponsors for making our first major event a success. We know that as long as long term care consumers continue to suffer neglect and abuse, as long as there continue to be barriers to affordable and accessible alternatives to institutionalization and as long as our elders continue to be denied the services they so desperately need, we will continue our advocacy.

35 Years of Advocacy .................. (continued on page 3)
**CANHR News**

**CANHR’s 35th Anniversary a Great Success**

CANHR’s 35th Anniversary Fundraising Gala on Saturday, May 4th, 2019 far exceeded our expectations. Held at San Francisco State University’s Towers Conference Center, over 200 supporters and sponsors attended the event (see front page and accompanying photos). Former Senator Mark Leno, who authored a number of CANHR bills and has been an ardent advocate for the aged and disabled, was the keynote speaker and gave an impassioned speech about organizing for positive change. Festivities included a cocktail reception, a silent and live auction, and dinner. We thank our many sponsors and supporters who made this event a success.

**Another CANHR Baby**

Congratulations to two former CANHR employees, Yvonne Hernandez, LTC Advocate and Marcus Nelson, AA/receptionist, who recently welcomed their first child, a baby girl in Henderson, Nevada.

**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.

**Donate to CANHR When You Shop on Amazon**

It’s not just for the holidays! Any time of the year Amazon will donate 0.5% of the price of your eligible Amazon purchases to California Advocates For Nursing Home Reform whenever you shop on AmazonSmile. AmazonSmile is the same Amazon you know - same products, prices, and service. Support CANHR by shopping at smile.amazon.com. On your first visit to AmazonSmile you will need to select, “California Advocates for Nursing Home Reform” as the charitable organization to receive donations from eligible purchases before you begin shopping. Amazon will remember your selection, and then every eligible purchase you make at smile.amazon.com will result in a donation.

**If You Want to Receive Alerts and the Advocate by email**

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 frontdesk@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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CANHR’s 35th Anniversary Gala
May 4th, 2019

▲ Charlie Ridgell and Pat McGinnis toast the Gala!
▲ (Left to right) Wendy York, Anoush Lancaster, Ardavan Aisley, and Kim Valentine enjoy the opening cocktail hour.
▲ Wendy York and Anoush Lancaster pose for the photobooth.
▲ The CANHR staff celebrate.
▲ The Lomhoffs enjoy the party.

Thank you to all who attended our 35th anniversary celebration. It was a fantastic event and we truly appreciate your support.
Focus On: Advanced Health Care Directives

What are Advance Health Care Directives?
Advance Health Care Directives (AHCDs) are meant to give adults control over their health care if there ever comes a time when they can no longer make reasoned decisions. AHCDs provide this control in two ways. One, they allow the principal (the person who signs and executes the AHCD) to name an agent to make health care decisions on their behalf if the principal becomes unable to make decisions. Two, the principal is encouraged to make some decisions in advance, such as end-of-life care decisions, and express their values and preferences to guide their agent and care providers.

CANHR’s website includes an AHCD and a set of detailed instructions for filling it out. [http://canhr.org/publications/ahcd.html](http://canhr.org/publications/ahcd.html)

Why Should I Make an AHCD?
Without an AHCD, you have a high risk that “bad” health care decisions will be made for you. Your wishes about health care will not be known and decisionmakers will not benefit from your guidance. Studies show that substitute health care decisionmakers are not very good at guessing what a patient would want unless they are told specifically in an AHCD. The question of who should make health care decisions for an incapacitated patient is also unanswered without an AHCD. While family members often fill this vacuum, California law does not officially recognize spouses or family members as decisionmakers and uncertainty can lead to disagreement and fights among families. A good AHCD makes health care decisions much easier.

What Should I Say in My AHCD?
Whatever you want! If there is anything your future health care agent and providers should know, you should include it. Generally, principals express their wishes regarding end-of-life care (Would you want to be on a ventilator to keep you alive? A feeding tube?), pain medications, and disposition of their remains. There should be a section on donating body parts and tissues. Last year, CANHR sponsored AB 3211 (Kalra) that enhanced the organ donation language in California’s statutory AHCD to better ensure organ donors are able to have their wishes fulfilled. Most importantly, though, the principal should explain any particular wishes they have about any type of health care as well as the things they consider important to quality of life.

What About POLSTs?
POLSTs are Physician Orders for Life Sustaining Treatment. They are supposed to be printed on bright pink paper and are often offered by nursing homes and assisted living facilities for their residents to complete. POLSTs serve some of the purposes of an AHCD by stating wishes in advance regarding end-of-life care. However, they are very detailed and meant ONLY for people who are terminally ill or have a chronic condition that is likely to end their life. They do not include a designation of agent and they do not capture the broad values and preferences that help guide most health care decisions. CANHR recommends that all adults have AHCDs and that POLSTs only be completed by people who are terminally ill.

Planning for incapacity is important and not that hard. AHCDs are critical documents to have in your incapacity plan. Please contact CANHR if you have any questions about incapacity planning or AHCDs.

Available for Free Download:

If You Think You Need A Nursing Home...

Medi-Cal Recovery:
What you Need to Know and How to Avoid It

Go to [www.canhr.org/medcal](http://www.canhr.org/medcal). Also available in Spanish and Chinese.
Labor Exploiters Operating RCFEs in California

A new exposé from Reveal focuses on illegal labor practices in California assisted living facilities, also known as RCFEs (Residential Care Facilities for the Elderly). The article reveals a shocking number of illegal labor cases where caregivers are exploited to supply facility operators with luxury goods and other wealth. The caregivers, often new immigrants with few resources, feel compelled to accept adverse working conditions and wages that are only one half to one quarter of the minimum wage.

While the labor practices of the facility operators are abhorrent, they are enabled by a widely tolerant state oversight system. Underpaying workers does not mean operators will lose their license as it appears labor enforcement actions are not triggering action from the Department of Social Services, which licenses the care homes. As described in the articles, labor law violators simply set up Limited Liability Companies (LLCs) or declare bankruptcy to shield themselves from the consequences of their bad conduct and perhaps even expand their operations. By putting an RCFE in the name of an LLC, the individual owner’s history can be hidden in their application for a license.

CANHR is currently sponsoring AB 737 (Eggman) which would empower the Department of Social Services to connect LLCs or other companies back to their individual owners to stop bad actors from controlling RCFEs, exploiting workers, and harming residents. The bill passed the Senate Committee on Human Services on June 10 and has been ordered to it’s third reading.

CLICK HERE to watch the PBS NewsHour video “Why Some Residential Caregivers Call Their Jobs ‘Indentured Servitude.’”

Court Puts Dycora Nursing Homes in Receivership

On April 18, 2019, the San Joaquin County Superior Court placed three nursing homes operated by Dycora Transitional Health & Living into receivership: Dycora Transitional Health & Living – Community Care – Fresno, Dycora Transitional Health & Living – Stockton, and Dycora Transitional Health & Living – Shafter. Golden Living, a nursing home chain that owns the buildings, sought the receivership order based on representations that the facility operators were insolvent. Dycora leased the facilities from Golden Living in 2017.

Anyone considering a nursing home operated by Dycora should take its financial instability into account. According to the Department of Public Health, Dycora also operates the following skilled nursing facilities in California: Dycora Transitional Health – Clovis, Dycora Transitional Health – Fowler, Dycora Transitional Health – Manchester, Dycora Transitional Health – Memory Care of Fresno, Dycora Transitional Health – Quail Lake, Dycora Transitional Health – San Jose, Dycora Transitional Health -Sanger, Golden Living Center – Galt, Golden Living Center – Portside, Golden Living Center – Reedley, Golden Living Center – Fresno, Merritt Manor Convalescent Hospital in Tulare, Porterville Convalescent Hospital, Twin Oaks Rehabilitation & Nursing Center in Tulare, and Kaweah Manor Convalescent Hospital in Visalia. Dycora is also operating the Twin Oaks Assisted Living Center in Tulare.

It appears the Department of Public Health allowed Dycora to take over operations of these facilities without ensuring that it has the money and capital to do so.

Dycora also operates nursing homes in Wisconsin. All eight of its facilities there were also put into court-ordered receiverships earlier in April 2019 due to its inability to pay its bills.

As Golden Living transitioned from a nursing home operator to a landlord in recent years, many residents of facilities it previously operated have suffered due to the financial collapses of the new operators. Several states have had to take over or close its former facilities in dire circumstances, including Pennsylvania, Kansas, Nebraska, South Dakota and other states.

DPH Takes Down HFCIS Website

In April 2019, the Department of Public Health (DPH) took down its Health Facilities Consumer Information System (HFCIS) website, which gave the public some information on the performance of licensed health facilities, including nursing homes. It has replaced it with Cal Health Find, which it launched in early 2018 and has been evolving since then.

DPH also launched a new State Enforcement Actions Dashboard that gives information on nursing home citation trends and includes links to each citation that has been issued since 2015. The site shows a large increase in the number of citations being issued to skilled nursing facilities, which grew from 335 in 2015 to 625 citations in 2018, another sign that it is a dangerous time to live in a California nursing home.
Did You Know?

Receiving an inheritance when on Medi-Cal

If you are on Medi-Cal and you receive an inheritance, it may jeopardize your benefits.

Medi-Cal recipients must report receipt of any income or assets that would affect the share of cost or eligibility to the county eligibility worker within 10 days. However, if an inheritance which is in the form of cash is received in a given month, it is considered income in the month of receipt, so it can be spent down for any purpose. To ensure one’s Medi-Cal is not discontinued in the following month due to being over the asset limit, one should spend down the inheritance received within the month. Because the cash inheritance is considered income in the month of receipt, the resident can gift the funds in the month of receipt, or spend it on anything they prefer. At the end of the month, the recipient can send proof that the funds have been spent/ transferred. Below are some options for spending down:

If you are in a nursing home:
- New clothes and shoes — but mark to prevent theft or loss
- New television, radio, telephone or an electronic reading device
- Prepay cable, telephone and internet
- New hearing aid, dental needs or eyeglasses
- Gift Cards of any amount (do not count as assets for Medi-Cal purposes)
- Prepay funeral and burial costs.

If the recipient receives a significant inheritance:
One may consider a Special Needs Trust. A Special Needs Trust (SNT) or a Pooled Trust (for persons over 65) is a way to reserve money for the person’s needs that Medi-Cal or SSI won’t pay for and it will not affect public benefits.

Call CANHR’s office at (800) 474-1116 for a lawyer referral to an estate planning attorney, or if you have any questions.

Dear Concerned Daughter in California City,

We are looking for a nursing home that will accommodate my mother’s vegan diet. Are nursing homes required to provide vegan meal options?

Concerned Daughter

Dear Concerned,

Yes. Effective January 1, 2019, a new California law, SB 1138, requires nursing homes to make available wholesome, plant-based meals of such variety as to meet the needs of residents in accordance with their physicians’ orders. Health and Safety Code §1265.10. Plant-based meals means entire meals that contain no animal products or byproducts, including meat, poultry, fish, dairy or eggs. The law was authored by Senator Nancy Skinner of Berkeley.

Many Californians choose non-meat or vegan diets for health, environmental and other reasons. They have the right to keep making these choices while living in a nursing home. Other laws are also supportive of this right. Nursing homes must provide nourishing meals that consider the preferences of each resident and reflect their religious, cultural and ethnic needs. 42 CFR §483.60.
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:** Passed Assembly Human Services Committee.

**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:** Passed the Senate and sent to the Governor.

**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:** Senate Health Committee Hearing on 6/26/19.

**AB 506 (Kalra) – Long Term Health Facilities**

This bill enhances the state nursing home enforcement system by: 1) increasing the penalties for state citations issued against nursing homes to keep up with inflation and 2) 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 used by courts.

**Status:** Referred to Senate Health Committee.

**AB 715 (Arambula) – Medi-Cal: End the Senior Penalty**

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:** Referred to Senate Health Committee.

**AB 1042 (Wood) – Home Upkeep Allowance**

Maintaining a residence outside of a nursing home is a major obstacle for Medi-Cal beneficiaries 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. This bill would base the Home Upkeep Allowance on the actual cost of maintaining a home, up to 100% of the FPL.

**Status:** Referred to Senate Health Committee.

**AB 1088 (Wood) – Medi-Cal Eligibility**

This bill would stop seniors and persons with disabilities from yo-yoing between free and Share of Cost Medi-Cal.

**Status:** Referred to Senate Health Committee.

**AB 1695 (Carrillo) – Skilled Nursing Facilities**

This SEIU-sponsored bill would require individuals and entities seeking to acquire or manage a skilled nursing facility (SNF) to obtain prior approval from the Department of Public Health. It would also require SNFs to give residents and their representatives written notice at least 90 days in advance before the sale or transfer of operations of a facility.

**Status:** Referred to Senate Health Committee.

**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:** Referred to Assembly Health Committee.

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**Status:** Passed the Senate and sent to the Governor.

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**Status:** Referred to Senate Health Committee.
New Rules for VA Aid and Attendance

If you are a senior veteran who served in the military during a time of war, you may be eligible for a unique benefit to assist you with home care and other community based services. The VA Aid and Attendance pension can be a lifeline for low-wealth veterans and their spouses who cannot afford to pay for medical supplies, assisted living, or in-home care workers. Veterans interested in receiving more information about this benefit are encouraged to contact their County Veteran Services Office:

www.calvet.ca.gov/VetServices/Pages/CVSO-Locations.aspx.

Senior veterans interested in this benefit also need to be on guard against individuals who pretend to be “volunteers,” seeking to help veterans qualify for Aid and Attendance benefits. Many of these so-called volunteers turn out to be hucksters looking to make money by selling services that are free at County Veterans Services Offices; others are looking for opportunities to sell unsuitable trusts or annuities.

New Rules

At the end of last year, the Department of Veterans Affairs (VA) published its final rules on how to qualify for these benefits. They made significant changes in how to evaluate trusts and annuities, and established draconian periods of ineligibility for veterans who apply with too many assets. The VA made these changes because they believed that too many potential beneficiaries were artificially becoming “impoverished” in order to qualify. While the new rules do little to deter or punish such predators, the rule change was expected to put an end to predators’ practice of getting high wealth seniors to move their assets into trusts and annuities in an attempt to appear “impoverished.” Now, if veterans place excess assets into a trust or annuity, they may find themselves ineligible for benefits for up to five years.

In California, it is illegal for an insurance agent to sell an annuity to qualify a senior for VA Aid and Attendance. If a veteran has purchased an annuity and has been disqualified from receiving benefits, he or she should contact CANHR for a referral to a civil litigator and also file a complaint with the Department of Insurance.

The Final Rule Effective October 18, 2018

Trust and Annuities - 38 CFR § 3.276(a)(5) & (6)

Purchase of an annuity or transfers to a trust after 10/18/18 will be penalized unless veteran retains control and the ability to liquidate; BUT then counted as an asset and counted as part of the net worth.

