Over the past five years, one of the most disturbing violations of state and federal laws has been the increase in discrimination against Medi-Cal beneficiaries who need nursing home care.

Call a nursing home and tell them that your mother, a Medi-Cal beneficiary, has dementia along with other medical issues and that her doctor has recommended a nursing home—good luck in finding a placement within 200 miles—or at all! Tell them that your mother is in the hospital on Medicare, and your chance of finding a nursing home placement increases 100 percent. Because Medicare reimbursements are higher than the Medi-Cal daily rates, discrimination against accepting Medi-Cal eligible residents has become the preferred way for nursing homes to increase their profits.

Illegal? Yes, such discrimination is illegal under both state and federal laws. In fact, certification for Medi-Cal is totally voluntary and nursing homes who wish to participate in the Medi-Cal program must sign a provider agreement certifying under penalty of perjury that they will adhere to all state and federal laws, which include a prohibition against Medi-Cal (Medicaid) discrimination. Despite these laws, nursing homes have found numerous ways of discriminating to reduce their Medi-Cal population and free beds up for private pay or Medicare residents.

If a resident does happen to find placement as a Medicare patient, when Medicare days are terminated, the facility will often tell the resident or the resident’s family that the resident must leave; that they only retain “short-term” residents; that they don’t have any Medi-Cal beds; or that the resident—despite all evidence to the contrary—no longer needs the nursing home level of care. These are falsehoods, of course, aimed at scaring residents out of the facility. The truth is that, in California, if a nursing home is certified for Medi-Cal—all the beds are Medi-Cal certified. There is no such animal as a “short-term” nursing home. If they have a bed at all, it’s a Medi-Cal bed.

Because Medi-Cal does not pay for a private room, a common practice is to transfer the resident to the Medi-Cal “wing”, i.e., a section of the facility with 2-4 bed rooms all on Medi-Cal with limited staffing and no rehab services or to transfer the resident to the acute care hospital and refuse to readmit them, regardless of their right to a bed hold, the right to return to the facility and their right, even if the bed hold time has passed, to the first available bed.

Nursing home discrimination against Medi-Cal beneficiaries and residents has become epidemic in California, and the state regulatory agencies do nothing to contain it. For more information about discrimination and resident discharges, please see our postcard and please send us your stories if you or your family member was subject to Medi-Cal discrimination: http://www.canhr.org/bnbform.html.

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CANHR News

CANHR Welcomes New Staff

Bea Laguyan started on August 1, 2019 as CANHR’s new administrative Assistant/receptionist, and Amber Roberts, who served as CANHR’s AA and receptionist over the past year, has moved on to be a Long Term Care Advocate. Welcome Bea and congratulations Amber!

AARP Recognition

Patricia McGinnis, CANHR’s Executive Director, was selected as an AARP Well-Being Champion for the AARP Public Policy Institutes’ Culture of Health initiative to champion change across America in the areas of health and well-being. Ms. McGinnis, one of ten leaders, all of whom are 50+, was selected as a change agent for nursing home practices. For more information on the AARP campaign for the culture of health see www.aarp.org/cultureofhealth/

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 percent 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.

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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State Investigation Finds Several Laguna Honda Residents Nearly Drugged to Death

When San Francisco City and County officials held a press conference on June 28, 2019 to address an abuse scandal at Laguna Honda, they described acts of its employees as horrific. They reported that a group of six employees abused 23 residents over a period of years, subjecting them to verbal and physical abuse, sexual harassment, drugging, humiliation and neglect. But they gave few details while assuring the public that residents were now safe.

The extreme nature of the abuse is now coming to light. On September 6, 2019, the San Francisco Examiner published a story describing findings of a California Department of Public Health investigation (CDPH) on the abuse scandal with a link to the State’s investigation report dated July 12, 2019.

Its most startling finding is that a licensed nurse and certified nursing assistant (CNA) intentionally gave powerful non-prescribed drugs to chemically restrain at least five residents throughout 2018 and early 2019, and perhaps longer. Laguna Honda’s Director of Pharmacy told investigators that the nurse had a bag of drugs that he likely withheld from other residents at Laguna Honda and he used these drugs to sedate residents under his and the CNA’s care. Evidence included a picture of the bag of drugs the nurse had texted to the CNA and multiple text exchanges about residents they were drugging. Among the drugs in the bag were Morphine, Clonazepam and Oxycodone and a syringe of Methadone Liquid Suspension. Read more

House Passes FAIR Act to Ban Forced Arbitration

On September 20, 2019, the U.S. House of Representatives passed the FAIR Act (Forced Arbitration Injustice Repeal), a groundbreaking bill that would restore the rights of millions of Americans to sue businesses, including nursing homes, that violate their rights. By prohibiting pre-dispute arbitration agreements that force arbitration, the bill would give back the right to go to court to victims who have signed arbitration agreements, often unknowingly. Its passage, by a vote of 225-186, is a historic milestone, however, the bill must be passed by the Senate and signed by the President before it becomes law. While the fight to restore basic legal rights for American citizens is not over, the House vote is a great step forward!

CANHR and Attorney General Becerra Call on Trump Administration to Withdraw Proposal to Roll Back Nursing Home Standards

In separate letters submitted to the Centers for Medicare and Medicaid Services (CMS) this month, CANHR and Attorney General Xavier Becerra urged CMS to withdraw proposed regulations that would gut key residents’ rights and core safety standards for nursing home residents. The proposed rollbacks are a brazen attempt to enrich nursing home operators at the expense of nursing home residents. Attorney General Becerra described the proposed rollbacks as illegal, reckless and immoral in a related press release and stated: “In California, we don’t turn our backs on those who do not have the ability to fight back.”

DHCS Confirms Nursing Facility Residents with Intermediate Care Needs Are Eligible for Medi-Cal Coverage

On September 3, 2019, the California Department of Health Care Services (DHCS) issued an alert clarifying that Medi-Cal coverage is available for residents who need “intermediate care,” not just for those who required “skilled” care. This confirmation became necessary because CenCal Health, a Medi-Cal health plan serving San Luis Obispo and Santa Barbara Counties, has aggressively sought to deny Medi-Cal coverage to nursing facility residents on the basis of its assessments that they do not need “skilled” care. The DHCS alert helpfully confirms that nursing facility residents on Medi-Cal are allowed to remain while either intermediate or skilled care services are needed. CANHR is working with an advocacy coalition to seek broader solutions to increasing coverage denials that are caused by the combination of outdated Medi-Cal regulations on nursing facility coverage and perverse financial incentives for Medi-Cal health plans to cut costs by denying nursing facility care to their members who need it.

Long Term Care News ............... (continued on page 5)
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 leginfo.legislature.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: Signed into Law!**

**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: Signed into Law!**

**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 minimum wage increases are reflected in the provider reimbursement rate. **Status: Held in Appropriations Committee.**

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

**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: Provisions in AB 715 were passed through a budget bill – SB 104.**

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

**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: Held in Appropriations Committee.**
Oppose

AB 999 (Patterson) – Disability Access: Statutory damages
This bill 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 disabled individuals’ ability to access facilities. Status: Dead.

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

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: Sent to the Governor for signature.

CANHR Watch

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

AB 1695 (Carrillo) – Changes in Nursing Home Ownership
This bill has been like a rollercoaster ride. Initially it would have set a 90-day deadline for the Department of Public Health (DPH) to act on nursing home licensing applications when ownership is changing to determine if new operators are fit. CANHR supported that version of the bill. Then it was amended to give nursing home operators permission to run a nursing home without a determination of fitness by DPH if it missed the 90-day review deadline. CANHR strongly opposed that version of the bill. The current version of the bill on the Governor’s desk does not have either of the above provisions. What is left of it would give most nursing home employees some short-term job protection during changes of ownership and give residents and their representatives 90-day advance notice of planned ownership changes. Status: Sent to the Governor for signature.

New Medicare Payment System for Skilled Nursing Facilities Takes Effect
On October 1, 2019, Medicare is implementing a new payment system for skilled nursing facilities (SNFs) that is called the Patient-Driven Payment Model (PDPM). How “patient driven” the complicated payment system is (or is not) remains to be seen. The Centers for Medicare and Medicaid Services (CMS) claims it will change the financial incentives for SNFs to better serve residents.

Advocates expect that many skilled nursing facilities will aggressively game the new system to serve their financial interests rather than residents’ needs. A particular concern is that Medicare beneficiaries will receive less therapy than they do now and that SNFs have an incentive to replace individual therapy services with less effective but cheaper group therapy services. Another concern is that skilled nursing facilities will cut off Medicare coverage and push out Medicare beneficiaries even faster than they do now. CANHR is interested in hearing from Medicare beneficiaries on their experiences with nursing home coverage under PDPM.

DA and AG Sue Santa Cruz Nursing Home for Dumping Residents
On September 12, 2019, the Santa Cruz County District Attorney and California’s Attorney General jointly sued the operators of Hearts & Hands Post Acute Care & Rehab Center, a skilled nursing facility in Santa Cruz, for an unsafe environment, extensive criminal
Making health care decisions for unrepresented nursing home residents (those who lack the mental capacity to make decisions and also lack a surrogate to make decisions on their behalf) has always been tricky. The California legislature attempted to address the uncertainty by adopting Health and Safety Code Section 1418.8, also known as the “Epple Act,” in the 1990’s. Section 1418.8 uses an inter-disciplinary team (“IDT”) approach, led by the resident’s physician, for reviewing options and deciding treatment for unrepresented residents.

Due to significant problems with Section 1418.8, CANHR, along with nursing home resident Gloria A., sued the Department of Public Health in 2013 to have the statute declared unconstitutional. The case is called CANHR v. Smith. (38 Cal. App. 5th 838) On July 22, 2019, the California Court of Appeal rendered its decision, finding the statute had two critical constitutional deficiencies but was not “unconstitutional.” The court’s 71-page opinion clarifies how decisions need to be made for unrepresented nursing home residents but also raises some important questions that will have to be answered by others - likely the state legislature.

The following steps highlight our best understanding of how to make health care decisions for unrepresented nursing home residents, based on the statute, the court opinion, and common sense.

First Step: Determining Capacity, Searching for Surrogates.

The Section 1418.8 process begins with the resident’s physician finding the resident lacks decisionmaking capacity and lacks a surrogate. These findings are necessary when “any medical intervention” is proposed by the physician. (Decision, p. 70) The physician’s determinations as to capacity and surrogate, and the “basis for those determinations,” have to be documented in the resident’s medical record. (1418.8(l)) The physician must interview the resident and conduct an investigation pursuant to subsections 1418.8(b) and (c). Though not required by the CANHR court, the physician should notify the resident that their capacity is being assessed and a search for surrogates is being made. (“giving notice . . .would maximize protection of the patient’s constitutional rights”) (p. 33)

A resident lacks decisionmaking capacity if they are “unable to understand the nature and consequences of the proposed medical intervention, including its risks and benefits, or is unable to express a preference regarding the intervention.” (1418.8(b) and (c) and Probate Code 4609)

A resident lacks a surrogate when there is no “person designated under a valid Durable Power of Attorney for Health Care, a guardian, a conservator,” or a family member or friend available and willing to “take full responsibility” for health care decisions. (1418.8(c) and (f)).

Second Step: Notice.

Once the resident’s physician has documented that the IDT decisionmaking process is warranted, written and oral notice to the resident is required, in a language the resident will understand. (pp. 27-28) The notice must tell the resident the following:

1. The resident has been found to lack decisionmaking capacity.
2. No surrogate decisionmaker is available.
3. A description of the proposed treatment being contemplated.
4. The treatment decision will be made by the IDT.
5. The resident has the right to have a patient representative participate in the IDT decisionmaking.
6. The resident has the right to judicial review to contest the physician’s findings, the use of the IDT, or the decisions of the IDT. (pp. 70-71)

The notice must be given immediately after the physician’s determinations of incapacity and lack of surrogate and before the recommended medical intervention. (p. 12) The notice should therefore be given before the IDT meeting in Step 3 and invite the...
A note regarding the patient representative. The court’s decision leaves a lot of uncertainty about who will serve as the patient representative. The court stated the patient representative must be unaffiliated with the nursing home, independent, and is the IDT member “most likely to dissent.” The court did not indicate what should happen if the resident prefers a different patient representative or does not want the assistance of a patient representative, but those cases would likely be best pursued in judicial review. (See Step 6)

Fourth Step: “Making” the Decision. Decisions by IDTs must achieve consistency with the resident’s wishes or, if the resident’s wishes are unclear, consistency with the best interest of the resident.

