

CITATION REPORT **California Nursing Homes**

2007

CANHR

CALIFORNIA ADVOCATES FOR NURSING HOME REFORM

650 HARRISON STREET, 2ND FLOOR

SAN FRANCISCO, CA 94107

www.canhr.org

Summary

CANHR staff prepared the citation summary descriptions in this report from original citations obtained from the California Department of Public Health (DPH). CANHR also publishes citation details on its *Nursing Home Guide* (www.nursinghomeguide.org) in order to inform consumers about enforcement actions taken against California nursing homes.

Overall in 2007, DPH issued 651 citations. Further broken down, DPH issued:

- 22 Class AA citations
- 120 Class A citations
- 529 Class B citations
- 0 Class WMF /WMO citations
- 2 Civil penalties for retaliation or discrimination

Explanatory Notes

In an effort to provide concise yet meaningful information about fines (“citations”) received by California’s 1,300 nursing homes, CANHR has summarized over 650 citations issued by the Licensing and Certification Division of the Department of Public Health to nursing homes in 2007.

California law authorizes the California Department of Public Health (DPH) to issue citations for violations of California or federal law that have harmed or endangered residents. When a nursing home receives a citation, it is fined based on the severity of the violation. See Health & Safety Code §§1424, 1424.5, and 1432.

Citation Classes

Class AA	The most serious violation, AA citations are issued when a resident's death has occurred due to nursing home violations, and carry fines of \$25,000 to \$100,000.
Class A	Class A citations are issued when violations present imminent danger to residents or the substantial probability of death or serious harm, and carry fines from \$2,000 to \$20,000.
Class B	Class B citations carry fines from \$100 to \$1000 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.
WMF or WMO	Willful Material Falsification or Willful Material Omission in the health record of a resident carries a fine from \$2,000 to \$20,000 for each citation.
R/D:	Civil penalties for Retaliation or Discrimination carry fines of up to \$10,000 when a facility is found to have retaliated against someone for expressing a grievance or filing a complaint.

Violations repeated within twelve months may be issued trebled fines (indicated as “x3”) – triple the normal amount.

Citation Report - 2007

Citations can be appealed. The type of appeal and the outcome can be any of the following types: Citation Review Conference (CRC), Arbitration, Court (Municipal, Justice or Superior), or Negotiation. The fine can either be Upheld, Reduced, Increased or Dismissed. In lieu of contesting the citation, a facility can pay the minimum amount required by law or 65 percent of the fine, whichever is greater.

Citations for Bedsores

Bedsores are sometimes referred to as pressure sores, pressure ulcers or decubitus ulcers. The following categories are used to describe their severity and are often used in citations issued due to bedsores.

- Stage I: Skin is not broken, but tissue consistency is altered when compared to an adjacent or opposite area. Light pigmented skin appears red, pink, or discolored. Skin may be unusually warm to the touch. The discolored area does not return to normal within 30 minutes after pressure is removed.
Stage II: The topmost layers of skin are broken, creating a shallow open sore, which may include drainage. At this stage, the sore is painful.
Stage III: The sore extends through the second layers of skin, which creates a crater. The wound has become deeper and tissue death is occurring.
Stage IV: The tissue breakdown extends into the muscle, tendon, joint and may extend to the bone. Typically, there is considerable dead tissue and drainage. This stage may cause muscle and bone loss. Stage IV may be life threatening.

Key to Layout

County -> Alameda County
Current facility name -> Alameda County Medical Center D/P SNF
Name at time of citation -> Alameda County Medical Center D/P SNF
Date of citation -> 7/3/2007
Fine -> \$600
CANHR's summary of the citation -> On 9/16/04, a resident complained she was injected with a sedative against her will and a towel was shoved in her mouth and over her nose, causing her to gag. The allegations were substantiated by another CNA later that day. The facility was cited for failure to ensure the resident was allowed to refuse treatment and failure to ensure she was free from mental and physical abuse. (Issued as Class B at \$600.) Citation #02103404058.
Class, DPH 'Type', CANHR categories are also indicated with arrows pointing to 'B', 'Patient Rights', and 'Physical Abuse Medication' respectively.

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Alameda County

Alameda County Medical Center D/P SNF

15400 Foothill Boulevard, San Leandro, CA 94578

Alameda County Medical Center D/P SNF

7/3/2007

B

\$600

Patient Rights

Physical Abuse
Medication

On 9/16/04, a resident complained she was injected with a sedative against her will and a towel was shoved in her mouth and over her nose, causing her to gag. The allegations were substantiated by another CNA later that day. The facility was cited for failure to ensure the resident was allowed to refuse treatment and failure to ensure she was free from mental and physical abuse. (Issued as Class B at \$600.) Citation #02103404058.

Evergreen Castro Valley Healthcare Center

20259 Lake Chabot Rd., Castro Valley, CA 94546

Evergreen Castro Valley Healthcare Center

3/26/2007

A

Comp.

\$15,000

Accidents

Neglect
Decubiti (Bedsore)
Patient Care

While being given a shower on 12/1/06 around 12:45 pm, a resident received second degree burns of the face, neck, shoulder and abdomen as a result of a sudden increase in water temperature. The investigation indicated that staff had made numerous complaints about the change in water temperature, and the situation was known by management. The resident was hospitalized and sent to a burn unit. She was also diagnosed with a Stage IV pressure ulcer of the left lower pelvis area. The facility was cited for failure to correct problems with the water system and to implement policies and training for staff in showering procedures resulting in the serious injury of a resident. (Issued as Class A at \$15,000.) Citation #02169503845.

Evergreen Castro Valley Healthcare Center

11/6/2007

A

Comp.

\$18,000

Patient Care

Careplan
Nutrition

On 4/27/07, a resident was admitted with poorly controlled diabetes and a history of both high and low blood sugar. The resident suffered a fall due to high blood sugar on 6/10 and was taken to the hospital. The resident fell again on 6/14, hitting her head on a glass door and suffering abrasions to the head. On 6/15, the resident's skin was cool, clammy and sweaty and she had high blood sugar. She was hospitalized with a diagnosis of "diabetes ketoacidosis," a diabetes that could lead to coma and death. The facility was cited for failure to develop a careplan to implement the doctor's detailed monitoring orders, failure to notify the doctor of changes in condition on at least 8 occasions, and failure to monitor her blood sugar and diet. (Issued as Class A at \$18,000.) Citation #02204904425.

High Street Care Center

3145 High Street, Oakland, CA 94619

High Street Care Center

10/22/2007

B

Comp.

\$500

Patient Rights

Discharge
Transfer

On 9/4/07, a 59 year old resident with mental disorders was given a 30 day notice of discharge citing that her health had sufficiently improved. The resident contested the discharge notice and it was determined the facility was in violation. Among the state's findings, it was noted that the facility had failed to provide a physician's document that the resident was properly assessed or that the facility had provided sufficient preparation and orientation to ensure a safe and orderly discharge. The state determined these violations produced a situation likely to cause significant humiliation, indignity, anxiety or other emotional trauma. (Issued as Class B at \$500.) Citation #02110904369.

Lakeshore Convalescent Hospital

1901 Third Avenue, Oakland, CA 94606

Lakeshore Convalescent Hospital

11/5/2007

B

Comp.

\$1,000

Patient Rights

Transfer

On 9/4/07, the facility issued a 30 day notice of discharge to a resident citing that he demonstrated inappropriate behavior and he had become a danger to himself and others, among other reasons. There was no documentation from the physician that the resident would be better served at another facility or was a danger to himself or others. The resident stated no one had informed him of his rights regarding transfer/discharge. The facility was cited for failure to follow Admission and Discharge Policy and Procedure. (Issued as Class B at \$1,000.) Citation #02120304418.

Redwood Convalescent Hospital

22103 Redwood Rd., Castro Valley, CA 94546

Redwood Convalescent Hospital

5/7/2007

B

\$600

Patient Rights

Bed Hold
Transfer
Patient Rights

On 4/6/07, the facility refused to readmit a 59 year old resident who had been hospitalized after repeated incidents of wandering away from the facility. A refusal to readmit hearing was held on 4/13/07, at which the resident's daughter stated the facility never sought her advice on how to address this concern. The facility was cited because it unnecessarily extended the resident's hospital stay by failing to afford the resident a bed-hold of seven days or offer the resident the next available bed upon discharge from the hospital. (Issued as Class B at \$600.) Citation #02110903934.

Butte County**California Park Rehabilitation Hospital**
2850 Sierra Sunrise Terrace, Chico, CA 95928

California Park Rehabilitation Hospital
9/19/2007 **B** Comp.
\$1,000 Patient Care Careplan

On 2/14/06, a CNA transferred a 97 year old female resident to her bed without assistance. The resident's careplan required a Hoyer lift and a second person to assist in any resident transfers. The resident's foot caught in a bed rail, resulting in three fractures. (Issued as Class B at \$1,000.) Citation #23199104248.

Chico Care Center

188 Cohasset Lane, Chico, CA 95926

Chico Care Center
3/29/2007 **B** Comp.
\$800 Patient Rights Physical Abuse
Mandated Reporting

On 12/10/05, a 95-year-old resident alleged he had been abused by a nursing assistant who was rough and "threw him around" after he requested to be left alone. The facility was cited for not reporting the allegation of abuse to the Department of Health Services within 24 hours as required by law. The facility reported the allegation on 12/12/05, more than 48 hours after the incident occurred. (Issued as Class B at \$800.) Citation #23156003839.

Country Crest

50 Concordia Lane, Oroville, Ca 95966

Country Crest
3/6/2007 **B** Comp.
\$3,000 Abuse Verbal Abuse
x3 Physical Abuse
Patient Rights
Dignity

On 1/26/06, a resident with diagnoses of dementia, Alzheimer's and hypertension was in the dining room sitting in her wheelchair. The resident began scratching her head when a CNA walked up to her, grabbed her wrist and yelled at her to put on her glove or she would be sent to her room until she learned to behave. The facility was cited for failure to keep residents free from verbal abuse, isolation and involuntary seclusion. (Issued as Class B at \$3,000.) Citation #23156003690.

Cypress Healthcare Center

1633 Cypress Lane, Paradise, CA 95969

Cypress Acres Convalescent Hospital
11/29/2007 **B** Comp.
\$750 Patient Rights Patient Rights

The facility did not return a resident's money to his estate following his death on 12/5/06. It owed a refund of \$4,560.67 that it had not paid six months after his death. The facility was cited because it failed to return the money to his estate within 30 days as required by law. (Issued as Class B at \$750.) Citation #23199104463.

Evergreen Gridley Health Care Center

246 Spruce Street, Gridley, Ca 95948

Evergreen Gridley Health Care Center
3/27/2007 **B** Comp.
\$1,000 Abuse Verbal Abuse
Physical Abuse

On 4/19/06, a nursing assistant witnessed an aide fling an 88 year old resident around in her wheelchair, yank hard on the wheelchair and then push it into her room and let it go. He also heard the aide yell at the resident, stating "I'm not your damn aide, shut up and just sit there." The facility was cited because the resident was subjected to verbal and physical abuse. (Issued as Class B at \$1,000.) Citation #23076303755.

Olive Ridge Care Center

1000 Exec. Parkway, Oroville, CA 95966

Olive Ridge Care Center
9/20/2007 **B** Comp.
\$750 Staffing Staffing

The facility failed to have at least one registered nurse on duty at all times (24 hours) in the facility as required by law. The violation of this regulation had a direct relationship to the health, safety, and/or security of the residents. (Issued as Class B at \$750.) Citation #23179304265.

Olive Ridge Care Center
9/20/2007 **B** Comp.
\$750 Staffing Staffing

The facility failed to provide the minimum required nursing hours per patient (3.2 hours), as required by law, on 10/14/06, 10/15/06 and 10/20/06. The violation had a direct relationship to the health, safety, and/or security of patients. (Issued as Class B at \$750.) Citation #23179303809.

Paradise Skilled Nursing

7419 Skyway, Paradise, CA 95969

Paradise Health Care
5/16/2007 **B** Comp.
\$1,000 Patient Care Dignity
Chemical Restraints
Physical Abuse
Medication

On 9/3/06 at 10:50 pm, a licensed nurse documented that a resident was upset and crying because of being handled roughly by a CNA while changing her. The resident allegedly struck out at the staff. She was also upset and crying on 9/5/06 because her hairdresser did not show up, and on 9/7/06 because staff didn't know her routine. On 9/13/06, the facility requested an order for Buspar 5 mg (psychoactive medication) twice a day because of striking out at staff. The medication was continued until her death on 10/18/06. The facility was cited for failure to protect the resident's dignity and to use psychoactive medications without adequate clinical basis. (Issued as Class B at \$1,000.) Citation #23076303945.

Riverside Convalescent Hospital

375 Cohasset Road, Chico, CA 95926

Riverside Convalescent Hospital
3/12/2007 **B** Comp.
\$1,000 Other Patient Care

On 5/24/06, two residents complained to a state evaluator that one of the staff persons had left a resident out on the patio at 10 pm and had refused to take her inside. They said that the staff told the resident she could do it for herself. Although the residents made a complaint to the facility staff, the offending employee continued to work and procedures were not followed that would have led to the suspension of that employee. The facility was cited for failure to implement their policy and procedure relating to abuse protection and reporting. (Issued as Class B at \$1,000.) Citation #23121403750.

Riverside Convalescent Hospital
3/20/2007 **B** Comp.
\$1,000 Medication Medication

During April, May and June 2006, the facility failed to administer Coumadin to a resident as ordered by his physician on 22 occasions. Coumadin is a medication used to thin the blood to prevent blood clots. The facility was cited because the many medication errors put the resident's health at risk. (Issued as Class B at \$1,000.) Citation #23190503822.

Riverside Convalescent Hospital
7/3/2007 **B** Comp.
\$1,000 Patient Rights Verbal Abuse
Physical Abuse
Dignity

On 4/13/07, a nurse tilted a resident's chair so far back that he began waving his arms and legs and yelling to have the nurse put him down. The nurse repeated the resident's cuss words back to him in a "mocking" tone. The facility was cited for failure to ensure the resident was not subject to verbal or physical abuse
(Issued as Class B at \$1,000.) Citation #23148404045.

Riverside Convalescent Hospital
7/3/2007 **B** Comp.
\$1,000 Administration Mandated Reporting

On 4/13/07, a nurse tilted a resident's chair so far back that he began waving his arms and legs and yelling to have the nurse put him down. The nurse repeated the resident's cuss words back to him in a "mocking" tone. The incident was not reported for three days. The facility was cited for failure to report the alleged abuse within 24 hours to the CDHS.
(Issued as Class B at \$1,000.) Citation #23148404046.

Riverside Convalescent Hospital
8/22/2007 **B** Comp.
\$1,000 Administration Verbal Abuse
Mandated Reporting

On 1/3/07, a staff member reported hearing a visitor yelling and screaming at a 59 year old female resident. The staff member reported this to the director of nursing. The director of nursing forwarded this to the administrator, who, in turn, notified the Ombudsman, but not the Department of Health. Although required by law to do so, the administrator told investigators that she didn't have to notify the Department. The facility was cited for failure to notify the Department of Health. (Issued as Class B at \$1,000.) Citation #23198804181.

Riverside Convalescent Hospital
9/25/2007 **B** Comp.
\$750 Staffing Staffing

The facility failed to provide the minimum required nursing hours per patient (3.2 hours), as required by law, between 2/01/07 to 2/12/07. The violation had a direct relationship to the health, safety, and/or security of patients (Issued as Class B at \$750.) Citation #23201904250.

Riverside Convalescent Hospital
10/10/2007 **A** Comp.
\$10,000 Medication Administration
Medication
Neglect
Supervision
Staff (Inservice)

On 11/14/06 at 6 am, an 87 year old female resident was given her roommate's morphine medication by mistake by a nurse. The facility had no employee file and no evidence of proper training or competency for this nurse. At 8:30 am, three different staff noticed that resident had her eyes closed, forehead was warm and was unresponsive to physical and verbal stimulation. Staff did nothing until 4:45 pm (8.25 hours later), when a fourth staff member checked on the resident, who, by this point, was still unresponsive with her head tilted backward; she was blue in the face with low breathing. Resident was sent to the ER. The facility's gross incompetence put the resident in serious risk of death.
(Issued as Class A at \$10,000.) Citation #23190504319.

Riverside Convalescent Hospital
12/4/2007 **B** Comp.
\$1,000 Patient Rights Patient Rights

On 10/29/07, a 69 year old resident who had the capacity to make her own health care decisions told a CNA she did not want a pillow placed under her feet. She was told by the CNA, "Yes, you do." According to the resident, the CNA ignored her repeated requests and "roughly" placed a pillow under her legs. The facility was cited for violating the resident's rights by forcing her to receive care despite her refusals. (Issued as Class B at \$1,000.) Citation #23198804465.

Riverside Convalescent Hospital
 12/4/2007 **B** Comp.
\$1,000 Patient Rights Verbal Abuse
 x3

On 10/2/91, a 91 year old resident was verbally abused by a visitor to the facility. The visitor was visiting another resident at the time. On 10/25/07, the state regulator interviewed the visitor who admitted to calling the 91 year old "a bitch." The facility was cited for failure to prevent the resident from being verbally abused by a visitor. (Issued as Class B at \$1,000.) Citation #23198804466.

Sunbridge Care Center For Paradise

8777 Skyway, Paradise, CA 95969

Sunbridge Care Center For Paradise
 2/15/2007 **A** Comp.
\$25,000 Patient Care Patient Care
Death Occurred Careplan
 Notification

A female resident was admitted to the facility on 3/29/05 with a careplan instructing staff to keep the resident in bed with the head of the bed elevated at a 45 degree angle. The resident had multiple hospitalizations related to possible aspiration pneumonia and respiratory distress. She was transferred to the ER on 9/3, 9/10, 9/17, 9/19, and 9/22/05. Paramedics frequently found the resident lying on her back facing upwards in bed. The resident was again hospitalized on 10/18/05 for respiratory failure secondary to recurrent aspiration. The resident returned to the facility on 10/24/05 and passed away on 11/6/05 due to aspiration pneumonia. The facility was cited for failing to revise the resident's careplan, failing to deliver treatment as ordered by the physician, and failing to notify the personal physician of a change in condition. (Issued as Class A at \$25,000.) Citation #23076303682.

Sunbridge Care Center For Paradise
 2/15/2007 **A** Comp.
\$25,000 Patient Care Neglect
Death Occurred Hydration
 Dignity

A resident was admitted on 1/16/06 with stage IV bedsores, paralysis, swallowing difficulties, tube feeding, and catheter with doctor's orders to record fluid intake and output. On 1/22/06, the resident's urine output was dark, cloudy, amber colored and of a low quantity. From 1/16 to 1/23, output was low but not reported to the doctor. On 1/23/06 at 9 am, the resident was found with a 103.6 temperature and no urinary output for 24 hours and sent to emergency. The resident was dehydrated and his catheter was not draining and released 1200 cc of thick blood and pussy urine. The nurse stated the resident arrived in a neglected state, not bathed, dirty hair, with long and dirty nails cutting into his palm. The resident died on 1/25/06 from aspiration pneumonia, urinary tract infection with sepsis, and renal failure. The facility was cited for failure to monitor his fluid intake and output, to notify the doctor concerning change of condition, and to provide basic grooming and personal hygiene. (Issued as Class A at \$25,000.) Citation #23076303676.

Sunbridge Care Center For Paradise
 4/5/2007 **B** Comp.
\$800 Patient Rights Theft & Loss

Over a two month period in late 2006 and early 2007, a resident loaned approximately \$150 to a CNA. The CNA quit work and never repaid the money. The facility was cited for failure to protect the resident's funds. (Issued as Class B at \$800.) Citation #23200103857.

Sunbridge Care Center For Paradise
 10/19/2007 **B** Comp.
\$1,000 Patient Care Verbal Abuse
 Mental Abuse

On 5/23/07, a male CNA alleged that a 67 year old male resident was mistreated by another (female) CNA. He stated that while they were assisting the resident in the bathroom, the female CNA grabbed the residents wrists, twisted them across his chest and used her own body weight to push him against the toilet. He then became agitated and she yelled at him, "Don't you f--king hit me, I'm pregnant. I'll f--king knock you out." Another CNA had to come to the room and force her to leave. She claimed the incident was self defense. The facility was cited for failure to ensure the resident was treated with dignity and respect, as well as free from verbal and physical abuse. (Issued as Class B at \$1,000.) Citation #23190504361.

Sunbridge Care Center For Paradise
 11/29/2007 **B** Comp.
\$1,000 Patient Care Supervision

On 3/30/07, a resident suffering from dementia wandered from the facility and was found by off-duty staff near a busy road. The assigned nurse and aide did not know where he was, did not know he had left the facility, and had not checked to make sure his Wanderguard was in place. He was not wearing it at the time of the incident. Two days earlier, the same resident was found by staff in a ditch near the road. The facility was cited because it did not provide adequate supervision. (Issued as Class B at \$1,000.) Citation #23190504462.

Sunbridge Care Center For Paradise
 11/29/2007 **B** Comp.
\$1,000 Patient Care Neglect
 Verbal Abuse

On 1/29/07, during the night shift, a CNA left a 74 year old resident lying in feces and urine after she repeatedly called out for help and used her call light. The resident reported the CNA acted in an angry manner and that she dreaded seeing him again. A licensed nurse said the CNA repeatedly would go into residents' rooms that had call lights on, turn them off, and then leave. Two other staff members also witnessed the neglect. (Issued as Class B at \$1,000.) Citation #23201904456.

Twin Oaks Health And Rehabilitation Center

1200 Springfield Dr, Chico, CA 95928

Twin Oaks Health And Rehabilitation Center
6/6/2007 **B** Comp.
\$750 Administration Staffing
 Administration

From December 2006 to February 2007, the facility employed an unlicensed person to perform registered nursing services on a full-time basis. The facility did not verify the individual's license prior to or during the time of employment. According to State records, the individual was not licensed and his interim permit had expired. The facility was cited because it failed to prevent an unlicensed and unsupervised staff member from performing professional nursing services. (Issued as Class B at \$750.) Citation #23199104000.

Twin Oaks Health And Rehabilitation Center
7/11/2007 **B** Comp.
\$1,000 Staffing Staffing

The facility was cited for repeatedly understaffing, particularly on weekends. A review of the facility records from 6/1/06 through 8/15/06 showed the facility was failing to provide the minimum number of staff. The lack of care staff deprived the patients of time that could have been spent implementing their plans of care or meeting their immediate needs. (Issued as Class B at \$1,000.) Citation #23150804069.

Twin Oaks Health And Rehabilitation Center
12/5/2007 **B** Comp.
\$750 Patient Care Fall

On 8/17/07, an 88 year old resident, who suffered from dementia and arthritis and was severely impaired and dependent on others for personal care, fell out of a Hoyer lift. The fall resulted in a contusion on her forehead, left elbow abrasion/contusion, and left hip bruise. The resident fell from the lift when a hook detached from one of the four holes in the support sling. The facility was cited for failure to prevent the accident which resulted in injury to the resident. (Issued as Class B at \$750.) Citation #23190904473.

Twin Oaks Health And Rehabilitation Center
12/5/2007 **B** Comp.
\$750 Administration Mandated Reporting
 Theft & Loss

A facility employee made long distance calls with a resident's personal cell phone without her consent. She and her family reported this to the facility and it did not report the incident to the Department of Public Health (DPH). The facility failed to notify DPH within 24 hours of the abuse allegation. (Issued as Class B at \$750.) Citation #23191304474.

Contra Costa County**Creekside Healthcare Center**

1900 Church Lane, San Pablo, CA 94806

Creekside Healthcare Center
11/20/2007 **B**
\$700 Patient Rights Physical Abuse

On 10/14/07 a resident refused incontinence care and a CNA, using her work-buddy CNA, turned and held down the resident. During the procedure, the resident was swearing and trying to scratch, bite, hit and kick the CNAs. When asked why they did not wait until the resident was calm before they attempted to change her, one CNA stated he thought it was OK and he just went into the resident's room to do what was needed to be done so he could leave. The facility was cited for failure to treat the resident with dignity and respect. (Issued as Class B at \$700.) Citation #02103004461.

Muir Senior Care

1790 Muir Road, Martinez, Ca 94553

Muir Senior Care
5/22/2007 **B** Comp.
\$1,000 Transfer Bed Hold

On 3/4/07, a resident was transferred to an acute care hospital. On 3/26/07, a Discharge Planner notified the facility that the resident was sufficiently stable for readmission. The facility refused to readmit the resident. The facility failed to provide the resident with a seven day bed-hold, a 30 day Transfer/Discharge Notice, and failed to readmit the resident to the first available bed. (Issued as Class B at \$1,000.) Citation #02103003973.

San Marco Nursing And Rehabilitation Center

130 Tampico Street, Walnut Creek, CA 94598

San Marco Nursing And Rehabilitation Center
2/9/2007 **B** Comp.
\$1,000 Patient Rights Verbal Abuse
 Physical Abuse

On 5/19/06, a visitor to the facility witnessed a Licensed Nurse forcibly pushing a resident down on the bed and saying, "God damn it, get back into bed, I told you not to get up!" The resident suffered a skin tear on the left lower arm and bruising on the right arm from the elbow to the wrist. The facility was cited for failing to keep the resident free from verbal and physical abuse. (Issued as Class B at \$1,000.) Citation #02158403708.

Del Norte County**Crescent City Nursing And Rehabilitation Center**
1280 Marshall Street, Crescent City, CA 95531

Crescent City Nursing And Rehabilitation Center
7/25/2007 **B**
\$1,000 Abuse Mandated Reporting
Sexual Abuse

On 7/14/06, a male resident was found with his pants down groping a female resident in her room. The facility was cited because it did not report the abuse to the Department of Health Services within 24 hours as required by law. (Issued as Class B at \$1,000.) Citation #11179203884.