Assets - 38 CFR § 3.275

Defined as fair market value of all real and personal property owned by the claimant and any dependents, less mortgages and other encumbrances.

Home, plus “residential lot area” that does not exceed two acres excluded, unless the additional acreage is not marketable.

Veteran does not have to live in the home for it to be excluded.

Personal effects – “suitable to and consistent with a reasonable mode of life, such as appliances and family transportation vehicles” – excluded.

Net Worth - 38 CFR § 3.274

Net worth limit is equal to the Community Spouse Resource Allowance (CSRA) under Medicaid (currently $126,420).

Increases annually per Social Security COLA.

Includes total of applicant’s or beneficiary’s annual income and assets.

Includes assets of the spouse.

Net worth calculated as of the date of the original claim; after a period of non-entitlement, or when VA receives information that net worth has changed.

Transfers of Assets - 38 CFR § 3.276

36-month lookback period triggered when there is a new claim or claim following a period of non-entitlement. This does not apply to transfers made prior to October 18, 2018.

Consumer Alert! ..........................

(continued on page 9)
Consumer Alert! ...................... (continued from page 8)

It only applies to “covered assets” i.e., asset that was part of claimant’s net worth, transferred for less than fair market value, and if not transferred, would have caused the net worth to be over the limit. Exceptions for transfers as a result of fraud or unfair business practices and for transfers to a trust established for a disabled child prior to age 18.

Medical/Care Expenses - 38 CFR § 3.278
The provisions for deductible medical expenses are more generous than the previously proposed rules; the limit on hourly rates for in-home care was eliminated; and payments for residential care or assisted living are still permissible.

Penalty Period- 38 CFR § 3.276(e)
Maximum period of ineligibility is 5 years (previous proposal was 10 years).

Starts the first of the month after the month last transfer was made.

Based on the MAPR for A&A for a married veteran divided by 12 and rounded down.

Only the amount of the assets transferred that exceeded the net worth subject to penalty.

Penalized transfers can be cured by partial or total return of assets.

Link to the US Government Federal Register:

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: DEAD.

AB 1709 (Jones-Sawyer) – Nursing homes: staff
This nursing home industry sponsored bill would modify qualifications for nursing home administrators by allowing administrators from other states to apply for licensure in California if they hold certification from the American College of Health Care Administrators even if they do not meet existing educational requirements in California. It would also make other changes to related requirements.

Status: Referred to Senate Health Committee.

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: Hearing in Assembly Judiciary Committee 7/2/19.
Past Speaking Engagements, Panel Discussions and Training Sessions

- **April 8:** Pauline Mosher and Julie Pollock presented to San Francisco State Gerontology Students about Home and Community-Based Services and Spousal Impoverishment.

- **April 9:** Jody Spiegel gave a presentation on an “Overview of Long Term Care in California” to the Alhambra Teacher’s Association - Retired.

- **April 15:** Prescott Cole was a panelist at the California District Attorneys Association National Elder and Dependent Adult Abuse Symposium in Orange County.

- **April 17:** Pauline Mosher made a presentation to PACE Social Workers at OnLok in San Francisco about CANHR Services and Long-Term Care Facility Transfer and Discharge Rights.

- **April 22:** Jody Spiegel participated in the RCFE Advocates Quarterly Meeting with Community Care Licensing.

- **April 22:** Prescott Cole was a guest lecturer at San Francisco State University speaking on the topic of financial elder abuse.

- **May 7:** Tony Chicotel made a presentation at the State Long Term Care Ombudsman coordinators’ conference. His topic was medical futility and end-of-life laws.

- **May 7:** Prescott Cole participated in the NAPSA conference call for the development World Elder Abuse Awareness Day Symposium.

- **May 10:** CANHR hosted an attorney training on Medi-Cal Basics: Eligibility & Recovery at the Burbank Gardens with speakers Carlos Arcos, Peter Stern and Pat McGinnis.

- **May 13:** Efrain Gutierrez hosted an information table at the Mother’s Day Luncheon in Los Angeles, courtesy of Councilman Curren D. Price, JR.

- **May 21:** Julie Pollock gave an in-service training to Kaiser social workers in San Francisco on Advocating for Your Clients on Medi-Cal.

- **May 21:** Prescott Cole presented at the Legal Assistance for Seniors 14th Annual Conference on Elder Abuse on restitution in San Francisco.

- **May 22:** Prescott Cole was a featured speaker presenting on financial elder abuse, restitution, and asset protection at the San Luis Obispo Legal Assistance Foundation’s 27th Annual One-Day Training Conference.

CANHR on the Move ........................(continued on page 11)
• **May 22:** Tony Chicotel provided a training on incapacity, decision making, and resident rights to the Sacramento Ombudsman office.

• **May 29:** Prescott Cole was the studio guest on KALW Radio our Legal Rights discussing Elder Financial Abuse.

• **May 29:** Julie Pollock gave a presentation at the Northern California American Case Management Association Conference in Napa on Nursing Home Myths and Realities.

• **May 29:** Efrain Gutierrez visited Theresa Lindsey Senior Center in Los Angeles.

• **May 31:** Prescott Cole made a presentation on Restitution at the California District Attorneys’ Association / CANHR training in Fresno.

• **June 3:** Prescott Cole made a presentation on Restitution at the State Bar’s Pathway to Justice conference in San Francisco.

• **June 5:** Executive Director Pat McGinnis presented a CANHR webinar on Medi-Cal Recovery.

• **June 7:** Prescott was a presenter at the 2019 Annual crime Victim Law Conference in Portland, Oregon.

• **June 10:** CANHR staff met with representatives of the South Korea National Health Insurance Service and the Ministry of Health and Welfare to discuss the efficacy of costs reports for nursing homes under Medicare and Medi-Cal.

• **June 15:** Tony Chicotel spoke to the Young Caregivers Support Group of the Family Caregiver Alliance in San Francisco about long term care.

• **June 18:** Tony Chicotel presented to the Orange County Council on Aging on hot topics in long term care.

• **June 20:** Tony Chicotel gave an overview of long term care discharges to Aging and Independence Services in San Diego.

• **June 26:** Tony Chicotel provided a webinar to the Family Caregiver Alliance about finding and paying for long term care.

▲ CANHR outreach coordinator Efrain Gutierrez and Councilmember Curren D. Price, JR. at the Mother’s Day Luncheon - L.A. Convention Center.

▲ CANHR staff attorney Jody Spiegel gave an overview of Long term care in California to the Alhambra Retired Teachers Association.
For over 35 years, CANHR has fought to improve the choices, care and quality of life for residents of Residential Care Facilities for the Elderly (RCFEs). Through our legislative advocacy, we have generated systemic changes that have positively impacted, and will continue to improve the lives of California’s 150,000+ RCFE residents. Below is a summary of key RCFE-specific legislation sponsored or supported by CANHR over the past three decades.

**Suitability of Ownership and Disclosure for RCFEs** • *AB 601* (Eggman)
This bill establishes specific suitability of ownership criteria for RCFEs, and requires applications for a new facility to disclose complete ownership information, including any person who holds a 10% or more beneficial interest in the facility. (Effective 1/1/16)

**Training and Qualifications of RCFE Staff** • *SB 911* (Block)
This bill increases the qualifications and training requirements for RCFE administrators and staff, and require facilities who accept and retain residents with restricted or prohibited health conditions to assist residents with accessing medical care in the facility. (Effective 1/1/16)

**RCFE Liability Insurance** • *AB 1523* (Atkins)
This bill requires each RCFE, as a condition of licensure, to obtain and maintain liability insurance in the amount of one million dollars per occurrence and three million in the annual aggregate to cover injury to residents or guests caused by the negligent acts of the licensee or its employees. (Sponsored by CARR, San Diego; effective 7/1/15)

**Increased Penalties** • *AB 2236* (Stone & Maienschein)
This bill was significantly amended and includes an enormously complicated civil penalty system for all categories of facilities; imposes a $10,000 fine against RCFEs for physical abuse or serious bodily harm; imposes a $15,000 fine for deaths due to violations; and creates four (4!!!) levels of appeal for RCFE providers to appeal the fines. (Effective 7/1/15)

**Resident & Family Councils** • *AB 1572* (Eggman)
This bill amends current laws to enhance the rights of resident councils and family councils in RCFEs. (Effective 1/1/15)

**Forfeiture of License** • *AB 1899* (Brown)
This bill would prohibit a person whose license has been revoked or forfeited for abandonment of the facility from being able to reinstate the license. (Effective 1/1/15)

**RCFE Staffing Requirements** • *AB 2044* (Rodriguez)
This bill requires an administrator or facility manager or designated substitute to be on premises 24/7, and for sufficient staff to be on premises 24/7 to carry out required responsibilities. This bill also requires at least one staff member with CPR and first aid training to be on premises at all times. This bill also requires staff to be trained on building and fire safety and responding to emergencies. (Effective 1/1/15)

**Statutory Residents’ Bill of Rights** • *AB 2171* (Wieckowski)
This bill creates a comprehensive, statutory bill of rights for RCFE residents. Although the rights became effective on January 1, 2015, 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. (Effective 1/1/15)

**Correction of Deficiencies, Inspection Reports, Suspension/Revocation of Licenses** • *SB 895* (Corbett)
This bill requires facilities to correct deficiencies within 10 days unless otherwise specified, and requires the Department of Social Services to post online...
instructions on how to obtain inspection reports, design an informational poster on reporting complaints and emergencies for display in RCFSs, and notify the State Ombudsman Office when it plans to issue a temporary suspension or revocation of a facility license. (Effective 1/1/15)

**Ban on Admissions • SB 1153 (Leno)**

This bill creates new penalties for non-compliance, including authorizing DSS to suspend the admission of new residents in facilities where there is a substantial probability of harm. (Effective 1/1/15)

**Increase in RCFE Application & Licensing Fees • SB 1382 (Block)**

This bill increases the initial and annual licensing fees for RCFSs for every sized facility and makes legislative findings that it is imperative that DSS be given adequate resources to support its mandate to provide consumer protection. (Effective 1/1/15)

**RCFE Residents Foreclosure Protection Act of 2011 • SB 897 (Leno)**

This bill requires RCFS licensees to notify the DSS, and residents and their representatives when the facility is in financial distress such as foreclosure or bankruptcy. It also provides for civil penalties and loss of licensure when a facility fails to notify residents and a resident is subsequently relocated and suffers transfer trauma. (Effective 1/1/12)

**RCFE Eviction Protection Act • SB 781 (Leno)**

This bill strengthens eviction protections by requiring RCFSs to provide a comprehensive written notice to residents faced with an eviction specifying the reason and facts supporting the eviction. The notice must also include information regarding the eviction process and residents’ right to challenge the eviction and a list of resources available to identify alternative housing and care options. (Effective 1/1/10)

**RCFE Resident Relocation Protection Act • AB 949 (Krekorian)**

This bill provides relocation protections for residents when a RCFS closes, including 60 days written notice, individualized relocation plans, refund of certain preadmission fees and a private right of action to enforce the relocation protections. (Effective 1/1/08)

**Refund of RCFE Pre-Admission Fees • SB 141 (Soto)**

This bill provides that RCFS residents are entitled to full or partial refunds of pre-admission fees under specified circumstances. (Effective 1/1/06)

**RCFE Rate Increases for Level of Care • SB 1662 (Soto)**

This bill requires licensees to issue a written notice of a rate increase due to a change in the level of care, including an itemization of additional costs, within two business days of the change. (Effective 1/1/05)

**RCFE Special Services • SB 540 (Soto)**

This bill requires a facility that advertises or promotes special care, programming or environments for residents with a health related condition to provide an accurate narrative description of these programs and services to prospective residents in writing prior to admission. (Effective 1/1/04)

**RCFE Admission Agreements • SB 211 (Dunn)**

This bill requires all RCFS admission agreements to include detailed explanations of fees and services, explanations of billing and payment, information regarding residents’ rights, and make copies of the agreement available to the public. (Effective 1/1/04)

**RCFE Fees, Pre-Admission Fees and Rate Increases • SB 1898 (Soto)**

This bill requires RCFSs to specify any fees, including pre-admission fees, in their admission agreements. This bill also requires licensees to provide 60 days written notice to residents prior to any increase in rates, other than rate increases due to a change in the level of care. It also prohibits an RCFS from charging security or damage deposits. (Effective 1/1/03)

**RCFE Consumer Information • SB 1630 (Rosenthal)**

This bill requires RCFSs to post the most current survey results, and requires DSS to make facility information available to the public. (Effective 1/1/99)

**RCFE Care Plan • AB 2155 (Keeley)**

This bill requires RCFSs to have a written service plan for each resident, and to inform residents and their representatives of the plan. (Effective 1/1/99)

**Family Councils in RCFSs • SB 1102 (Roberti)**

This bill allows for the organization of family councils in RCFSs. (Effective 1/1/90)
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

**Bay View Rehabilitation Hospital, LLC**
516 Willow Street, Alameda

**B **$1000 **Evictions 01/31/2019**
On 11/16/18, a resident was admitted to a hospital for a septic shock from a bladder infection. The resident’s condition was stabilized, and he was ready for discharge back to the facility on 11/20/18. Although he had lived at the facility for six years and considered it his home, the facility refused to take him back. The facility was cited for failing to readmit the resident in a timely manner after hospitalization. Citation # 020014724.

**Garfield Neurobehavioral Center**
1451 28th Avenue, Oakland

**B **$2000 **Physical Abuse 12/13/2018**
On 8/13/18 a resident was trying to get food for himself when a nurse’s assistant blocked him from doing so by grabbing his wrists and pushing him to the ground. The nurse’s assistant stated that they told the resident to sit down because they were busy doing something else and that when the resident did not obey, the nurse’s assistant didn’t want the food to become contaminated, so they began blocking the resident from eating. The altercation ended in the resident falling down due to being shoved by the nurse’s assistant. The facility was cited for failing to prevent physical abuse to its residents. Citation # 020014621.

### Contra Costa County

**Gateway Care & Rehabilitation Center**
26660 Patrick Avenue, Hayward

**B **$1000 **Fall Supervision 01/10/2019**
On 9/4/18, a CNA took a resident with dementia, muscle weakness and at high risk for falls to the bathroom, and put her on the toilet. The CNA went back to the room to turn off the bed alarm, returned to the bathroom, and saw the resident on the floor. As a result of the fall, the resident suffered multiple bruises, a broken hand bone and had to be taken to the hospital. The CNA said that she knew the resident needed assistance with bathroom activities and that she should not have been left alone in the bathroom. The facility was cited for failing to ensure that the resident received adequate supervision, which resulted in her being injured. Citation # 020014714.
Hayward Convalescent Hospital
1832 B Street, Hayward
B $1500 Transfer 12/7/2018
The facility failed to readmit a resident who was discharged to the hospital, because they could not care for such an aggressive patient. On 11/18/18 the resident was transferred to the hospital for aggressive behavior, and on 11/19/18 the resident was released with a doctor's note stating that he was medically cleared to be discharged after no episodes of aggression. The facility was cited for refusing to take the resident back due to what they called “violent behavior”. Citation # 020014632.