Consensus. If every member of the IDT agrees the resident lacks capacity, lacks a surrogate, and the proposed medical intervention is consistent with the resident’s wishes or best interests, the medical intervention may be initiated, provided the resident is notified and reminded of the right to judicial review.

No consensus. If there is any disagreement among members of the IDT, either the proposed treatment is rejected (because no substitute consent was obtained) or judicial review is required by filing a petition for substituted judgment under Probate Code Section 3201. (pp. 30, 35) For end-of-life decisions, mere “reservations,” should trigger judicial review. (p. 67)

Fifth Step: Judicial Review. Judicial review is required in the following cases:

Focus On ........................................ (continued on page 8)
• The resident disagrees with any part of the IDT process, the physician’s determinations, or the IDT’s decisions.
• The patient representative disagrees with any part of the IDT process, the physician’s determinations, or the IDT’s decisions.
• Consensus is not achieved but someone nonetheless wants to provide the proposed intervention. In this case, judicial review would be sought by the person desiring to make the proposed medical intervention.
• End-of-life decisions that will “directly and inexorably” lead to the death of a resident. (p. 66)

Judicial review may be initiated by filing a petition for substituted judgment under Probate Code Section 3201. A 3201 petition seeks a court’s authorization to provide, withdraw, or withhold medical treatment and may be filed by a health care provider or patient rep. Probate Code Section 3204 details what must be stated in the petition.

Sixth Step: Implementing the Intervention.
The intervention may be implemented once the IDT has reached consensus, but only after the resident has received notice of the IDT’s decision and had an opportunity to seek judicial review. (p. 71) In cases where the resident objects to the IDT’s determinations or refuses the proposed treatment judicial review is required before the intervention may be initiated. An IDT may never authorize non-emergency treatment on an unwilling resident as such an infringement of rights requires a court order. (p. 55)

Seventh Step: Reevaluation.
Section 1418.8(g) requires the IDT to meet “at least quarterly or upon a significant change in the resident’s medical condition” to reevaluate the treatment decisions made. During these reevaluations, the IDT should also review the prior determinations regarding the resident’s alleged incapacity and lack of surrogate to ensure nothing has changed. (p. 46) The IDT reevaluations are required in addition to other IDT reviews needed for any new health decisions requiring informed consent, including changes or adjustments to prior treatment decisions, e.g. increasing the dosage or frequency of a resident’s medications.

(Endnotes)
1 This is an abbreviated version of a longer article posted at canhr.org
2 All subsequent citations to page numbers refer to the Court of Appeal decision.

Long Term Care News ............... (continued from page 5)
activity in the facility and for engaging in a pattern of unsafely dumping residents to the streets, to unlicensed care homes and to hospitals without any notice of their rights. The lawsuit is just the latest evidence of the growing eviction crisis in California nursing homes and the extreme dangers residents are facing from nursing home operators who have no regard for their welfare.

Drug Company to Pay $116 Million for Kickback Conspiracy to Push Nuedexta on Nursing Home Residents with Dementia

On September 26, 2019, the U.S. Department of Justice announced that Avanir, a drug company based in California, had agreed to pay $116 million in criminal and civil penalties to resolve charges that it paid kickbacks and engaged in other illegal activities to market Nuedexta as a treatment for elders with dementia. The settlement resolves multiple whistleblower cases concerning the widespread use of Nuedexta to chemically restrain nursing home residents with dementia, which CNN first brought to public attention in its October 2017 story, The little red pill being pushed on the elderly.

Nuedexta is only approved to treat a rare neurological condition, pseudobulbar affect, that is characterized by uncontrollable laughing and crying. However, the government alleged that Avanir successfully capitalized on national efforts to reduce the use of antipsychotic drugs on dementia patients in nursing homes by aggressively marketing Nuedexta as a substitute method of controlling residents’ behaviors that would go unnoticed by regulators. According to the DOJ’s press release, the scheme worked so well that one doctor (a paid speaker for Nuedexta) had put entire units of residents on Nuedexta at a nursing home where he worked.

The settlement may not be strong enough to deter future misconduct by other drug companies. CNN’s story on the Avanir settlement reports that Medicare’s Part D prescription drug program spent roughly $225 million on Nuedexta in 2017, up more than 700% from five years earlier.
An Open Letter to Governor Newsom and Attorney General Becerra
About the Suffering of Nursing Home Residents in California

August 29, 2019

Dear Governor Newsom and Attorney General Becerra:

We write as legal counsel to plaintiffs Bruce Anderson, Robert Austin, John Wilson and the non-profit, California Advocates for Nursing Home Reform (“CANHR”). Our clients have been forced to sue the State to satisfy one of its most basic functions: to enforce the law and protect our most at-risk citizens from being unceremoniously “dumped” by nursing homes in favor of more lucrative residents. As detailed in the plaintiffs’ complaint, not only does the practice cause untold human suffering (one of our clients, John Wilson, died after we filed his case) but costs the State tens of millions of dollars in unnecessary hospital fees and related costs.

For years, our efforts to resolve the case with your representatives at the Department of Health and Human Services consistently have gone nowhere. That is due, in part, to the fact the individuals involved have been notoriously aligned with the nursing home lobby and unwilling to take meaningful action to stop abuse. Instead, the agency chose to litigate against nursing home residents and attempted to dismiss plaintiffs’ complaints, arguing that indigent residents should hire lawyers and sue facilities on a piecemeal basis.

On July 18, 2019, the Ninth Circuit ruled in favor of California’s 400,000 nursing home residents and their families. Enclosed is a copy of the Court’s decision in Anderson, et al. v. Ghaly, Secretary of Health & Human Services, No. 16-16193 (Ninth Cir., July 18, 2019). The decision reinstated the plaintiff’s lawsuit and held that California must do something to enforce the results of California’s transfer, discharge and readmission hearings. The hearings are mandated by federal law and are residents’ only recourse for securing readmission after being unlawfully discharged. But up until now, California, as a matter of policy, has refused to enforce those determinations. As a result, nursing homes have ignored them and residents have suffered the consequence.

On August 9, 2019, the Ninth Circuit issued its mandate in Anderson, returning the case to the District Court for litigation. This presents a good opportunity for your offices to alter the unfortunate course of events to date. As set forth below, we implore you to do the right thing and enforce meaningful remedies for our clients.

**Dumping is a one of the biggest threats to nursing home residents in California.** At issue in our case is an illicit practice known as “hospital dumping,” in which nursing facilities abandon Medi-Cal residents in hospitals and then refuse to readmit them, even when DHCS orders them to do so. Nursing homes do this to replace their poorest and neediest residents with more lucrative ones. The transfer trauma caused by dumping poses an acute threat to the health and welfare of residents, especially those suffering from dementia, and in some cases can be fatal. It also tears families apart.

**Cost to taxpayers.** In addition to profound harm this unlawful practice causes to the victims, it has cost California taxpayers more than $70 million in paying for unnecessary hospital beds for people who are not sick. The only beneficiary of dumping is the nursing home industry.

**The State’s failure to act.** Your predecessors, Governor Jerry Brown and Attorney General Kamala Harris, bitterly opposed enforcing DHCS decisions. In its 30-page Opinion, the Ninth Circuit blasted their position that California could satisfy the federal requirement to provide a “fair hearing” by offering a “meaningless show trial” with no enforcement.

**Our Clients.** The story of resident dumping and its effect on citizens is best told through our clients. Plaintiff Bruce Anderson (below) won his DHCS hearing. As a result of California’s refusal to enforce the decision, he was forced to live in a hospital for over a year, confined to a hospital bed and drugged with antipsychotics.

An Open Letter to Gov Newsom (continued on page 10)
Our client John Wilson (below), who also won his DHCS hearing, passed away while the case was on appeal. John had ALS. After becoming familiar with his caregivers at the nursing facility where he lived, he could communicate using eye movements. After he was dumped, he could not. He lived in a hospital for over six months with bills exceeding $800,000, all of which were paid by the State.

Our client Robert Austin (below), who also won his DHCS hearing, was coerced into a facility 400 miles from his home. This separated him from his sister Vera, who used to visit him every week, laundered his clothes and spent her holidays with him.

You can honor your public commitment to elder protection. We hope that your administration will take an enlightened view of this problem. Both of you have publicly stated that you care how we treat our elderly and that you want to protect health care access for Californians.

While the Ninth Circuit did not specify how the state must enforce DHCS decisions, it is clear from the Opinion that the state can no longer do nothing. It is also clear that the state has a panoply of robust enforcement powers – including precluding facilities from admitting new residents until they are in compliance with DHCS readmission orders – that it can use in an escalating fashion to obtain compliance with DHCS orders if it wants to do so.

On behalf of each of our clients and the untold tens of thousands of other residents affected by resident dumping, we appreciate your taking time to read this letter. The needless suffering described above and in the plaintiffs’ complaint is something that each of you, and those who work for you, are able to stop in an instant. Our request is to help us “Halt Resident Dumping in 5 Easy Steps:”

1. Enforce DHCS hearings by promptly enjoining facilities to adhere to hearing determinations.
2. Enforce hearing determinations by imposing escalating consequences for refusals to readmit, and by using the Attorney General’s resources to prosecute facilities that refuse to abide those orders.
3. Provide resources to enable dumped residents to contact the State or relevant resources (like those available through CANHR).
4. Identify the worst-offending repeat offender facilities and impose sanctions for dumping behavior, including withholding of Medi-Cal eligibility.
5. Provide restitution to the named plaintiffs.

We look forward to re-starting a dialogue with your office(s) and ending DHCS’s horrible policy without the need for further litigation.

Very truly yours,

Matthew Borden
Did You Know?

You Can Appeal Medicare Denials Based on “Failure to Progress/Improve” - Jimmo v. Sebelius

Adapted from materials prepared by the Center for Medicare Advocacy

Background

In 2013, a federal court approved the settlement agreement in Jimmo v. Sebelius, No. 5:11-CV-17 (D. Vt). The Jimmo Settlement confirmed that Medicare coverage of nursing home services must be determined on the basis of a beneficiary’s need for skilled care, not on the individual’s potential for improvement. Relevant chapters of the Medicare Benefit Policy Manual, now state that “[s]killed care may be necessary to improve a patient’s condition, to maintain a patient’s current condition, or to prevent or slow further deterioration of the patient’s condition.” The Jimmo Settlement pertains to all Medicare beneficiaries, regardless of whether an individual has traditional Medicare or is in a Medicare Advantage plan.

Despite challenges with the Settlement’s implementation, beneficiaries can successfully appeal these unlawful denials of medically necessary care by taking appropriate steps during the appeals process to support their argument that skilled care should be covered under the Jimmo Settlement.

Action Steps

Medicare beneficiaries or their representatives should take the following steps:

1. Request a copy of the beneficiary’s medical record. The nursing home must provide a copy or access to any documentation that it sends to Livanta (the California organization responsible for Medicare coverage appeals), including any records provided over the telephone. Use the medical record to support your argument that ongoing skilled care is medically necessary. Also, share the medical record with primary care professionals involved in the beneficiary’s care.

2. Seek letters of support from primary care professionals, such as the community physician and physical therapist, involved in the beneficiary’s treatment. The letter should address the beneficiary’s condition, detail why skilled care is still necessary in order to continue improving or maintaining the beneficiary’s condition, and how the beneficiary’s condition would worsen if skilled care were not provided. Include the support letters with your appeal request.

3. When requesting an appeal, explain why skilled care is still medically necessary, using the medical record and personal experience. If the beneficiary is improving, document the beneficiary’s progress and explain how terminating skilled care would negatively affect the beneficiary. If the beneficiary is truly no longer improving and needs maintenance therapy or nursing to slow or prevent further decline, then document why skilled care is necessary to maintain the beneficiary’s condition.

4. Reference the Jimmo Settlement in your appeal request. Remind decision-makers that Medicare coverage cannot be denied solely on the basis of an erroneous improvement standard. Quote the Settlement language and provide a citation. Additionally, include official materials from CMS’s Jimmo-dedicated webpage, including fact sheets and manual chapter revisions with red italics that indicate Jimmo-related changes.