Crescent City Nursing And Rehabilitation Center
7/25/2007 **B** Comp.
\$1,000 Patient Care Sexual Abuse
Careplan

On 7/14/06, a CNA observed a male resident groping and trying to have sex with a female resident suffering from dementia. The male resident also had a diagnosis of dementia and had a history of wandering into other residents' rooms and engaging in combative behavior with staff and other residents. The facility was cited for failure to protect a resident from sexual abuse. (Issued as Class B at \$1,000.) Citation #11179204075.

Fresno County**Alzheimer's Living Center at ELIM**
668 E. Bullard Ave, Fresno, CA 93710

Alzheimer's Living Center at ELIM
8/28/2007 **B** Comp.
\$1,000 Abuse Physical Abuse

On 5/7/06, a CNA slapped a 93 year old female resident in the face. During the state investigation, a staff person who witnessed the incident said the resident was falling asleep during the noon meal and the CNA hit her four times and yelled for her to wake up. Not getting the response she wanted, the CNA then slapped her an additional four times. The facility was cited for failure to protect the resident from physical abuse. (Issued as Class B at \$1,000.) Citation #04145404212.

Golden Cross Health Care of Fresno
1233 A Street, Fresno, CA 93706

Golden Cross Health Care of Fresno
2/9/2007 **A** Comp.
\$20,000 Abuse Neglect
Mental Abuse
Injury
Supervision
Fall

On 8/18/06, a 66-year-old resident who suffered from partial paralysis fell from bed and suffered an orbital fracture and dark bruising around her right eye, plus other injuries. Prior to the fall, the assigned nursing assistant intentionally ignored the resident's repeated requests to help move her away from the edge of the bed. The nursing assistant also ignored directions from a nurse supervisor to assist the resident. The facility was cited because it subjected the resident to abuse and neglect, resulting in serious injury. (Issued as Class A at \$20,000.) Citation #04113803698.

Golden Cross Health Care of Fresno
5/2/2007 **B** Comp.
\$1,000 Patient Rights Verbal Abuse
Mental Abuse

On 10/9/06, an 81-year-old male resident asked a staff member for some Mylanta to help with his stomach pain. The staff member told him to "shut up," and refused to give him the medicine. Later, while the resident was in hearing distance, the staff member told a CNA, "I'm gonna slap him!" The facility was cited for failing to ensure that a resident was free from verbal and mental abuse. (Issued as Class B at \$1,000.) Citation #04113803924.

Golden Cross Health Care of Fresno
9/11/2007 **B** Certif.
\$1,000 Staffing Staffing

During an unannounced visit on 6/6/06, it was found that the nurse to patient staffing ratio (nursing hours per patient per day) did not meet the required 3.2 hours per day for 27 out of 31 days in May, 2006. Furthermore, for 12 out of those 31 days, the ratio was 2.5 hours or less. The facility was cited for failure to meet the required 3.2 nursing hours per patient per day. (Issued as Class B at \$1,000.) Citation #04178203319.

Hope Manor, Inc

1665 'M' Street, Fresno, CA 93721

Hope Manor, Inc

2/8/2007

A

Comp.

\$18,000

Medication

Neglect
Medication

Around 8:15 p.m. on 1/12/06, a resident was administered three medications of another resident. One of the medications, OxyContin, causes sedation and respiratory problems, especially for the resident who was on dialysis. The resident was hospitalized for a narcotic overdose and experienced respiratory problems and reduced mental functioning. The facility was cited for providing the wrong medications causing serious physical harm to the resident. (Issued as Class A at \$18,000.) Citation #04134803697.

Glenn County

Sunbridge Care Center For Willows

320 North Crawford St., Willows, CA 95988

Sunbridge Care Center For Willows

12/11/2007

B

Comp.

\$1,000

Patient Care

Neglect
Notification
Hydration
Infection

Death Occurred

Over three days from 4/16/07 to 4/19/07, an 81 year old resident became very lethargic and weak, was unable to sit upright, had low blood pressure, and refused almost all of his meals. The facility was cited because it failed to timely notify his physician of the serious change in his condition. After physician notification on 4/19/07, tests showed the resident had pneumonia in both lungs, an acute infection and was dehydrated. He died on 4/25/07 at the facility. (Issued as Class B at \$1,000.) Citation #23198804489.

Humboldt County**Granada Healthcare And Rehabilitation Center**
2885 Harris Street, Eureka, Ca 955034896

Granada Healthcare And Rehabilitation Center
5/31/2007 **B** Comp.
\$1,000 Administration Dignity
Physical Abuse

On 10/14/06 around 9 am, the weekend supervisor observed a resident's hands tied together with a plastic bag. She instructed the two employees to untie the resident. Although the Director of Nurses was notified, the employees were not immediately suspended according to facility policy. The facility was cited for failure to follow its own policy, and for not notifying the licensing agency for 3 and half days after the incident instead of immediately or within 24 hours. (Issued as Class B at \$1,000.) Citation #11168603447.

Granada Healthcare And Rehabilitation Center
5/31/2007 **B** Comp.
\$1,000 Patient Care Dignity
Physical Abuse

On 10/20/06, a supervisor found a resident in her room with her hands in a "prayer position" and a plastic bag tied around her wrists. Three people saw the resident with her wrists tied but none of the staff removed the bag until directed by the supervisor. The facility was cited for failure to treat the resident with dignity and respect and failure to protect the resident from physical and mental abuse. (Issued as Class B at \$1,000.) Citation #11168603446.

Granada Healthcare And Rehabilitation Center
5/31/2007 **B** Comp.
\$1,000 Patient Care Dignity

On 10/19/06, a resident was observed in her wheelchair in the hall naked from the waist up. Four staff and one male resident walked by before an aide stopped to assist the resident with dressing. The facility was cited for failure to treat the resident with dignity and respect. (Issued as Class B at \$1,000.) Citation #11168603445.

Pacific Healthcare And Rehabilitation Center
2211 Harrison Avenue, Eureka, CA 95501

Pacific Healthcare And Rehabilitation Center
1/3/2007 **B** Comp.
\$1,000 Patient Rights Sexual Abuse
Careplan

On 11/2/05, a male resident was observed fondling another resident. The facility had prior knowledge of the male resident's inappropriate sexual behavior, but failed to prevent the sexual fondling of other residents. The facility was cited for failure to implement the facility abuse policy and procedure into the resident's careplan, including the assessment of the resident's personal history which identified him as a risk for sexually abusing other residents and failed to develop intervention strategies to prevent recurrence. (Issued as Class B at \$1,000.) Citation #11179203577.

Seaview Healthcare And Rehabilitation Center
6400 Purdue Dr, Eureka, Ca 955037098

Seaview Healthcare And Rehabilitation Center
7/12/2007 **B**
\$900 Medication Medication

On 5/11/07, a nurse confirmed he had administered medication to a resident which was intended for another resident. The resident who received the incorrect medication was transferred to a critical care unit, in stable condition, until her system was cleared of medications. The facility was cited for failure to ensure the resident was identified prior to administering medication. (Issued as Class B at \$900.) Citation #11159203999.

Imperial County**Valley Convalescent Center**

1700 S. Imperial Ave, El Centro, CA 92243

Valley Convalescent Center

6/8/2007	B	Comp.
\$950	<u>Patient Care</u>	Careplan Patient Records

On 4/20/07, a resident was taken from Valley Convalescent Center to the emergency room. The resident was in life-threatening shock. The facility had failed to properly assess the resident's care needs and to adequately document her medical record. Consequently, the resident suffered numerous health complications and had to undergo multiple invasive procedures, ultimately requiring insertion of a transvenous pace maker in order to maintain viability. (Issued as Class B at \$950.) Citation #09193704025.

Kern County**Bakersfield Healthcare Center**

730 34th Street, Bakersfield, CA 93301

Pleasant Care Convalescent Of Bakersfield

7/2/2007	B	Comp.
\$1,000	<u>Physical Environment</u>	Physical Environment

In January 2007, the facility used space heaters in several resident rooms during an extended malfunction of the heating system. The space heaters presented a hazard to residents because they were used in the vicinity of confused residents and because magazines and books were touching one of the space heaters. (Issued as Class B at \$1,000.) Citation #12144104010.

Californian Care Center

2211 Mount Vernon Avenue, Bakersfield, CA 93306

Californian Care Center

3/15/2007	A	
\$10,000	<u>Patient Care</u>	Medication

On 2/10/06, a Licensed Nurse administered insulin to the wrong resident. The resident who received the insulin was a 94-year-old female with no diagnosis of diabetes. The resident became unresponsive and was rushed to an emergency room with "blood sugar so low it failed to register via the glucometer." The resident who was supposed to receive the insulin, a 67-year-old female with diabetes, failed to receive her insulin and suffered elevated blood sugar levels. The facility was cited for medication errors that resulted in injury to a resident. (Issued as Class A at \$10,000.) Citation #12180003369.

Californian Care Center

6/13/2007	B	Comp.
\$1,000	<u>Patient Rights</u>	Physical Abuse Retaliation Against Resident

On 4/11/07, a CNA was assisting a resident with brushing his teeth. The resident is completely dependent on staff for eating, bathing, hygiene and toileting. The resident got mouth wash rinse on the CNA. The CNA became angry and they both exchanged insults. The CNA then threw baby powder over resident's entire head and body and walked out of the room. The facility failed to protect resident from physical and verbal abuse. (Issued as Class B at \$1,000.) Citation #12180003930.

Parkview Healthcare Center
10/31/2007 **B** Comp.
\$1,000 Transfer Transfer

On 6/27/07, a resident was refused readmission to the facility due to her need for an isolation room and had to be sent to another facility many miles away. It was determined that the facility did have a suitable room available and when investigators questioned the administrator, the quality Assurance Nurse and the Director of Nurses they all denied responsibility or knowledge of why the resident wasn't given that room. Because the resident was transferred out of the area, the family could only visit her once a week instead of daily. This had a profound negative impact on the resident's mental state. The facility was cited for failing to readmit the resident. (Issued as Class B at \$1,000.) Citation #12172004269.

Ridgecrest Healthcare Center
1131 North China Lake Blvd., Ridgecrest, Ca 93555

Ridgecrest Healthcare Center
8/22/2007 **B** Comp.
\$1,000 Patient Care Verbal Abuse

On 4/12/07, a student CNA witnessed another CNA intimidating a male resident. The CNA told the resident to "shut the hell up." The resident was extremely upset and agitated by the care he was receiving. The facility failed to protect the resident's right to be treated with dignity and respect and to be protected from verbal abuse. (Issued as Class B at \$1,000.) Citation #12144104177.

Rosewood Health Facility
1401 New Stine Road, Bakersfield, CA 93309

Rosewood Health Facility
4/25/2007 **B** Comp.
\$1,000 Patient Care Infection

The facility failed to accurately assess an intravenous site for one resident and failed to follow their policy regarding intravenous therapy from 7/12/05 to 7/16/05. The facility failed to check and document the intravenous site for 4 days, causing a bacterial infection in the resident's right arm, resulting in high fever and edema. (Issued as Class B at \$1,000.) Citation #12186803584.

Valley Convalescent Hospital
1205 Eighth Street, Bakersfield, CA 93304

Valley Convalescent Hospital
10/31/2007 **B** Comp.
\$1,000 Patient Care Neglect

On 2/3/07, a CNA was told by a Licensed Nurse (LN) to change a resident's bed pad which was soaked with old urine. The LN said she could see it was old by the color. Twenty minutes later, the LN observed that the CNA had still not changed the resident's bed pad. The facility was cited for failing to protect the resident from neglect. (Issued as Class B at \$1,000.) Citation #12186804358.

Valley Convalescent Hospital
11/7/2007 **B** Comp.
\$1,000 Patient Care Mandated Reporting Sexual Abuse

On several occasions between 3/2/07 and 4/18/07, a male resident was seen by staff members to inappropriately touch a female resident, placing his hands between her legs and under her blouse touching her breasts. The resident was cognitively impaired and unable to defend herself from these assaults. The facility was cited for failing to report the alleged incidents of abuse to the Department within 24 hours. (Issued as Class B at \$1,000.) Citation #12207304192.

Valley Convalescent Hospital
11/7/2007 **A** Comp.
\$20,000 Patient Care Careplan Sexual Abuse

On several occasions between 3/2/07 and 4/18/07, a male resident was seen by staff members to inappropriately touch a female resident, placing his hands between her legs and under her blouse touching her breasts. The resident was cognitively impaired and unable to defend herself from these assaults. The facility was cited for failing to assess the residents' psychosocial status, to develop and revise the careplans to address the resident needs and to notify the residents' physicians. (Issued as Class A at \$20,000.) Citation #12207304186.

Valley Convalescent Hospital
11/7/2007 **A** Comp.
\$20,000 Patient Care Sexual Abuse

On several occasions between 3/2/07 and 4/18/07, a male resident was seen by staff members to inappropriately touch a female resident, placing his hands between her legs and under her blouse touching her breasts. The resident was cognitively impaired and unable to defend herself from these assaults. The facility was cited for failing protect the resident from sexual abuse. (Issued as Class A at \$20,000.) Citation #12207304185.

Valley Convalescent Hospital
12/11/2007 **B** Comp.
\$1,000 Patient Rights Sexual Abuse

On 10/16/07, a male resident with a history of inappropriate sexual behavior with other female residents was observed with his hand up against the inner thigh of a female resident. The two were immediately separated. The facility was cited for failure to protect one resident from sexual abuse by another resident. (Issued as Class B at \$1,000.) Citation #12186804413.

Valley Convalescent Hospital
12/11/2007 **B** Comp.
\$1,000 Patient Care Sexual Abuse Careplan Supervision

On 7/17/07, a male resident was noted to have "recurrent sexual advances toward a specific female resident" and he was to be monitored on an hourly basis. On 9/27/07, he was found to have his left hand between the female resident's leg and under her inner thigh outside of her pants. The facility was cited for failing to follow the careplan of the male resident, which resulted in the sexual abuse of another resident. (Issued as Class B at \$1,000.) Citation #12186804357.

Kings County**Hanford Nursing & Rehabilitation Center**
1007 West Lacey Boulevard, Hanford, CA 93230

Hanford Nursing & Rehabilitation Center
12/5/2007 **B** Comp.
\$900 Patient Care Fall
 Injury
 Neglect

Less than two weeks after being admitted to recover from a left hip fracture, a resident fell on 3/25/06 after getting out of bed unassisted. Her physician then ordered a "tab alarm" to help alert staff when she was trying to get up without assistance. The nursing staff did not apply the tab alarm, leading to another fall on 3/31/06 when she climbed out of bed unassisted, fell, and fractured her right hip. (Issued as Class B at \$900.) Citation #04117704482.

Lake County**Evergreen Lakeport Healthcare Center**
1291 Craig Avenue, Lakeport, CA 95453

Evergreen Lakeport Healthcare Center
4/10/2007 **B** Comp.
\$1,000 Patient Care Fall
 Notification

A resident sustained an unwitnessed fall on 12/7/06. The resident exhibited uncharacteristic behavior from 12/8/06 until 12/9/06, but the resident's physician was not notified. Resident complained of severe pain on 12/9/06 and was taken to the hospital where he was found to have a right hip fracture. Facility was cited for failure to adequately assess and recognize a change in the resident's condition after a fall and notify the resident's physician of a change in the resident's symptoms, causing a delay in treatment for a hip fracture. (Issued as Class B at \$1,000.) Citation #11198303677.

Evergreen Lakeport Healthcare Center
5/21/2007 **B** Comp.
\$1,000 Patient Care Fall
 Injury
 Careplan
 Supervision

The facility failed to revise a resident's careplan to reflect the need to monitor her for safety concerns after discontinuing her wheelchair seat belt restraint on 4/5/06. The resident fell out of her wheelchair while unmonitored and suffered a laceration to her forehead on 4/28/06. The facility also failed to appropriately monitor the resident following the head injury.
(Issued as Class B at \$1,000.) Citation #11173803965.

Evergreen Lakeport Healthcare Center
6/8/2007 **AA** Comp.
\$80,000 Patient Care Neglect
 Feeding
 Death Occurred Staff (Inservice)
 Training

On 6/2/06, three days after admission, a 44 year old resident suffered a seizure and aspirated materials into her lungs. Staff stood and watched as she died because suction equipment needed to clear her airway was not available in her room or on the facility emergency cart. A nurse started CPR but stopped before paramedics arrived. The facility was cited for failing to assess for and prevent aspiration, failing to adequately train staff in emergency procedures, and failing to ensure emergency airway equipment was stocked and available. (Issued as Class AA at \$80,000.) Citation #11187103970.

Evergreen Lakeport Healthcare Center
 7/26/2007 **A** Comp.
\$20,000 Patient Care Patient Care

On 10/16/06, a resident was admitted to an intensive care unit with septic shock and urosepsis secondary to urinary catheter obstruction. The resident later told an investigator she had been asking for a catheter change for three or four days before she went to the hospital. She also stated the night shift staff had once left her on her bed for two hours with a leaky catheter. The facility was cited for failure to provide necessary care and services to prevent catheter leakage and obstruction which resulted in a serious infection and hospitalization. (Issued as Class A at \$20,000.) Citation #11135103501.

Evergreen Lakeport Healthcare Center
 10/26/2007 **B** Comp.
\$1,000 Staffing Staffing
 Neglect

During observation on 8/16/07, a resident was found in his wheelchair alone in a darkened room. He had not been bathed or shaved since his admission, seven days prior. Other residents did not receive oral hygiene care, had to wait over an hour for call lights to be answered and their personal belongings remained unpacked since admission. The facility was cited for failure to meet minimum staffing requirements in 19 out of 23 days reviewed, resulting in inadequate resident care and increased resident anxiety. (Issued as Class B at \$1,000.) Citation #11198304355.

Evergreen Lakeport Healthcare Center
 10/26/2007 **B** Comp.
\$1,000 Patient Care Feeding

During observations on 8/20/07, a resident who was on a feeding tube did not have the head of the bed elevated to a 45 degree angle, putting the resident at risk for aspiration of the tube feeding formula which increases the risk of pneumonia. In addition, the facility did not provide the resident with the physician-ordered formula to meet the resident's nutritional needs. The facility was cited for failure to ensure proper positioning and failure to provide the recommended tube feeding formula. (Issued as Class B at \$1,000.) Citation #11198304384.

Evergreen Lakeport Healthcare Center
 10/26/2007 **B** Comp.
\$1,000 Patient Care Transfer
 Feeding

During a review of records on 8/20/07, four residents who were transferred to the facility between 8/10/07 and 8/13/07 were not monitored for food intake per the transfer trauma nursing plan of care. All four residents had lost weight since admission. The facility was cited for failure to ensure the residents, who were at risk for transfer trauma, received necessary care and services to ensure adequate intake. (Issued as Class B at \$1,000.) Citation #11198304385.

Lassen County

Susanville Nursing & Rehab Center 2005 River Street, Susanville, CA 96130

Susanville Nursing & Rehab Center
 7/17/2007 **B** Comp.
\$750 Administration Medication

On 6/6/06, the Ombudsman's office faxed a report to the Department of Health stating that a resident alleged she was verbally abused by staff. The staff person had told a resident, "I missed your 5 pm medications, but I charted them, so you can take them or not." The facility was cited for failure to have made their own report to the Dept. and for failure to investigate the allegation within five working days of the incident. (Issued as Class B at \$750.) Citation #23132604076.

Susanville Nursing & Rehab Center
 12/4/2007 **B** Comp.
\$1,000 Patient Care Careplan
 Decubiti (Bedsore)

On 8/22/07, a 61 year old resident was left on a bedpan for 16 hours. This resulted in the formation of two Stage III pressure ulcers in the shape of the bedpan. The facility was cited for failing to implement the resident's careplan, which called for turning or repositioning of the resident every two hours to prevent the formation of pressure ulcers. (Issued as Class B at \$1,000.) Citation #23191304471.

Los Angeles County**Amberwood Convalescent Hospital**

6071 York Blvd., Highland Park, Ca 90042

Amberwood Convalescent Hospital

10/2/2007 **AA** Comp.
\$80,000 Patient Care Neglect

Death Occurred

On 5/1/05, an 88 year old resident died a day after being hospitalized due to a distended abdomen and altered level of consciousness. Due to the resident's severe bowel impaction, the hospital manually removed stool from her rectum shortly before her death. The hospital's autopsy report indicated the cause of death was thought to be shock brought on by acute inflammation and enlargement of the colon. The facility was cited because it did not implement the resident's careplan to prevent constipation and fecal impaction and did not identify her care needs through assessment of her bowel status. These failures led to her death. (Issued as Class AA at \$80,000.) Citation #97177003556.

Atlantic Memorial Healthcare Center

2750 Atlantic Ave., Long Beach, Ca 90806

Atlantic Memorial Healthcare Center

2/5/2007 **B** Comp.
\$1,000 Patient Rights Mandated Reporting

At 3 am on 5/18/06, a staff member reported that the resident's right eye was swollen with black and blue discoloration. The doctor was notified at 6:30 am. Family members were not notified although a similar incident had happened in January of 2006. The facility was cited for failure to investigate the incident and failure to report an injury of unknown source to the administrator and to the licensing agency. (Issued as Class B at \$1,000.) Citation #94126903683.

Ayer-Lar Health Care Center

16530 S Broadway, Gardena, CA 90248

Ayer-Lar Health Care Center

9/21/2007 **B** Certif.
\$1,000 Patient Care Careplan
 Fall
 Patient Care

A 54 year old male resident, who required extensive assistance with ambulation, fell four times in eight months while unattended. He sustained several injuries. The facility failed to implement his careplan to monitor him frequently. This had a direct relationship to the health, safety and security of the resident. (Issued as Class B at \$1,000.) Citation #91137904289.

Bel Tooren Villa Convalescent Hospital

16910 Woodruff Ave., Bellflower, CA 90706

Bel Tooren Villa Convalescent Hospital

8/31/2007 **B**
\$800 Patient Care Dignity
 Verbal Abuse

During the night shift on 6/14/07, an African American resident stated that a staff person kept singing the words "Whose My Nigga." The resident asked the staff to stop signing the words, but he continued. The resident was offended and humiliated. The facility was cited for failure to ensure the resident was treated with dignity and was free from verbal abuse. (Issued as Class B at \$800.) Citation #94054404215.

Briarcrest Nursing Center

5648 Gotham Street, Bell Gardens, CA 90201

Briarcrest Nursing Center

6/29/2007 **A** Comp.
\$20,000 Patient Rights Careplan
 Decubiti (Bedsore)
 Neglect
 Notification

Death Occurred

On 4/3/07, a resident's blood pressure was decreasing and her doctor was notified at 1:30 pm. The decrease in pressure continued, accompanied by nausea and vomiting, but her MD was not notified until 4:30 pm. She was not hospitalized until 5:50 pm, with a compromised condition requiring a 15 day hospital stay. Another resident's condition who was being treated for bedsore began to change around 3 am of 3/28/07, and the MD was notified at 7:30 am. Although conditions worsened, the MD was not notified until 11:30 am. Family was not notified of changes until 12:30 pm. The resident died of sepsis and pneumonia on 3/31/07. The facility was cited for failure to notify the physicians and family of changes in condition, and for failure to provide necessary care and supervision for the second resident. (Issued as Class A at \$20,000.) Citation #94164503955.

Briarcrest Nursing Center

6/29/2007 **B** Comp.
\$1,000 Patient Care Decubiti (Bedsore)

A resident admitted on 3/2/07 died less than a month later from sepsis. The resident had three bed sores at admission, but developed additional sores during his stay. An investigation determined the facility dietitian had recommended an inadequate amount of nutrition for the resident's tube feedings. The resident's protein levels became low and the facility failed to respond. The facility was cited for failure to prevent the development of bed sores and failure to properly treat bed sores once they had developed. (Issued as Class B at \$1,000.) Citation #94164504021.

Brierwood Terrace Convalescent Hospital

1480 S. La Cienega, Los Angeles, CA 90035

Brierwood Terrace Convalescent Hospital

12/28/2007 **B** Certif.**\$1,000** Patient Care Patient Care

On several occasions a male resident was discovered smoking in his bed, which directly violates the facility's policy of smoking in a specific area with staff members present. Between February and December of 2007, there were 25 entries documenting nurses discovering the resident smoking in bed. Additionally, on two separate occasions, multiple cigarette butts were found hidden in his room from overnight smoking. And finally, on 12/5/07, he was found asleep with a lit cigarette in his hand. The facility was cited for failing to ensure the resident did not smoke without a responsible adult present to ensure safety against fire hazards. (Issued as Class B at \$1,000.) Citation #97133204548.

Brierwood Terrace Convalescent Hospital

12/28/2007 **B** Certif.**\$1,000** Patient Care Injury Supervision

On 12/5/07, a male resident stated he was allowed to smoke unsupervised and allowed to carry his cigarettes and lighter with him. Later that day, the resident fell from his wheelchair while on the smoking patio. He stated he fell while attempting to pee in the bushes by leaning forward out of his chair. The resident had multiple abrasions on his face and he also lost his front tooth as a result of the fall. This was his third documented fall as a result of being left unsupervised in a smoking area. He was transferred to the hospital and then readmitted to the facility that afternoon. The facility was cited for failing to ensure each resident received adequate supervision to prevent accidents. (Issued as Class B at \$1,000.) Citation #97189204549.

California Healthcare And Rehabilitation Center

6700 Sepulveda Blvd., Van Nuys, CA 91411

California Healthcare And Rehabilitation Center

11/14/2007 **B** Comp.**\$1,000** Patient Rights Patient Rights

During an investigation the department found that a resident had been given narcotic medications in November and December 2006, and May 2007, without written consent from a family member. The resident's Advanced Directive Acknowledgment form indicated the medication restriction for the use of narcotics. The facility was cited for failing to allow refusal of treatment. (Issued as Class B at \$1,000.) Citation #92133204445.