Kindred Nursing and Rehabilitation - Medical Hill
475 29th Street, Oakland
B $2000 Physical Abuse 11/15/2018
On 9/11/18 a nurse's assistant (CNA) hit a resident four times with a “reacher”, which is a tool to help the resident. The resident had denied the CNA some cookies, which the CNA had asked the resident to share, so the resident took the cookies from her. The resident began to hit the CNA with her reacher, which the CNA took and hit the resident with three to four times. The facility was cited for failing to prevent physical abuse towards a resident. Citation # 020014579.

Masonic Home
34400 Mission Boulevard, Union City
A $15000 Fall Injury Patient Care 03/06/2019
A resident who was entirely dependent on staff to move between locations in her room and within the facility, and identified as at risk for falls, was left unattended sitting in her wheelchair at the nurses’ station. The resident wheeled herself into an elevator unattended, went to the facility’s basement, where her wheelchair rolled down a steep ramp, causing the resident to hit a wall and be ejected from her wheelchair. The resident suffered two broken vertebrae and cuts to her face. Citation # 020014847.

Washington Center
14766 Washington Avenue, San Leandro
B $1800 Careplan Fall Injury Neglect Patient Care Physical Environment Staff (Inservice) Training 04/16/2019
On 11/15/18, a resident known to have muscle weakness was transferred from a bed to a wheelchair by a CNA. The CNA attempted to use a mechanical lift. The CNA did not have additional staff assistance or training for proper use during transfer. The sling from the mechanical lift broke, and the resident fell to the floor. The resident sustained five rib fractures as a result of the fall. The DON was not able to produce documentation that the CNA received training on the use of the mechanical lift for transferring residents. Citation # 020014950.

Amador County

Kit Carson Nursing & Rehabilitation Center
811 Court Street, Jackson
A $10000 Fall Neglect 03/27/2019
On 11/28/18, a resident experienced an unwitnessed fall because the facility had failed to provide proper supervision and assistance. The resident was a known fall risk. The resident broke her femur as a result of the fall and died shortly after the fall on 12/6/18 due to a mix of complications including sepsis. Citation # 030014902.

Contra Costa County

Greenridge Senior Care
2150 Pyramid Drive, El Sobrante
B $2000 Transfer 9/18/2018
On 8/27/18, a resident was transferred to the hospital and on 8/28/18, one day later, was not allowed back by the facility. The facility didn't want to take the resident back because she had been verbally abusive towards another resident. The facility was cited with not attempting to reassess and readmit the resident after she was medically cleared to come home from the hospital. Citation # 020014417.

Walnut Creek Skilled Nursing & Rehabilitation Center
1224 Rossmoor Parkway, Walnut Creek
B $2000 Careplan Patient Care 05/14/2019
For two months, facility staff failed to monitor a resident’s worsening skin condition and failed to take steps to prevent skin ulcers from developing on a resident who required support with positioning and who had previously been deemed at risk for developing pressure ulcers. Although staff noticed a change in skin color over time and reported it to nurses, no additional steps were taken to care for the resident, leading to the development of an open ulcer on the resident’s tailbone which required a painful care procedure. Citation # 020015072.

Fresno County

Alice Manor Convalescent Hospital
8448 E Adams Ave, Fowler
A $20000 Evictions 03/29/2019
A 54 year old male resident with diabetes, dysphagia, schizophrenia and memory loss was discharged to an unlicensed room and board home on 2/1/19. The discharge was done suddenly and haphazardly, with no written notice to the resident, no evidence of improvement, no discharge planning and no assessment of the resident’s or room and board home’s ability to administer insulin or manage the resident’s incontinence, hygiene needs and puree diet. When asked what vetting the facility did to ensure the resident would be appropriately cared for, the Director of Nursing said,
“we didn’t check anything.” The room and board operator stated the facility was not truthful about the resident’s needs and that less than 24 hours after his transfer, he had to be hospitalized. The facility was cited for failing to ensure a safe discharge process and for placing the resident at great risk in an unlicensed facility unable to meet his needs. Citation # 040014915.

Raintree Convalescent Hospital
5265 E Huntington Ave, Fresno
A $20000 Deterioration Physical Environment 9/12/2018
On 9/20/17 a resident tripped over an uneven piece of sidewalk and fell, fracturing her hip, and requiring a five day stay at the hospital. When the resident was transferred back to the facility, the facility did not assign her the proper care and the resident developed bedsores while healing from her hip surgery. The facility was cited with failing to provide an environment free of hazards for the resident as well as failing to ensure that her condition did not deteriorate and that bedsores did not form. Citation # 040014405.

Glenn County
Willows Center
320 N Crawford St, Willows
A $10000 Patient Care 10/22/2018
On 7/15/18 after removing a tracheostomy tube from a resident’s throat, the nursing staff failed to reinsert the replacement tube, causing the resident to die from lack of oxygen. Two nurses took part in the tube-change, the first could not get the tube down the resident’s trachea, and the second believed she had properly set the tube, but the resident began gasping for air moments later. The tube-changing policy states clearly that the staff attempting the tube replacement should have a second, smaller tube on hand in case they cannot fit a tube of the previous size down the resident’s trachea. The facility was cited with not following professional standards of practice, resulting in a resident’s death. Citation # 230014450.

Humboldt County
Seaview Rehabilitation & Wellness Center, LP
6400 Purdue Dr, Eureka
A $20000 Medication 8/3/2018
The facility failed to discontinue a resident’s dosage of a painkiller when the resident was prescribed a different painkiller, giving her a double dose of medicine which resulted in digestive tract bleeding and ulcers. On 02/25/17, a nurse could not feel the resident’s pulse with her fingers and the resident’s heart rate was 11 beats per minute, at which point she was transferred to the hospital. At the hospital, the resident was found to have an upper digestive tract bleed due to ulcers as well as dehydration. The facility was cited with failing to administer the correct medication to the resident, resulting in imminent danger of death. Citation # 110013449.

B $2000 Sexual Abuse 2/15/2019
On 6/3/18 the facility failed to ensure that one resident did not sexually harass other residents repeatedly, or report episodes of sexual abuse to the state in a timely manner. The resident had dementia and repeatedly touched or molested other residents without supervision, including rubbing their knee, touching their genitalia and masturbating. These incidents were not reported to be investigated by the state but were investigated internally. The facility was cited with failing to report abuse within the mandated 24-hour reporting window. Citation # 110014797.

Kern County
Golden Living Center - Shafter
140 E Tulare Ave, Shafter
A $20000 Sexual Abuse Supervision 03/26/2019
An 86 year old female resident with dementia was sexually assaulted in her room on 12/9/18 by another resident. Afterward, the victim felt ashamed and remained very scared. The perpetrator had a history of inappropriate sexual behavior. In September 2018, the resident was observed making 21 inappropriate sexual advances, but monitoring inexplicably ended after September. After the assault, the perpetrator made several attempts to go into the victim’s room. The facility was cited for failing to take the necessary interventions to protect its residents from sexual assault. Citation # 120014729.

Kern County
The Rehabilitation Center Of Bakersfield
2211 Mount Vernon Ave, Bakersfield
B $2000 Bed Hold Evictions 03/26/2019
A 45 year old female resident with cerebral palsy had to be hospitalized on 1/25/19 for decreased oxygen levels. When the resident was stabilized and ready to return to the facility on 1/31/19, the facility refused her readmission despite the resident’s bed hold. The staff at the facility refused readmission because “her IV meds [medications] and TPN [total parenteral nutrition] are too expensive.” The facility was cited for refusing to readmit the resident. Citation # 120014868.
Los Angeles County

Beverly West Healthcare
1020 S Fairfax Ave, Los Angeles

B $2000 Medication 6/15/2018

The facility failed to accurately record the resident’s meal intake percentage, resulting in the resident being prescribed medicine she may not have needed. The resident was found with food from her meals left in front of her frequently, and complained about being constantly tired, so she was prescribed medicine to help with her depression. The medicine was administered, but the meal percentages eaten varied from report to report, suggesting that she may or may not have needed an appetite stimulant. The facility failed to ensure the resident did not take any unnecessary medications or that her meal intake was adequately monitored. Citation # 91004166.

B $2000 Medication Patient Care 12/19/2018

From 11/1/18-11/5/18, a facility failed to give a resident with a pacemaker his daily dose of Coumadin as prescribed by his physician. The resident, who was alert and oriented with cognition intact, stated he requested the medication but had not received it. The facility was cited for failing to ensure that the resident received Coumadin medication, which had the potential to result in a blood clot. Citation # 91004174.

B $2000 Transfer 8/3/2018

On 3/28/18 a resident was discharged from the facility while he still required medication and care to be administered by the facility. The resident was experiencing swelling in his feet, possible pneumonia and low levels of potassium when he was released to a Board and Care facility. The facility was cited for failing to allow the resident to stay at the skilled nursing facility until his health status had improved significantly. Citation # 920014316.

Brenthwood Health Care Center
1321 Franklin St, Santa Monica

B $2000 Transfer 8/3/2018

On 3/28/18 a resident was discharged from the facility while he still required medication and care to be administered by the facility. The resident was experiencing swelling in his feet, possible pneumonia and low levels of potassium when he was released to a Board and Care facility. The facility was cited for failing to allow the resident to stay at the skilled nursing facility until his health status had improved significantly. Citation # 920014316.

California Post-Acute Care
3615 E Imperial Hwy, Lynwood

B $2000 Patient Care Physical Abuse Verbal Abuse 6/15/2018

The facility failed to protect a resident from abuse when a staff member was witnessed by other staff verbally abusing one of the residents, threatening physical harm toward the resident. The staff person was not immediately separated from the resident by other staff, leading to further verbal threats of physical abuse. Citation # 940014139.

Bonnie Brae Convalescent Hospital
420 S Bonnie Brae St, Los Angeles

B $2000 Mandated Reporting Physical Abuse 7/23/2018

On 3/16/18 a resident was found to have bruising on his chest with no known cause, a sign of abuse, and the facility did not report it. Multiple staff members viewed the bruise and understood that bruises with no known origin can be a sign of abuse, but nobody, including the administrator, reported the incident to the Department of Public Health. The resident was not able to communicate, and therefore the origin of the bruise remained unknown. The facility was cited for failing to report an incident of abuse within the 24-hour mandated reporting period. Citation # 910014268.

B $2000 Patient Care Physical Environment 05/23/2019

During an unannounced visit on 4/15/19, the facility was cited for failure to establish a controlled smoking environment, and failure to have an outdoor area that was smoke-free for residents to enjoy fresh air. Many residents were observed smoking on the patio outside the designated smoking times, in close vicinity to non-smoking residents. The smoking area was also next to several sliding doors leading into resident rooms, which were left open. Citation # 920015102.
Camellia Gardens Care Center
1920 N Fair Oaks Ave, Pasadena
B $2000 Decubiti (Bedsores) Patient Care
11/29/2018
The facility failed to properly assess and care for a bed-ridden resident's bed sore, causing it to grow in size and severity. While the resident was admitted to the facility with a bedsore on his tailbone, due to staff not properly tracking the size and seriousness of the bed sore, or providing adequate measures to prevent deterioration, it grew, eventually requiring the resident had to be transferred to the emergency room for treatment for an infection. Citation # 950014612.

Catered Manor Nursing Center
4010 N Virginia Rd, Long Beach
A $18000 Fall Injury Patient Care Supervision
6/22/2018
Staff failed to provide adequate assistance and supervision of a resident diagnosed with brain damage and kidney failure while she was being turned in bed. While the care plan stated the resident was to be moved using two-person assistance, the resident was supervised by one staff member, and left unsupervised on her side in bed, resulting in the resident falling off the bed and suffering a fractured leg. Citation # 94001470.

B $2000 Physical Environment 9/18/2018
The facility failed to provide comfortable and safe temperatures to residents when the air conditioning unit broke. The rooms were between 82 and 88 degrees, well over the required 71 - 81 degree range, and the extreme heat affected 19 different residents. The facility’s air conditioner was broken for three days as the company came to fix it, and the facility did not invest in any methods of alternative cooling or rent air conditioners for their residents. The facility was cited for failing to provide adequate alternative cooling and for putting their residents at risk of dehydration and heat stroke. Citation # 910014411.

Clear View Convalescent Center
15823 S Western Ave, Gardena
B $2000 Fall 8/24/2018
On 4/30/18 a resident fell from her chair because she was not assisted into a fully seated position after walking around the dining room, resulting in a broken hip. The resident was being walked around the dining room by a staff member, and was helped into her seat, but right before she was fully seated, the staff member let go in order to help another resident. The first resident, who has balance problems, fell out of her chair and onto her hip, fracturing it and needing hospitalization. The facility was cited with failing to provide a walker to the resident and failing to provide two handed assistance until the resident was fully seated. Citation # 910014364.

Country Villa South Convalescent Center
3515 Overland Ave, Los Angeles
A $20000 Injury Neglect Physical Environment
2/14/2019
On 5/11/18, a resident’s left leg was fractured when it became caught beneath a wheelchair while a physical therapist wheeled him back to his room after a therapy session. The injury occurred because the footrest to the wheelchair was broken and not locked into position. After complaining of pain for two days, the resident was hospitalized, diagnosed, and underwent surgery to repair the fracture. The facility was cited for failing to prevent accident hazards, failing to assess and treat the resident’s injury accurately, and other failures. Citation # 910014817.

A $20000 Fall Physical Environment 03/21/2019
A resident who required total dependence on full staff performance, who was also a moderate fall risk, fell out of her bed and hit her head on the corner of her bedside table. The facility had made the transition to be restraint free and had earlier that month taken off the resident’s side rails on her bed. It was ordered that the resident instead get grab bars installed on her left and right side for turning in bed, but they never were installed. The CNA assisting the resident was not trained on how to work the resident’s low air mattress, and when the CNA looked away to grab a diaper, the resident slid off her bed and hit her head. On 10/19/18, the resident was taken to the hospital and was diagnosed with a brain bleed. The resident was put on mechanical ventilation and other life-sustaining medication until she passed on 11/11/18 due to her brain hemorrhage. Citation # 910014906.

B $2000 Medication 03/27/2019
Between October 2018 and February 2019, the facility failed to keep a resident who was on hospice care safe from medication errors. Apparently, due to a pharmacy labeling error, the facility did not administer the correct dosage of Cyclosporine (an immunosuppressant drug the resident was receiving following a kidney transplant) per her physician’s orders. In addition to this failure, the facility was cited for failing to ensure the hospice agency physician orders were reflected in her medical record and for other medication errors and discrepancies. Citation # 910014921.