Conclusion

While challenging a Medicare denial may seem daunting, beneficiaries can be successful by taking appropriate steps to support their claim in light of the Jimmo Settlement. For more information about the Jimmo Settlement and additional resources, please visit www.MedicareAdvocacy.org.
Dear Lost in Lassen County,

Finding a nursing home is hard. It can be especially difficult to find a nursing home willing to accept you when you are transferring from home or an assisted living facility as opposed to a hospital. People are often told the myth that there are no “Medi-Cal beds” available, or that there is a waitlist for a Medi-Cal bed. In reality, a facility cannot have a limited number of “Medi-Cal beds.” Any nursing home that is Medi-Cal certified must make every single bed in the facility available for residents paying through Medi-Cal so long as the resident needs nursing home services and those services are paid for. This myth is perpetuated because many nursing homes don’t want to accept Medi-Cal’s lower reimbursement rates. Instead, they prefer Medicare or private pay. It is much easier to get accepted into a nursing home when one is transferred from a hospital because after a three-night stay as an inpatient at the hospital, Medicare will pay for rehabilitation services at a nursing home. Often residents’ will use this as a way to get placement, and when their Medicare coverage ends, they switch to Medi-Cal. It is illegal for a nursing home to discharge a resident based on a change of payment from private pay or Medicare to Medi-Cal and residents’ have the right to transfer to Medi-Cal payment if they are eligible. (W&I Code §14124.7(a); 42 CFR §483.15(c)(1)(i); 42 USC §1396r(c)(2)(A)). It is also illegal for a nursing home to discharge a resident while their Medi-Cal is pending (W&I Code §14124.7).

I am having a difficult time finding a nursing home willing to accept my partner who is on Medi-Cal upon admission. What else can I do?

Sincerely,

Lost in Lassen County

Past Speaking Engagements, Panel Discussions and Training Sessions

- **July 9**: Julie Pollock and Prescott Cole visited Open Door Legal in San Francisco.
- **July 17**: Efrain Gutierrez hosted an information table at the South Bay Resources Partnership at the Torrance Memorial Medical Center.
- **July 22**: CANHR Staff Attorney Jody Spiegel participated in the RCFE Advocates Quarterly Meeting with Community Care Licensing.
- **July 31**: Julie Pollock and Prescott Cole gave an in-service training on Home Equity Protection to attorneys at Senior Adult Legal Assistance in Santa Clara.
- **August 20**: Julie Pollock gave an in-service training on alternatives to nursing homes and Medi-Cal Estate Recovery to social workers at the San Francisco Veteran’s Administration.

CANHR On The Move ................... (continued on page 13)
- **September 4**: CANHR Staff Attorneys Tony Chicotel and Jody Spiegel gave a training on Long Term Care Evictions for legal services and ombudsman at the Ron Olson Justice Center in Los Angeles, hosted by the Legal Aid Foundation of Los Angeles.

- **September 13**: Efrain Gutierrez hosted an information table at the South Pasadena Resource Senior Fair.

- **September 17**: CANHR Staff Attorneys Tony Chicotel and Jody Spiegel gave a training on Long Term Care Evictions for legal services and ombudsman at the Stanislaus Veterans Center in Modesto, hosted by Joyce Gandelman and Senior Law Project.

- **September 18**: CANHR Staff Attorneys Tony Chicotel and Jody Spiegel gave a training on Long Term Care Evictions at Central California Legal Services in Fresno.

- **September 19**: Efrain Gutierrez hosted an information table at the Annual Senior Luncheon in Los Angeles, courtesy of Councilman Curren D. Price, JR.

- **September 19**: Staff Attorney Tony Chicotel spoke to the San Francisco Bioethics Forum about decision making for unrepresented patients in light of the recent appellate court decision in the CANHR v. Smith case.

- **September 20**: Prescott Cole facilitated the CANHR/California District Attorneys Association Closing the Gap on Elder Abuse Training in Oakland.
Bad Deal, Bad Care

It’s Time to Stop Dumping Money Into California’s Nursing Home Chains

Reforming the AB 1629 Nursing Home Reimbursement System to Serve Residents Rather than Enrich Nursing Home Owners

Reforming AB 1629: No More Blank Checks for California Nursing Home Chains

Next year, California’s controversial and extraordinarily expensive reimbursement system for skilled nursing facilities – known as AB 1629 – will sunset. Reauthorizing AB 1629 offers a rare chance to redesign the failed reimbursement system to serve residents’ interests.

Instead of improved resident care, AB 1629 has produced billionaire owners, scandalous abuse and neglect, rampant discrimination against Medi-Cal beneficiaries and over a billion dollars per year in new General Fund costs while home and community-based services faced relentless cuts.

It is time to start over and create a reimbursement system that does not rely on blind trust with California’s disreputable nursing home chains. CANHR has issued a report, “Bad Deal, Bad Care,” to explain the problems with AB 1629 and to list the reforms available to the state to ensure that nursing home reimbursement is finally tied to quality care and fits properly into a long term care system that maximizes consumer well-being.

CLICK HERE TO READ THE FULL REPORT ON OUR WEBSITE (PDF)
CANHR welcomes memorial and honorary gifts. This is a great way to honor a special person or a loved one, while helping those who are long term care residents. Recent gifts have been made in the names of the following persons:

**In Honor Of**

- Robert Montoya
  - Deborah Moore
- Armando Morais
  - Alda Newcomer

**In Memory Of**

- Our Parents Mr. & Mrs. Kenneth C. Burchill
- Charlie Pellegrin, Helen Pellegrin
- Yolanda Carruthers
  - Pamela Carruthers, Julie Carruthers, Paula Carruthers, Jeffrey Carruthers
- Roy Johnson
  - Elizabeth Massie, Geraldine Murphy
- Sam Landau
  - Sarah Landau
- Jan Madden
  - Jenny Lanning
- Brunhilde Padgug
  - Inge Mitzner
- Betty Perry
  - Gail Perry
- In Loving Memory Ronald Randolph
  - Brenda Williams
- Vondina Thomson
  - The LIST Fund
- My Beloved Mother, Rita Twomey
  - Denise Twomey
- Bruno and Evelyn Wartman
  - Paddy Moran

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

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

Call the CANHR office or email patm@canhr.org to get more information and a free booklet on planned giving.
Give To CANHR

How Your Gift Helps

Your contributions help CANHR grow and thrive, so we can extend our services and support to ever more long term care consumers and their family members.

Why Donate?

CANHR is not a government agency. We are funded by membership donations, foundation grants, and publication sales. To continue our work, we need the support of people like you who are unwilling to ignore the abuse and loss that the elderly and disabled in this state suffer in long term care facilities.

What You Get

- Join a statewide network of informed and concerned consumers, caregivers, and advocates.
- Receive periodic updates on important legislation.
- Receive our quarterly newsletter, The Advocate, which includes important long term care information and a detailed report of citations issued against individual nursing homes.

DonateOnline:  www.canhr.org/membership/Join-CANHR.html

Mail-in Donation Form

To mail in your donation, please fill out the form and return it with your donation to:
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Enclosed is my check for:  □ $500 □ $100 □ $75 □ $50 □ Other ____________________________
This gift is in memory of: ____________________________________________________________
(or) in honor of: ________________________________________________________________
Contact me about legislation and other advocacy opportunities.
Save paper, send me The Advocate via e-mail. E-mail: ________________________________
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City/State: _________________________ Zip: _______________________________
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Facility Name: ________________________________
NEED AN ATTORNEY?

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CANHR prohibits the use of its name for the purpose of advertisement by attorneys, financial planners or any other organization or entity.
The following citation summaries are compiled from the citations issued by the California Department of Public Health to Northern 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.

**Marin County**

**Aldersly Skilled Nursing Facility**

326 Mission Ave, San Rafael

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<th>Citation</th>
<th>Description</th>
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<tr>
<td>B $2000</td>
<td>Mandated Reporting Transfer</td>
<td>08/09/2019</td>
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On 08/15/18, a resident was discharged to his home without the long-term care ombudsman being notified. The administrators were not aware that they had to report it to the ombudsman because the facility had no policies requiring them to do it. The facility failed to ensure that their policies protected the safety and rights of their patients. Citation # 110015153.

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<td>B $2000</td>
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On 10/03/18, a resident was discharged to his home without the long-term care ombudsman being notified. The administrators did not know they had to notify the ombudsman because the facility failed to create policies that required the notification of the ombudsman regarding any discharges or transfers. The facility failed to ensure that their policies protected the safety and rights of their residents. Citation # 110015154.

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On 08/31/18, a resident was discharged to her home with physical therapy and occupational therapy without the facility notifying the long-term care ombudsman. The administrators were not aware that they had to report it because the facility failed to create policies that required the notification of the ombudsman regarding any discharges or transfers. The facility failed to ensure that their policies protected the safety and rights of their residents. Citation # 110015152.

**Northgate Postacute Care**

40 Professional Center Pkwy, San Rafael

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<th>Citation</th>
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The facility failed to send the resident’s discharge
notice to the long term care ombudsman before the resident’s discharge. This resulted in the facility failing to provide the resident with an advocate who could inform the resident of their rights and discharge options. This failure allowed for a potentially inappropriate discharge. This was one of three citations of this manner against this facility. Citation # 110015147.

**B $1000 Notification 08/07/2019**
The facility failed to send the resident’s discharge notice to the long term care ombudsman. This resulted in the facility failing to provide the resident with an advocate who could inform the resident of their rights and discharge options. This failure allowed for a potentially inappropriate discharge. This was one of three citations of this manner against this facility. Citation # 110015149.

**B $1000 Transfer 08/07/2019**
On 6/19/18, a resident was discharged from the facility to her home without notice to the Ombudsman’s office, as required by law. The Ombudsman’s office did not receive notification until 7/6/18. It is required to notify the Ombudsman of any discharge or transfers so they may advocate for the resident. They ensure that the residents know of their rights and that they are discharged safely. The facility was cited for its failure to notify the local Long-Term Care Ombudsman, as required. Citation # 110015143.

**B $1000 Patient Rights Transfer 08/07/2019**
The facility failed to follow legal procedures while discharging a resident to their home. The facility failed to inform the local ombudsman of the discharge, which denied the resident an advocate who could inform them of their rights during the process. Citation # 110015146.

**B $1000 Transfer 08/07/2019**
The facility failed to send a copy of the notice of discharge to the long-term care ombudsman program before a resident was discharged home on 10/26/18, in violation of a California law requiring notice to the ombudsman. An ombudsman representative stated that this failure happened often. Citation # 110015150.

**Pine Ridge Care Center**
45 Professional Center Pkwy, San Rafael

**B $2000 Dignity Physical Abuse 07/12/2019**
A resident who required assistance in transfers from her wheelchair to the bed was told to go to bed at 6:30 pm, which was too early. When the resident expressed her desire to not go to bed, the CNA lifted her from under her arms, which was not part of the facility’s transfer policy, and threw her into the bed. This resulted in her body hitting the rail, and swelling in her legs. This rough transfer made the resident cry and endure other emotional trauma. The facility failed to treat the resident with dignity and respect. Citation # 110015192.
**Monterey County**

**Windsor Gardens Rehabilitation Center of Salinas**

637 E Romie Ln, Salinas

**B $2000 Medication 08/19/2019**

The facility failed to ensure that anti-convulsive medications were available to six residents who were prone to seizures and convulsions. Over the course of several months, the facility would run out of medications because the pharmacy, located 3 to 4 hours away, would have issues receiving the orders or delivering the orders. The facility was cited for not having certain medications available and for failing to reconcile when medications did run out. Citation # 070015282.

**Windsor The Ridge Rehabilitation Center**

350 Iris Dr, Salinas

**B $2000 Medication 06/10/2019**

On 6/3/19, a nurse reported to the DON and Administrator that she had been consuming the pain medication of two residents. Both residents had been prescribed opioids for pain and records indicated they had been given the medication at night 6 and 14 times for residents 1 and 2, respectively. Upon interview, the residents indicated they did not take pain medication and did not have pain at night. The facility failed to prevent drug diversion by a nurse when narcotic pain medication was taken from the pharmaceutical supply of two residents. Citation # 070015128.

**Placer County**

**Pine Creek Care Center**

1139 Cirby Way, Roseville

**B $2000 Injury Physical Abuse 06/19/2019**

On 4/17/19, a resident was injured by a CNA, receiving a bruise to the face. At the time, the resident yelled out and the charge nurse and an RNA went to check. The CNA was leaving the room and the resident was crying and said she did not want the CNA to take care of her. The resident’s weekly “Skin Observation summary,” dated 4/18/19, indicated a quarter size bruise on resident’s face. The CNA was terminated by the facility per policy. By allowing a CNA to injure a resident, the facility failed to ensure that the resident was free from abuse. Citation # 030015167.

**Siena Skilled Nursing & Rehabilitation Center**

11600 Education Street, Auburn

**A $20000 Fall Supervision Staff (Inservice) Training 06/17/2019**

On 3/16/18, a resident fell from their bed while being changed by a CNA. The fall caused blood to collect between the resident’s brain and skull, which is among the deadliest of all head injuries. The resident did with the cause of death listed as the brain injury resulting from the fall. Because the resident’s bed was not against a wall, as recommended in assessments, the resident fell when the CNA stepped away. There were no signs in the room indicating the resident was at risk for falling. The facility administrators stated that they assumed a CNA would know how to properly change a resident and did not provide any training. The facility failed to keep the resident’s environment free from accident hazards as possible and failed to provide adequate supervision, which resulted in the injury and death of the resident. Citation # 030015156.