California Healthcare And Rehabilitation Center

11/14/2007 **B** Comp.**\$1,000** Patient Care Patient Care

A resident was admitted to the facility on four different occasions. On the last readmission dated 2/24/07, the resident had abdominal rashes. The facility did not perform a dermatology evaluation until 3/30/07, when the resident was diagnosed with scabies. The facility did not follow procedures by isolating the resident, informing the resident's visitors/caregivers of the infection and by not conducting environmental disinfections. The facility was cited for failing to implement their infection control program to prevent and control the spread of scabies. (Issued as Class B at \$1,000.) Citation #92133204444.

Casitas Care Center

10626 Balboa Blvd., Granada Hills, CA 91344

Casitas Care Center

12/19/2007 **B** Comp.**\$1,000** Medication Medication Patient Care**Death Occurred**

On 8/18/07, a female resident, who was completely dependent on staff, was sent to the emergency room because she had refused to eat for two days and exhibited a diminished state of consciousness. She died on 8/23/07 from a heart attack. The facility care center had given her two psychotropic drugs of the same category with the same side effects. Even after the resident showed loss of appetite and signs of sedation, the facility continued to give her the same amount of medication. The facility failed to ensure the resident did not receive unnecessary drugs. (Issued as Class B at \$1,000.) Citation #92057004530.

Chandler Convalescent Hospital

5335 Laurel Canyon Blvd., North Hollywood, CA 91607

Chandler Convalescent Hospital

7/9/2007 **RD** Comp.**\$1,000** Administration Retaliation Against Resident

During a complaint investigation on 6/19/07, it was learned that a 76 year old male resident received a letter from a staff member stating they were aware, through multiple complaints from staff and other residents at the facility, of the resident's attitude and disparaging words towards staff and other residents. The letter warned the resident that the administration would not tolerate castigation to any person living or working at the facility and threatened the resident with a 30 day eviction notice if the behavior continued. Facility was cited for failing to ensure the resident was free from retaliation. (Issued as Class RD at \$1,000.) Citation #92057504081.

Chandler Convalescent Hospital
 7/9/2007 **RD** Comp.
\$1,000 Administration Retaliation Against Resident

During a complaint investigation on 6/19/07, it was learned that a 77 year old female resident received a letter from a staff member stating they were aware, through multiple complaints from staff and other residents at the facility, the resident was spreading rumors about the administration and speaking behind people's backs. The letter warned the resident that the administration would not tolerate malicious gossip about any person living or working at the facility and threatened the resident with a 30 day eviction notice if the behavior continued. Facility was cited for failing to ensure the resident was free from retaliation. (Issued as Class RD at \$1,000.) Citation #92057504080.

Chandler Convalescent Hospital
 8/9/2007 **B**
\$1,000 Patient Rights Physical Abuse

On 6/3/07, an 89 year old female resident reported that a staff member had squeezed her nipples after she got out of bed and asked for help going to the bathroom. The resident's roommate did not see the incident, but heard the staff member tell the resident to get back into bed and then heard the resident cry out, "Ouch, you are not supposed to do that." The facility was cited for failing to ensure that the resident was free from abuse. (Issued as Class B at \$1,000.) Citation #92057504170.

Chandler Convalescent Hospital
 9/10/2007 **B** Comp.
\$1,000 Physical Environment Patient Care Physical Environment

On 8/30/07, the local weather forecast reported a high temperature of 101 degrees Fahrenheit. Within the facility, three air conditioning units were not working. As a result, six residents were subjected to uncomfortable temperature levels. The violation had a direct relationship to the health and safety of the residents. (Issued as Class B at \$1,000.) Citation #92133204267.

Chandler Convalescent Hospital
 10/3/2007 **B** Comp.
\$1,000 Administration Administration

The facility failed to renew its state operations license, resulting in unlicensed operations from 3/1/07 until 10/1/07. Despite the fact that the facility had a copy of a license that indicated an expiration date of 2/28/08, an investigation determined that the facility had not paid its annual renewal fee. (Issued as Class B at \$1,000.) Citation #92133204314.

Chandler Convalescent Hospital
 12/7/2007 **B**
\$1,000 Patient Care Physical Abuse

On 10/31/07, a resident struck another resident in the forehead causing a bump and bruise. The resident had previously told the nurse he would hit his roommate if he did not stop moaning. The nurse moved the moaning resident to another bed that was in another room, but shared a wall with the complaining resident. The facility was cited for failing to protect the resident from physical abuse and failing to implement abuse policies by not adequately separating the residents to prevent the abuse. (Issued as Class B at \$1,000.) Citation #92131304508.

Chatsworth Park Care Center
 10610 Owensmouth Ave., Chatsworth, CA 91311

Chatsworth Park Care Center
 2/5/2007 **A** Comp.
\$25,000 Medication Medication Neglect

From 7/4/06 to 7/11/06, a resident was hospitalized due to an intracranial hemorrhage, Coumadin toxicity, and internal bleeding related to side effects of Coumadin, a blood thinning medication. The resident was not tested for known side effects during the six weeks prior to her hospitalization. The facility was cited because its failure to monitor known adverse effects and possible drug interactions presented an imminent danger of death or serious harm to the resident. (Issued as Class A at \$25,000.) Citation #92133203581.

Chatsworth Park Care Center
 3/16/2007 **B** Comp.
\$1,000 Patient Rights Injury

Between 1/21/07 and 1/24/07, the facility failed to implement their abuse prevention policies for a resident, which resulted in a three day delay to assess the resident's skin discoloration and bruising and to notify the administrator, department heads and the physician of the resident's injury of unknown origin. This violation had a direct relationship to the health and safety of the resident and other residents in the facility. (Issued as Class B at \$1,000.) Citation #92057003804.

Community Convalescent Hospital Of Glendora
 638 East Colorado Ave., Glendora, CA 91740

Community Convalescent Hospital Of Glendora
 9/25/2007 **B**
\$1,000 Medication Patient Care Medication

On 9/05/07, an inspection of the facility's medication room revealed that six residents had been given expired insulin. A loss of potency of the insulin may affect changes in blood glucose levels. Failure of the facility to discard expired insulin medication had a direct relationship to the health and safety of the residents. (Issued as Class B at \$1,000.) Citation #95164804293.

Community Convalescent Hospital Of Glendora

10/12/2007

B

\$600

Patient Care

Patient Care

During an evaluation on 7/8/07, an Occupational Therapist (OT) noted that a resident held her left arm in a flexed position and the left fingers had flexion contractures related to a cerebral vascular incident. The OT suggested the use of a splint to increase the range of motion and prevent further contracture. The resident received restorative nursing from 7/18/07-8/14/07, but the condition worsened. The physician ordered occupational therapy, which commenced and then stopped abruptly on 8/23/07. The resident then received no services or treatment until 9/12/07. The facility was cited for failing to provide care and occupational therapy. (Issued as Class B at \$600.) Citation #95057704352.

Country Villa Bay Vista Healthcare Center

5901 Downey Ave., Long Beach, CA 90805

Country Villa Bay Vista Healthcare Center

3/19/2007

B

Comp.

\$1,000

Physical
Environment

Fall

On 6/23/07, a resident, who was at risk for falls and had a brace on the right leg, fell and fractured her right femur. A CNA had just stood the resident up from a shower chair and left her unattended while she moved away to get a diaper. The CNA stated when she saw the resident began to slide on the wet floor, she was able to get hold of the resident's waist, but heard a pop or crack while she lowered the resident to the floor. The facility was cited for failure to ensure the resident was free from falling and injuring herself. (Issued as Class B at \$1,000.) Citation #94057903816.

Country Villa Belmont Heights Healthcare Center

1730 Grand Ave, Long Beach, CA 90804

Country Villa Belmont Heights Healthcare Center

5/25/2007

B

Comp.

\$1,000

Patient Care

Mandated Reporting

On 6/24/05, facility staff discovered a resident had bruising on her left, upper, inner thigh. How it happened was unknown. The facility administrator was notified three days later of the resident's bruising, which is a violation of State law requiring immediate notification. Moreover, the administrator did not immediately notify the Department of Health Services, also required by State law. On 6/29/05, the resident's family alleged she had been sexually assaulted. A gynecology consult was not obtained until the following day. The police were not called until 7/1/07, and the Department was not notified until the same day. The facility failed to report suspected abuse immediately as mandated by State law. (Issued as Class B at \$1,000.) Citation #94052103992.

Country Villa Los Feliz Nursing Center

3002 Rowena Ave, Los Angeles, CA 90039

Country Villa Los Feliz Nursing Center

11/29/2007

B

Comp.

\$1,000

Administration

Patient Care

Based on record review and interviews, the Department determined that one resident was diagnosed with scabies and another treated for suspected scabies in October of 2007. A random review of clinical records revealed 14 residents had recent diagnoses of rashes with itching. The Department defines an outbreak of scabies as at least two clinically suspected cases. The facility was cited for failing to report an outbreak of scabies. (Issued as Class B at \$1,000.) Citation #97206804470.

Country Villa Woodman Healthcare Center

13524 Sherman Way, Van Nuys, Ca 91405

Country Villa Woodman Healthcare Center

3/16/2007

B

Comp.

\$1,000

Patient Rights

Sexual Abuse

The facility staff failed to ensure Resident 1 was free from sexual abuse from Resident 2 who inappropriately touched Resident 1 on her right breast. A facility employee witnessed Resident 2 touching Resident 1 inappropriately in the dining room and reported the incident. (Issued as Class B at \$1,000.) Citation #921313033806.

Del Rio Convalescent Center

7002 E Gage Avenue, Bell Gardens, CA 90201

Del Rio Convalescent Center

2/9/2007

B

Comp.

\$1,000

Patient Rights

Sexual Abuse

On 6/23/06, a 45-year-old female resident complained that a staff member had paid her 60 cents to touch her private parts. The resident also claimed that the staff member touched her inappropriately two to five times each week for "soda money." During the facility's own investigation, the staff member admitted to giving the resident money and hitting her on the rear. The facility was cited for failing to ensure that its residents are free from sexual abuse. (Issued as Class B at \$1,000.) Citation #94057903701.

Doctors Convalescent Hospital

7926 S Painter Ave, Whittier, CA 90602

Doctors Convalescent Hospital

8/17/2007

B

\$1,000

Patient RightsSexual Abuse
Mandated Reporting

On 6/05/07, a female resident reported to staff that she had been sexually abused by another resident a few days prior. Staff did not report the allegation to state officials. The incident was not reported to the state or investigated until after an Ombudsman received an anonymous call and visited the facility 45 days after the alleged abuse. The facility failed to ensure all alleged violations involving abuse be reported immediately to the administrator and to other officials in accordance with state law. (Issued as Class B at \$1,000.) Citation #94164504191.

Doctors Convalescent Hospital

8/17/2007

B

\$1,000

Patient RightsPatient Care
Transfer
Notification

On 6/06/07, a resident was transferred from the facility to a Board and Care because he had no medical insurance coverage. However, the resident, who had a 25-year history of diabetes, had 21.38% weight gain in last 6 month period in the facility and his glucose was 396 the day before he was transferred. Moreover, his physician was not made aware of these health factors upon resident's transfer. The facility failed to ensure the resident was appropriately transferred when his health had sufficiently improved and no longer required the facility's services. (Issued as Class B at \$1,000.) Citation #94164504189.

Doctors Convalescent Hospital

8/17/2007

B

\$1,000

Patient RightsAdministration
Sexual Abuse

On 6/02/07, a 52 year old female resident was sexually accosted by a male resident. She reported the incident to staff, but they did not believe her, even though there were previous allegations of the male resident trying to touch female residents. Failure of the facility to ensure the resident was free from sexual abuse, and failure to follow their facility's policy and procedure on abuse prevention, had a direct relationship to the health and security of the resident. (Issued as Class B at \$1,000.) Citation #94164504190.

Doctors Hospital Of West Covina D/P SNF

725 S. Orange Avenue, West Covina, CA 91790

Doctors Hospital Of West Covina D/P SNF

8/15/2007

B

\$900

Patient RightsComp.
Dignity
Physical Abuse
Mental Abuse
Verbal Abuse

On 6/13/07, staff teased a resident about "having a crush" on a female Licensed Vocational Nurse, to the point of writing the resident's first name with the nurse's first name on the resident's chest with a black Sharpie permanent marker. This was done against the resident's wishes. The resident is unable to move or speak independently. The facility failed to protect the resident from verbal, physical and mental abuse. (Issued as Class B at \$900.) Citation #93175504180.

Driftwood Health Care Center-Torrance

4109 Emerald Avenue, Torrance, CA 90503

Driftwood Health Care Center-Torrance

8/1/2007

B

\$1,000

Patient CareComp.
Verbal Abuse
Dignity

On 6/8/07, a resident was admitted to the facility. She complained to staff on 6/21 that she was afraid to return to her room because a staff person was mean to her and was "badgering and intimidating" her in a loud and angry manner. Another staff person witnessed the "harsh" tone used by that staff person in dealing with the resident. The facility was cited for failing to protect the resident from verbal abuse. (Issued as Class B at \$1,000.) Citation #91126704150.

El Monte Convalescent Hospital

4096 Easy Street, El Monte, CA 91731

El Monte Convalescent Hospital

8/2/2007

B

\$1,000

Abuse

Comp.

Physical Abuse

On 3/19/07, a female resident reported to a facility staff member that she had been physically abused two times by a CNA. The CNA first hit the resident on the forehead and then, in a separate incident, hit the resident in the face and covered her mouth after the resident cried out during a diaper changing. The facility failed to report the allegation to the Department of Public Health until five days after it was reported. (Issued as Class B at \$1,000.) Citation #95153904160.

Ember Health Care - Monte Vista

5125 Monte Vista St., Los Angeles, Ca 90042

Ember Health Care - Monte Vista

8/8/2007

B

\$900

Abuse

Comp.

Physical Abuse

On 6/1/07, a CNA was seen violently shaking a 39 year old male resident and pushing his head into his pillow. The resident required extensive assistance from the staff for bed mobility and was totally dependent on the staff in transferring, locomotion, dressing, eating, toilet use, personal hygiene and bathing. During the investigation, the CNA claimed the resident had been trying to kick and hit her. The facility was cited for failure to ensure the resident was free from physical abuse by an employee. (Issued as Class B at \$900.) Citation #97186904040.

Empress Rehabilitation Center

1020 Termino Avenue, Long Beach, CA 90804

Empress Rehabilitation Center

5/15/2007

B

\$1,000

Administration

Comp.

Theft & Loss

The facility was cited for failing to thoroughly investigate allegations of one of their CNAs abusing a resident under his care. Employees at the facility had been aware of the CNA's practice of borrowing money from them and requesting pay advances. Also, residents had complained of his borrowing money from them and not paying it back. On 6/20/06, the CNA struck a resident who had been giving him money, but had refused to give him any more. The facility's failure to thoroughly investigate allegations of the CNA's abuses had a direct relationship to the health, safety and security of the residents at the facility. (Issued as Class B at \$1,000.) Citation #94164503950.

Empress Rehabilitation Center

5/15/2007

B

\$1,000

Patient Rights

Comp.

Physical Abuse

On 6/20/06 a CNA attempted to get money from a resident and became angry and struck the resident when the resident refused. The CNA had been know to "borrow" money from some of the residents and staff at the facility and had been known to be physically abusive to those who refused to comply with his requests. The facility was cited for failure to keep residents free from being abused. (Issued as Class B at \$1,000.) Citation #94164503949.

Empress Rehabilitation Center
6/8/2007 **B** Comp.
\$1,000 Patient Care Decubiti (Bedsores)

A resident admitted on 2/4/07 lost seventeen pounds in three weeks and developed five bed sores shortly thereafter. Despite the drastic weight loss and low albumin levels, the facility did not undertake any action to remedy the resident's poor nutritional status. The facility was cited for allowing clinically avoidable bed sores to develop and, once developed, failing to provide necessary treatment. (Issued as Class B at \$1,000.) Citation #94164504019.

Garden Plaza Convalescent Hospital
12029 S Avalon Blvd, Los Angeles, CA 90061

Garden Plaza Convalescent Hospital
1/11/2007 **B** Comp.
\$1,000 Patient Care Fall

On 11/4/06, a resident "slid" to the floor while being transferred from her wheelchair to her bed. Although the resident complained of pain to her right leg and continued to do so for over six hours, facility staff failed to properly assess her condition, thinking that she always complained of pain and had not actually "fallen" from the wheelchair. When the resident was finally sent to the emergency room, it was determined that she had a fracture of the right hip. The facility was cited for failure to properly notify the physician of the change in the resident's physical condition. (Issued as Class B at \$1,000.) Citation #94052103633.

Imperial Convalescent Hospital
11926 La Mirada Blvd, La Mirada, CA 90638

Imperial Convalescent Hospital
1/2/2007 **B**
\$1,000 Patient Rights Physical Abuse
Verbal Abuse

During the night shift on 11/22/06, an employee roughly handled a resident and told her to "shut up!" Another employee heard the and verbal abuse and the resident cry out with pain as did the resident's roommate. This same employee also treated another resident in a verbally abusive manner. The facility was cited for failure to ensure that residents are free from physical and verbal abuse. (Issued as Class B at \$1,000.) Citation #94164503598.

Integrated Nursing And Rehab Care of Glendora
805 West Arrow Highway, Glendora, CA 91740

Emmanuel Health Care And Rehabilitation Center
12/28/2007 **B** Comp.
\$1,000 Patient Rights Physical Restraints
Dignity

On 8/24/07, two staff members restrained a male resident in a wheelchair with a non-release seat belt by tying his back wheels to a handrail, so they could finish their morning chores without being disturbed by him. They claimed he was wandering into other residents' rooms and disturbing them. The restraint directly violated the facility's policy and procedure regarding physical restraints. The facility was cited for failing to ensure the resident was free from any physical restraint and maintaining the resident's dignity and respect. (Issued as Class B at \$1,000.) Citation #95153904545.

Lancaster Health Care Center
1642 W Avenue J, Lancaster, CA 93534

Lancaster Health Care Center
6/25/2007 **B** Comp.
\$1,000 Patient Care Physical Abuse

A 68 year old female resident indicated that on 5/21/07 an employee hurt her arm while turning her, yelled at her and told her to "Turn her white ass over." The resident asked for water and was told, "No, that will make you piss more." The resident also asked to be changed and the employee slapped a cold wet towel on the resident's private area. The employee left the room saying, "You need me, I don't need you." The facility was cited for failure to ensure the resident was treated with dignity and respect and not subject to verbal and physical abuse. (Issued as Class B at \$1,000.) Citation #92202904049.

Las Flores Convalescent Hospital
14165 Purche Avenue, Gardena, CA 90249

Las Flores Convalescent Hospital
4/25/2007 **B**
\$1,000 Patient Care Patient Care

On 3/30/06, a resident who was smoking in the designated smoking patio caught fire and suffered second and third degree burns. The resident had earlier been determined as an unsafe smoker and required constant observation. He had decreased safety awareness and a long beard which could be a fire hazard if a spark from his cigarette fell into his beard. He also had a habit of holding his head down when smoking. When the resident's beard ignited, an employee, who happened by, attempted to extinguish the fire with his hands. The fire wasn't controlled until another employee used a blanket. The facility was cited for failure to adequately supervise the resident. (Issued as Class B at \$1,000.) Citation #91058903919.

Las Flores Convalescent Hospital
6/8/2007 **A** Comp.
\$7,000 Patient Care Decubiti (Bedsores)

On 8/23/05, a resident was sent to an acute care hospital with multiple decubitus ulcers to the ankle and lower back, urosepsis and a blood infection. A review of the records indicated the facility had not been properly assessing or caring for her and an interview with the Director of Nursing elicited the statement, "Yes, I'm aware that there was no decubitus assessment nor treatment done for the resident during her first few months of admission." The facility was cited for failure to perform continuous skin assessments and a delayed physician's order for pressure sore treatment, which promoted the development of the pressure sores. (Issued as Class A at \$7,000.) Citation #91050803680.

Long Beach Care Center

2615 Grand Avenue, Long Beach, CA 90815

Long Beach Care Center, Inc.

5/2/2007	B	Comp.
\$1,000	<u>Patient Rights</u>	Fiduciary

On 12/13/07, a resident gave a CNA his ATM card in order for the CNA to withdraw \$100 for the resident. The next day, the CNA began an unauthorized series of withdrawals and by 1/19/07 she had taken more than \$5,000 from the account. When the resident received his statement and realized he had been victimized he told a facility of the loss. The facility did not take any recorded action against the offending CNA and she was allowed to continue her employment. The facility was cited for failure to prevent financial abuse and protect the resident from further abuse. (Issued as Class B at \$1,000.) Citation #94164503922.

Long Beach Care Center

5/2/2007	B	Comp.
\$1,000	<u>Abuse</u>	Fiduciary

In December of 2006, a CNA was able to get a hold of a resident's ATM card and pin number and began to withdraw money from the resident's account. Over a short period of time, the CNA had taken over \$5,000 from the resident's bank account. Although the facility was made aware of the allegation against the CNA, the CNA was allowed to continue to care for the resident she was suspected of financially abusing. The facility was cited for failure to notify officials in accordance with State law of the misappropriation of the resident's ATM card and for not suspending the CNA. (Issued as Class B at \$1,000.) Citation #94164503923.

Marina Care Center

5240 Sepulveda Blvd, Culver City, CA 90230

Marina Care Center

2/23/2007	B	Injury
\$1,000	<u>Patient Care</u>	Fall
		Supervision
		Careplan

A 91-year-old resident who was at high risk for falls and had dementia fell on 4/20/06 and 4/29/06. On the latter date, he fell down stairs outside of the facility while restrained in a wheelchair, hitting and cutting his head, leading to a four-day hospital stay. The facility was cited because it did not maintain adequate supervision of the resident when it failed to place the resident near the nursing station, per its careplan for the resident. (Issued as Class B at \$1,000.) Citation #91058903744.

North Walk Villa Convalescent Hospital

12350 Rosecrans, Norwalk, CA 90650

North Walk Villa Convalescent Hospital

12/10/2007	A	Comp.
\$10,000	<u>Patient Care</u>	Fall
		Supervision

On 9/22/07, a CNA attempted to transfer a resident, who required two person transfers or a gait belt transfer, by herself. The resident became dizzy and fell backwards onto his bed. The resident cried out and complained of right hip pain. Another employee heard the cries and came in to assist the CNA with repositioning the resident. Both employees then transferred the resident to the bathroom, but he further complained of right hip pain when set back into bed. The CNA called the physician, who ordered an x-ray that revealed a right hip fracture. The resident was transferred to the hospital that night and underwent surgery to repair the fracture. The facility was cited for failing to provide adequate supervision and assistive devices in transfers. (Issued as Class A at \$10,000.) Citation #94164504370.

Northridge Care Center

7836 Reseda Bl, Reseda, CA 91335

Northridge Care Center

4/23/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Decubiti (Bedsore)

A resident was admitted to the facility on 1/7/07, with a pressure sore on her right heel. There was no documentation of an assessment of the resident's heel from 1/8/07 through 1/12/07. On 8/12/07, on the insistence of a family member, the resident was transferred to an acute care hospital for treatment of an infection of the foot related to the pressure sore. The facility was cited for failure to provide a continuing assessment of the resident's heel blister. (Issued as Class B at \$1,000.) Citation #92057003917.

Norwalk Skilled Nursing & Wellness Centre

11510 Imperial Hwy, Norwalk, CA 90650

Emmanuel Health Care Center - Norwalk

6/8/2007	AA	Comp.
\$80,000	<u>Patient Care</u>	Fall
		Injury
		Neglect
		Notification

Death Occurred

On 8/15/05, a 54 year old resident, who was at risk for falls, was found on the floor with a serious injury to his forehead. The facility staff did not adequately assess the resident's injuries or notify his physician until the next day when he could not be aroused. He was then hospitalized, where it was determined he suffered huge cerebral bleeding. The resident died two days after being hospitalized. The facility was cited because its failures to immediately consult with the resident's physician about his injuries and conduct a comprehensive assessment were a direct proximate cause of his death. (Issued as Class AA at \$80,000.) Citation #94129603154.

Pacifica Hospital Of The Valley D/P SNF

9449 San Fernando Rd, Sun Valley, CA 91352

Pacifica Hospital Of The Valley D/P SNF

3/9/2007	B	Comp.
\$900	<u>Patient Rights</u>	Physical Abuse Mental Abuse

On 7/12/05, while an employee was changing a resident's diaper the employee pulled the pillow from underneath the resident's head, pushed her head down, and told her, "Keep it down if you don't want to get slapped." The resident sustained a neck injury from the incident. The facility was cited for failure to protect the resident from physical, verbal and mental abuse. (Issued as Class B at \$900.) Citation #93153803773.

Paramount Convalescent Hospital

8558 E Rosecrans Ave, Paramount, CA 90723

Paramount Convalescent Hospital

1/2/2007	B	Comp.
\$800	<u>Patient Rights</u>	Physical Abuse

On 6/24/06, a staff member was observed hitting a resident on her right hand and in the face to stop her from screaming, causing a bloody nose. The facility was cited for failure to ensure the resident was free of physical abuse. (Issued as Class B at \$800.) Citation #94127703597.

Pineridge Care Center

14122 Hubbard Street, Sylmar, CA 91342

Pineridge Care Center

4/25/2007	B	
\$1,000	<u>Medication</u>	Medication

A 40 year old resident with profound mental retardation, seizure disorder, and depression with psychotic features was receiving the wrong amount of medication from 12/9/06 until 3/8/07. The facility was cited for failure to properly administer the medication as prescribed by his physician, which had a direct relation to the health and safety of the resident. (Issued as Class B at \$1,000.) Citation #92057003920.