Crenshaw Nursing Home
1900 S Longwood Ave, Los Angeles
B $2000 Medication 12/21/2018
Beginning on 10/29/18 a resident experienced uncontrolled pain and discomfort, making him unable to sleep and causing him anxiety. The resident was transferred from the hospital to the facility with a diagnosis of back pain and anxiety, and a prescription for pain medicine. The
prescription was not filled for three days, causing the resident extreme pain, sleepless nights and increasing anxiety. The facility was cited with failing to manage the resident’s pain as outlined in their facility policy. Citation # 910014679.

Del Amo Gardens Care Center
22419 Kent Ave, Torrance

Citation # 91000000 Fall 12/14/2018

On 9/15/18 a resident suffered an unwitnessed fall from her bed onto the floor, resulting in blunt head trauma, a transfer to the hospital and her death the next morning. The resident had fallen at 3:30 AM and felt no pain from her injuries. The resident was monitored at 4:00, 5:00 and 6:00 during which time her condition did not worsen, but was discovered unresponsive at 7:00 by a family member who had been notified about the fall. The resident was transferred to the hospital and was found to have sustained bleeding in and around her brain, at which point she was put on comfort measures in order to ease her death. The facility had not notified the resident’s doctor of a worsening of condition, nor had the nurse who monitored the resident in the early hours of the morning properly completed her post-injury checks. The facility was cited for failing to adequately monitor the resident to prevent falls or inform her doctor of a change in condition. Citation # 910014640.

Citation # 9200014954.

WMF $1000 Willful Material Falsification
12/14/2018

On 9/15/18 a resident suffered a potentially deadly fall which a nurse in the facility failed to accurately document, resulting in delayed care and eventual death for the resident. The nurse did not accurately assess the resident’s condition, and, after leaving a message with the resident’s doctor, issued doctor’s orders calling for x-rays and a cold pack which were fabricated by her. The nurse felt that the orders she wrote up would be beneficial to the resident. The facility was cited with failing to prevent the nurse from willfully falsifying the orders. Citation # 910014648.

Dreier’s Nursing Care Center
1400 W Glenoaks Blvd, Glendale

Citation # 9200014955.

B $2000 Elopement 8/29/2018

The facility failed to provide adequate supervision and a safe environment for a resident who had a known elopement risk. The facility failed to provide the one to one supervision that the resident required. In addition, the facility also failed to ensure that their Wander Guard system (an alarm system activated when a resident wearing a Wander Guard band goes through the alarmed door) functioned properly. This failure resulted in the resident being hospitalized after the paramedics found him. Citation # 920014372.

Emerald Terrace Convalescent Hospital
1154 S Alvarado St, Los Angeles

B $2000 05/09/2019

On 3/21/19, a resident eloped. The resident was assessed as at risk for elopement and had a known history of wandering out of and leaving the facility. The documentation stated that the resident wandered out of the facility eight times from 3/17/19 - 3/21/19. The physician ordered that the resident had a Wander Guard wristband that sounded the door alarms when the resident wandered too close to or through the doorway. The physician also ordered that the resident be monitored. On 3/21/19, when the resident left the facility, two alarms sounded. The LVN did not immediately respond as required, and before identifying the cause of the alarm, surveillance cameras showed the LVN resetting the alarms. These failures resulted in the resident eloping from the facility, and she has remained missing. Citation # 920015055.

Four Seasons Healthcare & Wellness Center, LP
5335 Laurel Canyon Blvd, North Hollywood

B $2000 Medication 04/12/2019

An elderly female resident with major depressive disorder received Prozac and Trazadone. On 1/11/19, a nurse practitioner discontinued the Trazadone without tapering. On 1/21/19, the resident was diagnosed with a UTI, and on 1/22/19, she expressed a desire to die and cut her wrist with a broken picture frame. The facility was cited for not implementing a gradual dose reduction before discontinuing the resident’s Trazadone. Citation # 920014955.

B $2000 Elopement Security Supervision 04/12/2019

On 6/1/18, a resident eloped from the facility. That afternoon, the resident was discovered by police and taken to a General Acute Care Hospital for treatment for cuts on the resident’s face, received during the elopement. The facility did not report the elopement as required by regulation and facility policy. The facility violated regulations regarding reporting requirement which are notification within 24 hours for allegations of non-serious bodily injuries that are not the result of abuse and notification within five days of the result of investigations into the incident. Citation # 920014954.
Garden Crest Rehabilitation Center
909 Lucile Ave, Los Angeles
A $20000 Fall Injury Supervision 01/16/2019
On 4/21/18, a 95 year old resident who had dementia died about two hours after falling 14 steps in a stairway of the adjoining assisted living facility while in her wheelchair. She was found screaming and crying underneath her wheelchair at the base of the stairwell by staff at the assisted living facility where she had wandered without being detected. Paramedics took her to the hospital, where she died. Her death certificate stated she died of blunt force traumatic injuries from the fall. The resident had a prior history of wandering in the facility that put her at risk of harm. The facility was cited because it failed to accurately assess this safety risk, implement a wander device as called for in her care plan, identify safety risks after each fall, update her careplan and monitor her whereabouts. Citation # 920014704.

Gem Transitional Care Center
716 S Fair Oaks Ave, Pasadena
B $2000 Evictions Notification Patient Rights Transfer 11/16/2018
On or about 8/25/18, an 86 year old resident with intracerebral hemorrhage, dysphagia and gait abnormalities, who could not understand or make decisions, was discharged home from the facility. The Discharge/Transfer Notice stated, inaccurately, that the reason for the discharge was for the resident’s welfare, and the facility could not meet her needs. The facility did not send a copy of the Notice to the Ombudsman office. The facility was cited for violating the resident’s rights by the above conduct as the resident’s family member did not agree that the resident was well enough to go home, and the Ombudsman was unaware and unable to assist the family member during the discharge. Citation # 950014467.

Glenoaks Conv. Hospital
409 W Glenoaks Blvd, Glendale
B $2000 Careplan Physical Abuse Physical Restraints 12/4/2018
Facility staff used physical restraints to tie a 73-year-old resident diagnosed with Alzheimer’s to her Gerry-Chair with a bed sheet. Physical restraints were not included in the resident’s care plan, nor was her responsible party notified about the need to use physical restraints. Citation # 950014629.

Grand Park Convalescent Hospital
2312 W 8th St, Los Angeles
A $20000 Fall Injury Neglect 8/13/2018
On 3/29/18, a resident fell out of bed while being turned by a certified nursing assistant (CNA), who was alone. The resident sustained a skin laceration below her eye, a subdural hematoma (bleeding in the brain) and head wounds. She was hospitalized in the intensive care unit. The resident also suffered four earlier falls at the facility between 2/15/18 and 3/29/18. The facility was cited for failing to establish resident-specific and relevant care plan interventions after her falls, failing to perform neurological checks after a fall with head injuries and related failures. Citation # 920014327.

Greenfield Care Center Of Gardena
16530 S Broadway, Gardena
B $2000 Physical Abuse 10/9/2018
On 7/29/18 a nurses assistant was physically abusive towards a resident during transfer from the wheelchair to the toilet. The resident reported the incident, however the facility did not follow their policy and suspend the nurse’s assistant as soon as the allegation was made. The facility also failed to report the allegation of abuse to the Department of Public Health within the 24-hour mandated reporting period. The nurse’s assistant continued to work with the resident until the state investigation because the facility felt that the abuse did not occur. The facility was cited with failing to report the abuse in a timely fashion and failing to suspend the nurse’s assistant when the allegations were made. Citation # 910014467.

Guardian Rehabilitation Hospital
533 S Fairfax Ave, Los Angeles
A $20000 Mental Abuse Sexual Abuse 9/27/2018
On 5/9/15 a resident was closing his eyes while watching television when he felt something touch his penis. Upon opening his eyes, the resident saw the nurse standing over him covered in a blanket, manually masturbating him. This happened twice more, and before the third time, the resident set his phone to record the incident, which the nurse admitted to. The resident left the facility against medical advice the next day, failing to complete his antibiotic treatment, his physical therapy or his prosthetic leg training. The facility was cited with failing to ensure the resident was free of sexual abuse. Citation # 910014396.

Harbor Post Acute Care Center
21521 S Vermont Ave, Torrance
A $2000 A 11/30/2018
On 3/8/18 a resident fell in the bathroom, sustaining a hip fracture, required transfer to the hospital and underwent surgery to his hip. The resident stated that his nurse’s assistant would usually leave him alone in the bathroom, and this time the resident lost his balance...
and fell. Both the resident and the nurse’s assistant were aware that the resident required a two-person assist as well as supervision for toileting and transfer but neither were provided. The facility was cited with failing to provide the necessary supervision and care to the resident. Citation # 910014610.

**Heritage Rehabilitation Center**  
21414 S Vermont Ave, Torrance  
B $2000 Mandated Reporting Sexual Abuse  
8/23/2018

On 4/16/18 a nurse’s assistant stuck his finger into a resident’s rectum, which went unreported until 4/26/18. The nurse’s assistant had previously sexually assaulted a resident during care in October of the previous year. Both residents had unusual bowel movements that required care, and in both cases the nurse’s assistant put part of his finger into their rectum while providing care. The facility was cited for failing to report the incident on 4/16/18 within the mandated 24-hour reporting window, inhibiting the investigation into the matter. Citation # 910014360.

**Highland Park Skilled Nursing & Wellness Centre**  
5125 Monte Vista St, Los Angeles  
B $2000 Evictions Notification Patient Rights Transfer 11/26/2018

On 8/27/18, a facility refused to readmit a 41 year old resident with end stage renal disease, although the hospital had determined that she was stable and ready to transfer back to the facility. The resident went to the hospital on 8/15/18 for evaluation of blood in her vomit and stool. The facility was cited for failing to provide the resident or her responsible party with a written Notice of Transfer/Discharge at the time of transfer or by the next business day and failing to readmit her after the hospital notified them that she was stable and ready to discharge back to the facility. As a result of the facility’s conduct, the resident’s right to appeal the transfer and return to the facility were violated, and the resident had to stay in the hospital for six additional days (8/27/18 to 9/1/18). Citation # 950014604.

**Hollywood Presbyterian Medical Center D/P SNF**  
4636 Fountain Avenue, Los Angeles  
B $2000 Patient Care Staffing 11/19/2018

The facility failed to have a ventilator alert system that would notify the respiratory therapist and licensed nurse when the delivery of oxygen was compromised. The facility failed to ensure there was a system in place for rapid response to the residents’ ventilator alarms. This failure was due to what the staff verbalized was short staffing. One resident’s ventilator alarm was silenced, and another two residents’ ventilator system settings were not turned on and set up as ordered. There were 52 ventilator-assisted residents, and these failures put these residents at risk. Citation # 930014583.

**Inglewood Health Care Center**  
100 S Hillcrest Blvd, Inglewood  
A $16000 Fall 11/2/2018

On 7/29/18 a resident at the facility fell, puncturing his back with an 18 inch piece of glass and requiring emergency medical attention. The resident sustained a 20 cm cut along his back, required surgery and four blood transfusions. He was discharged to the facility 19 days later. Prior to the fall, the facility had failed to provide the resident with adequate supervision or non-slip socks. The facility also failed to ensure that his alarm was in place and working properly. The facility was cited with failing to enact its fall prevention policy. Citation # 910014547.

**Intercommunity Care Center**  
2626 Grand Ave, Long Beach  
A $20000 Elopement 10/26/2018

On 6/26/18 a resident at the facility went missing while waiting to be seen by a judge and was discharged from the facility as “Absent Without Leave (AWOL).” The nursing assistant that was responsible for the resident was not aware that he had a previous elopement, and the resident was not sent to the courthouse with an escort. The resident had gone to her old apartment and was transferred back to the facility by the police on 7/12/18. The facility was cited for failing to provide the resident an escort to and from the courthouse. Citation # 910014516.

**Joyce Eisenberg Keefer Medical Center**  
7150 Tampa Ave., Reseda  
A $20000 Careplan Fall Injury 03/29/2019

On 10/10/18, an 88 year old female resident fell and broke her femur while transferring from the bathroom to her bed. The resident was considered to have a high risk of falls and required a two-person assist for her activities of daily living. However, only one CNA was assisting the resident on the day she fell. The facility was cited for failing to provide the two-person assistance the resident needed and failing to develop an individualized fall prevention plan. Citation # 930014928.

A $20000 Careplan Fall Medication Neglect 03/29/2019

A resident suffered five falls from 9/11/18 to 1/7/19, including one that resulted in a broken arm. The resident had a known high risk for falls, exacerbated by multiple psychotropic medications, imbalance and cognitive impairments. The facility was cited for failing to: 1) develop and implement a timely fall prevention plan, 2) obtain a pharmacist’s review of the resident’s medication that increased fall risk, 3) ensure the resident was assisted in getting to the bathroom, and 4) ensure appropriate use and monitoring of psychotropic drugs and opioids. Citation # 930014929.
Kei-Ai South Bay Healthcare Center  
15115 S Vermont Ave, Gardena  
B $2000 Mandated Reporting Physical Abuse  
7/20/2018

The facility failed to adequately report an incident of abuse to the Department of Public Health, obstructing the investigation. On 3/18/18 the administrator of the facility received a report that a nurse’s assistant had hit a resident on the face and legs. The facility underwent its own investigation and did not find conclusive evidence, so they dropped it. They never reported the incident to the state. The facility was cited for failing to report an incident of abuse within the 24-hour mandated reporting period. Citation # 910014245.

La Crescenta Healthcare Center  
3050 Montrose Ave, La Crescenta  
B $2000 Dietary Services 7/27/2018

The facility failed to enact preventative measures to stop a resident from losing more than 5 percent of her body weight in one month. On 3/8/17 the resident weighed 152 pounds, but by 4/5/17 the resident had lost just over 20 pounds because she was not eating the majority of her meals. The resident’s meal percentage eaten was very low (30 percent average), but the back-up plan (offering the resident an alternate meal when meal percentage drops below 75 percent) was not followed and the resident continued not to eat fully for the month of March. The facility was cited with failing to take proper precautions to prevent extreme weight loss to the resident. Citation # 920014284.

Lakeview Terrace  
831 S Lake Street, Los Angeles  
B $2000 Neglect 03/01/2019

On 1/9/19, an unannounced complaint investigation was conducted at the facility regarding the quality of care being delivered to four residents. Based on observations, interviews and record reviews it was determined that the facility was using incompetent staff to administer intravenous IVs and medications. Furthermore, the facility failed to provide pharmaceutical services, including procedures that assured the administration of all drugs met the needs of each resident. These deficient practices resulted in residents not receiving antibiotics as ordered and had the potential for the development or worsening infections and decreased the efficacy of the antibiotic medications. Citation # 910014851.