**Sacramento County**

**Eskaton Care Center Fair Oaks**

11300 Fair Oaks Boulevard, Fair Oaks

**A $20000 Fall Supervision 05/14/2019**

A resident, who was a known fall risk and known to attempt to get out of bed without assistance was left unattended on 11/29/18. When the nurse returned to the room, the resident was found lying face down on the floor with a cut above his eye. The resident was transferred to the hospital where a CT scan showed that the resident had bleeding
in his brain. This failure to observe the resident resulted in a fall with a major injury. Citation # 030015037.

Sacramento Post-Acute

5255 Hemlock Street, Sacramento

B $2000 Fall Physical Environment Supervision 06/26/2019

On 1/14/19, a resident fell resulting in a mild swelling of the space between the brain and skull, as well as soft tissue swelling in the resident’s face. The resident required total dependence on two people for physical assistance with bed mobility because of their persistent vegetative state. At the time of the fall, only one CNA assisted the resident and positioned the resident on their side. The resident coughed which caused the fall. There were no bed rails or fall mats. The CNA stated that the resident’s bed was not large enough for the size of the resident. The facility failed to keep the resident’s environment free of accident hazards and failed to provide adequate supervision and assistive devices. Citation # 030015183.

Saint Claire’s Nursing Center

6248 66th Avenue, Sacramento

B $2000 Careplan Deterioration Dignity Infection Injury Neglect Patient Care Patient Records 05/14/2019

The facility was cited for failing to document and assist a resident with bathing and personal hygiene care for 23 days between 1/21/19 and 2/14/19. The refusal of care continued without goal-oriented intervention, and steps were not taken to assist the resident’s health decline. On 2/14/19, the resident appeared distressed and presented severe scrotal swelling, redness, and pain consistent with a fleshing eating bacteria infection of the scrotum. These violations, in combination, presented an imminent danger that death or serious harm occurred. Citation # 030015036.

Windsor Care Center of Sacramento

501 Jessie Avenue, Sacramento

B $2000 Evictions 05/30/2019

A resident with dementia was sent to an unlicensed room and board home on 12/20/18 despite inadequate discharge planning. The resident had no access to her money so she could not pay her rent and she did not receive home health and other services she needed. The facility was cited for unsafely discharging the resident and for failing to adhere to its policy requiring follow up to ensure each resident’s needs are met without interruption when moving from one level of care to another. Citation # 030015115.

San Francisco County

Laguna Honda Hospital & Rehabilitation Ctr D/P Snf

375 Laguna Honda Blvd., San Francisco

A $20000 Fall 5/21/2019

A female resident with dementia and impaired mobility fell from the toilet on 3/26/18 and shattered her hip, requiring surgery. The resident was assisted in the bathroom by a nurse, but the nurse left to find gloves. When the nurse returned, she found the resident on the floor. The facility was cited for failing to provide adequate supervision and assistance to residents to prevent accidents. Citation # 220015094.

San Joaquin County

Bethany Home Society San Joaquin County

930 W Main Street, Ripon

B $1000 Notification Transfer 06/03/2019

The facility failed to notify the local long term care Ombudsman program of four resident hospitalizations in early 2019. The law requires that copies of transfer notices be provided promptly to the Ombudsman. Citation # 030015098.

New Hope Post Acute Care

2586 Buthmann Avenue, Tracy
On 5/20/19, during an investigation of reported staff abuse against a resident, it was discovered that the facility had failed to provide the appropriate abuse training prescribed by the Department of Justice (DOJ). The DOJ training includes testing for new employees and giving them two handouts entitled, “Mandated Reporting Requirements” and “Employee Confidentiality Rights”. During an interview with the director of staff development (DSD), the DSD stated that she had been instructed by management to stop giving the DOJ tests back in 2016. The facility was cited for failing to provide the appropriate training within 60 day of hire.

Canyon Springs Post-Acute

180 N Jackson Ave, San Jose

On 4/2/19, an RN was observed administering a total of six medications to a resident. These medications were not fully dissolved. The RN did not give the full dose to the resident and discarded the remaining medication in the trash. The facility failed to ensure its medications error rates were five percent or lower. The facility had a 26.66% medication error rate when eight medication errors during 30 opportunities were observed. These failures had the potential to jeopardize residents’ medical condition and health.

Cupertino Healthcare & Wellness Center

22590 Voss Ave, Cupertino

On 10/7/18, a resident fell while trying to use the bedside commode by herself, and she fell to the floor. The resident sustained a broken hip, two skin abrasions, and swelling on the right side of her back. The resident stated that it took very long, over 40 minutes, for a staff member to come and help her. She noted that the staff did not check on her regularly. She would use the call light and call loudly to the staff for help. The facility failed to provide toileting for the resident when she had her fourth fall.
A resident diagnosed with Alzheimer’s fell four times with no staff present during 10/10/18 through 12/10/18. The resident fell in the courtyard, in her room and the hallway. The resident sustained a bruise on the mouth, redness on the cheek, skin tear on the nose and fracture to the right arm. The facility failed to monitor the whereabouts of a resident and implement fall care plan interventions. Citation # 070014745.

Los Altos Sub-Acute And Rehabilitation Center

809 Fremont Ave, Los Altos

B $2000 Notification Transfer 08/06/2019

The facility discharged a resident on 7/5/19 to a room and board (an independent setting), against the physician’s order. The resident had dementia, severe cognitive impairment and no medical capacity to make healthcare decisions. The facility failed to notify the resident’s responsible party and the Long Term Care Ombudsman of the resident’s discharge. This failure compromised the resident’s transfer/discharge rights and put the resident at risk. On 7/6/19, one day later, the resident was found wandering the streets after leaving the room and board and ended up in the hospital. Citation # 070014923.

Los Gatos Snf, Llc

16605 Lark Ave, Los Gatos

B $2000 Medication 07/02/2019

The facility was cited for having no documentation on the disposition of narcotic medications for 5 of 18 sampled residents. The facility was also cited for not ensuring its medication error rate was less than 5% when 5 medication errors out of 28 opportunities were observed during medication passes for 3 out of 9 residents for a medication error rate of 18.52%. Citation # 070015184.

B $2000 Elopement Injury Supervision 07/02/2019

The facility failed to provide adequate supervision to a resident who had a documented history of elopement. The resident was found on the side of the freeway on 6/5/18 with scrapes on his face due to a fall. Almost two weeks later, during an investigation on 6/17/19, the resident’s injuries were still noticeable. The resident had no WanderGuard on and he was sitting three steps from the front door without supervision. Citation # 070015186.

Mission De La Casa Nursing & Rehabilitation Center

2501 Alvin Ave, San Jose

B $2000 Neglect Other Patient Care Patient Rights Verbal Abuse 04/02/2019

On 3/25/19, a CNA was reported yelling at the resident while showering. The resident asked the CNA to apply her skin cream, and the CNA said, “No, I don’t care.” The facility failed to ensure the resident was free from abuse when a CNA yelled at the resident during and after a shower. This violation caused emotional distress and the impact of the well being of the resident. Citation # 070014923.

Mission Skilled Nursing & Subacute Center

410 N Winchester Blvd, Santa Clara

B $2000 Medication Patient Care Supervision 08/19/2019

During a survey on 8/8/19, it was discovered that the facility had failed to keep six residents free from unnecessary use of psychotropic medications. The facility failed to monitor and document the behavior of these six residents as required after they were given psychotropic medication. One of the six residents was a resident with dementia who was prescribed Seroquel (an anti-psychotic that is not intended or approved for dementia) without an Abnormal Involuntary Movement Scale (AIMS) assessment beforehand. Citation # 070015307.

Mt. Pleasant Nursing Center

1355 Clayton Rd, San Jose

B $2000 Fall Injury 01/18/2019

A resident who was severely impaired due to dementia suffered injuries from three falls during
2018. On 4/3/18, she suffered a bump on the head during the first fall. On 12/6/18, the resident fell and broke her hip while trying to go to the bathroom. On 12/20/18, she was hospitalized for a hip repair and fell again upon her return, this time suffering a skin tear and bump to her head. The facility was cited because it failed to use approaches to prevent falls that were appropriate to the resident’s cognitive status. Citation # 070014746.

**Saratoga Retirement Community Health Center**

14500 Fruitvale Ave, Saratoga

A $20000 Careplan Fall Supervision 07/03/2019

A resident, admitted in 2012 with diagnoses of muscle weakness, history of falling, high blood pressure and arthritis, fell from her bed on 5/11/19, broke a femur and died on 5/22/19 from complications. The resident had an Activities of Daily Living Functional Care Plan dated 3/2/19 that called for two person assists during bed mobility. On 5/11/19, a single CNA was changing the resident’s disposable brief when the resident shifted and fell from the bed, breaking her femur. A staff RN stated on a subsequent interview that two people would have been able to prevent the fall and injury. The Director of Staff Development stated the resident’s care plan was not implemented. The facility violated the regulation by not implementing the care plan for the resident and by not providing adequate supervision to resident’s to prevent accidents. Citation # 070015159.

**The Terraces At Los Altos Health Facility**

373 Pine Ln, Los Altos

B $2000 Careplan Fall Patient Care 08/13/2019

The facility staff failed to follow physician’s orders for one to one supervision of a resident at risk for falls, failed to monitor the resident to prevent multiple falls, failed to appropriately implement new care planning to prevent additional falls and failed to turn on a tab alarm that would alert staff if the resident attempted to get out of bed. As a result, the resident attempted to get out of bed to use the bathroom independently and fell for a 7th time, resulting in a spine and rib fracture. Citation # 070015304.

**Webster House**

437 Webster St, Palo Alto

A $20000 Sexual Abuse 07/15/2019

On 6/10/19, a female resident, who was alert and verbally responsive and suffered from multiple spinal ailments, reported that a CNA sexually abused her the night before. A review of the facility’s internal investigation on 6/10/19 indicated that the CNA claimed he was joking around. The facility suspended the CNA for inappropriate sexual conduct. On 6/13/19, the CNA was fired after the resident’s claim was substantiated. The CNA was arrested for rape, sexual penetration, oral copulation and sexual battery of an elder. The facility was cited for failure to ensure that the resident was free from any form of abuse. Citation # 070015228.

**Santa Cruz County**

**Hearts & Hands, Post Acute Care & Rehab Center**

2990 Soquel Ave, Santa Cruz

B $2000 Medication 07/29/2019

During a rectification survey on 7/15/19, the facility received a citation for its failure to document items removed from the emergency medication kits and its failure to ensure that used emergency medication kits were not returned to the pharmacy. The facility was also cited for having a 15.38% medication error rate when four medication errors out of 26 opportunities were observed during medication passes for two out of six residents Citation # 070015239.
Citation Watch - Consumer Report

The following citation summaries are compiled from the citations issued by the California Department of Public Health to Southern 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.

Kern County

Kern Valley Healthcare District D/P SNF
6412 Laurel Ave, Lake Isabella
B $2000 Mandated Reporting Patient Care Verbal Abuse 08/14/2019
On 5/16/19, a Dietary Aid at the facility stated that he observed a nursing assistant verbally mocking a resident with dementia. The Dietary Aide failed to report the incident of alleged verbal abuse to the Department within 24 hours. The facility was cited for failure to report incidents of alleged abuse within 24 hours. Citation # 120015249.

Los Angeles County

All Saints Healthcare
11810 Saticoy St, North Hollywood
A $20000 Decubiti (Bedsores) 5/8/2019
On 8/20/18, a resident, who had a feeding tube, ventilator and total dependence on staff for daily activities, was transferred to the Acute Care Hospital with a high fever and pressure ulcers on the right ear, sacrococcyx and right and left buttock. The resident underwent surgical debridement and was diagnosed with sepsis and infected decubitus wounds. The facility was cited for failing to properly assess the resident and implement a resident-specific care plan and pressure-relieving devices. Citation # 920015051.

Beacon Healthcare Center
919 N Sunset Ave, West Covina
B $2000 Evictions 8/31/2018
A resident with Parkinson’s disease and bipolar disorder was hospitalized on 6/15/18 for increased confusion. After the hospital determined the resident was ready for readmission on 6/18/18, the facility refused to take the resident back. The resident sought an appeal from the Department of Health Care Services’ Office of Administrative Appeals and subsequently received an order for readmission that the facility ignored. The facility was cited for failing to readmit the resident and leaving her without a place to go. Citation # 950014373.