Presbyterian Intercommunity Hospital D/P SNF

12401 Washington Blvd., Whittier, CA 90602

Presbyterian Intercommunity Hospital D/P SNF

4/23/2007	A	Comp.
\$5,000	<u>Patient Care</u>	Patient Care Careplan

The careplan for an 83-year-old female resident called for a gait belt to be used when she was walking during her physical therapy sessions. On 6/24/06, nursing staff failed to put the belt on the resident before she began a session. The resident lost her balance while walking and fell to the floor, suffering scratches, bruises, a right hip fracture, and a laceration to the head. The facility was cited for failing to follow their written policy on applying a gait belt prior to providing physical therapy. (Issued as Class A at \$5,000.) Citation #93166903672.

Royal Oaks Care Center

3565 E Imperial Hwy, Lynwood, CA 90262

Royal Oaks Care Center

12/11/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Dietary Services

Between 11/3/07, and 11/19/07, a resident who was at risk for nutritional problems lost 8.5 pounds. The facility did not properly monitor the resident's food intake or notify the Registered Dietitian when the resident began losing weight. The facility was cited for failure to ensure the resident's weight was maintained at an acceptable parameter. (Issued as Class B at \$1,000.) Citation #94164504477.

Royal Oaks Care Center

12/11/2007	B	Comp.
\$1,000	<u>Patient Rights</u>	Physical Abuse Other

The facility failed to interview a student nurse who witnessed a CNA allegedly abuse a resident on 11/2/07. The resident sustained an injury of discoloration to her left inner wrist and swelling to the right hand. The student nurse had witnessed hand movements behind the resident's privacy curtain that seemed abusive. The facility reported the alleged abuse to the Department of Public Health, but failed to conduct an adequate internal investigation. The facility's failure to follow their abuse policy in regards to thoroughly investigating allegation of abuse had a direct relationship to the health, safety and security of the residents. (Issued as Class B at \$1,000.) Citation #94164504478.

Sherman Oaks Health & Rehabilitation Center

14401 Huston Street, Sherman Oaks, Ca 91423

Sherman Oak Health & Rehabilitation Center

5/15/2007	B	Comp.
\$1,000	<u>Patient Rights</u>	Physical Abuse

On 4/3/07, a resident overheard an employee slapping a 94 year old female resident. She reported it the next day, after spending the evening comforting the upset and shaken resident. The employee denied slapping the resident, but was terminated for failing to comply with the facility's abuse policy. The facility was cited for failure to ensure that the resident was free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion. (Issued as Class B at \$1,000.) Citation #92057503961.

Sophia Lyn Convalescent Hospital

1570 N. Fair Oaks Avenue, Pasadena, CA 91103

Sophia Lyn Convalescent Hospital

4/18/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Supervision

On 12/1/06, a 53 year old resident, who was on hospice for symptoms of pain control management and comfort care for end stage liver disease, wandered from the facility and was not located for 43 hours. The resident was known to have periods of confusion, shook a lot when he walked and could fall down because he had problems with balance. The facility was cited for failing to provide adequate supervision and monitoring of the resident. (Issued as Class B at \$1,000.) Citation #97126903905.

Southland

11701 Studebaker Road, Norwalk, CA 90650

Southland

1/24/2007

B

Comp.

\$1,000Patient Care

Injury

Fall

Patient Care

On 11/18/07, a resident fell out of her wheelchair and sustained a black eye. The resident complained of leg pain two days after the fall, but she was not seen by a physician until 18 days after the fall. The physician identified a left tibia and left knee fracture. The facility was cited for failing to accurately and continuously assess the resident after she had a fall with injuries, which resulted in an 18-day delay in treatment. (Issued as Class B at \$1,000.) Citation #94164503629.

Southland

1/24/2007

B

Comp.

\$1,000Patient Care

Decubiti (Bedsores)

On 12/6/06, a doctor ordered a left leg immobilizer for a resident that was to be released and checked for circulation every shift for 10 minutes. By 12/30/06, a Stage I pressure sore on the left heel was identified but not documented, reported to the doctor or care planned. On 1/4/07, the pressure sore was Stage II, measuring 2 cm by 2 cm, and oozing blood. The facility was cited for failure to prevent pressure sores. (Issued as Class B at \$1,000.) Citation #94164503630.

Studio City Rehabilitation Center

11429 Ventura Blvd., Studio City, CA 91604

Studio City Rehabilitation Center

5/4/2007

B

Comp.

\$1,000Patient Rights

Physical Abuse

On 4/22/07, an employee entered a resident's room and began watching television without the resident's permission. When the resident objected, the employee pushed the resident while he was sitting in his bed and the resident hit his hand on the side of the bed, sustaining a bruise and a skin tear. The facility was cited for failure to ensure the resident was free from physical abuse. (Issued as Class B at \$1,000.) Citation #92131303941.

Sun Air Convalescent Hospital

14857 Roscoe Blvd., Panorama City, CA 91402

Sun Air Convalescent Hospital

10/18/2007

B**\$800**Patient Rights

Physical Abuse

Mental Abuse

On 9/8/07, a resident was watching TV when she was approached by a male resident who twisted her arm and stated, "I can do many things to you." The resident tried to call the police, but did not know the address and asked the licensed nurse to give it to them. The nurse told the police she would handle the situation and asked the offending resident to go back to his room. Three hours later the same resident returned and slapped the frightened resident across the face. The facility was cited for failing to ensure the resident was free from physical and mental abuse. (Issued as Class B at \$800.) Citation #92057504382.

Sylmar Health And Rehabilitation Center

12220 Foothill Blvd., Sylmar, CA 91342

Sylmar Health And Rehabilitation Center

7/9/2007

B

Comp.

\$800Patient Care

Patient Care

On 6/20/07, during a complaint investigation about suicide attempts of a 28 year old female with schizo-active disorder and polysubstance dependence, it was determined the facility had failed to properly adjust the plan of care for suicidal behavior after the resident had cut herself in January and again in March of 2007. The resident's plan of care lacked necessary approaches and interventions to protect the resident and prevent her from obtaining a sharp object while in the facility. (Issued as Class B at \$800.) Citation #92202904079.

Tarzana Health And Rehabilitation Center

5650 RESEDA BOULEVARD, Tarzana, Ca 91356

Tarzana Health And Rehabilitation Center

7/25/2007

B**\$1,000**Patient Rights

Dignity

A female resident, admitted on 5/18/07 with an Alzheimer's Disease diagnosis, was reported by a family member to be wearing someone else's dentures. The resident had not worn dentures for three years and was struggling to breathe with the ill-fitting dentures in her mouth. The facility was cited for failing to treat the resident with respect and dignity. (Issued as Class B at \$1,000.) Citation #92133204127.

Temple Community Hospital D/P SNF

235 N. Hoover St., Los Angeles, CA 90004

Temple Community Hospital D/P SNF

5/14/2007

B

Certif.

\$900Physical Environment

Physical Environment

On 5/02/07, during a recertification survey, the evaluator detected large amounts of rodent droppings throughout the facility's kitchen. The kitchen had dirty floors with encrusted food waste and gaps and holes in the floor and walls. Failure of the facility to protect the kitchen area from rodents had a direct relationship to the health and safety of the residents. (Issued as Class B at \$900.) Citation #93138903954.

The Rehabilitation Centre Of Beverly Hills

580 SAN VICENTE BOULEVARD, Los Angeles, CA 900484621

The Rehabilitation Centre Of Beverly Hills

7/31/2007

B

Comp.

\$1,000

Patient Care

Patient Care

Death Occurred

On 9/13/05, a resident fell while trying to walk unassisted. Five days later, the resident showed symptoms of severe headaches, was confused, slurred during speech and screamed and moaned when turned every two hours. The physician was notified and, after reviewing the resident, left an order to transfer the resident to a hospital if resident's condition worsened. His condition got worse and staff did not transfer him until the following morning. The resident was taken to the ER for surgery for removal of a subdural blood clot. After surgery, the resident was taken to the ICU where his condition declined and he died on 10/11/05. The facility failed to ensure that all orders written by a person lawfully authorized to prescribe be carried out. (Issued as Class B at \$1,000.) Citation #91128103350.

Van Nuys Health Care Center

6835 Hazeltine Ave., Van Nuys, CA 91405

Van Nuys Health Care Center

8/9/2007

B

Comp.

\$800

Patient Rights

Physical Abuse

On 7/6/07, a 61 year old female resident pushed a staff member's head away while seated next to him during an activity. The staff member responded by elbowing the resident in the abdomen and then extending his fist to the resident's face and asking, "Do you really want to be hurt?" The facility was cited for failing to ensure that its residents are free from abuse. (Issued as Class B at \$800.) Citation #92167604171.

Vermont Care Center

22035 S Vermont Ave, Torrance, CA 90502

Vermont Care Center

12/11/2007

B

Comp.

\$1,000

Abuse

Physical Abuse

On 3/1/07, two staff members were providing care to a resident who sometimes exhibited combative behavior. The resident became aggressive and began to fight the staff by kicking while they changed his pants. One of the employees "went on top" of the resident and started hitting him. The other employee pulled him off the resident, noticed the resident was bleeding and reported the incident to the charge nurse. The resident sustained a laceration and bump on his left temple. The facility was cited for failing to protect the resident from physical abuse. (Issued as Class B at \$1,000.) Citation #91167004514.

Vernon Convalescent Hospital

1037 W Vernon, Los Angeles, CA 90037

Vernon Convalescent Hospital

9/4/2007

B

\$1,000

Patient Rights

Theft & Loss

The facility staff failed to ensure written policies and procedures on theft and loss were implemented to prevent the misappropriation of a 78 year old male's property. On 4/26/07, the resident's wallet containing \$118, Medi-Care, Medi-Cal, Voting and Access cards were given to his nurse when he took his shower. After the shower, the nurse would not give his wallet back, resulting in the resident feeling violated. The nurse claims the resident never gave her his wallet. (Issued as Class B at \$1,000.) Citation #97126904007.

Vernon Convalescent Hospital

12/21/2007

B

\$1,000

Patient Rights

Bed Hold

On 12/4/06, a resident was transferred to an acute hospital from the facility. The resident was ready to return to the facility on 12/8/06, but the facility refused to readmit the resident on the grounds that he exhibited threats and posed a danger to other residents. On 12/18/06, a Readmit Hearing was held, concluding that the facility must readmit the resident. As of 12/20/06, the facility still refused to readmit the resident. The facility was cited for failure to issue a written notice of a seven-day bed hold. (Issued as Class B at \$1,000.) Citation #97050103596.

View Heights Convalescent Hospital

12619 S. Avalon Blvd., Los Angeles, CA 90061

View Heights Convalescent Hospital

7/9/2007

B

\$1,000

Patient Rights

Comp.

Dignity

A 44 year old female resident with schizoaffective disorder was hit in the back with a shoe thrown by a staff member following an argument. The resident was reportedly pacing the hallway and shouting when she was struck by the shoe. The employee was fired. The facility was cited for violating the resident's right to dignity and respect. (Issued as Class B at \$1,000.) Citation #94054404082.

View Heights Convalescent Hospital

9/19/2007

B

\$1,000

Abuse

Comp.

Physical Abuse

On 5/14/06, a CNA observed another staff member violently grab a resident to redirect him into the facility. The staff member called the resident the N-word and stated, "I wish you would flex up on me again." On 5/18/06, the same staff member was observed pulling a different resident out of bed and pulling his hair, resulting in the resident suffering knee abrasions. (Issued as Class B at \$1,000.) Citation #94129604285.

View Heights Convalescent Hospital

9/19/2007 **B** Comp.
\$1,000 Staff Treatment of Residents Administration
 Physical Abuse
 Verbal Abuse
 Patient Rights
 Mandated Reporting

On 5/14/06, staff physically and verbally abused a resident by grabbing him and forcing him into the facility. On 5/22/06, the same staff member physically abused another resident by yanking him out of bed until he fell. The first incident of abuse was not reported to the administrator until several days later; DHS was not notified until several weeks had gone by after both incidents. Failure of the facility to ensure residents' allegations of abuse were reported immediately had a direct relationship to the health, safety and security of all residents. (Issued as Class B at \$1,000.) Citation #94129604286.

Villa Elena Healthcare Center

13226 Studebaker, Norwalk, CA 90650

Villa Elena Healthcare Center
 8/31/2007 **B**
\$800 Abuse Verbal Abuse
 Dignity

On 1/28/07 around 1:40 pm, a resident went into the kitchen to ask what was for dinner. There was an argument with the kitchen staff who yelled at the resident in Spanish saying, "You are nothing, you don't have the right to ask for anything!" The resident was very upset. The facility was cited for failure to protect the resident from verbal abuse. (Issued as Class B at \$800.) Citation #94122504234.

Villa Maria Elena Healthcare Center

2309 N Santa Fe Ave, Compton, Ca 90222

Villa Maria Elena Healthcare Center
 8/31/2007 **B**
\$1,000 Patient Care Physical Abuse

A 49 year old female resident with seizure disorder and a Stage III pressure ulcer was slapped in the face by a CNA. The incident was witnessed by three other employees. The CNA claimed the resident was hitting him on the arm with a plastic water container while he was repositioning the resident. He responded by slapping the resident and pouring water into her face. (Issued as Class B at \$1,000.) Citation #94054404216.

Westlake Convalescent Hospital

316 S Westlake Ave, Los Angeles, CA 90057

Westlake Convalescent Hospital
 10/30/2007 **B** Comp.
\$1,000 Patient Care Neglect

A resident with a bad toothache suffered extreme pain from 5/27/07 until 6/8/07, when the facility failed to arrange emergency dental services. The resident continued to have excruciating pain for three days after the Department of Health Services began investigating the complaint on 6/5/07. A dentist extracted the tooth on 6/8/07. (Issued as Class B at \$1,000.) Citation #97138804411.

Windsor Convalescent Center of North Long Beach

260 E Market St, Long Beach, CA 90805

Windsor Convalescent Center of North Long Beach
 6/7/2007 **B** Comp.
\$1,000 Patient Rights Administration

On 5/7/07, a CNA was suspended for three days after a resident alleged the CNA called her "white trash." The facility failed to follow its policy of Prevention of Abuse by failing to report an alleged abuse to other officials in accordance with State law through established procedures and have evidence that all alleged violations are thoroughly investigated. (Issued as Class B at \$1,000.) Citation #94052104012.

Windsor Palms Care Center of Artesia

11900 East Artesia Blvd, Artesia, CA 90701

Windsor Palms Care Center of Artesia
 2/9/2007 **B** Comp.
\$1,000 Patient Care Medication

On 9/2/04, a 59-year-old female resident was prescribed psychotropic medications with adverse side effects, particularly related to heat. On 9/7/04, the resident was lying in the sun on the facility patio on a 108 degree day. She was thought to be asleep. Hours later, the resident was unconscious, with second degree burns and a body temperature of 109 degrees. The facility failed to monitor the resident for adverse side effects. (Issued as Class B at \$1,000.) Citation #94122503065.

Windsor Palms Care Center of Artesia

2/28/2007 **B** Comp.
\$1,000 Physical Environment Physical Environment

On 8/25/06, a 49-year-old female resident was severely cut after walking past a long, sharp metal rod protruding from a wheelchair footrest. The rod was supposed to have a black rubber cap to prevent injuries. The resident was sent to the hospital where she received nine stitches on her left leg. The facility was cited for failing to provide a safe environment which resulted in the injury of a resident. (Issued as Class B at \$1,000.) Citation #94057903760.

Marin County**Aldersly Skilled Nursing Facility**

326 Mission Ave., San Rafael, CA 94901

Aldersly Skilled Nursing Facility

12/20/2007 **A** Comp.**\$18,000** Patient Care Neglect**Death Occurred**Fall
Supervision

A female resident receiving aftercare for a hip fracture was left alone on a toilet on 9/12/07, despite a documented high risk of falls and a careplan that required bathroom supervision. The resident fell and re-fractured her hip and died six days later. Her physician stated that the fall might have been "the final straw" when she died. (Issued as Class A at \$18,000.) Citation #11148904324.

Country Villa Novato Healthcare Center

1565 Hill Road, Novato, CA 94947

Pleasant Care Convalescent - Novato

6/20/2007 **A** Comp.**\$18,000** Patient Care Physical Restraints
Injury

On 10/21/06, a resident was found entrapped between the mattress and the rail of her bed, causing bruising and pain. The facility was cited because it failed to assess the resident's need for the full side rails and used them as a form of restraint without a physician's order. The facility failed to identify the gap between the mattress and the rail as a potential for entrapment and the use of full length side rails as placing the resident at increased risk for serious injury and death from falling while going over the rails or entanglement in the rails. (Issued as Class A at \$18,000.) Citation #11148903504.

Hillside Care Center (of San Rafael)

81 Professional Center Parkway, San Rafael, CA 94903

Hillside Care Center (of San Rafael)

4/26/2007 **A** Comp.**\$18,000** Patient Care Neglect
Injury
Physical Environment
Supervision**Death Occurred**

On 11/11/06, a resident who had dementia fell after wandering from the facility at night into cold and rainy weather. An hour after he was discovered missing, the police found him outside the facility, wet and very cold, shivering in a fetal position. As a result of the fall, the resident suffered a brain injury and fractured his back, leaving him debilitated. He was hospitalized and died three weeks after the fall. Although the resident wore a wanderguard bracelet (alarm device) on his ankle, the facility reported that the system did not alert staff when he exited the facility. The facility was cited because it failed to adequately supervise the resident, failed to ensure that the wanderguard functioned properly, and failed to implement their policy to notify the police within 10 minutes of a missing resident. (Issued as Class A at \$18,000.) Citation #11168503545.

Hillside Care Center (of San Rafael)

8/14/2007 **A** Comp.**\$18,000** Patient Care Decubiti (Bedsores)

On 12/7/05, a medical professional anonymously reported an elderly resident of the facility was hospitalized with dehydration and stage II and III bedsores on the buttocks and coccyx. Records indicated he had skin redness but no bedsores when admitted to Hillside Care Center on 11/22/05, but he lost 13 pounds in the following two weeks before being hospitalized. The facility was cited for its failure to assess and develop a plan of care to prevent skin breakdown and for its failure to provide care to prevent bedsores, which contributed to the resident's decline and the development of stage II and III bedsores. (Issued as Class A at \$18,000.) Citation #11182804132.

Hillside Care Center (of San Rafael)

8/14/2007 **A** Comp.**\$18,000** Patient Care Hydration

On 12/7/05, an 88 year old male resident was transferred to an acute hospital for severe dehydration, kidney failure, and malnutrition. In the two weeks the resident spent in the facility, his condition declined profoundly, from stable to nearly comatose. The resident's clinical record indicates that only one of those days, between 11/23/05 and 12/6/05, did his fluid intake and output match his required fluid needs; no actions were taken to meet those needs. The facility was cited for failure to provide hydration assessment and a careplan for a resident who had potential for dehydration, resulting in hospitalization. (Issued as Class A at \$18,000.) Citation #11182804139.

Marin Convalescent & Rehabilitation Hospital

30 Hacienda Dr., Tiburon, Ca 94920

Marin Convalescent & Rehabilitation Hospital

11/1/2007 **B** Comp.**\$800** Patient Care Security
Sexual Abuse
Physical Abuse

On 12/21/06, resident 1 was found touching resident 2's genitalia. Resident 1 had already been accused of sexual abuse on 12/07/06, and his careplan was updated with written instructions to prevent further abuse. The facility failed to ensure resident 2 was safe from sexual and physical abuse. (Issued as Class B at \$800.) Citation #11198403694.

Marin Convalescent & Rehabilitation Hospital

11/1/2007 **B** Comp.**\$800** Patient Care Physical Restraints

The facility failed to implement their policies and physicians' orders by failing to ensure orders contained specific parameters for the use of physical restraints and that the placement of the restraints and the resident's mobility were checked every 30 minutes. The facility failed to ensure physical restraints were used to treat a resident's medical symptoms and not for convenience, to prevent the resident from engaging in unacceptable behaviors. (Issued as Class B at \$800.) Citation #11198403695.

Northgate Care Center

40 Professional Center Parkway, San Rafael, CA 94903

Northgate Care Center

1/31/2007	A	Comp.
\$20,000	<u>Patient Care</u>	Careplan

A female resident began developing pressure sores on her feet following hip replacement surgery. The facility failed to properly diagnose the pressure sores, did not develop a careplan, and attempted no interventions despite the fact that the sores were very likely caused by the use of ace bandages and ill-fitting shoes. The facility was cited for failing to comprehensively assess, careplan, and treat the pressure sores. (Issued as Class A at \$20,000.) Citation #11135103534.

Northgate Care Center

8/24/2007	B	Comp.
\$1,000	<u>Administration</u>	Mandated Reporting

On 5/13/07, a family member noticed bruises on a resident's arm. The family member reported this to the facility and the police. The facility was cited for failure to report the allegation of abuse to the department within 24 hours. (Issued as Class B at \$1,000.) Citation #11187204131.

Pine Ridge Care Center

45 Professional Center Parkway, San Rafael, CA 94903

Pine Ridge Care Center

3/14/2007	B	License
\$1,000	<u>Administration</u>	Administration

On 6/23/06, the Department of Health Services mailed to each licensee of a skilled nursing facility a request for accurate and up to date licensee and ownership information. The licensee was given 60 days to return the requested information. The licensee did not comply with the Department's request. The Department sent two more written requests, and made several phone calls regarding the request, all of which were ignored. The licensee was cited for failing to comply with the Department's request. (Issued as Class B at \$1,000.) Citation #11125703801.

Pine Ridge Care Center

5/31/2007	B	Comp.
\$800	<u>Administration</u>	Physical Abuse Mandated Reporting

On 9/6/06, a resident told facility staff that on the prior day a male employee spanked him three times on the buttocks while helping him out of the bathroom. The resident's written declaration stated: "I felt at the time that this was inappropriate, was sexually abusive and I said so." The facility was cited because it failed to report the incident of alleged abuse to the Department of Health Services within 24 hours. The incident was not reported until 9/13/06, 7 days later. (Issued as Class B at \$800.) Citation #11148903474.

Mendocino County**Pleasant Care Convalescent Of Ukiah - Closed**

131 Whitmore Lane, Ukiah, Ca 95482

Pleasant Care Convalescent Of Ukiah

6/9/2007	B	Comp.
\$1,000	<u>Administration</u>	Administration Fiduciary Theft & Loss

A resident's family made a payment to the facility of \$810 on 12/9/06, the same day in which the resident expired. On 2/28/06, a family member reported that the funds had still not been returned despite multiple contacts made to facility staff. A refund check was received and deposited, but on 3/29/07 a family member reported the check had been returned for non availability of funds. A replacement check had not been issued by 4/11/07 and there was no plan in place to replace the funds. Facility was cited for failure to return rental money to the family of a resident who expired. (Issued as Class B at \$1,000.) Citation #11100104026.

Pleasant Care Convalescent Of Ukiah

7/24/2007	B	Comp.
\$1,000	<u>Administration</u>	Administration

A review of the employee files for nine CNAs on 7/13/07 revealed there was no documentation from the employment registry for six of the CNAs, and three with documentation did not include verification of skills check or certification. Verification of abuse training was provided for four of the nine CNAs, but no verification of comprehension of their role as required. The facility was cited for failure to ensure that staff providing care was qualified, oriented to daily tasks and equipment, and qualified supervision was provided. (Issued as Class B at \$1,000.) Citation #11100104123.

Pleasant Care Convalescent Of Ukiah

7/30/2007	B	Comp.
\$1,000	<u>Physical Environment</u>	Physical Environment

On 7/3/07, an allegation was made that the kitchen in the facility was preparing food in an unsanitary manner. Observations revealed the garbage disposal was slimy and surrounded by flies and the dishwasher was leaking dirty water. An interview with an administrator revealed she was aware of the issue and claimed to be fixing the broken appliances. On 7/19/07, the equipment was in the same condition. The facility was cited for failure to ensure appliances were maintained in a clean and sanitary condition and operable at all times to ensure safety and well being of residents. (Issued as Class B at \$1,000.) Citation #11168604130.

Pleasant Care Convalescent Of Ukiah
 8/2/2007 **B**
\$1,000 Patient Rights Dignity
 Physical Abuse

On 7/29/07, a staff member entered a resident's room to put her to bed. The resident requested to stay up for another 30 minutes and the staff member agreed. Another staff member later entered the room and attempted to force the resident into bed against her will. The resident was saying, "Please, please let me stay up just 30 minutes more." When the resident resisted, she sustained a bruise to her thumb and forearm. The facility was cited for failure to protect the resident from abuse and treat her with dignity and respect. (Issued as Class B at \$1,000.) Citation #11203804153.

Sherwood Oaks Health Center
 130 Dana Street, Fort Bragg, CA 95437

Sherwood Oaks Health Center
 3/16/2007 **A** Comp.
\$15,000 Patient Care Medication

On 5/27/06, a resident attempted suicide. On 5/31/06, the resident returned to the facility with a prescription for an increase in Prozac and Lithium from a psychiatrist. On 6/20/06, a Department of Health Services surveyor visited the facility to investigate the suicide attempt. At this time, the surveyor discovered that the resident had not received the increased dosage since 5/31/06. The facility was cited for failing to administer the resident's increased medication dosages to treat his depression and mood disorder. (Issued as Class A at \$15,000.) Citation #11182803782.

Ukiah Convalescent Hospital
 1349 S. Dora St., Ukiah, CA 95482

Ukiah Convalescent Hospital
 12/12/2007 **B** Comp.
\$800 Patient Care Verbal Abuse
 Dignity

A fragile, elderly female resident was told to "shut up" by a psychiatric technician when she asked to have her legs repositioned. The technician was hired through a registry agency. The facility failed to screen her licensing status and her level of training. The facility was cited for failing to ensure the resident was free from verbal abuse. (Issued as Class B at \$800.) Citation #11172404503.