B $2000 Careplan Fall Patient Care 03/05/2019

A resident with dementia was identified as being at risk for falls due to her diagnosis and poor muscle tone. The facility failed to assess the resident’s risk for falls properly, failed to develop a specific plan to prevent falls, and failed to implement its policies and procedures for managing falls. These failures led to the resident falling while trying to get out of bed, sustaining a cut to her face, which was closed with stitches. Citation # 910014855.

Lancaster Health Care Center  
1642 W Avenue J, Lancaster  
A $20000 Fall 7/20/2018

On 10/4/17, a resident fell while being transferred from bed to wheelchair, resulting in a thigh fracture that required surgery. The resident was required to have two nurses present while transferring and was required to wear a gait belt. The nurse who transferred the resident alone on 10/4/17 failed to use a gait belt and as a result the resident fell. The facility had not made it clear in the resident’s careplan that two person transfers were necessary. The facility was cited with failing to follow its careplan and trip/fall policies. Citation # 920014255.

Las Flores Convalescent Hospital  
14165 Parche Ave, Gardena  
B $2000 Mental Abuse Verbal Abuse 7/26/2018

On 3/14/18 a nurse’s assistant told a resident to take a shower because she smelled like urine. The nurse’s assistant’s comments made the resident feel humiliated, so she began to refuse care for the next two days, though this was poorly documented, and on 3/23/18 the resident left the facility against medical advice. The resident stated that she left because the staff would tell her that she smelled and regularly open her window even when it was cold to relieve the smell. The resident felt like she had no other choice than to leave the facility. The facility was cited for failing to follow its residents rights policy and for allowing the resident to be verbally and mentally abused. Citation # 910014274.

A $15000 Fall 11/21/2018

On 8/6/18 a resident at the facility attempted to get out of bed on her own, resulting in a fractured leg and a trip to the hospital. The resident’s bed alarm and chair alarm were not functional or checked every shift by staff. The resident’s careplan was not altered to record these attempts. The facility was cited for failing to ensure that the resident did not suffer any falls and that all facility policies and plans were followed. Citation # 910014589.

A $12000 Medication 12/13/2018

The facility failed to ensure that its level of medication error was fewer than 5 percent. After investigation, it was found that the facility’s medication error rate was at 31 percent, when nine out of twenty-nine residents were prescribed improper medications. The facility was cited with failing to keep its medical error rate at a reasonable level, putting multiple residents at risk of injury or death. Citation # 910014650.
On 3/23/18 a resident hit a third resident with a water pitcher. On 3/23/18 the abusive resident had been talking too much, so his roommate told him to shut up, to which the resident responded by slapping him in the face. The abused resident was moved and the abusive resident was given a new roommate. On 3/31/18 a nurse’s assistant walked in on the abusive resident about to hit his roommate in the face with a pitcher of water, but the resident was able to block the pitcher with his arm. The facility was cited with failing to develop a care plan or take direct action to curb the resident’s abusive behaviors and ensure his roommates were not abused. Citation # 910014426.

On 4/12/18, a resident known to fall and elope left the facility unattended, and after screaming for help, attempted to stand, fell, and fractured her right shoulder. The resident required four paramedics to get her off of the floor and was subsequently transferred to the hospital. The facility was cited for failing to provide the resident with adequate supervision and failing to respond to her calls for help. Citation # 910014550.

Lawndale Healthcare Center
15100 Prairie Ave, Lawndale

B $2000 Physical Abuse 9/21/2018
On 2/20/18, two residents of the facility with muscle weakness and difficulty walking were not accurately assessed for falls. The residents were at risk for serious injury. One of the residents had a fall sustaining severe head trauma, nasal fracture, and teeth fractures. The resident was transferred to a hospital for further treatment. The facility failed to provide each resident with the necessary care and service to maintain the well-being of the resident and prevent accidents. Citation # 940014122.

Long Beach Healthcare Center
1201 Walnut Ave, Long Beach

A $20000 Fall 11/2/2018
On 8/8/18 a resident was left on the toilet unattended, and after screaming for help, attempted to stand, fell, and fractured her right shoulder. The resident required four paramedics to get her off of the floor and was subsequently transferred to the hospital. The facility was cited for failing to provide the resident with adequate supervision and failing to respond to her calls for help. Citation # 910014550.

On 8/30/18, a resident was hospitalized and admitted to the ICU due to respiratory failure and a severely distended abdomen. She was intubated and placed on a ventilator. Thick secretions came from her mouth and the tube that had been inserted. When a new urinary catheter tube was inserted, approximately 200 ccs of thick creamy brown urine drained from her bladder into the catheter tubing. X-rays showed large amounts of stool within her colon. She remained in the hospital until her death on 9/11/18, which was caused by acute respiratory distress and severe sepsis. The facility neglected the resident prior to hospitalization. She had no bowel movement for seven days, but no assessment was done. The facility did not develop or implement a care plan for her catheter. It did not monitor her as her condition deteriorated. The facility failed to immediately call 911 or consult with her physician when her condition changed. These failures led to a delay in the resident’s diagnosis, care and treatment and were a direct proximate cause of her death. Her family members described the neglect. One of them stated: “She died because of negligence in the facility where she resided for over 16 years...On the morning that she was transferred to the hospital, she was so dirty with a very bad odor and her abdomen was as large as a nine-month pregnant woman. When they passed a tube, fecal matters came out of the tube. She was transferred late to the hospital, and if the facility had transferred her out to the hospital on time, her condition would have been better.” Another family member stated: “I visited the resident very often, and her condition was deteriorating and was foul smelling. Her stomach was so big as if she had three soccer balls inside of her stomach due to the accumulation of fecal matters. The facility was not taking good care of the resident.” Citation # 940014770.

Long Beach Post Acute
1201 Walnut Ave, Long Beach

B $2000 Physical Environment 8/24/2018
The facility failed to provide comfortable and safe temperatures to residents, who were living and eating in rooms heated to over 81 degrees. The rooms were 84 and 85 degrees, well over the required 71 - 81 degree range, and if the residents complained about being hot, they were moved to the dining room, which had a large fan and was cooler than the resident’s rooms. The air conditioning was working, but not enough, and the residents were drinking ice water to stay cool. The facility was cited with failing to provide a safe living environment for the residents. Citation # 910014367.
Longwood Manor Convalescent Hospital
4853 W Washington Blvd, Los Angeles
**A $20000 Neglect Patient Care 8/17/2018**
Beginning on 3/4/18, the facility was not aware that a resident had gone missing from the facility for 12 days, until 3/16/18. The resident went out on pass and was not back within 72 hours, so she was officially discharged. No search was undergone for the resident, and no investigation or report was filed, even though she often left on pass and came back in the same day. No family member or responsible person was informed when the resident did not come back from her out on pass. The resident was ultimately found dead in a storage locker 2700 miles away in Pennsylvania, wearing nothing but her hospital gown despite the cold weather. The facility was cited for failing to conduct an investigation, report the missing resident, or provide adequate supervision to the resident.
Citation # 910014330.

Los Palos Convalescent Hospital
1430 W 6th St, San Pedro
**A $16000 Fall Supervision 7/31/2018**
The facility failed to follow its fall prevention policy in the case of a resident who fell eight times in eleven months, the last fall resulting in a stay at the hospital. The resident sustained a broken hip which required a nail to be inserted in order to heal. The resident was at high risk for falls, but was not given adequate supervision or care during any of eight falls in her bathroom, from her bed or onto the floor. After each of the residents falls, no further plan was decided upon in order to correct the falling behaviors. The facility was cited for not following its fall prevention policy or providing an adequate plan to correct falling behaviors.
Citation # 910014305.

Maclay Healthcare Center
12831 Maclay St, Sylmar
**B $2000 Careplan Fall Injury Patient Care 11/26/2018**
A resident with paralysis on one side of the body, deemed by staff a high risk for falls, and required assistance with all transfers, standing and walking, was not provided with a physician-recommended escort during medical transport to a clinic appointment. The resident’s wheelchair was not properly secured to the van, and the resident was not provided with a buckle to secure him to the wheelchair. When the driver hit the brakes hard during a stop, the resident fell face down on the van floor, slid to the front of the van, and suffered cuts to his nose and eye.
Citation # 920014607.

Maple Healthcare Center
2625 Maple Ave, Los Angeles
**A $20000 Fall 02/13/2019**
On 3/31/18, a resident who was a noted fall risk was found sitting on the floor near the restroom. On 4/1/18, the resident expressed a pain level of 7 out of 10 and was sent to the hospital for evaluation. At the hospital, it was determined that his thigh bone was fractured near the hip socket. The facility was cited for failing to properly assess and have a proper care plan for a resident who was at risk for falling.
Citation # 940014812.

Mayflower Care Center
5043 Peck Rd, El Monte
**B $2000 Careplan Patient Care Patient Rights 12/4/2018**
The facility failed to follow a physician’s order for a psychiatric evaluation prior to discharging a resident diagnosed with dementia and psychosis to a facility with a lower level of care. Staff did not ensure that the resident was discharged to the facility most suitable to meet his needs, did not properly prepare or orient the resident prior to discharge, failed to give advanced notice, and failed to complete discharge planning prior to moving the resident to an Assisted Living Facility (ALF). As such, after 1 day in the new ALF, which was not prepared to manage the resident’s behaviors, the resident was put on a 5150-involuntary psychiatric hospital hold.
Citation # 950014626.

Monrovia Gardens Healthcare Center
615 W Duarte Rd, Monrovia
**B $2000 Mandated Reporting Patient Care Patient Rights Physical Abuse Verbal Abuse 12/7/2018**
Three staff members witnessed a nursing assistant “rough handling” two different residents. The witnesses stated that this particular nursing assistant was rude and rough, especially to residents who could not communicate. She was seen “force feeding” a resident while using profanity and being rough to another resident during a transfer. The facility was cited for failure to report allegations of abuse to the department.
Citation # 950014638.

Monrovia Post Acute
1220 Huntington Dr, Duarte
**B $2000 Physical Abuse 12/21/2018**
On 7/7/18, a CNA heard a resident crying for help. When she entered the resident’s room she witnessed her being slapped across the face and leg by the resident’s attending CNA. The resident was 90 years old and suffering from dementia, glaucoma and unable to walk or feed herself. The CNA who did the slapping stated that the resident had bitten her. The facility was cited for failure to ensure that the resident was free from physical abuse.
Citation # 950014678.
Mount San Antonio Gardens
900 E Harrison Ave, Pomona
B $2000 Transfer 03/14/2019
On 10/21/18, a resident who was at risk for falls and required a two-person assist during transfers was dropped by a single staff person who was trying to help her onto the toilet. During the transfer, the resident told the CNA she was getting dizzy and that her legs were giving out. As the CNA struggled to lower her to the ground, the resident’s foot became twisted and sustained a fracture. The facility was cited for failing to provide the resident with a two-person assist during transfer. Citation # 950014885.

Olympia Convalescent Hospital
1100 S Alvarado St, Los Angeles
B $2000 Mandated Reporting 7/26/2018
On 3/27/18 a resident was found to have bruises of unknown origin on her upper torso and breast area. Bruises of unknown origin are a sign of abuse and should be reported immediately, however the facility failed to perform an investigation or report the issue. The facility was cited with failing to report a possible episode of abuse within the mandated 24 hour reporting period. Citation # 920014287.

Palos Verdes Health Care Center
26303 Western Ave, Lomita
B $2000 Chemical Restraints 05/09/2019
A review of the drug regimens for 27 residents revealed inappropriate use of psychotropic drugs to control the behavior of many residents in the facility. Fourteen residents were given psychotropic drugs for reasons other than to treat specific conditions. Ten were given as needed (PRN) psychotropic drugs beyond the legal limit of 14 days. Seven residents had duplicative psychotropic drugs, from the same pharmacological class, without a documented clinical rationale. Twenty-one residents did not have timely gradual dose reduction attempts, and ten residents did not have adequate monitoring for target behaviors and adverse effects. Psychotropic drugs were given to residents to make “it easier to provide care,” ensure residents “follow instructions better,” and make them “easier to talk to.” Some residents were given drugs to address their “sad face.” The facility had multiple breakdowns of the regulatory processes meant to protect against inappropriate drugging of residents, from physician oversight and pharmacy consultant services to nursing documentation and supervision. Citation # 910014327.

Playa Del Rey Center
7716 W Manchester Ave, Playa Del Rey
A $15000 Elopement 9/21/2018
The facility failed to ensure that three of its residents would not elope the facility and did not install functional “wanderguards” or provide the residents with adequate planning and supervision. On 5/14/18 the first resident eloped from the facility, went through a gate, locked it behind him, and fell further down the way, fracturing his hand. The resident had a wanderguard, a lock and alarm on the resident’s door, which was not checked for functionality during the shift on 5/14 and the alarm did not sound when the resident left. The second resident did not elope but had a history of eloping and was ordered a wanderguard which was never installed. The third resident was at high risk of eloping but no careplan was ever developed for him. The facility was cited with failing to put necessary precautions in place to prevent resident elopement. Citation # 910014419.

Royal Oaks Manor - Bradbury Oaks
1763 Royal Oaks Dr, Duarte
A $20000 Careplan Decubiti (Bedsores) Neglect Patient Care 11/30/2018
Between 9/25/18-11/3/18, a resident admitted to the facility without pressure sores developed a Stage 2 pressure sore to the tailbone which deteriorated to Stage 3, and caused her to complain of daily pain and sit at the edge of her bed moaning and crying. The facility was cited for the following conduct: failing to implement the resident’s care plan to reposition every 2 hours or as needed, and to

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remove pressure from her tailbone; failing to include in the resident’s care plan her preference to sit most of the day in the wheelchair, and interventions to ensure removing pressure, repositioning and toileting; and failing to refer her to physical therapy for recommendations about posture and devices to address proper body alignment while in a wheelchair. Citation # 950014611.

Royal Palms Post Acute
630 W Broadway, Glendale
B $2000 Bed Hold 7/20/2018
On 3/26/18 a resident was transferred to the hospital because of extreme pain in her sitting bones as well as bedsores. When the resident attempted to gain readmission to the facility on 3/27/18, she was denied her seven day bed-hold. The facility was cited with not informing the resident of her seven day bed-hold as well as not allowing resident readmission before her rightful bed-hold period was up. Citation # 920014258.

San Fernando Post Acute Hospital
12260 Foothill Blvd, Sylmar
A $20000 Fall 02/22/2019
On 6/2/18, a 58 year old resident who was partially paralyzed was being transferred back into her bed when the mechanical lift’s sling ripped apart, causing her to fall to the floor. The fall fractured the resident’s hip requiring surgery and four days of hospitalization. The facility was unable to provide investigators with any documented evidence that the sling was inspected before use. The facility was cited for failing to provide a safe environment to ensure that residents did not fall or elope. Citation # 950014688.