Bel Tooren Villa Convalescent Hospital
16910 Woodruff Ave, Bellflower
A $20000 Decubiti (Bedsores) 8/30/2018
An 88 year old resident who was admitted in March 2018 with no pressure sores developed a large, infected stage IV pressure sore in her sacral area due to neglect by the facility. She was hospitalized on 4/20/18 and required surgical treatment on the bone-deep infected wound. The facility was cited for failing to provide timely interventions, failing to notify her physician when its treatment was ineffective and of signs of infection, and failing to provide a pressure-reducing mattress per her care plan. Citation # 940014353.

A $20000 Fall Injury Patient Care Staffing 11/2/2018
A 95 year old female resident with a high risk for falls had an unsupervised fall on 5/17/18, hitting and injuring her head. She was not found until a family
member visited her room and found her on the floor by her commode. The family member began yelling for help, and the resident was transferred to the hospital for trauma evaluation and to suture the laceration on her head. The facility was cited for failure to follow the resident’s fall care plan and failure to adequately supervise the resident. Citation # 940014549.

Bell Convalescent Hospital
4900 Florence Ave, Bell
A $20000 Injury 07/10/2019
analysis, broke his shoulder (humerus) on 10/17/18 while being transferred from his bed to a shower chair. The resident’s care plan required two staff members to perform all transfers, as well as the use of a mechanical lift. When the resident suffered injury, he was transferred without the use of a lift by a single CNA. In a report to the Department of Public Health, the facility stated the injury was not from abuse but from “age-related osteoporosis.” The facility was cited for failing to implement the resident’s care plan and failing to use the proper technique regarding transfers from bed to chair. Citation # 910015217.

Bellflower Post Acute
9710 Artesia Blvd, Bellflower
AA $100000 Careplan Patient Care 7/27/2018
An 82 year old male resident with chronic constipation died on 3/31/18 due to bowel obstruction and sepsis. The resident had been on a toileting program to encourage regular bowel movements but records of its implementation could not be located. On 3/30/18, the resident was found with a distended abdomen that was painful to the touch. The resident’s physician was notified and ordered the resident to be transferred to the hospital. He was not transferred until nearly eleven hours later after various treatments were unsuccessful. The resident had a massive fecal bowel obstruction. The resident had not had a bowel movement for days but this may not have been recorded as some staff members were noting “smears of stool” in the resident’s diaper as bowel movements. The facility was cited for several failures of care, including the failure to properly record bowel movements and to provide competent nursing care. Citation # 940014247.

A $20000 Sexual Abuse Supervision 11/21/2018
On 9/13/18, two days after she was admitted to the facility, a 75 year old resident with dementia was sexually abused by a 60 year old male resident who had been exhibiting inappropriate sexual behavior and demanding other residents to have sex with him. The male resident was found in her room with the door closed, where he was standing over her. Her pants and adult brief were off and she had a white milky discharge in her vaginal area. A certified nurse assistant (CNA) who was present when a nurse examined the victim reported that the nurse refused to send her to the hospital for an exam. Two physicians stated she should have been immediately sent to the hospital for a sexual assault exam but was not because they were not informed of the circumstances. The male resident was supposed to have been on one-to-one supervision due to prior inappropriate sexual behavior but the facility had not assigned anyone to monitor him. The facility was cited for failing to protect the resident from sexual abuse. Citation # 940014601.

Beverly West Healthcare
1020 S Fairfax Ave, Los Angeles
B $2000 Retaliation Against Staff 6/15/2018
On 4/1/18, the facility was cited for failing to prevent retaliation against a resident’s family member after she reported that the CNA was not using a washbasin while washing the resident’s genital area. She had also given the number of the local ombudsman’s office to another resident who wanted to file a complaint against the same CNA. The facility failed to protect the right of the residents and their representatives to report misconduct without fear of retaliation. Citation # 950014155.

B $2000 Infection 6/15/2018
The facility was cited on 5/1/18 for failing to ensure their standard of infection practices on multiple residents. The first resident, who had a personal history of urinary tract infections, was cleaned without the use of a washbasin, one of the facility’s required supplies for perineal care. The second resident had foul-smelling containers of food next to her bed because it was not stored in the refrigerator. The third and fourth residents had tubings that were touching the floor, which put them at risk of cross-contamination. Citation # 950014157.

Briarcrest Nursing Center
5648 Gotham St, Bell Gardens
A $6000 Physical Abuse Supervision Verbal Abuse 8/3/2018
A resident who had dementia and was determined as a high risk for elopement had a plan of care that required supervision. A registered nurse stated that the
resident was not aggressive unless she was grabbed. On 4/7/18, the resident wandered unsupervised into another resident’s room where a visitor verbally and physically abused her. The visitor grabbed her by the neck and hair, which left her with skin discoloration. The facility’s failure to supervise the resident resulted in the resident experiencing abuse. Citation # 940014310.

**Broadway By The Sea**
2725 E Broadway, Long Beach

B $2000 Careplan Fall Injury Patient Care Physical Environment Staff (Inservice) Training 08/08/2019
On 6/29/19, a resident with muscle weakness, who needed two or more staff to assist her, was helped to the shower by one CNA. The CNA turned the resident too quickly, and the resident hit her face on the side rail in the bathroom. This practice resulted in the resident sustaining a right eyebrow cut, bleeding, bruising and pain. The CNA did not check the Special Needs List and did not ask a nurse how many staff members the resident required for mobility. The facility failed to train staff on potential accident hazards and to use the physical assistance of another staff member to assist the resident safely. Citation # 910015287.

**Broadway Manor Care Center**
605 W Broadway, Glendale

WMF $1000 Neglect Patient Care 04/17/2019
After a resident experienced high blood pressure and respiratory distress, the facility staff delayed in calling 911 to transfer the resident to the emergency room for care. After the resident died, a facility staff member entered false information into the medical record, indicating that the resident’s family member refused to consent to a hospital transfer, when in fact, they had not. Citation # 950014966.

**California Post-Acute Care**
3615 E Imperial Hwy, Lynwood

B $2000 Mandated Reporting Physical Abuse Verbal Abuse 7/20/2018
A facility reported incident was received on 2/15/18, and an unannounced visit was made to the facility on 3/2/18 to investigate the report that a CNA was being abusive to two residents. Both residents described the CNA to be rough and rude. The residents informed a different CNA that the first CNA called them nicknames, cursed at them, failed to take them to the restroom and rough handled them when transferring to a bed. The second CNA relayed the report to a third CNA but neither reported the incident to anyone else. The facility failed to implement and follow its report of abuse policies which endangered their residents from further abuse. Citation # 940014260.

B $2000 Bed Hold 9/5/2018
On 5/11/18, the Department received a complaint of the facility refusing to readmit one of its residents. An investigation revealed that a resident had been transferred to a hospital for evaluation, and on 4/27/18, the hospital phoned the facility Director of Nurses (DON) to say that the resident’s insurance had authorized the resident could be transferred back into the facility. The resident’s seven day bed hold expired on 4/29, but the facility did not readmit the resident once because they had already reassigned the bed to someone else. The resident did not get readmitted into the facility until 17 days later when a bed became available on 5/14. The facility was cited for failing to readmit the resident during the seven day bed hold. Citation # 940014389.

**Catered Manor Nursing Center**
4010 N Virginia Rd, Long Beach

B $2000 B 10/19/2018
On 7/9/18, a resident was verbally abused by the Assistant Director of Nurses (ADON) and Social Services Designee for taking pictures of her roommate without her roommate’s permission. This interaction left the resident uncomfortable and stated that she did not want the ADON to come into her room after that. The resident’s roommate also disclosed that the ADON is rude and condescending when speaking to other residents. The facility was cited for failing to protect the residents from verbal abuse and failing to ensure that the abuse policy is being followed. Citation # 940014500.

**Community Care Center**
2335 Mountain Ave, Duarte

A $20000 Supervision Staffing 10/25/2018
In the early morning hours of 4/12/18, a 41 year old female resident with a developmental disability collapsed in a facility hallway. She was discovered by another resident but neither the CNA, or LVN assigned to the building, could be found because they were taking their breaks in another building. As a result, the resident did not receive CPR for at least 25 minutes and paramedics were not called for at least 52 minutes. The resident passed away later that morning. The facility was cited for failing to ensure residents who required hourly monitoring were adequately monitored and for providing insufficient supervision for residents. Citation # 950014517.

B $2000 Elopement 11/14/2018
On 6/2/18, a resident with a schizoaffective disorder
and a history of wandering about the facility without a plan or purpose eloped from the facility. A review of the Psychiatric Progress notes indicated that the resident would repeatedly express a desire to go to “Percivilage”, a place that did not exist. On 6/2 at 2:30 pm, the resident was discovered missing from the facility and the staff reported this to the sheriff’s office at 9:30 pm. As of 10/12/18 the resident still hasn’t been found. The facility was cited for failing to ensure that the resident, who was at risk for elopement, was provided with adequate supervision. Citation # 950014518.

B $2000 Bed Hold Evictions 02/22/2019
A 26 year old resident with schizophrenia was seen fighting another resident on 11/22/18. The next day, the resident was hospitalized for a psychiatric evaluation. The resident was not notified of his bed hold rights and was not readmitted, despite never receiving a discharge notice. The facility was cited for failing to give a discharge noticed and for failing to hold the bed. Citation # 950014835.

Country Villa Belmont Heights Healthcare Center
1730 Grand Ave, Long Beach
B $2000 Careplan Deterioration Hydration Neglect Patient Rights Physical Environment 10/5/2018
The Department received a complaint on 7/23/18, alleging the facility was very hot, the air conditioner was not working and fans were not provided to the residents. The facility’s temperature was not maintained between 71 and 81 degrees Fahrenheit. During an interview, a resident stated, “Very hot, and they don’t have any ice for her water.” The facility maintenance supervisor recorded the room temperature at 91.5 degrees F. The facility failed to ensure temperatures in the resident’s rooms were maintained at a comfortable level and keep the air conditioning unit system and ice machine. Citation # 940014464.

Country Villa Claremont Healthcare Center
590 S Indian Hill Blvd, Claremont
B $2000 Careplan Patient Care Patient Records 07/27/2018
A resident’s medical record was not properly maintained when no initial report of his condition was noted upon admission to the facility, nor was information regarding any of his medical conditions, or health issues, entered into the facility electronic medical records. Citation # 950014280.

A $20000 Fall Supervision 07/27/2018
Less than two hours after being admitted, a resident who was legally blind and at risk for falls walked out of his room without assistance, hit the door frame and fell to the ground. The resident sustained head and back injuries. The facility’s failure to assess the resident’s needs and failure to provide adequate supervision resulted in the resident’s injuries and consequential transfer to the hospital’s ICU. Citation # 950014281.

Del Rio Gardens Care Center
7002-4 East Gage Avenue, Bell Gardens
B $2000 Injury Mandated Reporting Notification Patient Care 12/7/2018
During the morning of 9/7/18, a nursing assistant observed swelling on the right thigh of a resident but did not report it to anyone. The swelling was not reported to a nurse until late that afternoon. At 9:40 pm on 9/7/18, the resident received x-rays that revealed a fractured femur (thigh bone) and was transferred to the hospital. The facility was cited for failure to ensure unusual occurrences are reported to the Department. Citation # 940014639.

Downey Care Center
13007 Paramount Blvd, Downey
B $2000 Careplan Injury Mandated Reporting Patient Care Physical Abuse 10/19/2018
On 6/29/18, a nursing assistant noticed that a resident with hemiplegia (inability to move one side of the body) was grimacing with pain. The nursing assistant also noticed swelling on her right leg. The staff left a message for the facility physician, which was not returned until 5.5 hours later. The facility then ordered x-rays, which revealed a fracture in the resident’s right femur (thigh bone). The facility was cited for failure to notify the physician and responsible party promptly and failure to report the incident to the department. As a result, the resident’s hospitalization was delayed by 13.5 hours and the injury was not thoroughly investigated to find out possible causes. Citation # 940014501.