Valley View Skilled Nursing Center
 1162 S. Dora Street, Ukiah, CA 95482

Valley View Skilled Nursing Center
 4/9/2007 **B** Comp.
\$1,000 Patient Rights Physical Abuse
 Supervision

The facility was cited for failing to ensure that a 65-year-old resident received sufficient monitoring to prevent him from self abusive behaviors on 9/28/06, slapping a resident on 12/3/06, hitting his 91-year-old roommate's legs with a wheelchair on 12/9/06, and assaulting an 88-year-old resident on 1/21/07. (Issued as Class B at \$1,000.) Citation #11108603880.

Valley View Skilled Nursing Center
 4/26/2007 **B** Comp.
\$1,000 Patient Care Careplan
 Fall
 Supervision

On 9/17/06 around 7 am, a resident was found on the street next to her tipped over wheelchair. She suffered multiple cuts and bruises on her right cheek, above her right eye, and on her right elbow, forearm, hand and knuckles. The facility was cited for failure to provide an updated careplan and to provide adequate supervision to prevent wandering and falls. (Issued as Class B at \$1,000.) Citation #11135103381.

Valley View Skilled Nursing Center
 5/15/2007 **B** Comp.
\$1,000 Patient Care Decubiti (Bedsore)
 Notification

In January 2007, an 85 year old resident was diagnosed with two Stage III pressure sores on her heels that developed at the facility. Although the facility had determined the resident was at risk of pressure sores, it failed to give her care to prevent them. It also failed to notify her physician when the pressure sores were identified. (Issued as Class B at \$1,000.) Citation #11198303678.

Valley View Skilled Nursing Center
 8/10/2007 **B** Comp.
\$1,000 Patient Care Neglect
 Hydration
 Careplan

On 11/25/06, a resident was hospitalized for treatment of dehydration and urosepsis. Despite determining that the resident was at high risk of dehydration due to Alzheimer's Disease and a severe cognitive impairment, the facility neglected to develop a care plan to maintain proper hydration or to monitor her fluid intake. The facilities neglect resulted in her hospitalization. (Issued as Class B at \$1,000.) Citation #11159103977.

Valley View Skilled Nursing Center
 8/24/2007 **A** Comp.
\$20,000 Patient Rights Physical Abuse
 Verbal Abuse

During March 2007 and preceding months, two nursing assistants were observed pinching and pulling on a 78 year old resident's nipples and penis, as well as teasing and ridiculing the resident. The resident, who was paralyzed on his left side and totally dependent on staff for care, reported that one of the nursing assistants tried to shove feces in his mouth, causing him continued emotional distress. Two employees witnessed multiple incidents of abuse, but did not report it when it occurred. In describing the abuse, one of them stated, "It was just sick." (Issued as Class A at \$20,000.) Citation #11203803853.

Valley View Skilled Nursing Center
 8/24/2007 **B** Comp.
\$1,000 Patient Care Verbal Abuse
 x3 Physical Abuse

During an interview on 3/15/07, a 56 year old male resident reported that the CNA assigned to his care would give him cold showers and he did not want to be cared for by that CNA anymore. Further interviews with other CNAs revealed that the resident was frequently threatened with cold showers, transferred to and from the shower naked and wet, hit in the head with a soap bottle, and humiliated in various ways. The facility was cited for failure to develop and implement policies to protect a resident from verbal, mental, sexual, or physical abuse, corporal punishment, and involuntary seclusion. (Issued as Class B at \$1,000.) Citation #11203803952.

Valley View Skilled Nursing Center
 8/24/2007 **B** Comp.
\$1,000 Patient Care Mental Abuse
 x3 Privacy

An investigation on 3/14/07 revealed that a CNA reported seeing a video another CNA had made with his cell phone. The video showed a sleeping resident being shaken awake and startled into screaming. The CNA reported she had also seen pictures of residents on the CNA's cell phone. "One appeared to be the naked body of an older woman." The facility was cited for failure to protect the residents' privacy and dignity and failure to treat the residents with dignity and respect. (Issued as Class B at \$1,000.) Citation #11203804213.

Modoc County

Surprise Valley Community Hospital D/P SNF Main & Washing., P.O. Bx 246, Cedarville, CA 96104

Surprise Valley Community Hospital D/P SNF
 6/6/2007 **B** Comp.
\$500 Patient Rights Verbal Abuse
 Physical Abuse
 Patient Rights

On 11/10/06 at approximately 10:30 am, one staff overheard another staff yelling at a 91 year old resident to "get away from the nurses' station and go to bed." At 10:40 pm the same night, the resident was seen outside on the patio. The same nurse started yelling at the resident to come in and begin pulling her roughly to her room. When another resident told the nurse to stop yelling, the nurse turned and yelled at that resident saying, "Mind your own G...damn business, I don't give a f... what you do, this does not concern you." The facility was cited for failure to protect one resident from verbal and physical abuse, and another resident from verbal abuse. (Issued as Class B at \$500.) Citation #23086104001.

Windsor Monterey Care Center

1575 Skyline Drive, Monterey, CA 93940

Monterey Care Center

5/17/2007	B	Comp.
\$400	<u>Patient Rights</u>	Verbal Abuse Mental Abuse

While providing care to a resident on 4/2/07 at 10:45, a CNA was observed making derogatory remarks, e.g., "I'm f-ing tired of her," and threatening the resident, e.g., "shut the f-up." In response to the resident's question, the CNA responded, "Yes, I'm going to kill you, you are going to die." The facility was cited for failure to protect the resident from abuse. (Issued as Class B at \$400.) Citation #07170303940.

Windsor Monterey Care Center

7/13/2007	B	
\$650	<u>Patient Rights</u>	Physical Restraints Dignity

On 6/21/07, a licensed nurse used a sheet to tie a 79 year old resident to a wheelchair. The nurse claimed that staff weren't available to supervise the resident. The resident had been restless due to pain, but the nurse did not assess the pain. The facility was cited because it did not treat the resident with dignity and respect, it did not obtain a physician's order for the restraint and it did not notify the resident's family prior to the application of the restraint. (Issued as Class B at \$650.) Citation #07207704092.

Windsor Monterey Care Center

8/21/2007	B	Comp.
\$750	<u>Patient Care</u>	Supervision

The facility failed to provide competent supervision when staff neglected to supervise and prevent a resident from exiting the facility through two alarmed exit doors on 5/25/07. The facility received a phone call at 7:45 pm from a taxi driver, telling them he was bringing the resident back to the facility. They weren't aware the resident was missing until then. The facility also failed to maintain the WanderGaurd alarm on the doors, which does not sound when a WanderGaurd is worn on a resident's ankle, as it was in this case. (Issued as Class B at \$750.) Citation #07207704162.

Napa County**Beverly LivingCenter - NAPA**

705 Trancas Street, Napa, CA 94558

Sierra Vista Nursing And Rehabilitation Center

7/6/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Physical Abuse Mental Abuse

On 11/2/06, a 60 year old female resident was being bathed by a CNA who was rough, rude, spoke in an angry tone, used profanity, and caused the resident to fear for her safety. The resident reported the incident to her son and to a nurse, but the incident was not investigated or reported. The facility was cited for failure to ensure the resident was free from abuse, corporal punishment, and involuntary seclusion, as well as failure to develop and implement procedures that directed staff on whom to report abuse allegations to. (Issued as Class B at \$1,000.) Citation #11078603575.

Beverly LivingCenter - Napa

8/31/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Physical Abuse

On 8/10/07, a dietary aide witnessed a CNA come into the dining room, put her open, flat hand in a crying resident's face and pushed her back into her wheelchair leaving a mark on the resident's face. The CNA then pulled the resident's shirt up hard against her neck as if choking her to attach the wheelchair alarm. The facility was cited for failure to ensure the resident was free from physical abuse and mental anguish. (Issued as Class B at \$1,000.) Citation #11182604194.

Beverly LivingCenter - Napa

8/31/2007	AA	Comp.
\$100,000	<u>Patient Care</u>	Fall

Death Occurred

On 8/16/06, an 85 year old resident, with diagnoses that included dementia, poor safety awareness, and a history of seizures, fell backwards from his wheelchair and injured his head. The resident was assessed by the staff after the fall who determined that, other than having a "goose egg" lump on the back of his head, he was fine. The next day, the resident was non-responsive and taken to the hospital where he died on 8/22 from intracranial bleeding. The facility was cited for failure to provide an appropriate wheelchair and for failure to provide adequate supervision. (Issued as Class AA at \$100,000.) Citation #11187104222.

Napa Nursing Center, Inc.

3275 Villa Lane, Napa, CA 94558

Napa Nursing Center, Inc.

5/11/2007	A	Comp.
\$15,000	<u>Patient Care</u>	Hydration Careplan

On 5/23/06, a 114 lb. resident was admitted with a doctor's order to provide 500 cc of fluid per shift because of high risk of dehydration. During 9 days in May, ordered fluid intake levels were not reached, and for 5 of those days, the fluid intake was only 180 to 200 cc. During 14 days in June, the fluid intake was only 120 to 240 cc. On 6/13/06, the resident had a fever and antibiotics were ordered on 6/14, but were not given for 8 hours. Around 8 am on 6/15, the resident was sent to an ER with a decreased level of consciousness and diagnosed with acute dehydration and urinary tract infection. The facility was cited for failure to follow doctors orders for hydration and antibiotic medication. (Issued as Class A at \$15,000.) Citation #11168503914.

Napa Nursing Center, Inc.

11/9/2007	B	
\$1,000	<u>Patient Care</u>	Decubiti (Bedsore) Careplan

A resident was admitted to the facility on 10/20/06 with diagnosis of a stroke. Nurses notes dated the same day documented the resident's buttocks were red and the careplan indicated a pressure relieving mattress was to be provided to the resident. The facility failed to provide the mattress as of 2/1/07. The facility failed to notify the physician when a new open area developed on the resident's buttocks on 1/1/07. These failures contributed to further deterioration of the resident's buttocks pressure sores and the development of six Stage II pressure sores, as well as a delay in treatment. (Issued as Class B at \$1,000.) Citation #11168504434.

Napa State Hospital D/P SNF

2100 Napa-Vallejo Highway, Napa, Ca 945586293

Napa State Hospital D/P SNF

5/23/2007	B	Comp.
\$600	<u>Physical Environment</u>	Fall Physical Environment

A 61 year old resident, with a careplan in place for falls, was on a commode chair in the bathroom on 3/16/07. Supervisory staff was closing the curtain around the resident when the resident stood up on his own and shifted his weight to one side, which resulted in the handle of the chair breaking. The resident fell to the floor and hit his head, resulting in a laceration which required five sutures. Staff stated she did not notice the chair being broken or bent before the resident used the chair. Facility was cited for not checking equipment on any regular basis to ensure its safety. (Issued as Class B at \$600.) Citation #15110603964.

Nevada County**Golden Empire Convalescent Hospital**

121 Dorsey Drive, Grass Valley, CA 95945

Golden Empire Convalescent Hospital

6/6/2007	B	Comp.
\$3,000	<u>Patient Care</u>	Verbal Abuse Mandated Reporting x3

On 11/27/06, a staff overheard one resident calling another resident "a fat old lady" and said that she was "going to kill her." The verbally abused resident said that she was scared of her roommate. The facility was cited for failure to report the verbal abuse to the department immediately or within 24 hours as required by law. (Issued as Class B at \$3,000.) Citation #23199203756.

Golden Empire Convalescent Hospital

6/6/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Physical Abuse Verbal Abuse Medication

On 11/17/06, a nurse attempted to force a 90 year old resident to take medications against her will by grabbing the resident's arms and threatening her, causing the resident to scream and cry. The abuse was witnessed by other residents and staff. The facility was cited because the resident was subjected to physical and verbal abuse. (Issued as Class B at \$1,000.) Citation #23198903759.

Golden Empire Convalescent Hospital

6/6/2007	B	Comp.
\$1,000	<u>Administration</u>	Sexual Abuse Mandated Reporting

On 12/3/06, a resident reported being inappropriately touched on "her privates" by a male aide. She was "very tearful and upset." The facility was cited for failure to report alleged sexual abuse immediately or within 24 hours to the department as required by law. (Issued as Class B at \$1,000.) Citation #23101603807.

Golden Empire Convalescent Hospital

6/6/2007	B	Comp.
\$1,000	<u>Administration</u>	Theft & Loss Mandated Reporting

On 12/8/06, a resident reported that \$250 was stolen from his wallet. The facility was cited for failure to report the fiduciary abuse immediately or within 24 hours to the department as required by law. (Issued as Class B at \$1,000.) Citation #23101603808.

Grass Valley Care Center

107 Catherine Lane, Grass Valley, CA 95945

Grass Valley Convalescent Hospital

4/4/2007 **B** Comp.
\$1,000 Patient Care Verbal Abuse
 Dignity

On two occasions, nursing assistants verbally abused a 24-year-old resident who suffered from a brain injury. On 5/12/06, a nursing assistant yelled at the resident and then took her to her room to punish her after the resident touched the aide's soda can in the dining room during breakfast. On 7/24/06, a different nursing assistant yelled "Why don't you just suck on that finger you just stuck down there..." after the resident touched him with feces on her hands. The facility was cited because it did not treat the resident with dignity and respect. (Issued as Class B at \$1,000.) Citation #23191303852.

Grass Valley Convalescent Hospital

4/4/2007 **B** Comp.
\$1,000 Patient Care Physical Abuse
 Dignity
 Verbal Abuse

On the evening of 8/27/06, a 91-year-old female resident with Alzheimer's Disease came close to an LVN while he was preparing medications. The LVN yelled, "Get the hell out of my face," and when she did not move, he pushed the resident and told her again, "Go away." The facility was cited for failing to treat the resident with dignity and respect and failure ensure that the resident was free from verbal and physical abuse. (Issued as Class B at \$1,000.) Citation #23191303862.

Grass Valley Care Center

11/30/2007 **B** Comp.
\$1,000 Medication Medication

On 10/15/07, an LVN administered massive doses of influenza vaccine to two residents. The LVN had assumed the residents were to be given the complete contents of 5 milliliter bottles without realizing each bottle actually contained 10 doses. The LVN stated he assumed each bottle was for single dose and he should have read the label more carefully. The facility was cited for failure to ensure the residents received the correct dose of influenza vaccination as prescribed. (Issued as Class B at \$1,000.) Citation #23201904455.

Meadow View Manor

396 Dorsey Drive, Grass Valley, CA 95945

Meadow View Manor

3/20/2007 **B** Comp.
\$1,000 Patient Care Careplan
 Medication

On 2/23/06, 2/25/06 and 3/16/06, a resident required hospital emergency treatment due to heavy bleeding from her nose. Prior to these episodes, the resident's doctor had prescribed Plavix, a drug whose side effects include nosebleeds. Despite the known risk, the nursing staff did not use any method to control the bleeding, nor did it evaluate her needs or update her careplan after any of the episodes. (Issued as Class B at \$1,000.) Citation #23150803815.

Spring Hill Manor Convalescent Hospital

355 Joerschke Dr, Grass Valley, CA 95945

Spring Hill Manor Convalescent Hospital

3/7/2007 **B** Comp.
\$900 Abuse Sexual Abuse

On 7/28/06, four staff members witnessed a visitor lift up a resident's blouse and touch the resident's breast three times. The facility was cited for failure to protect the resident from sexual abuse. (Issued as Class B at \$900.) Citation #23101603751.

Tahoe Forest Hospital D/P SNF

10121 Pine St., P.O. Bx 759, Truckee, CA 96160

Tahoe Forest Hospital D/P SNF

3/13/2007 **B** Comp.
\$1,000 Patient Rights Physical Abuse

On 4/9/06, a CNA observed a nurse shake her fist in the face of an 85-year-old resident, hold the resident's wrist above her head and yell at her while a waist restraint was applied. This caused the resident to cry and repeat "please help me," and left bruising on her wrists. The facility was cited for failing to protect a resident from physical abuse. (Issued as Class B at \$1,000.) Citation #23156003691.

Tahoe Forest Hospital D/P SNF

3/13/2007 **B** Comp.
\$1,000 Patient Rights Physical Abuse

On 4/9/06, an 85-year-old female resident that required assistance transferring into her wheelchair, began hitting and yelling at the CNA transferring her. A licensed nurse began yelling and shaking her fist at the resident causing the resident to cry and beg the first CNA and another CNA nearby who had observed the nurse's actions, for help. The facility was cited for failure to report the incident to the Department of Health Services until 4/11/06, more than 52 hours after the alleged incident. (Issued as Class B at \$1,000.) Citation #23156003689.

Orange County

Alta Gardens Care Center

 13075 Blackbird Street, Garden Grove, Ca 92843

Alta Gardens Care Center

3/21/2007 **B** Comp.
\$1,000 Patient Care Careplan
 Patient Care

On 11/1/06, a resident was readmitted to the facility. The resident was identified as at high risk for falls and a careplan was initiated to address the risk. On 12/21/06, the resident was found lying on the floor of her room, having fallen off her bed while trying to climb out of it. The resident suffered a left hip fracture. The facility was cited for failing to plan the resident's care based upon an initial and continuing assessment of the resident's needs, with input, as necessary, from health professionals involved in the care of the resident. (Issued as Class B at \$1,000.) Citation #06124203828.

Anaheim General Hospital-Buena Park Campus-D/P

 5742 Beach Boulevard, Buena Park, Ca 90621

Anaheim General Hospital-Buena Park Campus-D/P Snf

5/29/2007 **B** Comp.
\$1,000 Patient Rights Patient Rights

A resident who had lost her eyeglasses went from October 06 until mid March of 07 without having any glasses. This caused the resident to be hindered in her activities and unable to read books or do crossword puzzles, which provided enjoyment when in bed. The resident was frustrated, angry and unable to participate in other activities in which glasses would have been useful. The facility was cited for failure to provide eyeglasses which, under the circumstances, caused significant humiliation, indignity and emotional trauma to the resident. (Issued as Class B at \$1,000.) Citation #06184003872.

Buena Park Nursing Center

 8520 Western Avenue, Buena Park, CA 90620

Buena Park Nursing Center

2/28/2007 **A** Comp.
\$15,000 Patient Care Careplan
 Infection

On 7/22/06, a resident was sent to the emergency room with urinary leakage around her catheter causing the bladder opening into the vagina that required surgery. In addition, the resident had a 103.4 temperature caused by an infection in the intravenous site of a chest tube providing nutrition. The facility was cited for failure to follow the careplan and failure to notify the doctor when the resident's catheter was displaced and reinserted four times within one week. (Issued as Class A at \$15,000.) Citation #06124203658.

Buena Vista Care Center

 1440 South Euclid Street, Anaheim, CA 92802

Buena Vista Care Center

1/23/2007 **B** Comp.
\$1,000 Patient Care Medication

A resident diagnosed with Parkinson's disease and esophageal reflux was admitted to the facility on 9/6/06. On 9/7/06, the resident was prescribed a muscle relaxer, but the medication was never administered during the resident's stay at the facility. Other medications that the resident was prescribed were either missed during certain shifts or not administered in a timely manner. The facility was cited for failing to implement their pharmaceutical policy and procedures pertaining to medication orders and medication administration. (Issued as Class B at \$1,000.) Citation #06124203643.

Carehouse Convalescent Hospital

 1800 Old Tustin Road, Santa Ana, Ca 92705

Carehouse Convalescent Hospital

3/22/2007 **A** Comp.
\$7,500 Patient Care Fall

On 1/25/07, a wheelchair bound resident who was at risk for elopement and falls was found outside the facility at the bottom of a staircase. The resident sustained multiple facial fractures, a fractured vertebrae of the neck, a laceration to his eyebrow and multiple abrasions. The facility was cited for failure to ensure the resident was wearing a Wander Guard to alert staff if he left the facility. (Issued as Class A at \$7,500.) Citation #06177403792.

Carehouse Convalescent Hospital

4/10/2007 **A** Comp.
\$5,000 Patient Care Medication

On 2/5/07, a resident was admitted to the facility with physicians' orders to receive dialysis three times per week. On 2/9/07, the resident was transferred to the acute hospital because the facility had failed to administer any dialysis treatments for six days. The facility was cited for failure to notify the physician of the inability to obtain dialysis services and failure to ensure treatments were administered as prescribed. (Issued as Class A at \$5,000.) Citation #06124203835.

Coastal Communities Hospital D/P SNF

2701 S. Bristol Street, Santa Ana, CA 92704

Coastal Communities Hospital D/P SNF

10/11/2007	A	Comp.
\$20,000	<u>Patient Care</u>	Patient Care Mandated Reporting

Death Occurred

The facility failed to ensure nursing services included a continuing assessment of a resident. On 5/20/07, the resident was found unresponsive, with low blood pressure and without a palpable heart rate. The resident underwent approximately 40 minutes of "code blue" procedures before being transferred to the intensive care unit. The resident sustained a second "code blue" and subsequently passed away on 5/21/07. The facility was also cited for failing to conduct and record an investigation into the incident and for failing to report the death to the Department of Public Health. (Issued as Class A at \$20,000.) Citation #06124204262.

Coastal Communities Hospital D/P SNF

10/23/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Fall Careplan

On 10/5/07, a resident sustained a fall from a Hoyer lift, which resulted in a swollen and painful right knee with blisters developing later. According to the CNA assisting the resident, one of the hooks on the lift was loose and became unhooked in the transfer process. A post fall assessment documented two CNAs present at the time of the fall, but it was later revealed that only one CNA was operating the lift, while the other new CNA observed. The CNA was later terminated for providing poor patient care. The facility was cited for failing to ensure a resident's careplan pertaining to transfers was consistently implemented. (Issued as Class B at \$1,000.) Citation #06124204380.

Country Villa Seal Beach Healthcare Center

3000 Beverly Manor Road, Seal Beach, CA 90740

Country Villa Seal Beach Healthcare Center

2/27/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Hydration Patient Care

Death Occurred

On 8/7/06, a resident with a high risk of dehydration was found to be unconscious and feverish. A nurse was alerted, but took an hour to check on the resident. The resident's condition rapidly deteriorated, and the resident was transferred to an acute hospital three hours after the nursing staff was initially notified of his condition. The resident died on 8/19/06 from acute urosepsis. The facility was cited for failing to show attempts were made to control the fever or assess the resident's urinary status, as well as failing to provide emergency medical care when a resident had a significant change of condition. (Issued as Class B at \$1,000.) Citation #06183503747.

Fountain Care Center

1835 W. La Veta Avenue, Orange, Ca 92868

Fountain Care Center

1/30/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Careplan Patient Care

On 11/3/06, a resident was transferred from to the facility from an acute hospital. The resident was assessed as a high risk for falls, and so was placed in a room near the nurse's station. However, the resident was later moved to a room at the end of the hall. On 11/23/06, the resident fell trying to get out of bed, and suffered a severe head injury, bruising to the left upper shoulder, left leg, and left hip injury. The resident's new room was out of visual sight of staff at the nurse's station. The facility failed to plan resident care based upon an initial an continuing assessment of the resident's need. (Issued as Class B at \$1,000.) Citation #06124203656.

Gordon Lane Care Center

1821 E. Chapman Avenue, Fullerton, Ca 92831

Gordon Lane Care Center

9/26/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Physical Restraints Patient Rights Physical Abuse Mental Abuse

The facility failed to implement their Policy and Procedure pertaining to the "emergency" use of physical restraints. On 5/24/07, the facility staff placed a female resident in a wheelchair with a physical restraint without a physician's order, secondary to the resident's "threatening" behavior. The facility also failed to ensure the resident was free from mental and physical abuse when she tested positive for marijuana and alcohol on 5/24/07. (Issued as Class B at \$1,000.) Citation #06124204264.

Greenfield Care Center of Fullerton, LLC

330 W. Bastanchury, Fullerton, Ca 92835

Greenfield Care Center of Fullerton

1/17/2007	B	Comp.
\$1,000	<u>Patient Rights</u>	Dignity Verbal Abuse Patient Care

Declarations dated 11/10/06, and signed by six residents, detailed their complaints pertaining to verbal abuse by the facility's social worker designee/ director (SSD). The residents described the SSD as demeaning to residents and staff, deceptive, brutal, angry and purposely inattentive. The SSD was terminated. The facility was cited for failing to ensure all residents were treated as individuals, with dignity and respect, and not subjected to verbal abuse of any kind. (Issued as Class B at \$1,000.) Citation #06124203626.

Greenfield Care Center of Fullerton
 1/24/2007 **B** Comp.
\$750 Patient Care Fall
 Careplan

At 1 pm on 9/14/06, a resident was found lying on the floor, sustaining a cut on the right cheek bone of 1 cm. He was taken to the ER and diagnosed with a fracture. The facility was cited for failure to follow the careplan that called for a wheelchair alarm for a resident with a history of falls and agitated behavior. (Issued as Class B at \$750.) Citation #06177403645.

Lake Forest Nursing Center
 25652 Old Trabuco Road, Lake Forest, CA 92630

Lake Forest Nursing Center
 1/17/2007 **B** Comp.
\$1,000 Patient Care Medication
 Patient Records

On 10/08/06, resident was admitted with multiple bedsores, protein and calorie malnutrition among other diagnoses. The facility failed to flush his catheter on 10/31/06, did not administer Procrit (stimulates red blood cells to treat anemia) on 11/15/06 and 11/22/06, and did not administer five doses of iron 11/07/06 through 11/09/06. The facility was cited for failure to ensure all medications and treatments were administered as prescribed by the physician. (Issued as Class B at \$1,000.) Citation #06124203632.