SeaPort 17th Care Center
1330 17th St, Santa Monica
B $2000 Careplan Deterioration Elopement Fall Hydration Injury Neglect Notification Patient Care Security Supervision 04/18/2019
On 1/12/19, a resident known to wander away from the facility was left unattended. The facility failed to monitor the resident’s whereabouts and the function of the WanderGuard at the facility exit. The device was unable to alert and sound the alarm when the resident left the facility unnoticed. The resident was found and was admitted to a hospital two days later. The resident’s physical examination indicated weakness and dizziness that lead to a fall and severe dehydration. Citation # 910014957.

St. John Of God Retirement And Care Center
2468 S St Andrews Pl, Los Angeles
B $2000 Physical Restraints 9/6/2018
On 4/18/18 a resident at the facility was held down in order to take a blood sample after telling the staff members who had been give orders in the case of any non compliance to respect the resident’s wishes and report the incident to her physician. There had been five previous cases of the resident refusing a blood sample, and this was the first time any incident occurred. The facility was cited with improperly restraining a resident, infringing on her rights. Citation # 910014386.

Stoney Point Healthcare Center
21820 Craggy View St., Chatsworth
A $2000 Fall 7/27/2018
On 4/4/18 a nurse’s assistant solo-carried a resident from the bed to her wheelchair, causing her to fall and sustain a thighbone fracture and knee dislocation. The resident’s careplan did not call for two person transfers, but the administrator of the facility stated that it should have and that the nurse’s assistant should not have attempted to carry the resident alone. The facility was cited for failing to update the resident’s careplan with the proper information and with failing to properly transfer the resident with two staff members. Citation # 920014291.

Studio City Rehabilitation Center
11429 Ventura Blvd, Studio City
B $2000 Sexual Abuse 9/14/2018
A nurse’s assistant at the facility attempted to kiss a resident that was under his charge. The nurse’s assistant approached the resident from behind while he was assisting her and moved his head closer to hers. The resident made it clear that she did not want to kiss him. He came back twice that day, the first time trying again and the second time asking if she was mad at him. The facility was cited for failing to ensure all residents were free from sexual abuse. Citation # 920014414.

Tarzana Health And Rehabilitation Center
5650 Reseda Blvd, Tarzana
B $2000 Physical Abuse 04/05/2019
On 7/20/18, a resident complained to the facility that she had been roughly handled by a CNA when that staff member grabbed her hand hard while getting her ready for the morning. Evidence of the force used by the CNA was
the discoloration of the resident’s skin on her right middle finger. The facility was cited for failing to report the incident to the Department in a timely manner as required by law. Citation # 920014938.

The Orchard - Post Acute Care
12385 Washington Blvd, Whittier
B $2000 Administration 2/6/2019
The facility administrator failed to post his license in the lobby of the facility. The director of nursing was questioned on 12/26/18, at which point he did not know that the administrator’s license was not on display and could not recall when the administrator was last in the facility. The facility was cited with failing to post the documents in the agreed-upon location, following its policy. Citation # 940014805.

University Park Healthcare Center
230 E Adams Blvd, Los Angeles
B $2000 Injury Patient Care Transfer 02/22/2019
On 12/14/17, an 81 year old resident with severe cognitive impairment complained of pain on her left arm and shoulder and had purple discoloration on three fingers on her left hand. Based on interview and record review, it was determined that the resident, who required extensive assistance from two or more persons for transfers, was injured while being transferred by one person from a shower chair to a wheelchair via a stand-up machine that stopped working during the transfer process. The resident was sent to the hospital after an x-ray revealed that her left shoulder was broken. The facility was cited for failing to ensure that the resident received two or more person assistance during transferring to prevent accidents. Citation # 940014834.

Verdugo Hills Hospital D/P SNF
1812 Verdugo Blvd., Glendale
B $2000 Mandated Reporting Verbal Abuse 11/8/2018
The facility failed to properly report an alleged incident of verbal abuse to the Department of Health as required by law after a visitor reported to staff that they overheard a resident being verbally abused by a visiting family member. Citation # 930014574.

Vermont Healthcare Center
22035 S Vermont Ave, Torrance
B $2000 Nutrition 8/22/2018
The facility failed to prevent a resident from losing 24 pounds in two months. On 6/11/18 records showed that the resident had experienced a 12 pound weight loss from the previous month, and on 7/1/18 the resident had lost another 12 pounds from their 6/11/18 weight. No preventative measures were taken at any point before 7/1/18, on which day the resident was put under meal supervision and a plan was created. A bedsore was also found on the resident’s heel, which had not healed due to the resident’s poor diet. The facility was cited for failing to uphold its Nutrition and Hydration policy. Citation # 910014352.

View Heights Convalescent Hospital
12619 Avalon Blvd, Los Angeles
A $20000 Fall 9/19/2018
The facility failed to prevent a resident from falling or alter his careplan after four falls within a six month period. The resident fell three times from 7/7/16 to 10/6/16, sustaining a fractured knee. The resident’s careplan was not updated to reflect his fall risk. On 12/23/16 the resident fell a fourth time, biting his tongue and requiring a trip to the hospital and stitches to repair the quarter inch deep wound. The facility was cited for failing to update the resident’s careplan as well as failure to provide supervision to prevent the resident from falling. Citation # 910014421.

Wellsprings Post-Acute Center
44445 N. 15th St West, Lancaster
A $20000 Decubiti (Bedsores) 01/10/2019
In September 2018, a resident developed multiple, infected stage IV pressure sores on his buttocks and heel following a period where he suffered a significant weight loss and became malnourished due to poor meal consumption. The resident was hospitalized on 9/28/18 due to sepsis and the severe pressure injuries. On 10/16/18, the hospital discharged him to another skilled nursing facility on hospice services, and he died several days later. The facility was cited because it failed to conduct accurate weekly skin assessments, implement pressure ulcer prevention treatment, notify his physician of the significant weight loss and evaluate his poor meal consumption. These failures resulted in the development of the pressure sores and led to his hospitalization and death. Citation # 920014716.

Windsor Palms Care Center of Artesia
11900 Artesia Blvd, Artesia
A $20000 Careplan Fall Injury Patient Care 7/6/2018
The facility failed to adhere to the care plan for a resident diagnosed with dementia and Alzheimer’s, which included preventative measures based on the resident’s history of falls. The resident was not adequately supervised, no bed alarm was put in place and staff did not properly follow the fall risk steps. These failures led to the resident falling twice, sustaining a laceration and bruising to her head, requiring hospitalization. After a later fall, the resident suffered a loss of consciousness and a concussion. Citation # 940014216.
**Marin County**

**Professional Post Acute Center**
81 Professional Center Pkwy, San Rafael

A $20000 Decubiti (Bedsores) 05/29/2019
The facility violated the regulation by failing to prevent the development of pressure ulcers on the base of the pelvis (Stage IV), left hip (Stage III) and right hip (Stage II) in a resident, requiring hospitalization. The resident was admitted to the facility on 1/30/18 with pressure ulcers and the admission MDS indicated the resident was at risk for developing pressure ulcers. On 7/21/18 quarterly MDS indicated the resident had no pressure ulcers. On 8/3/18 the discharge MDS indicated the resident had one Stage III ulcer and one unstageable one. Citation # 110014932.

A $20000 Careplan Fall Supervision 05/29/2019
The facility violated the regulation by failing to 1. Provide adequate supervision and 2. Develop a resident-centered care plan to prevent falls for a resident. The resident had 13 documented falls, all occurring in her room, during a seven month period from 01/23/18 to 08/11/18, resulting in cuts, bruises, swelling, and major brain injury after the fall on 8/11/18. As a result of the brain injury, the resident required surgery, was placed on a feeding tube, hospitalized in the intensive care unit, and experienced a severely diminished quality of life. Citation # 110014932.

**Napa County**

**Golden Livingcenter Napa**
705 Trancas St, Napa

B $2000 Notification 12/7/2018
The facility failed to notify the Ombudsman of the transfer of a resident to their home. On 7/11/18 the resident was transferred to their home because they were no longer able to afford long term care. The Ombudsman's office was closed and the resident had not signed the transfer paperwork, so the facility did not send it. Because of this failure, the resident was not able to access an advocate who could inform them of their rights and actions in this situation. Citation # 110014524.

**Orange County**

**Carehouse Healthcare Center**
1800 Old Tustin Ave, Santa Ana

B $1500 Patient Care 9/13/2018
The facility failed to give a resident the treatment her doctor ordered, resulting in the resident being hospitalized after experiencing fluid overload. On 6/20/18 the doctor ordered the resident to be kept on a low-fluid intake regimen. The order was never carried out and the resident continued to drink as much liquid as she wanted to. On 7/11/18 the resident began complaining of chest pain and difficulty breathing, for which she was transferred to the hospital, where she was diagnosed with fluid overload, high blood pressure, and a disease of the brain. The facility was cited with failing to monitor and enforce a physician’s orders to reduce the resident’s fluid intake. Citation # 060014397.

**Flagship Healthcare Center**
466 Flagship Rd, Newport Beach

B $2000 Fall Physical Environment Supervision 05/16/2019
On 2/2/19, a resident fractured her left thigh bone when her wheelchair wheel caught an open drain in the outdoor smoking area, causing a fall. There were no signs or warnings around the open drain, and neither residents nor staff were given instructions or warnings about the drain and smoking area. Staff also did not supervise residents when using the smoking area. The facility staff failed to inspect the area for hazards. As a result, the facility violated regulations by not keeping the environment free of accident hazards and by not providing adequate supervision of residents. Citation # 060015084.
On 1/22/19, a male resident with a diagnosis of muscle weakness and cognitive impairment received electrical stimulation therapy (“e-stim”) to his lower left leg. The machine was applied at high intensity: 60 microamperes when the usual setting was only 30 microamperes. The resident was left alone in his room to receive the e-stim, without instructions on how to stop it. The resident experienced intense pain, and then burns, to his left leg where the pad was placed. The burns subsequently turned into open wounds to his muscle, requiring prolonged wound care and removal of damaged tissues. Citation # 060014924.

On 3/26/19, a resident was discharged to a Board and Care facility. The resident had previously been diagnosed and was under treatment for several conditions, including diabetes, high blood pressure and seizures. The resident also had paralysis on one side and could not communicate through speech. The resident was discharged to a Board and Care facility, but that facility was not capable of providing the level of care needed and was not informed of the resident’s medical needs. The resident was subsequently admitted to an acute care hospital having not received the medical care needed. Contrary to facility policy and regulation, the facility failed to ensure the receiving facility was fully aware of the resident’s medical care needs. Citation # 060015112.

On 10/19/18, a male resident with a diagnosis of dementia was tied to his bed by a nursing assistant, who wrapped him in a sheet “like a rope” from his waist down to his ankles. A family member visited the resident and found him in that state. The facility was cited for failure to self-report the incident to the Department of Public Health. Citation # 250014792.

On 2/6/19, the Director of Nursing (DON) was interviewed regarding an incident with an LVN. The DON stated that controlled medications were missing. The pharmacy confirmed that they received the orders written and faxed by the LVN. The DON said based on her investigation; she found out that the LVN wrote prescriptions, and faxed them to the pharmacy. The LVN would strike out the orders afterward so it would appear as a computerized error. The DON verified with the physicians that the medications were not prescribed for any residents. The LVN did not admit nor deny the allegations. The DON confirmed that the incident was not reported to law enforcement. Citation # 250014958.

On 11/17/17 a resident at the facility was discharged to a room and board establishment, which did not provide staff members to care for the resident, who required assistance. The facility was aware that the resident required assistance and that the room and board establishment did not provide caregivers. The facility was cited for failing to implement a safe discharge process and provide sufficient care to the resident. Citation # 250014345.

On 12/18/17 a resident at the facility was discharged to a room and board establishment, which did not provide staff members to care for the resident, who required assistance. The facility was aware that the resident required assistance and that the room and board establishment did not provide caregivers. The facility was cited for failing to implement a safe discharge process and provide sufficient care to the resident. Citation # 250014346.
B $2000 Transfer 8/29/2018
On 11/22/17 a resident at the facility was discharged to a room and board establishment, which did not provide staff members to care for the resident, who required assistance. The facility was aware that the resident required assistance and that the room and board establishment did not provide caregivers. The facility was cited for failing to implement a safe discharge process and provide sufficient care to the resident. Citation # 250014347.

B $2000 Transfer 8/29/2018
On 12/6/17 a resident at the facility was discharged to a room and board establishment, which did not provide staff members to care for the resident, who required assistance. The facility was aware that the resident required assistance and that the room and board establishment did not provide caregivers. The facility was cited for failing to implement a safe discharge process and provide sufficient care to the resident. Citation # 250014347.

WMF $2500 Mandated Reporting Patient Records 04/16/2019
On 8/20/18, it was determined that the facility had two different Medication Administration Records (MAR) for July 2018. The first record obtained indicated that the resident’s Debrox solution (a solution used for removing earwax), was not administered all of July 2018. Additionally, there was no written physicians order for the solution during this month. There was later a second copy of the Medication Administration Records from July of 2018 that was received by the department from the facility’s Medical Record Director that indicated that it was administered every day of July 2018. The facility was unable to explain this discrepancy. These facts indicated that there was willful material falsification in the medical record for the resident. Citation # 250014909.

B $2000 Notification 04/17/2019
On 6/20/18, the facility failed to ensure a written notice of transfer was provided to the local long term care ombudsman when the resident was transferred to a hospital. This failure put the resident at risk of being transferred without a clear understanding of the appeal process and his appeal rights. Citation # 250014707.

Jurupa Hills Post Acute
6401 33rd St, Riverside

B $2000 Mandated Reporting Verbal Abuse 8/6/2018
On 2/10/18, a resident verbally threatened her roommate at the facility, saying she was going to physically harm her. The incident went unreported by the facility for 46 hours, allowing time for more abuse to occur. The facility was cited for failing to report an incident of abuse within the 24-hour mandated reporting period. Citation # 250014275.

B $2000 Mandated Reporting Physical Abuse 03/20/2019
On 10/21/18, a male CNA was heard yelling at a 69 year old female resident with dementia who was unable to verbalize her needs, and a thump was heard as if the resident was pushed into a wall. The Administrator stated that he did not report the incident because the CNA told him the noise occurred when the resident slapped him on the face. The facility was cited for failing to report an allegation of abuse to the Department within two hours, and provide a written report of the facility’s investigation to the Department within five days. Citation # 250014869.