B $2000 Fiduciary Patient Records Theft & Loss 10/24/2018
An employee at the facility told an 80 year old male resident to sign multiple checks payable to the employee, supposedly to deposit the checks in the resident’s bank account. The employee then deposited the checks in her personal bank account. The employee stole a total of $12,600 from the 80-year-old resident over several months. The facility was cited for failure to ensure that the residents were free from financial abuse. Citation # 940014514.
A 76 year old resident, who was admitted for rehabilitation of a fractured femur on 2/7/18, died five days later due to neglect. She received high doses in duplicative amounts of nonsteroidal anti-inflammatory drugs (NSAID) that placed her at high risk for bleeding. The facility’s medical director stated that she should have been closely monitored to prevent GI problems, and that “I would have never have prescribed the combination of medications that the resident was receiving with a blood thinner.” The resident had episodes of vomiting and constipation on 2/10/18, but her physician was not notified of the change in her condition. Paramedics took her to the ER on 2/12/18 after she could not be aroused. Copious amounts of coffee ground material, indicative of bleeding, were suctioned from her and CPR was initiated. She died of cardiac arrest and GI hemorrhage an hour after being admitted to the hospital. The facility was cited for failing to adequately monitor her for medication side effects, to report her change of condition to her physician, to prevent the use of unnecessary drugs, to monitor her bowel movements and to use non-pharmacological interventions. These violations were a direct proximate cause of her death. Citation # 940014466.

Downey Community Health Center
8425 Iowa St, Downey

B $2000 Patient Records 7/6/2018
A resident with diagnoses of schizophrenia and anxiety was readmitted to a facility on 3/19/18. The resident became verbally aggressive and was transferred to an Acute Care hospital at 7:45 pm. The next day, a review of the Resident Behavior Monitoring Form indicated that the first LVN monitored the resident from 5:15 pm to 7:45 pm, every 15 minutes. When interviewed, the first LVN stated that she was not assigned to that resident and only initialed the form regarding the resident at the direction of a second LVN, who says they had documented the resident’s location. The second LVN admitted to asking the first LVN to initial the form regarding the resident. By failing to prevent its staff from lying, the facility to prevent a willing material falsification of a resident’s health record. Citation # 950014225.

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

B $2000 Transfer 9/13/2018
On 5/12/18, the facility failed to report the transfer of a resident with cancer and alcohol dependence to the resident’s representative and the Office of the State Long-term Care Ombudsman. The resident was transferred to a General Acute Care Hospital Emergency Room for temporary and involuntary commitment because the resident was a danger to themselves, also referred to as Code 5150. Citation # 940014409.
failing to ensure sufficient preparation before discharge, failing to develop and implement an individualized discharge planning process, and failing to ensure a safe discharge. Citation # 950014900.

**B $2000 Administration Careplan Notification Patient Records Patient Rights Transfer**

03/21/2019

A resident, with severe impairment and required extensive assistance, was discharged from the facility by a physician’s order on 10/26/18. The facility RN stated that she was not responsible for making arrangements to obtain the discharge orders from the physician, filling out the paperwork or preparing the discharge medications. The facility discharged the resident to a Psychiatric Hospital and failed to ensure sufficient preparation before the discharge. The facility failed to secure a safe discharge, implement facility policy on Transfer/Discharge notice, give at least 30-day notice and send notice to the Office of State Long Term Care Ombudsman. Citation # 920014904.

**Fidelity Health Care**

11210 Lower Azusa Rd, El Monte

**B $2000 Elopement Injury Supervision**

8/16/2018

The facility failed to ensure proper functioning of the WanderGuard system and failed to ensure that the CNA did not leave the resident unattended and unsupervised when he was found outside of the facility’s premises. The resident eloped and was found 18 hours later, in another city, with a large bruise on his hand and wrist, and a broken thumb. The resident was determined as at risk for elopement. When he walked out of the facility, no alarm sounded and when the CNA saw the resident outside, she left him to get help. When the CNA returned, the resident was gone. Citation # 920015312.

**Garden View Post-Acute Rehabilitation**

14475 Garden View Ln, Baldwin Park

**A $20000 Neglect 07/27/2018**

A female resident passed away from cardiac arrest after choking on her breakfast. On 1/24/18, the resident was found alone, sitting still on her bed, with her head down and remnants of food around her mouth and bib. The CNA was informed and the resident received CPR before being transported to the General Acute Care Hospital where the resident passed away that same day. Due to the resident’s clinical conditions such as dementia, Parkinson disease and narcolepsy, staff supervision was required while she ate to ensure that the food was being eaten properly for her own safety. The facility was cited for its failure to provide the necessary care and services to maintain the well-being of their residents in accordance with professional standards and plan of care. Citation # 950014292.

**Glendale Post Acute Center**

250 N Verdugo Rd, Glendale

**A $20000 Fall 12/14/2018**

On 9/3/18, a 71 year old resident who was unable to walk safely without assistance fell and sustained a head injury. He was hospitalized for 3 days and treated for intracranial bleeding. The fall occurred when the resident, who was walking unassisted, tried to move a wheelchair that was blocking the entrance to his room. The facility was cited because it failed to assist the resident while walking and failed to keep the environment free from accident hazards. Citation # 950014660.

**Golden State Colonial Healthcare Center**

10830 Oxnard St, North Hollywood

**B $2000 Decubiti (Bedsores) 8/14/2019**

The facility failed to prevent the development of a stage three pressure ulcer (including full thickness tissue loss), for a resident who was at risk of developing pressure ulcers. The facility failed to monitor the pressure ulcer and failed to implement a care plan when redness was identified. Citation # 920015312.

**Green Acres Healthcare Center**

8101 Hill Dr, Rosemead

**B $2000 Transfer 01/30/2019**

On 10/17/18, a resident, with moderate cognitive impairment and diagnoses including dementia and schizophrenia, was discharged to an independent living facility. Three days later, on 10/20/18, the police found the resident in a park, confused and unable to walk. The police brought the resident to a hospital where he was diagnosed with dehydration, received intravenous fluids and discharged to a second skilled nursing facility on 10/27/18. The first facility was cited for failing to ensure sufficient orientation and preparation before discharge by not following its policy on “Safe Discharge to Lower Level of Care,” and for failing to discuss with the resident’s primary physician his inability to care for himself. Citation # 950014780.

**Greenfield Care Center Of South Gate**

8455 State St, South Gate

**B $2000 Dietary Services Nutrition 9/7/2018**

On 07/19/18, the facility failed to store, prepare and serve certain foods, such as custard, turkey and refried beans, by professional food safety standards to 90 out of 92 residents. The facility also failed to maintain the ice maker to prevent the accumulation of mold. The
foodborne pathogens and mold that resulted from the facility’s failures had a direct or immediate relationship to the health of their residents. Citation # 940014394.

**Griffith Park Healthcare Center**  
201 Allen Ave, Glendale  
B $2000 Patient Rights Physical Abuse  
10/19/2018  
On 7/20/18 a CNA hit a resident with a belt causing red marks and swelling on the side of the head behind the eye area. The incident was witnessed by another CNA who reported the incident. The attacking CNA was escorted out by the police in handcuffs and a review of the police report confirms the injuries to the resident. The facility failed to ensure the resident was free from abuse and corporal punishment, violating regulations and facility policy. Citation # 950014509.

**Huntington Post Acute**  
150 Bellefontaine St, Pasadena  
A $20000 Feeding Hydration Infection Neglect Nutrition 12/21/2018  
As of 9/17/18, a 65 year old resident sustained a severe weight loss of 24 pounds in one month without medical and nutritional interventions. On 9/24/18, a family member said the resident “looked horrible” and he was hospitalized via 911 per her request. The resident was in critical condition with diagnoses of sepsis with septic shock and C-Diff. The resident underwent two abdominal surgeries in hopes of saving his life. The facility was cited because it did not provide him adequate nutrition and hydration, did not notify his physician of the severe weight loss and numerous other failures. Citation # 950014662.

**Idle Acre Sanitarium & Convalescent Hospital**  
5044 Buffington Rd, El Monte  
B $2000 Elopement 7/18/2018  
A 68 year old male resident with dementia and encephalopathy left the facility unnoticed on 2/27/18 and 3/16/18. On 3/16/18, the resident was found by police knocking on a neighbor’s door. The facility was cited for failing to identify the resident’s high risk for leaving unattended and failing to provide adequate supervision for the resident. Citation # 950014250.

**Intercommunity Healthcare & Rehabilitation Center**  
12627 Studebaker Rd, Norwalk  
AA $100000 Patient Care 8/3/2018  
On 3/9/18, a resident with a history of respiratory failure was in the process of being weaned off of a ventilator onto a T-collar mask. He was not being monitored and became unresponsive. The resident was transferred to a hospital where he died. A T-mask is a device that is placed over a surgically created hole through the front of the neck, then into the breathing tube that leads to the lungs. The weaning protocol calls for blood testing to measure oxygen and carbon dioxide levels in the lungs. The facility was cited for failing to follow the proper procedures on ventilator weaning. Citation # 940014298.

**Kei-Ai South Bay Healthcare Center**  
15115 S Vermont Ave, Gardena  
A $20000 Fall Injury 06/21/2019  
On 3/27/19, a resident fell and fractured her knee when a CNA attempted to transfer her from her bed to a
wheelchair without assistance from another staff member and without the use of a mechanical lift as required by her care plan for safety reasons. The resident suffered pain and swelling and was subsequently hospitalized for treatment of the fracture. The facility was cited for failing to follow the resident’s care plan and failing to train the CNA on safe transfers using the lift. Citation # 910015180.

La Brea Rehabilitation Center
505 N La Brea Ave, Los Angeles
B $2000 Mandated Reporting Physical Abuse 10/5/2018
On 8/23/18 during an unannounced visit, a resident reported a staff person had hit her on 5/10/18 and that she had told other staff about the incident. A note in the communication system used by staff indicated the resident told the charge nurse at the time of the incident and that the staff member accused was told to avoid the resident. A limited investigation was done by the social services director but no investigative report was created by the Administrator. The facility did not report the allegation or submit an investigative report to the appropriate agencies. As a result, the facility violated their policy and applicable codes. Citation # 950014465.

La Paz Geropsychiatric Center
8835 Vans St, Paramount
A $16000 Sexual Abuse 11/17/2018
On 7/21/18, a resident was raped by another resident and sustained multiple injuries. The victim was 64 years old and was supposed to receive special assistance to prevent sexual assault after an earlier incident with another resident. The perpetrator was 67 years old and had previously expressed a desire to have sexual intercourse with the victim but his careplan was not amended. Video surveillance showed a CNA walking through the hallway past the victim’s closed room door three times during the assault. The CNA was trained to check on residents whose door was closed but did not on these occasions. The rape was discovered by a laundry staff person who walked into the room and saw the perpetrator on top of the victim and a “pool of blood” on the victim. The facility was cited for failure to provide the resident with a wheelchair without sharp edges. It was also noted that the resident continued using the wheelchair without the protective rubber cap until 12/31/18, 18 days after the injury occurred. Citation # 940014930.

Lakeview Terrace
831 S Lake Street, Los Angeles
B $2000 Evictions Transfer 06/27/2019
A female resident with developmental disabilities and multiple physical conditions was transferred to a hospital more than 30 miles away on 4/8/19. The resident was driven to the hospital by the “facility driver” accompanied by a CNA. The facility was cited for failing to provide: 1) sufficient preparation for a safe and orderly transfer or discharge due to an inappropriate mode of transport and 2) inappropriate personnel to accompany the resident during the transfer or discharge. Citation # 920015179.

Lakewood Healthcare Center
12023 Lakewood Blvd, Downey
B $2000 Mandated Reporting Physical Abuse 8/10/2018
On 4/19/18, a 65 year old resident hit a 71 year old resident on the right side of her head with the back of her hand causing her pain and blood on her scalp. The incident occurred in the presence of two CNAs, and one of them reported it to the LVN, but the LVN did not notify the Administrator nor the Director of Nursing. The facility was cited for failing to report the resident-to-resident abuse incident to the Department of Public Health within 2 hours. Citation # 940014320.

Leisure Glen Post Acute Care Center
330 Mission Rd, Glendale
B $2000 Physical Environment 04/03/2019
On 12/13/18, a resident, diagnosed with Parkinson’s disease and required two-person assist for transfers, sustained a skin injury to the lower right leg while being transferred into a wheelchair by one staff. While being transferred, the resident was cut by a sharp metal edge on the front wheel that was missing its protective rubber cap. The resident’s wound did not respond to treatment, increased in size, required surgical debridement and got infected with MRSA, a bacteria that causes infections and is highly resistant to antibiotics. The facility was cited for failure to provide the resident with a wheelchair without sharp edges. It was also noted that the resident continued using the wheelchair without the protective rubber cap until 12/31/18, 18 days after the injury occurred. Citation # 920014930.

Long Beach Healthcare Center
3401 Cedar Ave, Long Beach
A $20000 Careplan Medication Notification Patient Care 8/15/2018
On 4/13/18, a 61 year old resident with kidney failure who had physician’s order for dialysis treatment three times a week, was transferred to a hospital via 911 emergency. The resident had refused to sign forms to receive dialysis and missed several treatments. At the hospital, she had abnormal lab results that led to potentially lethal abnormal heart rhythms requiring emergency evaluation and treatments due to not receiving patient care.
the dialysis treatments. The facility was cited for failing to implement the physician’s order for the resident to receive dialysis three times a week, failing to notify the physician of resident’s refusal to receive dialysis treatments and failing to adhere/implement resident’s plan of care for “Hemodialysis.” Citation # 940014331.