Leisure Court Nursing Center
 1135 Leisure Court, Anaheim, CA 92801

Leisure Court Nursing Center
 7/17/2007 **B** Comp.
\$1,000 Patient Rights Sexual Abuse
 Supervision

On 4/29/07, a CNA reported to the LVN that a female resident had been inappropriately touched by another male resident. The CNA witnessed the male resident grab the female resident's breasts, touch her and try to kiss her. The resident called for help, and the CNA noted the resident's gown was partially down and her blanket was displaced. The male resident had a history of sexually inappropriate behavior. The facility was cited for failure to ensure the male resident was consistently monitored and failure to ensure the female resident was free from mental, sexual and physical abuse. Additionally, the facility failed to conduct an investigation of the incident. (Issued as Class B at \$1,000.) Citation #06124204093.

Manorcare Health Services - Fountain Valley
 11680 Warner Avenue, Fountain Valley, CA 92708

Manorcare Health Services - Fountain Valley
 8/14/2007 **B** Comp.
\$1,000 Patient Care Patient Care

Death Occurred

On 5/26/07, a female resident was admitted to the facility with diabetes and kidney failure. Her physician's orders required immediate contact if her blood glucose levels dropped below 70. Over the next five days, they dropped significantly. On 6/1/07, emergency medical service transported the resident from the facility to the hospital. She exhibited signs of severe hypoglycemia and her blood glucose level was documented at 39. She passed away on 6/17/07 in the hospital. The facility was cited for failure to continually assess the resident, failure to implement their policy and procedures pertaining to hypoglycemia and failure to promptly notify the physician of any significant changes in blood glucose levels. (Issued as Class B at \$1,000.) Citation #06124204174.

Mesa Verde Convalescent Hospital
 661 Center Street, Costa Mesa, Ca 92627

Mesa Verde Convalescent Hospital
 4/17/2007 **A** Comp.
\$25,000 Patient Care Mental Abuse
 Physical Abuse

On 2/17/07, a resident was attacked in his bed while sleeping. The resident stated that he was awakened by someone holding a pillow over his face. The resident was unable to fend off his attacker or yell for help. The staff was unaware that an unidentified person had entered the facility after visiting hours. The facility was cited for failure to protect the resident from mental and physical abuse. (Issued as Class A at \$25,000.) Citation #06177203878.

New Orange Hills
 5017 E. Chapman Avenue, Orange, Ca 92869

New Orange Hills
 4/10/2007 **B** Comp.
\$1,000 Patient Care Patient Care

Death Occurred

On 12/27/06, a resident complained of nausea, abdominal and back pain and reported "not feeling well." The resident's stomach was distended and hard and later that day, the resident began to have shortness of breath. His respiratory condition grew worse throughout the day, until reaching a point where the resident was unable to speak in a whole sentence without taking a breath. At least four hours after his condition initially changed, the resident was transferred to an acute hospital. The facility was cited for failing to ensure that the resident's condition was continually assessed, and for failing to promptly notify the physician of a change in condition. (Issued as Class B at \$1,000.) Citation #06124203842.

Park Anaheim Healthcare Center

3435 W. Ball Road, Anaheim, CA 92804

Park Anaheim Healthcare Center
 8/21/2007 **A** Comp.
\$20,000 Patient Care Patient Care

Death Occurred

On 4/26/07, a resident pulled out his PICC line and disconnected his tracheostomy "T-Bar" apparatus. As a result, the resident was found unresponsive and subsequently died. The records indicated the resident had repeated periods of anxiety manifested by pulling out tubes and there was a plan of care that addressed his problem. The facility was cited for failure to administer the medication prescribed to alleviate agitation and for failure continually assess the resident . (Issued as Class A at \$20,000.) Citation #06124204197.

Park Regency Care Center

1770 W. La Habra Blvd., La Habra, CA 90631

Park Regency Care Center
 8/23/2007 **B** Comp.
\$1,000 Patient Care Medication

On 4/17/07, a resident was transferred into the facility from an acute care hospital. The resident's records revealed that over the next six days in the facility, the resident's blood glucose was recorded as "hi" and the physician was never notified. On 4/23/07, the resident left the facility against medical advice. On 7/10/07, the resident's husband forwarded a letter to the Department complaining about his wife's lack of care. After an investigation, the facility was cited for failure to properly administer insulin to the resident as prescribed by the physician. (Issued as Class B at \$1,000.) Citation #06124204199.

Park Regency Care Center
 9/26/2007 **B** Comp.
\$1,000 Patient Care Medication

Death Occurred

The facility failed to administer all medications as prescribed. On 11/14/05, a resident was admitted with a physicians order for Lovenox injections, every 12 hours, for four days, to prevent blood clots. However, there is no documented evidence the resident received these injections. The facility also failed to ensure lab tests were obtained as ordered to determine the dosage of the resident's blood thinners. The resident was transferred to an acute care hospital on 11/29/05, when she suffered a stroke after not receiving preventative medications, and died three days later. (Issued as Class B at \$1,000.) Citation #06124204292.

Sea Cliff Healthcare Center

18811 Florida Street, Huntington Beach, Ca 926481997

Sea Cliff Healthcare Center
 4/17/2007 **A** Comp.
\$30,000 Patient Care Medication

On 1/25/07, a diabetic resident was transferred to the acute hospital with a blood glucose level of 822. Anything over 500 is considered "high." The resident had missed five doses of insulin in six days. The facility was cited for failure to ensure all medications were administered as prescribed. (Issued as Class A at \$30,000.) Citation #06124203893.

Villa Valencia Health Care Center

24552 Paseo De Valencia, Laguna Hills, CA 92653

Villa Valencia Health Care Center
 2/8/2007 **B** Comp.
\$1,000 Patient Care Patient Care

On 9/21/06, a resident was sent from the facility to an acute hospital. Hospital staff found that the resident's catheter was clogged because it had not been changed monthly as required by his careplan. The resident had developed a swollen bladder, urinary tract infections, and two pressure sores. In addition, the facility failed to change the catheter and to obtain urine sensitivity prior to starting the resident on an antibacterial drug, as ordered by the physician. (Issued as Class B at \$1,000.) Citation #06184003614.

Villa Valencia Health Care Center
 4/5/2007 **B** Comp.
\$1,000 Patient Rights Sexual Abuse
 Patient Care

On 1/15/07, a resident reported to nursing staff that a CNA had acted inappropriately on three separate occasions while giving her a shower. On the first occasion, the CNA had fondled her breast, and on the second and third occasions, he had asked her if she wanted to go into a corner in the shower room and have sex. The CNA continued to be assigned to care for the resident until 1/31/07, despite the resident's repeatedly expressed fear of the CNA. The facility was cited for failing to investigate the resident's allegations in a timely manner, as well as failing to protect the resident by having the CNA continue to be assigned to her. (Issued as Class B at \$1,000.) Citation #06184003843.

Windsor Gardens Care Center of Fullerton

245 E. Wilshire Ave., Fullerton, CA 92632

Windsor Gardens Care Center of Fullerton
 7/10/2007 **B** Comp.
\$1,000 Patient Care Fall
 Supervision

On 2/26/07, a resident sustained an injury to the back of his head, described as a "bone protrusion." On 3/14/07, a second injury occurred when the resident fell from his wheelchair and sustained a scalp laceration. Based on the documentation reviewed, the facility failed to ensure the resident was continually assessed following the two incidents with injuries. (Issued as Class B at \$1,000.) Citation #06124204068.

Windsor Gardens Convalescent Center of Anaheim

3415 West Ball Road, Anaheim, CA 92804

Windsor Gardens Convalescent Center of Anaheim
 12/11/2007 **B** Comp.
\$750 Patient Care Decubiti (Bedsores)

On 7/12/06 a resident who was totally dependent on staff for transfers was assessed as a substantial risk for developing bed sores . The records documented five areas on his body where bedsore had developed. On 9/3/06 the resident was transferred to an acute care hospital with thirteen areas were documented as having decubitus ulcers. The facility was cited for not implementing a proper plan to address the resident's impaired skin integrity. (Issued as Class B at \$750.) Citation #06183504511.

Placer County

Colonial Healthcare

12225 Shale Ridge Lane, Auburn, Ca 95602

Colonial Healthcare
7/6/2007 **B** Comp.
\$1,000 Abuse Physical Abuse
Mandated Reporting

On 4/6/07, a 74 year old female resident was subjected to physical and emotional abuse when two CNAs witnessed another CNA pour five packets of pepper into the resident's coffee, after the resident specifically asked for no pepper in her food. The two CNAs who witnessed the incident failed to report it to administrative staff until 4/10/07, four days later. The administrative staff then failed to report the incident to the Department of Health Services until 4/13/07, seven days after the incident. (Issued as Class B at \$1,000.) Citation #03207204065.

Colonial Healthcare
7/18/2007 **B** Comp.
\$1,000 Patient Rights Physical Abuse
Mandated Reporting

The facility failed to ensure a 64 year old female resident was free from physical abuse when a CNA was rough with her on 9/11/06. The incident was witnessed by another CNA and was reported to an LVN. Neither the CNA who witnessed the abuse nor the LVN completed a Report of Suspected Dependent Adult/Elder Abuse or reported the incident to the Ombudsman office or the Department of Health Services within two working days. The facility also failed to perform and document in the medical record an examination/assessment of the resident after the alleged physical abuse. (Issued as Class B at \$1,000.) Citation #03140704096.

Colonial Healthcare
8/2/2007 **B** Comp.
\$1,000 Patient Rights Physical Abuse
Mental Abuse

In late April 2007, during a Friday shower, a CNA from the registry threw a soapy washcloth overhand and with force at a male resident, saying, "Do it yourself!" The same CNA had previously rammed the same resident into a dining table during dinner. The facility was cited for failure to check whether the CNA had elder abuse training and to protect the resident from physical and psychological abuse. (Issued as Class B at \$1,000.) Citation #03207204143.

Colonial Healthcare
8/2/2007 **B** Comp.
\$1,000 Abuse Physical Environment

On 4/30/07, the facility failed to thoroughly investigate a 74 year old male resident's fractured arm of questionable origin as required by the facility's abuse procedure, when the Director of Nurses and the Executive Director stated on 6/1/07, "There is no investigative report." These failures put the resident at further risk for possible physical abuse when the administrative staff failed to report the fracture of questionable origin (potential abuse) to the Department of Health Services until 5/10/07, ten days later. Staff believe the fracture was caused by the resident's hand getting caught between his bed and the wall. (Issued as Class B at \$1,000.) Citation #03207204133.

Colonial Healthcare
9/5/2007 **B** Comp.
\$1,000 Facility Self-Report - Abuse Physical Abuse
Verbal Abuse
Mandated Reporting

On 1/23/06, a resident reported someone jumped on her in bed and beat her up. A Chaplain reported to the Social Services designee on 1/24/06 that the above resident and her roommate said a CNA had physically and verbally abused both residents. The facility did not follow its own procedures in investigating the incident immediately, contacting the doctor and residents' representatives, and waited several days before informing licensing and the Ombudsman of the alleged abuse. The facility was cited for failure to report the abuse immediately or within 24 hours as required by law and for failure to ensure residents were free from physical and verbal abuse. (Issued as Class B at \$1,000.) Citation #03179404232.

Colonial Healthcare
9/5/2007 **B** Comp.
\$1,000 Facility Self-Report - Abuse Physical Abuse
Dignity

On 10/5/06, a resident told staff that her CNA was "rough and slapped me across the face." The facility was cited for failure to follow its own policy and procedures to report the alleged abuse and change in condition to the doctor and the resident's representative, to document it in the resident's record, and to change the careplan. The facility was also cited for failure to protect the resident from abuse. (Issued as Class B at \$1,000.) Citation #03179404231.

Colonial Healthcare
9/5/2007 **B** Comp.
\$1,000 Facility Self-Report - Abuse Physical Abuse
Mental Abuse
Retaliation Against Resident
Neglect

On 10/5/06, a CNA forced a resident to get dressed against his will, banged his legs when he was forcefully placed in a wheelchair, and left him in his room unattended for four hours. The resident was very distraught and sobbed when asked about the incident. The facility was cited for failure to report the alleged abuse and change in condition to the doctor and the resident's representative, to document it in the resident's record, and to change the careplan. The facility was also cited for failure to protect the resident from abuse. (Issued as Class B at \$1,000.) Citation #03179404233.

Colonial Healthcare
9/14/2007 **B** Comp.
\$1,000 Patient Care Patient Care
Mandated Reporting

A 79 year old female resident was found with a bruise on her upper arm on 6/16/06. Her physician was not notified until 6/21/06, when the bruise worsened. X-rays taken on 6/22/06 revealed a fractured bone in her upper arm. On 6/23/06, seven days after the bruise was first noted, she finally received a splint and pain medication. Additionally, at this time, she was prescribed seizure medication - the apparent source of the fracture was a 6/15/06 tonic/clonic seizure. The facility was cited for failure to notify the physician of changes in the resident's condition and failure to immediately investigate an injury of unknown origin. (Issued as Class B at \$1,000.) Citation #03157704023.

Colonial Healthcare
 10/12/2007 **B** Comp.
 \$1,000 Abuse Physical Abuse
 Mental Abuse

During investigation of a complaint on 7/27/07, a resident reported he was physically and verbally abused by a CNA. Investigation confirmed that on or about 7/8/07, a CNA scratched the resident's thighs and buttocks when roughly pulling down his briefs, shaved him in a rough jabbing manner and was verbally abusive. The facility was cited for failure to protect the resident from physical and verbal abuse. (Issued as Class B at \$1,000.) Citation #03210404226.

Colonial Healthcare
 11/27/2007 **A** Comp.
 \$20,000 Patient Care Administration
 Careplan
Death Occurred Fall
 Staff (Inservice)
 Training

On 11/11/05, a 92 year old resident fell from her bed to the floor while trying to go to the bathroom. She suffered a fractured left hip that required surgery. As a result, she died on 11/17/05. The resident had a previous history of falls. The CNA responsible for the resident's care left her in bed without proper alarm devices. The CNA had a record of negligent care, but the facility did not provide her with the proper training for identified weaknesses. The facility failed to provide the resident with necessary safety and to provide staff with required regular in-service education. (Issued as Class A at \$20,000.) Citation #03116904460.

Foothill Oaks Care Center
 3400 Bell Road, Auburn, CA 95603

Foothill Oaks Care Center
 6/20/2007 **A** Comp.
 \$20,000 Patient Care Patient Care

On 8/6/06, an 84 year old female was admitted to the facility and was assessed as alert, oriented and friendly. On 8/13/07, she was admitted to an ER in an altered level of consciousness "most likely secondary to opiates and dehydration" and "dehydration secondary to poor oral intake". A review of her records at the facility indicated she had been consuming 50% or less of her meals and less than 50% of her estimated fluid requirements. After her discharge from the hospital, the resident could not hold intelligent conversations and would hold papers upside down to read. The facility was cited for failure to properly assess and provide necessary fluids to ensure the resident's hydration needs were met. (Issued as Class A at \$20,000.) Citation #03166204031.

Foothill Oaks Care Center
 8/22/2007 **B** Comp.
 \$1,000 Patient Care Physical Abuse
 Patient Care
 Patient Rights

On 7/17/07, a LVN grabbed a 95 year old female resident's wheelchair from in front of the LVN's med cart, swung the wheelchair around in a half circle and pushed the wheelchair ten feet away while the resident was still sitting in it. The facility was cited for failure to fully protect the rights of each resident from any form of abuse or mistreatment. Facility also cited for failing to request a Social Services worker to monitor the resident's emotion concerning the incident, as well as the resident's reactions to her involvement in the investigation. (Issued as Class B at \$1,000.) Citation #03207204203.

Foothill Oaks Care Center
 10/23/2007 **B** Comp.
 \$1,000 Patient Care Fall
 Careplan

On 10/25/07, a 75 year old female resident experienced an un-witnessed fall, after which she complained of pain in her right hip. The resident's physician was not notified immediately after the fall or when the pain increased. The resident was transferred to an acute care hospital days later where a right hip fracture was found and operated on. The facility was cited for failing to develop a careplan related to pain management after the un-witnessed fall and for failing to notify the resident's physician. (Issued as Class B at \$1,000.) Citation #03125504388.

Lincoln Manor, Inc.
 1550 Third Street, Lincoln, CA 95648

Lincoln Manor, Inc.
 5/2/2007 **B** Comp.
 \$1,000 Patient Care Medication
 Careplan

On 3/16/05 at 6:30 am, a LVN tested a resident's blood sugar and found it very low, but injected insulin. The resident went in and out of lethargy, thrashed and said "I am going crazy." She was sent to an ER and diagnosed as hypoglycemic. The facility was cited for failure to do a proper assessment and follow doctor's orders. (Issued as Class B at \$1,000.) Citation #03138403925.

Lincoln Manor, Inc.
 8/3/2007 **B** Comp.
 \$1,000 Patient Care Notification

The facility failed to follow their undated "Discharge to Home" and undated "Orders, Physician, Telephone" policies when they discharged a resident on 11/16/06 without the attending physician's knowledge or consent and falsified a phone order indicating he had ordered the discharge. The facility also discharged another resident to a lower level of care without contacting the physician, and on 11/13/06 a LVN wrote a discharge order as a telephone order and discharged the resident without notifying the physician. (Issued as Class B at \$1,000.) Citation #03171504155.

Oak Ridge Healthcare Center

310 Oak Ridge Drive, Roseville, CA 95678

Oak Ridge Healthcare Center

4/19/2007	A	Comp.
\$20,000	<u>Patient Care</u>	Patient Care

On 2/7/05, a diabetic resident was transferred to an acute care hospital with a blood sugar level of 1134 (normal range 70-110). The facility was cited for failure to develop and implement a care plan, provide a continuous assessment of the resident's condition and follow physician's orders for monitoring the resident's blood sugar. (Issued as Class A at \$20,000.) Citation #03125503886.

Oak Ridge Healthcare Center

4/19/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Careplan Hydration

The facility was cited for failing to complete a 2/4/05 physician's order for laboratory tests for a complete blood count, basic metabolic panel and an albumin level as ordered for a resident. The facility failed to ensure the nursing staff identified care needs and developed an individual written careplan based upon continuing assessments of the resident's fluid intake for the prevention of urinary tract infections during the period of 10/5/04 and 2/4/05. The facility also failed to ensure the resident's fluid intake and output measurements were monitored for a 72 hour period between the dates of 2/4/05 and 2/7/05 as ordered by her physician. (Issued as Class B at \$1,000.) Citation #03125503885.

Roseville Care Center

1161 Cirby Way, Roseville, CA 95661

Roseville Care Center

4/24/2007	B	Comp.
\$500	<u>Abuse</u>	Physical Abuse Verbal Abuse

On 5/19/06, CNA hurt a resident's broken leg while changing her. The CNA then responded to the resident's cries by stating, "You are not in pain. You are just a cry baby." The resident remained scared and fearful the CNA would return to her room and hurt her again. The facility failed to protect the resident from physical and emotional abuse. (Issued as Class B at \$500.) Citation #03157703906.

Siena Care Center

11600 Education Street, Auburn, Ca 95603

Sienna Care Center

9/14/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Administration Careplan Fall Notification

On 5/21/07, a resident suffered a fall while trying to reach the bathroom unattended. Staff did not perform an in-depth head to toe assessment, notify the physician, complete a post fall evaluation, or update the resident's careplan as required by the facility's policies and procedures for falls. Upon investigation of the incident, it was discovered that the facility failed to complete a bladder continence assessment and toileting careplan for the resident on admission (2/19/07), as well as when the attending physician discontinued the patient's indwelling catheter on 3/27/07. (Issued as Class B at \$1,000.) Citation #03157704261.

Sierra Hills Care Center

1139 Cirby Way, Roseville, CA 95661

Sierra Hills Care Center

10/12/2007	B	Comp.
\$1,000	<u>Medication</u>	Hydration Medication

On 2/9/07, at about 12 noon, the facility received physician's orders for IV fluids every hour to be administered to a resident who was at risk for dehydration. The order was not implemented until 9PM. On 2/10/07, the resident was transferred to the acute care hospital to be treated for dehydration. The facility was cited for failure to initiate the physician's orders in a timely manner. (Issued as Class B at \$1,000.) Citation #03178204338.

Riverside County**Alta Vista Healthcare**

9020 Garfield Ave., Riverside, CA 92503

Alta Vista Healthcare

10/19/2007	A	Comp.
\$20,000	<u>Patient Care</u>	Hydration Neglect Careplan

On 9/20/05, a resident was admitted requiring total care and dependent on a G-tube for food and fluids. On 5/16/06, the doctor ordered increased fluids and, on 5/18/06, tests to check urine, respiratory status, and X-rays to rule out pneumonia. The resident had a high temperature on 5/18. There was no evidence tests had been done or the doctor notified about the high temperature that continued until 5/24 when the resident's wife reported his poor condition. He was sent to the hospital where he was diagnosed with fever, dehydration, urinary tract infection, and inadequate oxygen levels. The facility was cited for failure to follow doctor's orders, notify the doctor of change of condition, and to monitor the resident's fluids and respiratory condition resulting in hospitalization. (Issued as Class A at \$20,000.) Citation #25173204347.

California Nursing & Rehabilitation Center

2299 North Indian Canyon Drive, Palm Springs, Ca 92262

California Nursing & Rehabilitation Center

1/19/2007	B	Comp.
\$1,000	<u>Patient Rights</u>	Theft & Loss

On 6/4/05, a 66-year-old male resident entered the facility with several credit cards and about \$3,400 cash in his wallet. The RN placed these valuables in an envelope in a safe deposit. On 6/8/05, the operations manager of the facility opened the safe, discovering that the envelope was missing. Investigations over the next few weeks revealed that although there is a written policy for procedures to put valuables into the safe, but there is no policy for the procedure of removing valuables. The resident suffered the loss of around \$3,400 and several credit cards. The facility was cited for failure to develop and implement policies and procedures that secure and protect a resident's personal property. (Issued as Class B at \$1,000.) Citation #25143703157.

Corona Care Convalescent

1400 Circle City Drive, Corona, Ca 92879

Pleasant Care Convalescent - Corona

9/13/2007	A	Comp.
\$15,000	<u>Patient Care</u>	Fall

On 5/3/07, a resident lacerated her eye and fractured her skull after falling from her bed while taking a bed bath. The attending CNA stated it was the first time she had taken care of the resident and tried to get somebody to help her, but nobody was available. The CNA stated she attempted to turn the resident to her side, but the resident was heavy and totally dependent. Her attempt to turn her caused the resident to continue rolling out of the bed. The facility was cited for failing to implement resident care policies and procedures related to turning residents in bed. (Issued as Class A at \$15,000.) Citation #25205604270.

Life Care Center Of Corona

2600 S. Main Street, Corona, Ca 92882

Life Care Center Of Corona

10/4/2007	A	Comp.
\$20,000	<u>Patient Care</u>	Decubiti (Bedsore) Careplan

In July 2006, a 65 year old developmentally disabled resident developed an infected, Stage III bedsore on his buttocks just a few weeks after being admitted to the facility in June 2006 without any skin problems. The resident was usually left sitting in his wheelchair all day without being repositioned. The facility was cited because its careplan failed to address the resident's immobility and risk of bedsore. Due to the neglect, the resident was hospitalized on 9/19/06 for surgical treatment of the infected bedsore. (Issued as Class A at \$20,000.) Citation #25172704308.

Life Care Center Of Corona

10/25/2007	A	Comp.
\$15,000	<u>Patient Care</u>	Supervision

On 5/8/06, a resident who was at risk for injury due to wandering eloped from the facility and was gone for 15 1/2 hours. The resident had walked 25 miles and sustained blisters so severe he was confined to a wheelchair on his return. The facility was cited for failure to implement the care plan and provide adequate supervision for the resident. (Issued as Class A at \$15,000.) Citation #25154904397.

Manorcare Health Services-Hemet

1717 West Stetson Avenue, Hemet, Ca 92545

Manorcare Health Services-Hemet

3/13/2007	AA	Comp.
\$75,000	<u>Patient Care</u>	Injury Fall Supervision

Death Occurred

On 1/6/06, an 83-year-old resident fell from his wheelchair, striking his head, causing a closed head injury and internal bleeding around the brain. He was hospitalized and died a week later on 1/13/06 after life support was removed. The resident had a diagnosis of Alzheimer's Disease and was almost totally dependent on the facility for care. He required a safety device, a lap buddy, when in the wheelchair, to prevent falls. The facility was cited because its staff observed that the physician-ordered lap buddy was not in place and failed to protect the resident from falling, which resulted in his death. (Issued as Class AA at \$75,000.) Citation #25154503781.

Monterey Palms Health Care Center

44-600 Monterey Avenue, Palm Desert, CA 92260

Monterey Palms Health Care Center

8/23/2007 **A** Comp.**\$12,000** Patient Care Injury
Careplan

On 10/28/06, a resident with Osteoporosis suffered fractures of both legs just above her knees after staff had used a towel behind her legs as a means to transfer her to and from bed. The resident was hospitalized after yelling of pain to both knees. Her careplan called for the use of a mechanical lift during transfers. The facility was cited because the resident suffered serious injury due to its failure to implement an individual careplan related to transfers and failed to use correct techniques when transferring residents in and out of bed. (Issued as Class A at \$12,000.) Citation #25199304187.

Vista Pacifica Center

3674 Pacific Avenue, Riverside, CA 92509

Vista Pacifica Center

10/16/2007 **B** Comp.**\$1,000** Abuse Careplan
Physical Abuse

On 8/30/06, a resident was hit in the face and pushed to the ground by another resident, causing a black eye and other cuts. Despite at least six documented incidents of physical abuse in the two months prior to the incident, the abusive resident's careplan was not revised. The facility was cited for failing to protect their residents from abuse. (Issued as Class B at \$1,000.) Citation #25189904337.