Manorcare Health Services-Palm Desert
74350 Country Club Dr, Palm Desert

B $2000 Notification 05/22/2019
An 83 year old resident was admitted to the facility on 11/19/18. On 11/29/18, the resident was transferred from the facility to a hospital due to a change of condition, but the ombudsman was not notified of this transfer. As a result of this failure to notify, the ombudsman was unable to ensure the resident’s transfer was safe and that the resident was aware of the appeal process if the facility refused the resident’s readmission to the facility. Citation # 250014976.

MONTEREY PALMS HEALTH CARE CENTER
44610 Monterey Ave, Palm Desert

B $2000 Mental Abuse 8/17/2018
On 1/27/18 a nurse’s assistant took a video making fun of a resident, who was partially naked, and posted it to the social media platform, Snapchat. The nurse’s assistant’s video showed the resident’s exposed genital area and stated “this is what we have to deal with every day” referring to the resident. The facility was cited with failing to protect its residents from mental abuse and failing to enforce its cell phone policy. Citation # 250014196.

B $2000 Mandated Reporting Notification Transfer 04/15/2019
On 4/6/18, a resident was transferred to an acute care hospital. The facility failed to give the local long term care ombudsman a written notification of the transfer. This failure placed the resident at risk of not understanding the appeal process and her appeal rights. Citation # 250014783.

Palm Grove Healthcare
1665 E 8th St, Beaumont

A $10000 Fall 9/19/2018
On 9/20/17 a resident was left alone with another resident who pushed him to the ground, breaking his hip. The resident had wanted to go to the bathroom but it was occupied, so his nurse’s assistant left him in front of the bathroom and allowed him to go unattended. During that
time, the resident entered the bathroom and approached
the other resident who felt threatened and pushed him
down. The facility was cited for failing to supervise
the resident at all times in order to prevent falls.

Palm Springs Healthcare & Rehabilitation Center
277 S Sunrise Way, Palm Springs
B $200 Transfer 11/28/2018
The facility failed to administer a written notice of discharge
to the resident or the Ombudsman. On 6/28/18 the resident
was discharged from the facility without documentation
that he received the required information preparing him
for discharge. The facility had also neglected to inform the
resident’s Ombudsman prior to the discharge. The facility
was charged with failing to follow its discharge policy.

B $200 Transfer 11/28/2018
The facility failed to administer a written notice of discharge
to the resident or the Ombudsman. On 7/13/18 the resident
was discharged from the facility without documentation
that he received the required information preparing him
for discharge. The facility had also neglected to inform the
resident’s Ombudsman prior to the discharge. The facility
was charged with failing to follow its discharge policy.

B $200 Transfer 11/28/2018
The facility failed to administer a written notice of discharge
to the resident or the Ombudsman. On 7/10/18 the resident
was discharged from the facility without documentation
that he received the required information preparing him
for discharge. The facility had also neglected to inform the
resident’s Ombudsman prior to the discharge. The facility
was charged with failing to follow its discharge policy.

B $200 Transfer 11/28/2018
The facility failed to administer a written notice of discharge
to the resident or the Ombudsman. On 7/9/18 the resident
was discharged from the facility without documentation
that he received the required information preparing him
for discharge. The facility had also neglected to inform the
resident’s Ombudsman prior to the discharge. The facility
was charged with failing to follow its discharge policy.

B $200 Transfer 11/28/2018
The facility failed to administer a written notice of discharge
to the resident or the Ombudsman. On 7/17/18 the resident
was discharged from the facility without documentation
that he received the required information preparing him
for discharge. The facility had also neglected to inform the
resident’s Ombudsman prior to the discharge. The facility
was charged with failing to follow its discharge policy.

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The facility failed to administer a written notice of discharge
to the resident or the Ombudsman. On 7/13/18 the resident
was discharged from the facility without documentation
that he received the required information preparing him
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for discharge. The facility had also neglected to inform the
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was charged with failing to follow its discharge policy.

B $200 Transfer 11/28/2018
The facility failed to administer a written notice of discharge
to the resident or the Ombudsman. On 7/17/18 the resident
was discharged from the facility without documentation
that he received the required information preparing him
for discharge. The facility had also neglected to inform the
resident’s Ombudsman prior to the discharge. The facility
was charged with failing to follow its discharge policy.

Premier Care Center For Palm Springs
2990 E Ramon Rd, Palm Springs
B $2000 Mandated Reporting Physical Abuse
11/14/2018
On 6/23/18 one resident approached another resident who was
near the nurse’s station, grabbed her arm and shook it. This
was seen by the nursing staff but was not reported until two
days later, on 6/25/18. The facility was cited with failing to
report abuse within the mandated 24-hour reporting window.

B $2000 Mandated Reporting Physical Abuse
11/14/2018
On 6/23/18 one resident approached another resident with a
pad from their bed and hit the other resident with it repeatedly.
This was seen by the nursing staff but was not reported until
two days later, on 6/25/18. The facility was cited with failing to
report abuse within the mandated 24-hour reporting window.

Rancho Mirage Health and Rehabilitation Center
39950 Vista Del Sol, Rancho Mirage
B $2000 Dignity Mandated Reporting Patient
Care Physical Abuse 5/3/2019
On 9/2/18, a female resident was observed to be very
upset. She told a nurse that a nursing assistant had just
aggressively yanked her out of bed and ripped all the
covers off. Two days later, on 9/4/18, the resident appeared
anxious and “not her normal self” and again reported that
staff ripped off her clothes and forced her to go to bed the
night before. On 9/5/18, the resident stated that someone at
the facility put their hands on her, causing bruising. When
interviewed, the facility’s Director of Nursing said these
were mere “delusions.” The facility was cited for failure
to report incidences of alleged abuse to the Department.

Citation # 250014942.
Citation # 250014889.
The facility was cited for failing to provide proper transfer notice. The resident, the resident’s representative, or the Ombudsman had been given a written transfer notice as required by law. The facility was cited for failing to provide a copy of a resident transfer notice to the long term care Ombudsman office. A resident had been transferred to the hospital on 5/24/18. The facility had no records that the resident, the resident’s representative, or the Ombudsman had been given a written transfer notice as required by law. The facility was cited for failing to provide proper transfer notice. Citation # 250014888.

The Grove Care and Wellness
3401 Lemon St, Riverside

A $10000 Deterioration 8/14/2018
The facility failed to properly assess and treat a patient’s diarrhea, leading to dehydration, septic shock and death. On 2/3/16 the resident began to have diarrhea and notified the staff, but the first time the staff reacted to it was 2/5/16. In the interim period, the resident began experiencing increased levels of fatigue and impulsiveness. Stool was not collected and tests which were requested on 2/5/16 were not taken until 2/7/16. On 2/8/16 the resident was transferred to the hospital, on 2/9/16 she went into septic shock and kidney failure, on 2/10/16 her entire large intestine was removed, and she passed away on 2/25/16. The facility was cited for failing to assess and treat the diarrhea and failing to notify a physician when the resident’s condition worsened. Citation # 250014269.

The Village Healthcare Center
2400 W Acacia Ave, Hemet

A $10000 Deterioration 8/14/2018

The facility failed to properly assess and treat a patient’s diarrhea, leading to dehydration, septic shock and death. On 2/3/16 the resident began to have diarrhea and notified the staff, but the first time the staff reacted to it was 2/5/16. In the interim period, the resident began experiencing increased levels of fatigue and impulsiveness. Stool was not collected and tests which were requested on 2/5/16 were not taken until 2/7/16. On 2/8/16 the resident was transferred to the hospital, on 2/9/16 she went into septic shock and kidney failure, on 2/10/16 her entire large intestine was removed, and she passed away on 2/25/16. The facility was cited for failing to assess and treat the diarrhea and failing to notify a physician when the resident’s condition worsened. Citation # 250014269.

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she was fat, smelled bad and that her daughter never came
to visit. These statements upset the roommate and caused
her to cry. The Department was not notified until 1/16/19.  
Citation # 030014994.

Norwood Pines Alzheimers Center  
500 Jessie Avenue, Sacramento

B $2000 Fall Neglect 04/17/2019
On 1/4/19, a resident at the facility experienced an unwatched fall, even though it was known that she was completely dependent during transfers and toileting. Regardless of the resident’s yelling concerning her pain and the visible swelling and discoloration of her leg, a physician was not notified of her fall, and the resident was not taken to a doctor until three days later. X-rays revealed that the resident had a broken shinbone, and the facility neglected her care for three days. Citation # 030014943.

Windsor Care Center of Sacramento

501 Jessie Avenue, Sacramento

B $2000 Security Supervision 04/24/2019
On 1/6/19, a resident ran away from the facility at 3 am, by exiting through two gates that were both supposed to be secured. The resident was found 8 hours later in the cold rain with a broken nose, facial injuries and scraped knees. Upon inspection by DPH personnel, the facility’s gates were not secured from the inside and were able to be opened without a key – violating facility procedure. The facility was found to have violated regulations by not providing adequate supervision of residents and not keeping the environment free of hazards by not securing facility exits. Citation # 030014978.

Windsor El Camino Care Center

2540 Carmichael Way, Carmichael

B $2000 Mandated Reporting Physical Abuse 05/10/2019
On or about 2/21/19, a resident and a CNA witnessed a licensed nurse place his hand over another resident’s face, push the resident back into her wheelchair and block her room door with a chair so that she could not leave the room. The facility was cited for failing to report an allegation of physical abuse to the Department within 24 hours. Citation # 030015047.

San Benito County

Hazel Hawkins Memorial Hospital D/P SNF  
911 Sunset Dr, Hollister

B $2000 Fall Supervision 05/02/2019
A resident with degenerative bone diseases, glaucoma and dementia, had 29 recorded falls from 3/21/18 to 3/29/19, one resulting in a hip fracture on 11/26/18. Nine days prior, the resident had received a score indicating a high risk of falling on the Morse Fall Scale. The facility was aware of the fall risk and had previously initiated a careplan on 10/10/16 that indicated a high risk for falls. Visual checks and careplan intervention every hour were not being documented and monitored. The facility failed to prevent accidents by not providing supervision to prevent falls and did not develop, revise, or implement resident-centered careplan and interventions to prevent future falls. Citation # 070015002.

San Bernardino County

Bear Valley Community Hospital D/P SNF  
41870 Garstin Drive, Big Bear Lake

B $2000 Verbal Abuse 9/6/2018
The facility failed to prevent the verbal harassing of multiple residents at their facility by a single nurse’s assistant. The nurse’s assistant on regular occasions would scream at the residents to make her orders known, chastise them and threaten them. When another nurse’s assistant reported this to the Ombudsman and her director of nursing, her director of nursing started screaming at her, claiming that she should not have told the Ombudsman and that she just lost them one of their stars. The facility was cited with failing to stop their residents from being verbally abused. Citation # 240014382.

Community Hospital of San Bernardino D/P SNF  
1805 Medical Ctr Dr., San Bernardino

A $5000 Fall Staff (Inservice) Training 7/26/2018
On 4/16/18 a resident fell from a sling scale during weighing and broke their hip. The staff had neglected to properly criss-cross the sling straps, which resulted in the resident slipping out of the straps and falling to the ground. The resident was transferred to the hospital and diagnosed with a fractured hip. The facility was cited for failing to establish and carry out fall procedures for weighing the resident. Citation # 240014270.
A $20000 Fall  9/21/2018

A resident at the facility suffered multiple instances of falls and on 5/1/18 was transferred to the hospital with bleeding in the brain. The patient sustained five falls from 2/22/18 to 5/1/18. The first fall was 16 days after admission, and the final two falls were on the same day, 5/1/18, wherein she hit her head twice sustaining a brain injury and requiring a ventilator. During this five-fall period, no revisions were made to the residents careplan and her routine and safety precautions remained the same. The facility was cited with failing to identify the reason and implement preventative measures for the resident’s falls, causing eventual life threatening harm to the resident. Citation # 240014403.

Meadows Ridge Care Center
1700 E Washington St, Colton

B $2000 Patient Care  8/16/2018

On 5/29/18 a resident left out on pass and did not return. The facility was aware that the resident had bipolar disorder and paranoid schizophrenia, but they did not allow for sufficient supervision or caution when allowing him to leave. On 5/29/18, the sign out sheet stated that his destination was “Store” but the resident said “Goodbye” and that he was catching the bus back to Riverside. There was no search conducted a day later when the resident was missing or when the discrepancy between the sheet and his claimed destination was discovered. The Facility was cited because they wrongfully diagnosed the resident able to go out on pass unattended and they did not do everything in their power to search for the resident when his absence became increasingly concerning. Citation # 240014338.

Mill Creek Manor
2278 Nice Ave, Mentone

A $10000 Neglect  8/1/2018

On 5/5/18 a resident was found outside in direct sunlight during a shift change with severe second degree sunburns and heat stroke. The nurse’s assistant (CNA) that was supposed to be taking care of the resident had left earlier due to an emergency and the nursing staff was not informed for an hour and fifteen minutes. When the staff realized the first CNA was not there, they assigned a second CNA to the first CNAs residents but did not tell her what care the residents needed. When the resident was found (by an unrelated nurse’s assistant), he was transferred to the hospital with internal temperatures of 104 degrees and critical condition of multiple bodily systems. The facility was cited with failing to properly supervise the resident. Citation # 240014293.

A $15000 Fall Hydration Nutrition 8/16/2018

Beginning on 12/7/17 and ending two weeks later, a resident at the facility stopped eating regularly and the facility did nothing to improve her diet and declining condition. The resident ate a total of 9% of her meals from 12/7/17 to 12/20/17 and lost 15 pounds from 12/13/17 to 12/20/17, which is a week’s time. The nurse’s were aware of the resident’s loss of appetite, but no action was taken. When the resident was less responsive on 12/21/17, the facility send her to the hospital. At the hospital, the resident was diagnosed with septic shock, kidney injury and small bowel obstruction, and died on 1/11/18. The facility was cited for not doing everything in its’ power to diagnose the resident and help her to receive the nutrients she needed. Citation # 240014339.

Rialto Post Acute Center
1471 S Riverside Ave, Rialto

A $15000 Fall Injury Neglect 10/10/2018

On 2/25/18 a resident at the facility fell forward onto a mattress pad and hurt his forehead, resulting in pain and dizziness. His pain and dizziness increased throughout the next day. On 2/26/18 the resident’s doctor called the hospital, telling them that the resident would be a direct admit. The resident was not sent to the hospital by the facility, who waited a day to send him, and on 2/27/18 the resident’s condition declined. He had another fall before finally being transferred. After being transferred, the resident passed away after arriving at the emergency room. The facility was cited with failing to obey the physician's orders and transfer the resident directly to the hospital. Citation # 240014468.