A $20000 Dietary Services Feeding Nutrition 11/14/2018
On 6/4/18, a 73 year old resident who had Parkinson’s disease was hospitalized with severe protein malnutrition and septic shock in an emaciated condition after he lost 38.2 lbs. (22% of his body weight) during the prior six months at the facility. A family member stated that he was unable to feed himself due to tremors and that the staff left his meal trays on the bedside table without helping him to eat. The facility was cited for not following his physician’s orders, not assisting the resident with meals, not conducting a dietary evaluation and other failures. Citation # 940014578.

B $2000 Patient Care 12/7/2018
On 7/23/18, the facility staff failed to properly care for a resident in need of assistance with feeding after a staff member brought the resident a cup of coffee, and instead of assisting with drinking, left it in front of the resident on the table. The resident attempted to drink on his own, spilled hot coffee on his lap, resulting in 2nd degree burn. Citation # 940014625.

Maclay Healthcare Center
12831 Maclay St, Sylmar
B $2000 Infection Neglect Patient Care 2/13/2019
The facility failed to provide mouth care to a resident who was totally dependent on staff for activities of daily living. As a result, the resident had live maggots in his mouth. The resident’s diagnosis included severe mental impairment and his care plan included mouth care. When the maggots were found, they were coming out of the resident’s mouth. When oral care and suction was performed, about 26 maggots were removed. The resident’s chief complaint was respiratory distress, as the maggots contributed to the resident’s aspiration and respiratory problems. The facility failed to ensure the resident was free from neglect, which caused his Myiasis (infection with a fly larva), an infection that is rarely acquired in the United States. Citation # 920014814.

Mission Care Center
4800 Delta Ave, Rosemead
B $2000 Transfer 9/14/2018
A resident was discharged from a facility to a family member and taken to a hotel room on 5/19/19. The resident needed extensive help with activities of daily living including dressing, toileting, eating, and bathing. The resident was admitted to an acute care hospital that same day with a fracture of the left thigh. The facility failed to plan for a safe discharge that met the health and safety needs of a resident. Specifically, the facility failed to identify the ability and availability of the family member caregiver, to instruct the family member on the care needed by the resident, to inspect the discharge location for accessibility and safety and to discharge the resident with the necessary medical equipment. Citation # 950014413.

Monrovia Post Acute
1220 Huntington Dr, Duarte
B $2000 Patient Care Patient Rights 8/2/2018
The facility staff failed to follow policies regarding a resident’s right to create an advanced directive. When a resident became incapacitated and no other decision-maker was available, a facility physician, not a member of the facility’s Bioethics Committee, made the decision to not resuscitate. As a result, the resident died without the staff attempting CPR. Citation # 940014308.

Montebello Care Center
1035 W Beverly Blvd, Montebello
B $2000 Administration Careplan Patient Rights Physical Abuse Security Supervision 07/05/2018
A CNA stated that another CNA would go to a resident’s room and stay with the resident after her shift. The facility Administrator said a romantic relationship between staff members and residents is absolutely not allowed in the facility. On 3/7/17, while a resident was sitting at the facility front patio, the CNA’s spouse slapped the resident on the face. The resident sustained redness on the right side of the face. The facility failed to ensure its residents has the right to be free from abuse and neglect. Citation # 940014220.

Norwalk Meadows Nursing Center
10625 Leffingwell Rd, Norwalk
B $2000 Verbal Abuse 8/10/2018
On 4/18/18, the Department of Public Health received a complaint about a resident who said he was being bullied and harassed by a CNA. The resident alleged that the CNA came into his room at 3 am, shook his bed frame and asked him if he was gay. The resident also stated that the CNA had gone over to his roommate’s bed, drew the curtain and “did something” to that resident. His roommate suffered from a brain disease and memory problems. The facility was cited for failing to contact the Department promptly, placing the two residents at risk for abuse. Citation # 940014324.

Norwalk Skilled Nursing & Wellness Centre
11510 Imperial Hwy, Norwalk
A $20000 Fall 7/20/2018
On 3/14/18, a resident, with a high risk of falls, was found sitting on the floor and indicated that she was having pain in her leg. Later that day, she complained to the physical therapist about her left leg hurting. The resident’s Progress Notes indicated she was experiencing pain. By 3/25/18, the resident was no longer able to ambulate. On 3/28/18, an x-ray was taken, which concluded that her left leg was broken just below the ball and socket joint. The facility was cited for failure to provide the necessary care she needed after complaining for over 13 days about the pain in her leg. Citation # 940014257.

Pacific Villa, Inc.
3501 Cedar Ave, Long Beach
A $20000 Decubiti (Bedsores) 8/15/2018
In April 2018, an 80 year old resident developed two unstageable pressure sores (one to his sacral coccyx and one to his left buttck) and was hospitalized for treatment of the wounds. The facility was cited for its failures to turn the resident every two hours, to ensure the resident received adequate protein for wound prevention and healing, to use a pressure-relieving mattress per his care plan and to refer the resident to the registered dietitian for a nutritional assessment. Citation # 940014337.

Paramount Convalescent Hospital
8558 Rosecrans Ave, Paramount
B $2000 Transfer 12/7/2018
The facility failed to properly discharge a resident to another facility that could adequately meet their need for a hoyer lift and oxygen. The resident was sent to a lower level of care Assisted Living Facility, and the staff at that facility were not made aware of the resident’s medical needs. As a result, within a few hours of discharge, the resident’s oxygen tank ran out, the resident became short of breath and transferred by ambulance to an emergency room. Citation # 940014637.

Pasadena Care Center, Llc
1640 N Fair Oaks Ave, Pasadena
A $20000 Patient Care 06/29/2018
At 10:15 am on 2/22/18, a 70 year old resident, diagnosed with diabetes and depressive disorder, had shallow breathing and was not responding to verbal or tactile stimuli. The resident’s blood pressure was lower than the normal range. There was no documentation that the resident’s heart, or breathing rate, was monitored to ensure that immediate CPR could be initiated if required. The paramedics found the resident lying on her back with no heartbeat and no respiration. The paramedics were able to revive the resident by performing CPR and then transported her to the hospital where she died. The facility was cited for its failure to continuously monitor the resident’s heart and respiratory rate; for its failure to provide CPR to the resident. Citation # 950014205.

Penn Mar Therapeutic Center
3938 Cogswell Rd, El Monte
A $20000 Physical Abuse Physical Environment Supervision 02/08/2019
On 10/19/18, a resident with schizophrenia and a history an appeal was granted, the facility failed to contact the resident when a bed became available. The facility was cited for failing to protect the resident’s discharge and readmission rights. Citation # 940014694.
of assaulting others, attacked another resident with a piece of wood taken from a loose armrest of a chair. The CNA who was assigned to monitor the residents was playing chess with another resident when the incident happened. The attacked resident sustained skull fractures and was transferred to the hospital. The facility’s failure to maintain the chair’s armrests and failure to provide supervision resulted in the resident’s injury. Citation # 950014803.

Providence Little Company of Mary Subacute Care Center
1322 West 6th St, San Pedro
B $2000 Patient Care 8/16/2019
On 6/27/19, a Respiratory Therapist (RT) entered a resident’s room that was on contact isolation without wearing personal protective equipment or washing their hands. While in the resident’s room, the RT touched the resident’s tracheostomy tubing with her bare hands and then touched her own hair. The RT walked out of the resident’s room, wheeled the Workstation on Wheels (WOW) cart down the hall without washing her hands or performing proper sanitation procedures on the WOW. The facility was cited for the RT’s failure to exhibit proper sanitation processes when working with residents and other facility equipment. Citation # 910015317.

Rio Hondo Subacute & Nursing Center
273 E Beverly Blvd, Montebello
B $2000 Careplan Fall
The facility failed to adequately supervise and assist a 102 year old resident with a history of falls. The facility staff did not update the resident’s care plan after repeated falls to put measures in place to prevent future falls, and as a result, the resident fell again, sustaining a bruise and laceration to the forehead, which required stitches. Citation # 940014406.

Rose Villa Healthcare Center
9028 Rose St, Bellflower
A $20000 Fall 12/26/2018
The facility failed to ensure that a resident, who was at risk for falls and needed assistance with showers, received supervision and assistance to prevent falls as indicated in his care plan. The resident had previous incidents of showering unattended and had two recent falls before this incident. According to the resident, on 9/25/18, he asked the CNA to take a shower and the CNA said yes. When the CNA never showed, he took a shower unassisted, which he stated he usually did, when he stood up from the shower chair and slipped on the floor. The resident sustained a three-part break in his ankle and required surgery. Citation # 940014670.

Royal Terrace Health Care
1340 Highland Ave, Duarte
A $20000 Patient Care 07/11/2018
On 1/14/18, an 88 year old resident, with chronic obstructive pulmonary disease, had phlegm and was wheezing with crackle-breath sounds. The x-rays indicated that he had an infection in his lungs. On 1/15/18, the resident had labored breathing, with a respiration rate of 15 breaths per minute. CPR was administered by the paramedics but was unsuccessful. The resident was pronounced dead at 10:20 pm. The resident’s medical records show no documentation of his vital signs or oxygen saturation levels. The facility failed to effectively monitor the resident’s respiratory conditions, as well as recognize his need for emergency intervention to prevent further decline and death. Citation # 950014199.

San Marino Manor
6812 N Oak Ave, San Gabriel
B $2000 Infection Mandated Reporting Patient Care 09/03/2019
The facility failed to identify and report an outbreak of scabies to the local health department when three out of five residents were treated with anti-scabies medication. The facility also failed to develop and implement its infection prevention and control program when four of five residents had signs and symptoms of scabies. Lastly, the facility failed to conduct an ongoing system of surveillance to identify possible infections including staff who were exposed and complained of symptoms of scabies. These failures put the residents’ health and safety at risk. Citation # 950015363.

Santa Fe Convalescent Hospital
3294 Santa Fe Ave, Long Beach
B $2000 Careplan Elopement Patient Care Supervision 7/26/2018
A 76-year-old male resident with dementia, deafness, muteness, difficulty swallowing and a g-tube, left the facility unsupervised on 2/2/18, likely around 9 pm. He was found the next day at 6:44 am by the police at a bus stop over 4 miles away. The facility was cited for failure to provide adequate supervision to prevent accidents, and failure to ensure residents receive care according to professional standards and a person-centered plan of care. Citation # 940014279.

Shoreline Healthcare Center
4029 E Anaheim St, Long Beach
B $1500 Careplan Feeding Injury Patient Care Staff (Inservice) Training 10/24/2018
On 6/27/18, a 70 year old male resident choked on a ham sandwich. The facility staff failed to properly perform
the Heimlich maneuver and remove the obstruction in his airway. By the time the paramedics arrived, the resident was unresponsive and in full cardiac arrest. The paramedics removed the food from the airway, provided defibrillation, and the resident was intubated and transferred to the hospital, in a coma and breathing through a ventilator. A hospital report indicated the Ethics Committee recommended a “Do Not Resuscitate” and the resident was extubated (breathing tube removed) on 7/7/18. The resident died on 7/8/18. Citation # 940014526.

B $2000 Evictions Notification Patient Care
12/7/2018
A 78 year-old male resident with a history of both high and low blood pressure, difficulty walking, congestive heart failure and use of a pacemaker, was admitted to the facility on 8/20/18. Nine days later, on 8/29/18, he was discharged home. At the time of discharge, the resident had low blood pressure, but the physician was not notified. A family member drove the resident home, and upon getting out of the car the resident immediately fainted and fell. The family called 911 and the resident was transported to the hospital, where he was noted to be weak and pale. The facility was cited for failure to notify the physician of the resident’s low blood pressure and failure to ensure the resident was in stable condition prior to discharge. Citation # 940014628.

St. Andrews
2300 W Washington Blvd, Los Angeles
B $2000 Physical Abuse 06/14/2019
On 8/31/18, a resident observed a CNA hit another resident on the face. As a result, the resident sustained a purplish bruise measuring 1.5 by 1.4 centimeters on the left corner of his eye. The resident who was hit had severe cognitive impairment and was not able to answer questions about the incident. The facility was cited for failure to notify the physician of the resident’s right to be free from physical abuse. Citation # 910015161.