Sacramento County**Applewood Care Center**

1090 Rio Lane, Sacramento, Ca 95822

Applewood Care Center

6/19/2007 **A** Comp.**\$20,000** Patient Care Hydration

The facility failed to continually assess and provide the necessary fluids to ensure a resident's hydration needs were met after she was identified on 3/15/06 as being high risk for dehydration. The facilities failure resulted in the resident becoming dehydrated and being transferred to an acute care hospital on 3/27/06. Resident was again transferred to an acute care hospital on 4/7/06 where she was diagnosed with very severe dehydration. (Issued as Class A at \$20,000.) Citation #03166204032.

Applewood Care Center

6/21/2007 **AA** Comp.**\$100,000** Patient Care Neglect**Death Occurred**

On 2/4/07, an 82 year old resident died due to asphyxiation after he began choking while being fed dinner by a nursing assistant. The resident had previously expressed a desire for full resuscitation and stated he "wants whatever it takes to sustain his life." Despite this wish, a facility RN stopped CPR before paramedics arrived and assumed care. The local fire department arrived and found the resident in bed, with a heart beat, with no one performing CPR. Fire fighters performed CPR for about 20 minutes before the resident was pronounced dead. (Issued as Class AA at \$100,000.) Citation #03166204037.

Arden Rehab & Health Center

3400 Alta Arden Expressway, Sacramento, Ca 95825

Arden Rehab & Health Center

7/12/2007 **AA** Comp.**\$100,000** Patient Care Neglect**Death Occurred**

On 4/9/05, a 73 year old resident died after being admitted to an ER with a urinary tract infection, sepsis, respiratory failure and electrolyte disturbance. It was determined she died as a result of not receiving appropriate antibiotic treatment over an 11 day period. In addition, it was noted the resident's catheter was unchanged for 57 days. The facility was cited for failure to continually assess the residents failure to notify the physician and failure to follow the physician's outstanding orders. (Issued as Class AA at \$100,000.) Citation #03173404070.

Arden Rehab & Health Center
7/31/2007 **B** Comp.
\$1,000 Patient Care

On 6/4/05, a resident requiring careful monitoring of fluids was admitted to the facility. A careplan was initiated to monitor hydration, but ongoing assessments were not documented. Failures on the part of the facility to follow the careplan resulted in the resident being admitted to an acute hospital on 7/25/05 and again on 8/13/05 for dehydration, sepsis and a Urinary Tract Infection. The facility was cited for failure to take appropriate steps to ensure the resident was hydrated, monitor fluid intake and output according to policy, and review and update the resident's careplan as necessary. (Issued as Class B at \$1,000.) Citation #03169804134.

Arden Rehab & Health Center
8/3/2007 **A** Comp.
\$15,000 Patient Care Patient Care

Death Occurred

On 11/9/05, an 87 year old female resident was transferred from the facility to an acute hospital as a result of poor care. Within two months of her admission to the facility on 7/12/05, the resident's condition declined severely due to her low fluid intake/output. Although the hydration levels were monitored, no changes were implemented to increase it. Her condition was compounded by her pressure wounds, which require significant hydration to heal. On 11/25/05, the resident passed away in the facility. The facility was cited for failure to provide adequate care for the resident, including failure to develop and implement care plans for the resident's fluid intake/output resulting in hospitalization and death. (Issued as Class A at \$15,000.) Citation #03167704163.

Arden Rehab & Health Center
8/3/2007 **B** Comp.
\$1,000 Patient Care Decubiti (Bedsore)

On 11/09/05, an 87 year old resident was sent to the hospital with septic shock due to an infected right hip and acute renal failure. According to the resident's careplan, she was to be assisted with bed mobility, assessment of ulcers every week, and notification to the physician of deterioration or lack of improvement at least every two weeks. The facility was cited because it had failed to implement the physician's orders and for not notifying the physician of her deteriorating condition. (Issued as Class B at \$1,000.) Citation #03167704161.

Arden Rehab & Health Center
9/20/2007 **B** Comp.
\$1,000 Patient Care Patient Care

On 6/09/07, a resident requested a hot pack to be applied to her back. A CNA responded to her request and applied a makeshift pack that leaked hot water on resident's skin. The resident sustained second degree burns. The facility's policies state that only a licensed nurse or physical therapist are authorized to apply hot packs, and only "hydrocollator packs" are to be used for heat pack therapy. The facility failed to ensure the necessary care and services be provided to the resident. (Issued as Class B at \$1,000.) Citation #03169804280.

Arden Rehab & Health Center
10/11/2007 **B** Comp.
\$1,000 Patient Care Fall Injury

Following admission for therapy to recover from a left hip fracture, a 77 year old resident fell twice, resulting in a left leg fracture that required hospitalization and surgery. On 9/5/05, she was found on the floor after climbing out of bed with raised siderails. A second fall on 9/8/05 was undocumented. The facility did not investigate the falls. The resident was not hospitalized until 9/11/05 when she was screaming in pain. The facility was cited because it failed to identify needed safety measures or establish a care plan to keep her safe from falls. (Issued as Class B at \$1,000.) Citation #03169804345.

Arden Rehab & Health Center
10/11/2007 **B** Comp.
\$1,000 Abuse Injury Physical Abuse Mandated Reporting

In June 2007, a resident had bruising and swelling of the left eye and multiple bruises on her left arm. The causes of the injuries were not known and not investigated by the facility. The facility was cited for not investigating the injuries, not reporting the injuries to the Department of Public Health and not promptly notifying the resident's public guardian. (Issued as Class B at \$1,000.) Citation #03169804344.

Arden Rehab & Health Center
10/30/2007 **B** Comp.
\$1,000 Medication Medication

The facility failed to ensure a 91 year old female resident's drug regimen was free from unnecessary drugs. The facility did not reduce the dose of Depakote (a drug that alters behavior) as recommended by the Interdisciplinary Team on 10/7/05 until 11/11/05, and they did not document the indication for use and monitoring the effectiveness of each dose of Ativan (a drug used for anxiety) administered between 11/2005 and 2/2006. The facility also failed to maintain a system of drug records of receipt and disposition of all controlled drugs by not ensuring the Medication Records, Nurse's Medication Notes and the Controlled Drug Records between 11/2005 and 2/2006 were reconciled for the resident's Ativan administration. (Issued as Class B at \$1,000.) Citation #03190104408.

Arden Rehab & Health Center
12/21/2007 **AA** Comp.
\$100,000 Patient Care Decubiti (Bedsore)

Death Occurred

On 10/9/05, an 89 year old resident developed a pressure sore on her right heel and right upper foot that later became severely infected and gangrenous. Her right foot "fell off" on 11/28/05. A nurse reported that if she had lifted the leg without supporting the foot, the foot would have separated from the leg. The odor from the infected foot was so bad the facility had to keep her door closed and use a fan to try and keep the odor from other rooms. The resident died on 12/15/05. The facility was cited because its multiple failures to assess, identify care needs, obtain and carry out physician orders, and implement facility policies led to the resident's death. Additional neglect of this resident is described in citation #03-16980004537. (Issued as Class AA at \$100,000.) Citation #03169804419.

Arden Rehab & Health Center

12/21/2007 **B** Comp.
\$1,000 Patient Care Hydration
 Neglect
 Injury

An 89 year old resident was hospitalized on 10/10/05 due to profound dehydration with multi-organ system failure and a foot wound which became septic. A week earlier the resident had fractured her leg, which led to the life-threatening decline in her health. The facility was cited because it failed to develop a care plan for the resident's dehydration risk, failed to monitor the provision of necessary fluids, and failed to implement its policies on fluid intake and output. (Issued as Class B at \$1,000.) Citation #03169804537.

Asbury Park Nursing And Rehabilitation Center

2257 Fair Oaks Blvd., Sacramento, CA 95825

Asbury Park Nursing And Rehabilitation Center

10/16/2007 **B** Comp.
\$1,000 Patient Care Patient Care

An 83 year old male resident with a history of prostate cancer was admitted to the facility on 11/27/06. Physician's orders required his catheter be changed once a month and the urinary drainage bag every two weeks. A review of the resident's records in January and February of 2007 revealed there was no documented evidence these orders were ever carried out. He developed a UTI on 3/6/07 and was admitted to the acute hospital on 3/14/07 with dead tissue around the head of his penis and a wound where the catheter dug into the head. The facility was cited for failure to implement the resident's care plan resulting in the resident's deterioration and eventual hospitalization. (Issued as Class B at \$1,000.) Citation #03148804336.

Bruceville Terrace - D/P SNF Of Methodist Hosp.

8151 Bruceville Road, Sacramento, CA 95823

Bruceville Terrace - D/P SNF Of Methodist Hosp.

1/23/2007 **AA** Comp.
\$100,000 Medication Medication
 Neglect
 Notification

Death Occurred

On 10/17/06, a 74-year-old resident died almost immediately after the facility administered a massive overdose of intravenous morphine. The resident had a terminal illness and was admitted for comfort care. The facility was cited because it did not administer the medication as ordered, did not monitor the resident's response to the medication, did not follow its policies on medication administration and did not notify his physician of the medication error until four days after his death. These failures led to the resident's death. (Issued as Class AA at \$100,000.) Citation #03140703486.

El Camino Care Center

2540 Carmichael Way, Carmichael, CA 95608

El Camino Care Center

3/28/2007 **B** Comp.
\$1,000 Patient Care Patient Care

Death Occurred

On 8/1/06, the wife of a resident found him alone and unresponsive with a breathing mask over his mouth and nose. The resident had been undergoing a breathing treatment but was left unattended. It was not until the visitor called for help that the facility staff started CPR and called for an ambulance. The resident was transferred to the acute hospital where he was declared dead. The facility was cited for improper patient care. (Issued as Class B at \$1,000.) Citation #03149503794.

Elk Grove Care & Rehabilitation Center

9461 Batey Avenue, Elk Grove, CA 95624

Elk Grove Care & Rehabilitation Center

6/19/2007 **B** Comp.
\$1,000 Patient Care Fall
 Supervision

On 1/12/04, an 89 year old resident did not receive adequate supervision while being transferred on a mechanical Vera lift by one person instead of two. This resulted in an avoidable fall, which caused a fracture to the resident's left femur. The fracture was not discovered until two days after the fall occurred. Facility was cited for failure to provide adequate supervision and assistance. (Issued as Class B at \$1,000.) Citation #03173404028.

Emerald Gardens Nursing Center

6821 24th Street, Sacramento, CA 95822

Emerald Gardens Nursing Center

10/1/2007 **B** Comp.
\$800 Patient Care Notification

On 7/24/07, an 81 year old male resident fell from his bed. He complained of hip pain and a subsequent x-ray revealed a hip fracture. Despite the facility's policy to notify a physician as soon as a change of condition occurred, a doctor was not notified until seven hours later. The facility was cited for failing to timely respond to the resident's broken hip. (Issued as Class B at \$800.) Citation #03173404294.

Eskaton Care Center Fair Oaks

11300 Fair Oaks Blvd, Fair Oaks, CA 95628

Eskaton Care Center Fair Oaks

7/26/2007 **A** Comp.
\$15,000 Patient Care Patient Care

On 8/22/05, a resident was sent to a General Acute Care Hospital with urosepsis and dehydration. An investigation revealed the nursing staff had not initiated a preliminary plan of care on his admission (on 8/14/05) for the resident's indwelling catheter. The facility was cited for failure to properly assess the resident for hydration needs and for failure to promptly notify the resident's physician when his condition changed. (Issued as Class A at \$15,000.) Citation #03179404128.

Eskaton Care Center Fair Oaks
7/26/2007 **B** Comp.
\$1,000 Patient Care Decubiti (Bedsores)

On 8/27/05, a 91 year old male resident was transferred to an acute hospital for a Stage II bedsore. The bedsore was first documented two days prior, on 8/25/05, but no care was initiated to prevent further skin breakdown, nor was the resident's physician informed of the change in his status. The resident had no skin abnormalities when he was admitted on 8/14/05, but over 11 days the resident's coccyx deteriorated from reddened skin to a Stage II bedsore. The facility was cited for failure to properly develop and follow a careplan to prevent the formation of bedsore, as well as monitor and change the plan according to the condition of the resident. (Issued as Class B at \$1,000.) Citation #03179403780.

Eskaton Care Center Fair Oaks
10/11/2007 **B** Comp.
\$1,000 Patient Care Patient Care
Careplan
Neglect

A resident's colostomy bag was not changed for 36 days from 6/7/05 to 7/11/05. She suffered repeated episodes of painful skin excoriation (an abraded area where the skin is torn or worn off) around her colostomy opening between 7/11/05, and 2/10/06. The facility was cited for failure to develop a care plan to address the resident's colostomy care needs and assess the resident's skin condition on a weekly basis. (Issued as Class B at \$1,000.) Citation #03179404342.

Gramercy Court

2200 Gramercy Drive, Sacramento, CA 95825

Gramercy Court
1/16/2007 **B** Comp.
\$1,000 Patient Care Medication

On 7/28/06, an 86-year-old female resident was transferred from an acute hospital to the facility for pain management, but her migraine pain medication was not delivered to the facility. The resident suffered a migraine headache on 7/29/06, and her family ordered that she be transferred back to the hospital. The facility was cited for failing to ensure that the resident received her prescribed medications. (Issued as Class B at \$1,000.) Citation #03166203609.

Gramercy Court
6/19/2007 **A** Comp.
\$20,000 Patient Care Neglect

Death Occurred

On 3/21/06, an 84 year old resident was transferred via ambulance to an ER with acute renal failure caused by dehydration. The ambulance report stated, "per nurse," the resident had not been eating or drinking for two days. An interview with the facility LVN indicated the resident would eat and drink if assisted. The resident was discharged to another skilled nursing facility on "comfort care" where she expired two days later. (Issued as Class A at \$20,000.) Citation #03166204033.

Gramercy Court
7/26/2007 **B** Comp.
\$1,000 Patient Care Decubiti (Bedsores)

On 2/13/06, an 84 year old resident with multiple diagnoses was assessed and determined to have significant risk of bed sores. No subsequent care planning was performed. One month later, the resident developed three Stage II bedsore. The facility was cited for its failure to prevent bedsore and appropriately careplan. (Issued as Class B at \$1,000.) Citation #03166204124.

Gramercy Court
9/17/2007 **B** Comp.
\$1,000 Abuse Physical Abuse

On 8/1/07, an 87 year old resident reported a CNA roughed her up during the night shift. The resident suffered a puffy elbow, discolored arm, discoloration on her forehead and a swollen area behind her ear. The facility was cited because it failed to protect the resident from abuse, did not report the alleged abuse to appropriate professional and licensing boards, and did not develop a careplan to address the resident's injuries. (Issued as Class B at \$1,000.) Citation #03166204251.

Heritage Care Center

5255 Hemlock Street, Sacramento, CA 95841

Heritage Convalescent Hospital, Inc.
1/16/2007 **B** Comp.
\$1,000 Patient Care Supervision

On 7/2/06, a male resident with dementia wandered from the facility. The resident had previously attempted to leave the facility on numerous occasions, and was wearing a wander guard alarm bracelet. Later that day, the fire department found the resident sitting on the sidewalk, complaining of chin pain that he sustained as a result of a fall. An investigation revealed that although the resident's wander alarm bracelet was working, the alarm on the door had been turned off. The facility was cited for failing to protect the health and safety of a resident. (Issued as Class B at \$1,000.) Citation #03166203636.

Heritage Care Center
4/5/2007 **B** Comp.
\$1,000 Administration Mandated Reporting
Infection
Physical Environment

The facility failed to report to the Department of Health Services and the County Health Department a gastroenteritis outbreak within 24 hours after seven residents were identified on 12/7/06 with symptoms of nausea, vomiting and/or diarrhea. By the time it reported the outbreak four days later, over 60 residents and staff were ill. Ultimately, 39 residents and 35 employees were treated for symptoms of gastroenteritis, including four residents who required hospitalization. The investigation determined that the facility had not maintained the sanitizing equipment in its dishwasher in good working order. (Issued as Class B at \$1,000.) Citation #03170103655.

Manorcare Health Services -- Citrus Heights

7807 Uplands Way, Citrus Heights, CA 95610

Manorcare Health Services

1/4/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Careplan Hydration Supervision

On 2/17/05, a resident was admitted with a high risk for dehydration related to a 1500 cc per day fluid restriction and the use of diuretic therapy. His careplan required careful monitoring and recording of food and fluid intake and output. According to the records, from 2/27 to 3/5/05, intake at meals was recorded and averaged 120 cc below required levels, and there was no recording of fluid intake made during this period by nursing staff. On 3/6/05, the resident was sent to the hospital and diagnosed with a temperature of 102.5, low blood pressure, elevated heart rate and abnormal lung sounds. The facility was cited for failure to follow the careplan and to monitor and record food and fluid intake. (Issued as Class B at \$1,000.) Citation #03140703610.

Norwood Pines Care Center

500 Jessie Avenue, Sacramento, CA 95838

Norwood Pines Care Center

7/17/2007	B	Comp.
\$750	<u>Abuse</u>	Sexual Abuse

On 5/11/07, an 81 year old female resident was sexually assaulted by a male resident. While the female resident slept in her wheelchair, the male resident stood over her, took his penis out of his pants, and rubbed it on her face, mouth and lips. The male resident had sexually assaulted another female resident in 2005 and displayed other inappropriate sexual behavior. The facility was cited for failure to protect the resident from sexual abuse. (Issued as Class B at \$750.) Citation #03141304099.

Pioneer House

415 P Street, Sacramento, CA 95814

Pioneer House

7/5/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Injury Patient Care Fall Neglect

On 2/24/07, a 76 year old resident suffered a fractured leg when he fell near his bathroom after getting out of bed around midnight. His assigned aide neglected to attach a bed alarm, which was supposed to alert staff when the resident tried to get out of bed. The resident's physician had ordered the bed alarm because the resident had a high risk of falling and had poor safety awareness. The facility was cited for failure to ensure the resident's bed alarm was functioning properly. (Issued as Class B at \$1,000.) Citation #03166204057.

Rosewood Terrace Care & Rehabilitation

6041 Fair Oaks Blvd., Carmichael, CA 95608

Rosewood Terrace Care & Rehabilitation

3/29/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Fall

On 8/21/05, staff found a resident who had fallen in the bathroom. Nurses' notes indicated that she was treated for a skin tear on her elbow with "no other injuries." The resident complained of continual pain. The facility waited at least 43 hours before sending her to the hospital where it was determined that she had a hip fracture. The facility was cited for failure to ensure that the resident received the required ongoing assessments after she had fallen. (Issued as Class B at \$1,000.) Citation #03149503793.

Rosewood Terrace Care & Rehabilitation

3/29/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Decubiti (Bedsore)

On 2/20/07, a resident was hospitalized for treatment of grossly infected Stage IV bedsores. The facility did not provide needed wound care during the prior 10 days, during which time the bedsores developed an odor "so foul and prominent it escaped the room and penetrated the halls causing a persistent foul smell..." The facility was cited because its failures resulted in the resident's Stage IV bedsores becoming re-infected. (Issued as Class B at \$1,000.) Citation #03149503859.

Saint Claire's Nursing Center

6248 66th Avenue, Sacramento, CA 95823

Saint Claire's Nursing Center

6/19/2007	A	Comp.
\$10,000	<u>Patient Care</u>	Hydration

On 1/2/06, a resident was transferred to an acute care hospital after she was found in a lethargic and nonverbal state. The resident's care plan indicated she required monitoring for signs and symptoms of sufficient fluid intake. The resident's emergency room diagnoses included severe dehydration and urinary tract infection. The facility was cited for failure to assess the resident, implement her care plan and provide adequate fluids. (Issued as Class A at \$10,000.) Citation #03166204034.

Sunbridge Brittany Care Center

3900 Garfield Avenue, Carmichael, CA 95608

Sunbridge Brittany Care Center

3/9/2007	B	Comp.
\$1,000	<u>Medication</u>	Medication

On 10/3/05, a 64 year old male resident was admitted to the facility for hip rehabilitation. He was medicated as directed but on 10/6/05, his lab results indicated a critically high reaction to the medication prescribed. The resident's physician was not notified of this reaction until 10/9/05, when the resident himself called 911 and was transferred to the emergency room. The facility was cited for failure to notify the resident's physician of an unusual response to medication, violating his health and possibly causing him to have a longer recovery time. (Issued as Class B at \$1,000.) Citation #03178203771.

Sunbridge Brittany Care Center
 10/10/2007 **B** Comp.
\$1,000 Abuse Dignity
 Mandated Reporting
 Mental Abuse
 Neglect
 Verbal Abuse

On 6/18/07, CNA verbally abused a 68 year old female resident while assisting her in the bathroom. The CNA told the resident, "You're going to be sitting on your face if you mess with me." The resident asked for another staff member's help and the CNA left her standing on tiptoe with her pants pulled halfway down as she tried to hold on to the assist bar for approximately 5 minutes. Another CNA was present and told her she was a "mandated reporter," but did not report the incident. The facility failed to protect the resident from mental and verbal abuse and to report the incident to the Department of Public Health within 24 hours. (Issued as Class B at \$1,000.) Citation #03163704325.

Sunbridge Brittany Care Center
 10/10/2007 **B** Comp.
\$650 Abuse Dignity
 Mandated Reporting
 Mental Abuse
 Neglect
 Physical Abuse

On 6/20/07, a CNA refused to shower Resident 1. The following day on 6/21/07, CNA told Resident 2, "I'm tired of cleaning your sh--ty butt," and left her hanging in a mechanical lift for over 5 minutes unattended. Both residents, who were roommates, felt tearful and humiliated by the CNA's treatment. The facility failed to report these incidents within 24 hours to the Department of Public Health, as well as to notify the CNA board within 5 days. The facility also failed to protect residents from neglect, physical, verbal and emotional abuse. (Issued as Class B at \$650.) Citation #03163704318.

Sunbridge Care & Rehabilitation For Carmichael
 8336 Fair Oaks Blvd., Carmichael, CA 95608

Sunbridge Care & Rehabilitation For Carmichael
 6/15/2007 **B** Comp.
\$800 Patient Care Decubiti (Bedsore)

On 1/23/07, the family of an 85 year old female resident discovered she had a bedsore on her buttocks. A care plan for the sore was not initiated until 11 days after the family discovered it. Interviews and investigation on 1/26/07 revealed that the sore resulted from lack of skin assessments by her nurse, which had been ordered in October of 2006 by the resident's physician. The facility was cited for failure to follow physician's orders for periodic assessment of the resident in order to prevent bedsores from developing. (Issued as Class B at \$800.) Citation #03193003864.

Sunbridge Care & Rehabilitation For Carmichael
 6/15/2007 **B** Comp.
\$1,000 Patient Care Mental Abuse
 Physical Abuse
 Careplan

From 11:45 pm on 5/28/06 to 1:30 am on 5/29/06, a resident was left alone in the dining room with the door closed and the TV volume turned up. The resident's daughter found her mother in this condition slumped over in her wheelchair, crying and agitated. The facility was cited for failure to follow the careplan for a resident with a bipolar disorder requiring a supportive therapeutic environment. (Issued as Class B at \$1,000.) Citation #03193003214.

Sunbridge Care & Rehabilitation For Carmichael
 7/24/2007 **B** Comp.
\$1,000 Patient Care

The facility failed to ensure a 90 year old female resident had adequate supervision and assistance devices when placed in her wheelchair on 6/14/06 without a lap tray in place. There was a doctor's order for the lap tray to keep the resident in the proper position. On 6/14/06, the resident fell from her wheelchair because the lap tray was not in place, resulting in a laceration to her forehead which required two sutures. (Issued as Class B at \$1,000.) Citation #03173404113.

Sutter Transitional Care Center - Midtown D/P SNF
 2600 L Street, Sacramento, CA 95816

Sutter Transitional Care Center - Midtown D/P SNF
 7/19/2007 **B** Comp.
\$1,000 Patient Care Medication
 Careplan

During a three month period from 10/18/03 to 1/20/04, a resident with infected Stage III and IV bedsores did not receive appropriate pain evaluations or interventions, which affected her ability to fully participate in rehabilitation. A family member stated, "They didn't give her pain medicine before debriding the wound. Sometimes she'd tell me that she just wanted to die or kill herself because of the pain." The facility was cited for failure to follow its own policy and procedures for pain assessment. (Issued as Class B at \$1,000.) Citation #03149504105.

Sutter Transitional Care Center - Midtown D/P SNF
 9/4/2007 **B** Comp.
\$1,000 Abuse Verbal Abuse

On 6/8/06, a visitor overheard a CNA who was behind the privacy curtain verbally abusing her brother's roommate for about fifteen minutes. The abused resident was a 53 year old who had been rendered totally dependent after being hit by a car. The facility was cited for failing to ensure the resident was not subjected to verbal abuse. (Issued as Class B at \$1,000.) Citation #03180604230.

Vintage Estates of Sacramento

501 Jessie Avenue, Sacramento, CA 95838

Vintage Estates of Sacramento
 3/2/2007 **B**
\$1,000 Patient Care Mandated Reporting

On 11/13/06, the DON reported an incident of suspected sexual abuse of a resident by a CNA that occurred in "approximately August 2006." The Housekeeping Supervisor (HS) reported the incident to the DON on 11/9/06. The facility was cited because the DON failed to report the incident to the Department of Health Services within 24 hours, and the HS, a mandated reporter, failed to report the incident for over two months. (Issued as Class B at \$1,000.) Citation #03140703703.

Vintage Estates of Sacramento
 4/17/2007 **B** Comp.
\$1,000 Abuse Theft & Loss
 Fiduciary
 Mandated Reporting

On 3/22/06, a resident's Responsible Party (RP) contacted the Administrator about the suspicious use of the resident's Social Security number. The RP had discovered that someone had been using it to start utility and phone services and suspected that it might be an employee of the facility. Although the Administrator assured the RP that the matter would be looked into, there was no evidence that anything was done. Later it was determined by the Department of Justice that an employee had been using the resident's Social Security number. The facility was cited for failure to report the allegation of fiduciary abuse when it was first notified by the resident's Responsible Party. (Issued as Class B at \$1,000.) Citation #03173403897.