Upland Rehabilitation And Care Center
1221 E Arrow Hwy, Upland

AA $30000 Medication 12/28/2018

The facility failed to give a resident the proper dosage of Potassium Chloride, as prescribed by the doctor, resulting in the resident’s elevated level of potassium, heart attack and death. On 3/28/18 the doctor prescribed the resident three potassium tablets per day for three days. On 3/29/18, when the resident’s potassium level was even lower than it had been, the doctor prescribed potassium chloride in liquid form. This shipment did not come until 4/1/18. The resident was given extra doses of the liquid, contrary to doctors orders, and on the morning of April second the patient was transferred to the hospital with an overdose of potassium in her blood. The resident passed away in the hospital 3 hours after being admitted. The facility was cited with failing to follow a doctor’s prescription, resulting in the death of a resident. Citation # 240014652.
San Diego County

Arroyo Vista Nursing Center
3022 45th St, San Diego

B $2000 Decubiti (Bedsores) 12/20/2018
The facility failed to prevent a resident from developing bedsores while while she was at high risk for them, as her leg was in an immobilizer. On 9/29/17 the staff documented that the resident had a bruise on her right leg, but did not associate the bruise with a deeper injury or the immobilizer. On 10/1/17 the staff noted that the bruise had become a red open wound and that the immobilizer was on the leg with the wound, but did not develop a plan or consider the immobilizer the cause of the wound. On 10/20/17 the wound was recorded again, except this time as yellow and non-viable. The resident went on to develop bedsores on her foot and buttocks as well, while very little notice of this deterioration was reported to the resident’s physician. The resident was transferred to the hospital on 11/17/15 and diagnosed with three gangrenous bedsores and MRSA. The facility was cited with failing to assess and treat the resident’s bedsores in a timely fashion. Citation # 100014665.

Kearny Mesa Convalescent And Nursing Home
7675 Family Circle Drive, San Diego

B $800 Mandated Reporting Physical Abuse 12/20/2018
On 5/25/18 two residents got into an altercation which ended in verbal abuse as well as physical abuse. The first resident verbally abused the second resident, who got upset, approached the first resident and slapped her in the face. The nurse who witnessed this informed the next shift but did not inform any of the necessary authorities or the residents’ families. The facility was cited with failing to assess and treat the resident’s bedsores in a timely fashion. Citation # 100014665.

San Francisco County

California Pacific Medical Center - St. Luke’s Campus Hospital
3555 Cesar Chavez Street, San Francisco

B $2000 Mandated Reporting Mental Abuse 6/27/2018
On 9/7/17 the parent of a resident found the resident in their room with a pillowcase on top of their face, unable to remove it. The resident had trouble moving voluntarily, so they could not remove the pillowcase, and when the parent found the resident, they had a look of fear on their face. The facility claimed that covering the resident’s face was part of a calming intervention, which was not part of his careplan. The facility was charged with allowing the resident to be abused, as well as failing to report the abuse within the mandated 24-hour reporting period. Citation # 220014194.

Laguna Honda Hospital & Rehabilitation Ctr D/P Snf
375 Laguna Honda Blvd., San Francisco

A $20000 Injury Physical Environment 03/14/2019
The facility failed to removed risks for fire. The resident, who had a known nicotine dependence, had a lighter, matches and an e-cigarette charger in his backpack that were not inventoried. The resident injured himself by starting a fire while smoking in his bed with an oxygen machine present. The resident suffered from smoke inhalation and third-degree burns on his face, neck and left arm. This injury required the resident to be intubated and undergo both skin debridement and skin grafting. This failure caused significant harm to the resident and had the potential to cause significant harm or death to other residents. Citation # 220014881.

San Francisco Health Care
1477 Grove St, San Francisco

B $2000 Medication 03/14/2019
The facility failed to ensure that a resident was free of significant medication error. The resident was prescribed 2.5 ml of a morphine sulfate solution every four hours. The resident was instead given 7.5 ml (three times the dosage) at 9 am on both 10/7/18 and 10/8/18. The resident was also given morphine after the order was discontinued on 10/8/18 and 10/9/18. This failure resulted in heavy sedation that caused the resident to have decreased oxygen levels and decreased food and fluid intake. Citation # 220014880.

San Joaquin County

Clearwater Healthcare Center
1517 Knickerbocker Drive, Stockton

B $1000 Mandated Reporting Mental Abuse 05/08/2019
At 10:23 am on 1/18/18, the Social Services Director of the facility met with a resident who had made accusations of mistreatment. The resident told them that he had been attacked by a staff member and had his leg broken two times since being admitted. A
review of the records indicated that a “progress note” dated 1/18/18 timed at 1:51 pm stated, “... resident’s perceived mistreatment has been addressed”. The facility was cited for failing to make a report about alleged or suspected resident abuse to the Department as required by law. Citation # 030015040.

St. Jude Care Center
469 E. North Street, Manteca
B $1000 Mandated Reporting Neglect 04/04/2019
A female resident with partial paralysis asked a CNA to change her incontinence brief on 6/24/17. The CNA demurred, stating a different CNA would change the brief later. No CNA came to help, and the resident ended up soaking her entire bed in urine. A staff person wrote a letter of concern to the facility’s management but did not report the incident as abuse or neglect to the State as required by law and facility policy. The facility was cited for failing to report the incident within 24 hours. Citation # 030014914.

Windsor Hampton Care Center
442 E Hampton Street, Stockton
B $2000 Notification 10/10/2018
On 7/17/18 a resident was given a notice of transfer from the facility which was not fully completed and contained incorrect information. The notice of transfer was not sent to the Ombudsman, though it is required to do so. The facility was cited with failing to follow its discharge policy by providing a completed notice to the resident or notifying an Ombudsman 30 days prior to the discharge. Citation # 030014476.

San Mateo County
Linda Mar Care Center
751 San Pedro Terrace Rd, Pacifica
B $2000 Evictions Notification 04/09/2019
Following a complaint investigation, the facility was found to have failed to provide copies of resident discharge notices to the long term care Ombudsman office. The records of five discharged residents were reviewed, and the facility failed to send copies to the Ombudsman in all five cases. The facility was cited for failing to send copies of resident discharge notices to the Ombudsman. Citation # 220014948.

San Mateo Medical Center D/P SNF
222 West 39th Avenue, San Mateo
B $2000 Fall 9/26/2018
On 1/6/17 a resident that had been admitted nine hours earlier fell from their bed and had to be transferred back to the hospital and treated for both external and internal bleeding from their head. The staff was aware that the resident was at risk for falling and was also given the order to transfer the resident to a bed closer to the nursing station. They did not move the resident closer and on 1/6/17, nine hours after admission, the resident fell and was not responded to for 15 minutes. The facility did not implement fall prevention and neglected to answer the resident’s call light, resulting in a wound on the back of the resident’s head that required stapling shut. Citation # 220014436.

Santa Clara County
Amberwood Gardens
1601 Petersen Ave, San Jose
B $2000 Careplan Patient Care Sexual Abuse Supervision 05/02/2019
On 3/18/19, a male resident with inappropriate sexual behavior problems manifested by non-consensual touching of residents was seen standing beside another resident’s bed and touching her chest area. On 4/15/19, the same male resident entered another resident’s room and put his hand underneath her blanket and touched her “private” area over her diaper. Although the male resident’s care plan had an intervention which included visual monitoring every 30 minutes, the CNA assigned to him on 4/15/19 was not informed about his behaviors and his need for visual monitoring. The facility was cited for failing to supervise a resident with a known history of sexual abuse from inappropriately touching two female residents. Citation # 070014972.

Camden PostAcute Care, Inc.
1331 Camden Ave, Campbell
B $2000 Careplan Fall Injury Patient Care 03/19/2019
A male resident was admitted on 6/12/15 with a diagnosis of dementia, blindness, and a high risk for falls. On 5/30/18, the resident fell when a staff member pushed his wheelchair without the footrests and rolled into a rock, which caused the resident to fall out of his wheelchair. Again, on 3/3/19, a staff member pushed the resident’s wheelchair without footrests, when he fell out and broke his nose. The facility was cited for failure to ensure the resident environment remained free of accident hazards. Citation # 070014866.

B $2000 Careplan Decubiti (Bedsores) Patient Care 03/19/2019
A paraplegic male resident was admitted to the facility on 5/2/18 with a high risk for pressure sores. Despite having redness on his tailbone upon admission, the facility failed to develop a care plan for pressure sores, or treat the resident to prevent the development of a pressure sore, for several months. The resident developed an unstageable pressure sore on his tailbone. Citation # 070014865.
Cupertino Healthcare & Wellness Center
22590 Voss Ave, Cupertino
B $2000 Medication Patient Care 04/24/2019
On 4/7/19, the facility had a 21.42 percent medication error rate when there were six medication errors during 28 opportunities that were observed during the medication passes for three of four observed residents. These mistakes included mixing of medications into a G-tube, incorrect dosages and not administering certain medications. The facility failed to ensure its medication error rates were less than five percent. This failure had the potential to jeopardize residents’ medical condition and health. Citation # 070014959.

B $2000 Decubiti (Bedsores) Injury Neglect Patient Care 04/24/2019
From 4/1/18 to 1/31/19, the facility failed to provide necessary services and treatment to a resident at risk for skin breakdown and pressure ulcer formation. This failure included: 1) Nurses did not provide preventive skin treatments as ordered by the resident’s doctor; 2) Nurses did not provide pressure ulcer treatments as ordered; 3) Staff did not provide snacks as ordered (nutritional status can affect skin integrity); 4) Staff did not turn and reposition the resident every two hours; and 5) Staff put diapers on the resident when it was not necessary. The facility was cited for failing to prevent the development, worsening and recurrence of resident’s buttock Stage 3 pressure ulcer. Citation # 070014961.

B $2000 Careplan Fall Injury Patient Care Staffing 04/24/2019
A male resident with a high risk for falls suffered a fall on 2/23/18 after transferring from his wheelchair to his bed unassisted. Then on 1/17/19, the resident fell again near his toilet bowl, resulting in a broken left collar bone. The Director of Nursing admitted that no new fall interventions had been implemented after the first fall on 2/23/18. The resident’s records indicated that he got up unassisted over 400 times from 9/1/18 to 1/17/19, despite requiring assistance for transferring. The short-term care plan showed that before the 1/17/19 fall, it had been an hour and a half since a staff member last checked the resident. Citation # 070014960.

Mission De La Casa Nursing & Rehabilitation Center
2501 Alvin Ave, San Jose
B $2000 Careplan 03/15/2019
On 2/7/19, a female resident with a diagnosis of dementia was transferred to the hospital due to alleged “aggressive behavior.” On 4/22/19, the facility refused to readmit the resident. A hospital report indicated the resident did not require hospitalization but only care at a nursing facility. The report also stated the resident was cooperative and pleasant. The resident filed an appeal with the state due to the refusal to readmit, and the facility was ordered to readmit the resident. Following the appeal decision, the resident was readmitted on 5/15/19. The facility was cited for failure to readmit and failure to issue a written notice of discharge. Citation # 070015103.

B $2000 Careplan Fall Injury Patient Care Medication 05/16/2019
A female resident fell in the shower on 11/9/18 and suffered moderate to severe pain in the right hip, pelvis, low back and tailbone. The resident was offered only Tylenol. The facility was cited for failing to ensure that pain management was provided to the resident. Citation # 070015082.

A $20000 Fall Injury Patient Care Physical Abuse 05/16/2019
A female resident fell while in the shower on 11/9/18 around 10 am. The resident received x-rays at approximately 1 pm, which revealed a pelvic fracture. At about 5:30 pm, the resident’s oxygen saturation was measured at 88 percent. The resident was “noted yelling for help” and complaining of pain and shortness of breath at 8 pm. Soon after, the resident became unresponsive. The resident was pronounced
dead at 8:30 pm on 11/9/18. The autopsy report indicated the cause of death was “cardiovascular disease complicated by blunt force pelvic injury due to ground-level falls.” The facility was cited for failure to transfer the resident to the emergency room after an x-ray showed a fracture, and failure to administer oxygen and notify the resident’s physician if oxygen levels dropped below 90 percent. Citation # 070015086.

**Vi At Palo Alto**
600 Sand Hill Rd, Palo Alto
A $20000 Fall 6/15/2018
On 5/9/18 a nurse’s assistant dropped a resident while practicing an improper lift, causing the resident to sustain a fractured elbow and bleeding in his brain. The nurse's assistant was attempting to lift the resident alone, which he had been instructed against, when the resident fell. The resident passed away on 5/21/18. The facility was cited for failing to follow their transfer/lift policy, resulting in a resident’s fall and eventual death. Citation # 070014100.

**Sonoma County**
**Park View Post Acute**
3751 Montgomery Dr, Santa Rosa
B $2000 Physical Abuse 4/3/2019
An 88-year-old male resident needed assistance using the toilet many times on 10/6/18. The staff member caring for him became angry and handled him roughly, “tossing him like a rag doll.” This was witnessed by a nurse. The staff member stated he lost his patience because so many call lights were going off and he needed help. Another 80-year old male resident stated this same staff member yelled at him on 10/6/18, telling him not to drink water so he would not need to go to the bathroom so much. Citation # 110014564.

**Tulare County**
**Merritt Manor Convalescent Hospital**
604 E Merritt Ave, Tulare
B $2000 Administration Bed Hold 05/28/2019
On 3/27/19 the facility refused to readmit a resident after the resident had been admitted to an acute care hospital for one day. The hospital’s records indicated the resident was treated for possible urinary tract infection and was at a normal baseline mental status and was not agitated. A physician noted that they did not feel that further imaging, lab or observation was warranted and that the resident was to be discharged. The facility was cited for failing to allow a resident to return after hospitalization. Citation # 120015003.

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**Ventura County**
**Thousand Oaks HealthCare Center**
93 W Avenida De Los Arboles, Thousand Oaks
B $1710 Bed Hold 8/22/2018
On 3/30/18 a resident who had been recently aggressive and violent was found with blood on her pillow and transferred to the hospital. On 4/3/18 the hospital attempted to send the resident back to the facility, however the facility turned the resident away because of behavioral issues. The facility was cited with failing to adhere to their 7-day bed hold policy. Citation # 050014302.

**Ventura Post Acute**
4020 Loma Vista Rd, Ventura
B $1805 Mandated Reporting Verbal Abuse 8/23/2018
On 7/1/18 a student nurse verbally assaulted a resident while serving her food. The incident was reported to the director of nurses and the student nurse was asked not to return to the facility. The director of nurses did not report the incident to the state until the student nurse reported it, 30 days later. The facility was cited for failing to report an incident of abuse within the 24-hour mandated reporting period. Citation # 050014317.

**Yolo County**
**Alderson Convalescent Hospital**
124 Walnut Street, Woodland
B $2000 Mandated Reporting Neglect 03/26/2019
On 1/26/19, a resident was found with her gown, brief, sheet and mattress soaked with urine. A report of suspected abuse or neglect was not sent to the Department of Public Health until 1/31/19. The facility was cited for failing to report the allegation of abuse or neglect within 24 hours as required by law. Citation # 030014908.
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