Vernon Healthcare Center
1037 W Vernon Ave, Los Angeles
A $20000 Infection Patient Care 11/21/2018
Ten days after she was initially admitted, a 55 year old resident was hospitalized on 8/20/18 with purulent urine, severe sepsis and a urinary tract infection related to poor care of her urinary catheter. She was hospitalized for eight days, where she required intubation and IV antibiotics to treat the life threatening infection. The facility was cited for failing to provide necessary care for the resident’s catheter. Citation # 940014595.

Windsor Convalescent Center of North Long Beach
260 E Market St, Long Beach
B $2000 Patient Care 12/21/2018
A resident diagnosed with a psychotic disorder with delusions and schizophrenia was not properly provided adequate care according to his care plan when staff failed to implement a physician’s order by using a wander alert device for the resident or monitor his departure from the facility. As a result, the resident left, unnoticed, from the facility and was found 25 miles away, and then, was admitted to an emergency hospital on an involuntary psychiatric hold. Citation # 940014675.

Windsor Palms Care Center of Artesia
11900 Artesia Blvd, Artesia
B $2000 Careplan Decubiti (Bedsores) 8/8/2018
The facility failed to ensure a resident’s open skin wound, which was found on 6/13/18, did not progress to a stage III pressure ulcer. The resident, who had an open skin wound on his inner buttock and sacrococcyx, was turned according to his turning schedule and was found on 6/18/18 with a towel put into his diaper, potentially causing further skin breakdown. The facility’s failures resulted in an increase in size with the formation of a slough within eight calendar days. Citation # 940014323.

Villa Elena Healthcare Center
13226 Studebaker Rd, Norwalk
B $2000 Mandated Reporting Sexual Abuse 9/4/2018
On 5/7/18 at 9 am, a resident yelled that a female restorative nursing assistant (RNA) had raped her and applied feces on her body. The resident told an investigator she felt pain in her buttocks because the RNA used a towel and inserted something wet twice into the resident’s buttocks. The allegation was not reported to the administrator until 5 pm on 5/7/18, 7 and 1/2 hours after it was made. The accused RNA continued to work at the facility that day and the two following days despite a facility policy to suspend or reassign an alleged perpetrator. The facility was cited for failure to immediately report the allegation of abuse and to suspend or reassign the alleged perpetrator per its policy. Citation # 940014376.
The Ellison John Transitional Care Center
43830 10th Street West, Lancaster
A $20000 Fall Injury Neglect 10/19/2018
On 5/15/18, a resident fractured his forearm when he fell while getting out of bed to go to the bathroom. His broken arm was treated at the hospital, and he returned to the facility. The resident had three other falls at the facility; two of them also occurring as he was trying to go to the bathroom. The facility was cited for failing to intervene to prevent future falls and failing to anticipate and meet the resident’s needs for toileting in accordance with his care plan. Citation # 920014503.

Orange County
Healthbridge Children’s Hospital - Orange D/P SNF
393 S. Tustin Street, Orange
B $2000 Bed Hold 08/06/2019
The facility failed to send a notice of discharge to two separate residents, or their legal representatives, in the month of April. Both residents had a transfer to the hospital and did not receive their required seven day bed hold. This failure prevented the opportunity for the residents to participate in the decision making process. Citation # 060015266.

Hy-Lond Garden Grove
9861 West 11th Street, Garden Grove
B $1000 Administration Fall Injury Neglect Patient Care Patient Rights 08/20/2019
On 5/31/19, a CNA and RN discovered that a female resident had discoloration on her left toe and bruising on her right thigh. X-rays indicated that she sustained a fracture, caused by a fall, that required surgical repair. The resident fell when her Direct Support Professional was transferring her over from her bed to her wheelchair. There was another Direct Support Professional in the room, but she was coerced to not report the incident. The facility failed to conduct an investigation until 6/26/19, 26 days after the RN had reported it. The facility was cited for failing to investigate the incident soon after the report of injury had been made. Citation # 060015322.

Newport Subacute Healthcare Center
2570 Newport Blvd, Costa Mesa
B $1500 Decubiti (Bedsores) Patient Care 8/20/2019
A female resident who was a high risk for pressure sores, and who was completely dependent on staff for repositioning, developed a facility-acquired pressure sore on her right heel. The staff failed to follow interventions to prevent the pressure sore, including “offloading” weight from the heal by positioning the legs in a certain way. The facility was cited for failure to provide the necessary care and services to prevent the development of pressure sores. Citation # 060015323.

Orange Healthcare & Wellness Centre, LLC
920 W La Veta Ave, Orange
B $2000 Patient Care Physical Environment Supervision 08/12/2019
On 6/4/19, a resident with cognitive impairment, who had been acting erratically and was under a physician’s order to “monitor for behaviors of schizophrenia and delusions,” was left alone outside, unsupervised and with a lighter. The resident started a fire in the facility’s garbage can located directly outside the facility’s front door. The flames melted the garbage can and spread to a nearby tree, which was in direct contact with the building. The Fire Department arrived to put out the fire. The facility was cited for failure to ensure the environment remains free of accident hazards and failure to ensure each resident receives adequate supervision. Citation # 060015292.

Windsor Gardens Convalescent Center of Anaheim
3415 W Ball Rd, Anaheim
B $2000 Medication 07/08/2019
A resident who required insulin had no documentation that his blood sugar levels were being monitored or that his insulin was being administered. On 4/10/19, the resident was transferred to the hospital for high blood sugar levels, fever and low oxygen levels. On 4/15/19, the resident was readmitted to the facility. For three days, there was no documentation that the facility monitored the resident’s blood sugar levels or administered the insulin until 4/18/19. On 4/18/19, the resident was transferred back to the hospital for high blood sugar and elevated blood urea nitrogen levels. The facility’s failure to administer the medication and failure to monitor the resident’s blood sugar levels resulted in two hospital visits, putting the resident at risk. Citation # 060015220.

Riverside County
Banning Healthcare
3476 W Wilson St, Banning
B $2000 Careplan Chemical Restraints Patient Care 06/14/2019
The facility was cited for failure to ensure a 77-year-old female resident with a diagnosis of dementia was free from multiple unnecessary anti-psychotic medications, including Seroquel, Haldon and Geodon. On 3/11/19, the resident was observed slumped over and sleeping
in her wheelchair and on the activities couch. A January 2019 pharmacy consultant review recommended evaluating “excess sedation” and “possible duplication” in the resident’s medication, yet there is no evidence the facility evaluated the resident’s medications. The Director of Nursing was unable to provide justification for the use of multiple antipsychotic medications or documentation of non-pharmacological interventions for dementia-related behaviors. Anti-psychotic medications are not FDA-approved to treat dementia-related behaviors and are often used as a “chemical restraint.” Citation # 250014973.

Blythe Post Acute Llc
285 W Chanslor Way, Blythe
B $2000 Administration Careplan Mandated Reporting Patient Care Sexual Abuse Supervision 07/03/2019
On 8/11/18, a male resident diagnosed with Alzheimer’s was witnessed holding a female resident’s hand on his private area while in the hallway. According to her medical records, the female resident had severe cognitive skills. The DON stated during an interview that the incident was not reported because both residents were diagnosed with dementia. The facility failed to notify the California Department of Public Health within 24 hours of an allegation of sexual abuse involving the two residents. Citation # 250015008.

B $2000 Mandated Reporting Sexual Abuse 07/03/2019
On 12/20/18, an unannounced visit to the facility was conducted to investigate an allegation of sexual abuse. On 9/9/18, a male resident was found touching a female resident’s breast in the hallway. In an interview on 1/23/19, the Administrator stated the facility staff were told to report incidents involving two patients with dementia to the Ombudsman only. The facility failed to notify the California Department of Public Health of an allegation of sexual abuse within 24 hours resulting in a delay of an independent investigation of the state survey agency, and implementation of corrective action. The facility’s failure increased the risk of further abuse of the female resident and other facility residents. Citation # 250015071.

On 12/18/18, an 83 year old resident with dementia and severe cognitive impairment was left out in the lobby without any staff supervision, which enabled another resident to sexually abuse her for the fourth time. The victim had been sexually abused by the other resident on three separate occasions between 8/11/18 and 9/9/18. The facility was cited for failing to provide an environment free from sexual abuse. Citation # 250015071.

Centinela Grand, Inc.
2225 N Perris Blvd, Perris
B $2000 Decubiti (Bedsores) 06/19/2019
On 2/19/19, the Department received a complaint from an acute care hospital about a 58 year old resident they admitted from the facility who had sepsis and purulent discharges from his eyes, penile, sacral, ankle and heel pressure wounds. The Department’s investigation noted that there was no documented evidence that licensed nursing staff members had evaluated the resident’s pressure wounds from 9/25/18 through 2/7/19, nor was there evidence that the facility was using pressure reducing devices. The facility was cited for failure to properly assess the resident’s pressure wounds or having provided pressure reducing measures. Citation # 250015134.

Devonshire Care Center
1350 E Devonshire Ave, Hemet
B $2000 Mandated Reporting Patient Care Physical Abuse Verbal Abuse 08/23/2019
On 3/11/19, a nurse’s aid witnessed a nursing assistant roughly handle and mock a resident while changing her briefs. The resident was a 71-year-old female admitted to the facility on 9/7/17 with a diagnosis of Alzheimer’s disease. On the date of the incident, the nursing assistant grabbed both wrists of the resident and shook her forcefully three times, while mocking the resident. After the incident was reported, the nursing assistant was terminated. The facility was cited for failure to ensure a patient was free from physical abuse. Citation # 250015230.

Jurupa Hills Post Acute
6401 33rd St, Riverside
B $2000 Mandated Reporting Physical Abuse 07/25/2019
On 5/11/19, a resident was found sitting in her bedroom, in her wheelchair, hitting her roommate on her hand with her own call light. The facility did not report the altercation to the CDPH until 5/15/19, almost 110 hours after the incident. The facility was cited for failing to report the abuse incident to the CDPH within 24 hours. Citation # 250015185.

Magnolia Rehabilitation & Nursing Center
8133 Magnolia Ave, Riverside
B $2000 Careplan Feeding Supervision 06/20/2019
On 2/11/19, at 12:45 pm, a resident, who required one-to-one supervision while eating due to his eating disorder, was observed coughing while sitting alone in his room eating a sandwich. Later that day, at 5:46 pm, the resident was observed coughing while attempting to eat soup. On 2/14/19, the Assistant DON stated to the inspector that the facility did not have policies or procedures for one-to-one supervision during meals. The facility was cited for failure to ensure adequate supervision was provided to prevent residents from choking on their meals. Citation # 250015078.

B $2000 Fall Supervision 06/26/2019
A resident who was a high risk for falls fell four times in six weeks. Regardless of these falls, the resident was not moved to a low bed, and the resident did not receive floor mats until 2/12/19 even though the DON had requested he get them immediately. It was on the resident’s last fall on 2/10/19 that the resident sustained a fall that resulted in a laceration to his face. The facility’s failure to provide the necessary care to the resident resulted in an injury that required him to be transferred to an acute care hospital. Citation # 250015079.

San Luis Obispo County
Bayside Care Center
1405 Teresa Dr, Morro Bay
A $17100 Fall 06/27/2019
On 2/21/19, a female resident fell from her Hoyer lift and sustained multiple injuries, including a broken clavicle and a head laceration. The resident required two people to assist her transfers, but only one CNA helped transfer the resident into her bed. The CNA stated, “I... couldn’t find anyone, so I did it by myself. I know it should be a two-person assist, but I couldn’t find any other CNA.” The facility was cited for failing to provide adequate assistance and prevent accidents. Citation # 050014856.

Tulare County
Twin Oaks Rehabilitation & Nursing Center
897 N M St, Tulare
A $20000 Fall 06/26/2019
A 65 year old female resident, with multiple sclerosis and paraplegia, fell from a mecanical lift, broke her ankle and cut her head on 1/17/19. The resident was being moved from a Geri-chair to her bed with a Hoyer lift operated by one CNA. The resident’s careplan called for transfer assistance by two staff members. The facility was cited for failing to implement the resident’s careplan. Citation # 120015117.

Ventura County
Windsor Terrace Of Westlake Village
250 Fairview Rd, Thousand Oaks
A $18050 Fall Injury 08/09/2019
On 2/16/2019, an 86 year old resident, who had severe cognitive impairment related to dementia and a history of repeated falls, told a nurse he needed to go to the bathroom. Instead of helping him, the nurse left him alone while he went to to look for assistance. The resident stood up from his wheelchair, fell, and sustained a left hip fracture requiring surgery and a three-week hospital stay. The facility was cited because the resident’s serious injury occurred when it left him unsupervised in this situation despite his known high risk for falls and injury as evidenced by his diagnosis, history and assessments. Citation # 050015119.