Vintage Estates of Sacramento
 9/12/2007 **B** Comp.
\$1,000 Patient Care Fall

On 5/16/07, a blind resident, who was at high risk for falls, was walking unassisted through the dining room when she was struck by a resident who had been pushed by a third resident. The resident fell and hit her head and elbow sustaining a subarachnoid hemorrhage (bleeding in the brain). The resident was transferred to an acute care hospital and subsequently placed on hospice care rather than attempt surgery. The facility was cited for failure to provide adequate supervision and failure to implement the resident's careplan. (Issued as Class B at \$1,000.) Citation #03157704257.

Walnut Whitney Care Center

3529 Walnut Avenue, Carmichael, CA 95608

Walnut Whitney Care Center
 5/9/2007 **B** Comp.
\$1,000 Patient Care Decubiti (Bedsore)

On 3/14/03, a 62 year old male resident requiring total staff assistance for any movement was admitted to the facility. Between 3/15/03 and 3/22/03, the physician's treatments orders were not implemented by the staff. The resident developed 18 wounds, including 13 bedsore between Stages II and IV and five areas of broken skin, as a result of the staffs' failure to follow the resident's treatment plan. On 3/22/03, the resident was moved to an acute hospital for treatment of his worsened condition. The facility was cited for failure to carry out physician's orders, which resulted in his worsened health. (Issued as Class B at \$1,000.) Citation #03170703948.

Walnut Whitney Care Center
 5/9/2007 **A** Comp.
\$20,000 Patient Care Decubiti (Bedsore)

Between the dates of 1/14/03 and 3/6/03, a resident who was at risk for pressure sores developed three Stage II and one Stage III pressure sore. The resident was transferred to an acute care hospital on 3/6/03, with a diagnosis that included malnutrition and sepsis. The facility was cited for failure to provide treatment to prevent the development of pressure sores, implement care plans, follow physician's orders and conduct skin assessments. (Issued as Class A at \$20,000.) Citation #03170103448.

Walnut Whitney Care Center
 5/9/2007 **B** Comp.
\$1,000 Patient Care Patient Care

On 1/14/07, a 62 year old male resident with diabetes was admitted to the facility. Between 1/14/03 and 3/6/03, his blood levels were not maintained, his care plan was not followed and his condition declined significantly over the two months. He was admitted to the emergency room on 3/5/03. The facility was cited for failure to provide comprehensive assessments and high quality of care. (Issued as Class B at \$1,000.) Citation #03170103938.

San Benito County

Hazel Hawkins Memorial Hospital D/P SNF
 911 Sunset Drive, Hollister, Ca 95023

Hazel Hawkins Memorial Hospital D/P SNF
 3/7/2007 **B** Comp.
\$1,000 Patient Rights Mental Abuse
 Dignity

On 2/19/07, the facility failed to ensure a resident was treated with dignity and respect when a CNA was rough in providing care, did not allow the resident to choose what to wear and behaved in a manner the resident perceived as mean, harsh and as a result instilled unnecessary fear in the resident. (Issued as Class B at \$1,000.) Citation #07202403778.

Hazel Hawkins Memorial Hospital D/P SNF
 4/20/2007 **B** Comp.
\$1,000 Abuse Mandated Reporting
 Physical Abuse

On 2/6/07, a male resident was allegedly dropped into a shower chair roughly by the CNA assisting him. The resident was visibly distressed after the incident and a licensed nurse attempted to determine the cause of his distress. She was unsuccessful, but filed a suspected abuse report to the ombudsman office. When interviewed about the incident on 2/20/07, the resident was visibly upset about his treatment. The facility was cited for failure to notify the Department of Health Services immediately or within 24 hours of an incident of alleged abuse. (Issued as Class B at \$1,000.) Citation #07105503758.

Hazel Hawkins Memorial Hospital D/P SNF
 4/20/2007 **B** Comp.
\$1,000 Patient Rights Dignity

On 2/6/07, a male resident was allegedly dropped into a shower chair roughly by the CNA assisting him. Afterwards, he was visibly distressed, so a licensed nurse attempted to determine, unsuccessfully, what happened; later stating in an interview that the resident had burst into tears upon questioning. When interviewed about the incident on 2/20/07, the CNA claimed the resident attempted to hit him as he prepared the resident for the shower, though no documentation supported his claim. The facility was cited for failure to treat the resident with dignity and respect (Issued as Class B at \$1,000.) Citation #07105503909.

Hazel Hawkins Memorial Hospital D/P SNF
 5/22/2007 **B** Comp.
\$1,000 Patient Care Patient Rights
 x3

On 4/12/07, a female resident reported a CNA's mistreatment of her roommate. The facility never reported or investigated the allegation. The resident stated she heard the CNA yelling at her roommate followed by sounds of slapping. A review of the resident's record revealed that between 8/23/06 and 3/17/07, bruises on her arms of unknown origin were documented but never investigated. A male resident in the same facility reported a housekeeper took ornaments belonging to him with significant sentimental value. The facility was cited for failure to develop and implement policies and procedures that prohibit mistreatment, neglect, abuse of residents, and misappropriation of resident property. (Issued as Class B at \$1,000.) Citation #07160703904.

Hazel Hawkins Memorial Hospital D/P SNF
 8/1/2007 **A** Comp.
\$20,000 Dietary Feeding
 Dietary Services
Death Occurred Neglect

On 6/16/07, an 88 year old resident began choking when a nursing assistant fed her a chicken sandwich instead of the pureed food her doctor had ordered due to her swallowing problem. The resident died about an hour later after being transferred to a hospital emergency room. It was discovered the staff member fed her a meal prepared for another resident. The facility was cited because it fed the resident food that caused her to choke, leading to her hospitalization and death. (Issued as Class A at \$20,000.) Citation #07170304062.

Hazel Hawkins Memorial Hospital D/P SNF
 8/15/2007 **B** Comp.
\$1,000 Patient Rights Dignity
 Physical Abuse
 Verbal Abuse

In July 2007, a 95 year old resident tearfully asked to leave the facility because he was distraught over rough care and verbal abuse from a nursing assistant. Five months earlier, the facility had been cited because the same aide treated this resident roughly, yet he was still assigned to the resident's care. Also in July 2007, a 94 year old female resident reported that an aide scrubbed her too hard during a bath and continued the rough treatment even after she complained. The facility was cited because it did not treat the residents with dignity and respect. (Issued as Class B at \$1,000.) Citation #07207604184.

Hazel Hawkins Memorial Hospital D/P SNF
 8/30/2007 **A**
\$15,000 Patient Care Supervision
 Medication
 Neglect

The facility failed to assess a resident's bowel status and administer medications as prescribed by her physician for constipation. After eight days without a bowel movement, the resident was sent to an emergency room where a fecal impaction was manually removed. The resident remained hospitalized for seven days with fever, abdominal discomfort and vomiting. (Issued as Class A at \$15,000.) Citation #07160704211.

Citrus Nursing Center

9440 Citrus Avenue, Fontana, CA 92335

Citrus Nursing Center

10/11/2007 **AA** Comp.\$100,000 Patient Care Injury
Fall
Neglect**Death Occurred**

A facility staff member dropped a 91 year old resident on her head on 2/24/07, causing injuries that led to her death nine days later. The death certificate stated she died from blunt force head injury. A CNA dropped the resident while moving her from a wheelchair into her bed using a Hoyer Lift (mechanical lift). The facility violated its policy and the resident's careplan by not providing two staff members to assist with the transfer. (Issued as Class AA at \$100,000.) Citation #24000004343.

Community Convalescent Center of San

1676 Medical Center, San Bernardino, Ca 92411

Community Convalescent Center of San Bernardino

4/10/2007 **B** Comp.\$1,000 Patient Rights Verbal Abuse

On 5/31/06, a LVN reported to another LVN that she had changed a resident's feeding tube. The resident interrupted her and said it was not true. The LVN then put her finger in the resident's face and said, "You are a lying bitch, how could you see when your eyes were closed?" The other LVN immediately reported the incident to the Director of Nurses. The facility was cited for failing to keep residents free from abuse. (Issued as Class B at \$1,000.) Citation #24170403879.

Crestview Convalescent Hospital

1471 S. Riverside, Rialto, CA 92376

Crestview Convalescent Hospital

3/7/2007 **B** Comp.\$1,000 Physical Environment Patient Care
Careplan

A 56 year old male resident was not assessed for his ability to smoke independently in the facility, as was required by the facility's formal policies and procedures. On 6/24/06, the resident's smoking led to a fire in his room. A CNA saved the resident and his roommate and put the fire out. All three were hospitalized for smoke inhalation. (Issued as Class B at \$1,000.) Citation #24075603761.

Crestview Convalescent Hospital

3/7/2007 **B** Comp.\$1,000 Physical Environment Physical Environment

On 2/28/06, family visiting a resident complained that the ceiling was leaking rain water at the foot of the resident's bed and onto his bed linen. The compliant further stated that, during a previous visit a month earlier, the facility had been using bed pans and a bucket on the floor to catch the leaking water. The family was concerned about the possibility of mold/mildew since the resident had a history of asthma. The staff's response to the complaint was, "It's raining outside." The facility was cited for failure to maintain a safe and healthy environment for the resident. (Issued as Class B at \$1,000.) Citation #24075603770.

Hillcrest Nursing Home

4280 Cypress Drive, San Bernardino, CA 92407

Hillcrest Nursing Home

7/28/2007 **B** Comp.\$1,000 Patient Care Other

On 10/28/05, a CNA left an 83 year old old resident, who required extensive assistance with transfers, walking and locomotion, alone in a tub. When the CNA returned, she found the resident on the floor with a laceration and lump above the left eye and a laceration on one of her toes. The facility was cited for failure to properly supervise the resident during bathing time. (Issued as Class B at \$1,000.) Citation #24139403241.

Ontario Healthcare Center

1661 South Euclid Avenue, Ontario, CA 91761

Ontario Healthcare Center

3/19/2007 **A** Comp.\$16,000 Patient Care Fall

On 11/4/06, a 71 year old resident, who needed extensive assistance for bed mobility and had total dependence for transfers, bathing and hygiene, fell from a Hoyer Lift while being lifted onto her bed. The fall caused a laceration on the back of her head. The resident was taken to the acute hospital where she remained for five days. The personnel file showed the CNA who had been tending to the resident had not been properly trained on how to use the Hoyer lift. The facility was cited for failing to properly train staff. (Issued as Class A at \$16,000.) Citation #24073703811.

Sky Harbor Care Center

57333 Joshua Lane, Yucca Valley, CA 92284

Sky Harbor Care Center

10/24/2007 **AA** Comp.\$100,000 Patient Care**Death Occurred**

On 4/13/07, an 86 year old resident fell to the floor and suffered fractures to both knees when a CNA dropped her while transferring her without help from another staff member and without the use of a gait belt, as required by the resident's careplan. She underwent surgery on 4/16/07 and died two days later from complications from the leg fractures. The facility was cited because its neglect led to the resident's death. (Issued as Class AA at \$100,000.) Citation #24204204394.

Waterman Convalescent Hospital

1850 N. Waterman Avenue, San Bernardino, CA 92404

Waterman Convalescent Hospital

3/15/2007	B	Comp.
\$1,000	<u>Patient Rights</u>	Physical Abuse Mental Abuse

On 6/26/06, a LVN overheard a CNA tell a 91 year old resident to shut up. The LVN then saw the CNA hit the patient on the right leg. The CNA was suspended and, after an in-house investigation, subsequently terminated. The facility was cited for failing to keep resident's free from physical and mental abuse. (Issued as Class B at \$1,000.) Citation #24170403800.

San Diego County**Brighton Gardens Of Carmel Valley**

13101 Hartfield Avenue, San Diego, Ca 92130

Brighton Gardens Of Carmel Valley

5/30/2007	B	Comp.
\$1,000	<u>Abuse</u>	Dignity

Two residents were subject to verbal abuse on separate occasions, 4/15/07 and 4/27/07, when a CNA cursed in Tagalog (a foreign language) in their presence. The incidents directly violated the facility's policies on Abuse Prevention and Skilled Nursing Patient Protection, which explicitly state the facility does not tolerate the use of derogatory language within hearing distance of a resident. The facility was cited for failure to treat each individual with dignity and respect and ensure each resident is free from verbal or physical abuse of any kind. (Issued as Class B at \$1,000.) Citation #08139903994.

Brighton Place - San Diego

1350 N Euclid Ave, San Diego, CA 92105

Brighton Place - San Diego

5/1/2007	B	Comp.
\$600	<u>Patient Care</u>	Decubiti (Bedsore)

A 77-year-old resident who was admitted to the facility on 11/29/06 was assessed to have a high risk for skin breakdown. Although the resident had no pressure sores at the time that she was admitted, by 2/27/07 she had a pressure sore on her coccyx. By 3/22/07, the pressure sore measured seven cm by ten cm. The bedsore was found during an examination of the resident by her oncologist, and had to be brought to the attention of facility staff because the staff did not know it existed. The facility was cited for failing to continually assess the resident's skin for changes in condition. (Issued as Class B at \$600.) Citation #09199603926.

Brighton Place - Spring Valley

9009 Campo Road, Spring Valley, CA 92077

Brighton Place - Spring Valley

1/11/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Fall Physical Restraints

Death Occurred

On 11/21/06, a 94-year-old resident was observed on the floor next to her bed after apparently climbing over the bed rail. She was bleeding from the mouth, lethargic with sluggish pupils and changed level of consciousness. She was moved back to the bed while awaiting the 911 response. Facility staff took no measures to stabilize her head, neck or spine. She suffered a fracture of the cervical spine and died 11/25/06. The facility was cited for failure to have clear policies and procedures to safely move a resident who had fallen. (Issued as Class B at \$1,000.) Citation #09182203631.

Edgemoor Geriatric Hospital D/p SNF

9065 Edgemoor Drive, Santee, CA 92071

Edgemoor Geriatric Hospital D/p SNF
 10/19/2007 **B** Comp.
\$700 Patient Care Physical Environment

On 7/26/07, a 36 year old female resident with Huntington's chorea severely burned her hand while pouring coffee in the staff lounge room. The lounge room is supposed to be locked at all times. The facility failed to ensure resident safety by not keeping the lounge locked. (Issued as Class B at \$700.) Citation #09152904364.

Fredericka Manor Care Center

111 Third Avenue, Chula Vista, Ca 91910

Fredericka Manor Care Center
 1/18/2007 **B** Comp.
\$900 Administration Administration

On 1/2/07, the facility internally audited its personnel files, discovering that an employee lacked evidence of a current vocational nursing license. The employee was hired 8/2/06 without ever providing such a license. Further investigations revealed that the employee never actually took the Vocational Nursing Board Exam. The facility was cited for failure to verify an employee's credentials, directly affecting the health, safety, and security of the residents. (Issued as Class B at \$900.) Citation #09191403647.

La Jolla Nursing and Rehabilitation Center

2552 Torrey Pines Rd., La Jolla, CA 92037

La Jolla Nursing and Rehabilitation Center
 2/1/2007 **B** Comp.
\$1,000 Patient Care Decubiti (Bedsore)

On 12/21/06, a resident was admitted to the facility with an existing Stage I pressure sore on the left buttock, and a Stage II pressure sore on the right buttock. The careplan initiated on admission stated that the resident's skin would be evaluated every week, but was never implemented. On 1/2/07, the resident was transferred to the acute hospital with severe back pain. Staff discovered a Stage III bedsore on the resident's coccyx, and the resident's left buttock bedsore was now at Stage II. The facility was cited for failure to assess the resident and failure to provide treatment. (Issued as Class B at \$1,000.) Citation #08130503674.

La Jolla Nursing and Rehabilitation Center
 7/18/2007 **B** Comp.
\$1,000 Patient Care Patient Care

Between 3/28/07 and 5/23/07, a 74 year old female resident, requiring assistance with all activities of daily living, fell four times. On the last fall, the resident's left hip bone shattered into fragments. She had a careplan because she was at risk for falls, but it was not adequately developed or followed. The facility was cited for failure to ensure that each resident receives adequate supervision and assistance devices to prevent accidents. (Issued as Class B at \$1,000.) Citation #08134204108.

Las Villas De Carlsbad Health Center

1094 Laguna Drive, Carlsbad, CA 92008

Las Villas De Carlsbad Health Center
 3/5/2007 **B** Comp.
\$1,000 Patient Care Physical Environment
 Injury

A licensed nurse fell on a female resident when he was transferring her from her bed to a wheelchair. The wheelchair rolled out from underneath the resident, causing the nurse to lose his balance. The resident suffered two broken fingers and several cuts as a result of the fall. The facility was cited for failing to ensure that the wheelchair's locking brakes were secured before initiating the resident transfer. (Issued as Class B at \$1,000.) Citation #08158803768.

Manorcure Health Services

15632 Pomerado Road, Poway, CA 92064

Manorcure Health Services
 4/20/2007 **B** Comp.
\$900 Patient Care Hydration

Over a period of two weeks, from 2/06/07 to 2/21/07, a male resident at risk for dehydration declined from normal levels of hydration to extreme dehydration and an altered level of consciousness. The resident's careplan stipulated hydration management, including monitoring of fluid intake and frequency and amount of urination. On 2/21/07, the resident was transferred to the hospital due to severe dehydration. The facility was cited for failure to identify and subsequently continue to assess the resident's needs. (Issued as Class B at \$900.) Citation #08130403908.

Palomar Continuing Care Center D/P Snf

1817 Ave Del Diablo, Escondido, Ca 92029

Palomar Continuing Care Center D/P Snf
 4/13/2007 **A**
\$20,000 Patient Care Decubiti (Bedsore)

Death Occurred

A resident was admitted to the facility on 7/28/04 with no skin breakdown recorded in the initial assessment. By the time the resident was discharged on 10/30/04, she had Stage IV (to the bone) pressure sores on each heel. Her left leg was amputated on 11/26, and she died on 12/15/04. The facility was cited for failure to prevent progression of pressure sores, ensure adequate treatment was provided and notify the physician and responsible party when there was a need to alter treatment. (Issued as Class A at \$20,000.) Citation #08103403894.

Villa Las Palmas Healthcare Center

622 South Anza St., El Cajon, CA 92020

Villa Las Palmas Healthcare Center		
12/14/2007	B	Comp.
\$850	<u>Patient Care</u>	Decubiti (Bedsores)

A 79 year old male resident was admitted to the facility on 5/12/07. Two days after being discharged, the resident had to be transferred to a hospital for two pressure ulcers on his heels. The facility had failed to identify the resident's ulcers despite his documented high risk for developing them. The facility also failed to implement any preventative measures for skin impairment. (Issued as Class B at \$850.) Citation #09193604518.

Villa Rancho Bernardo Care Center

15720 Bernardo Center Drive, San Diego, CA 92127

Villa Rancho Bernardo Care Center		
6/1/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Supervision Careplan

On 2/16/07, a 71 year old male was admitted with a diagnoses of Alzheimer's disease and dementia. His assessment documented a history of wandering, including a previous elopement from an assisted living facility. Despite his history of elopement, confusion and frequent incidents of wandering at the facility, the resident was transferred from the secure unit to the open unit on 3/13/07. A transfer assessment was never done and his careplan was never updated. On 5/19/07, the resident was found wandering in a neighboring city, having suffered a facial contusion and abrasions during the two-hour elopement. The facility was cited for failing to develop a careplan to prevent the resident from eloping. (Issued as Class B at \$1,000.) Citation #08152003997.

Village Square Nursing And Rehabilitation Center

1586 W. San Marcos Blvd., San Marcos, CA 92069

Village Square Nursing And Rehabilitation Center		
4/5/2007	AA	Comp.
\$100,000	<u>Patient Care</u>	Neglect

Death Occurred

On 12/31/06, a resident who was at risk for blood clots due to hip surgery was transferred to an acute care hospital with an occluded artery. There was no documentation the facility staff monitored and assessed the resident for circulatory problems despite physician's orders from 12/14/06. Circulation could not be restored to the leg, amputation was declined and the resident died on 1/2/07. The facility was cited for failure to assess the resident's condition. (Issued as Class AA at \$100,000.) Citation #08125903875.

Vista Healthcare Center

247 E. Bobier Drive, Vista, Ca 92084

Pleasant Care Convalescent - Vista		
6/1/2007	B	Comp.
\$1,000	<u>Patient Rights</u>	Dignity Verbal Abuse

On 5/10/07, a CNA instructing a student CNA class entered the room of a resident and used profane language while on her cell phone. Three students reported the CNA was subsequently verbally and physically abusive with the 73 year old resident. When he complained she was being too rough while shaving him, the CNA told him "Shut up," "I hate you so much" and "If you don't stop you'll be lucky I don't slice your neck." The facility was cited for failing to ensure the resident was treated with dignity and respect. (Issued as Class B at \$1,000.) Citation #08140004005.

Pleasant Care Convalescent - Vista		
10/19/2007	B	Comp.
\$1,000	<u>Abuse</u>	Physical Abuse

On 10/2/07, a staff person heard a commotion in a resident's room. When she entered it, she saw a CNA holding the resident's hands and slapping him with a closed fist on the left side of his face. The staff then pulled the CNA out of the room and into the central supply room and asked her what she was doing. The CNA told her she felt like she needed to slap the resident to calm him down. The facility was cited for failing to ensure the CNA received appropriate supervision. (Issued as Class B at \$1,000.) Citation #08152004374.

Vista Knoll Specialized Care Facility

2000 Westwood Road, Vista, CA 92083

Vista Knoll Specialized Care Facility		
12/4/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Infection Careplan Neglect

An 85 year old female was admitted to the facility on 9/25/07 following abdominal surgery. Physician's orders called for daily and as needed dressing changes with wound treatment. A careplan was initiated for the wound, calling for monitoring of the wound and reporting signs/symptoms of infection to the physician. The treatment nurse called out sick on 10/6 and 10/7, leaving the resident's wound untreated and not reassessed for two days. The resident developed a significant wound infection during these two days with surrounding cellulitis over a fairly large area. The resident required hospitalization and surgical intervention to treat the infection. (Issued as Class B at \$1,000.) Citation #08140004479.

San Francisco County**Jewish Home D/P Snf**

302 Silver Ave, San Francisco, CA 94112

Jewish Home D/P Snf
5/9/2007 **B**
\$1,000 Patient Care Physical Abuse

On 3/7/07, an intern witnessed a CNA hit an 85 year old resident across the face with a bib. The facility was cited for failing to ensure a resident was free from physical abuse. (Issued as Class B at \$1,000.) Citation #22116303936.

Jewish Home D/P Snf
5/9/2007 **B** Comp.
\$1,000 Patient Rights Verbal Abuse
Mental Abuse

On 2/25/07, a CNA was rude and yelled at an 87 year old resident. As a result, the resident reported being afraid of her. The facility was cited for failing to ensure the resident was free from verbal and mental abuse. (Issued as Class B at \$1,000.) Citation #22116303942.

Jewish Home D/P Snf
5/9/2007 **B** Comp.
\$1,000 Abuse Mandated Reporting

On 2/25/07, an 87 year old resident reported to a charge nurse that a CNA was rude to her and yelled at her. As a result she was afraid of the CNA. The facility was cited for not reporting the incident to the Department of Health Services until 3/5/07. (Issued as Class B at \$1,000.) Citation #22116303947.

Laguna Honda Hospital & Rehabilitation Ctr D/P Snf

375 Laguna Honda Blvd., San Francisco, Ca 941161499

Laguna Honda Hospital & Rehabilitation Ctr D/P Snf
2/21/2007 **B** Comp.
\$1,000 Patient Care Injury
Careplan

On 11/11/05, a resident fell, resulting in a hip fracture. On 6/30/06, the resident fell again, resulting in a subdural hematoma. The facility further failed to follow another resident's careplan by providing her with a wheelchair for long distance locomotion, resulting in a fall on 5/20/06 that fractured her nose, and caused pain and difficulty eating due to loose teeth. The facility was cited for failure to implement the careplans of two residents according to the methods indicated in their careplans. (Issued as Class B at \$1,000.) Citation #22173503715.

Laguna Honda Hospital & Rehabilitation Ctr D/P Snf
2/21/2007 **B** Comp.
\$1,000 Patient Care Injury
Patient Care

On 5/18/06, a resident fell and was screaming in pain. Facility staff found her on the floor, stood her up and put her on a gurney to take her for an x-ray. The x-ray showed she had a shattered and displaced bone above her left knee. Moving a resident with a fracture can cause further injury. On 10/21/06, another resident fell. Staff stood him up, sat him in a wheelchair, and put him in bed, where they did his post-fall assessment. A physician evaluated the resident and sent him to the hospital for surgical repair of his hip fracture. The facility was in violation for having failed, on both occasions, to adequately assess the residents after their falls. (Issued as Class B at \$1,000.) Citation #22173503713.

Laguna Honda Hospital & Rehabilitation Ctr D/P Snf
3/13/2007 **AA** Comp.
\$100,000 Patient Care Supervision
Careplan

Death Occurred

On 10/30/06, an 82-year-old female resident eloped from her room, which was located on the third floor of the facility. She was found outside the facility on the ground with blood coming out of her right ear. An investigation revealed that she either fell or jumped to her death. The resident had previously eloped from the facility six times since her admittance on 6/23/05. The facility was cited for failing to review and implement the careplan for a resident who had a history of multiple elopements. (Issued as Class AA at \$100,000.) Citation #22183803716.

Laguna Honda Hospital & Rehabilitation Ctr D/P Snf
5/10/2007 **B** Comp.
\$1,000 Patient Care Physical Abuse
Dignity

On 3/14/07, a CNA squeezed and bent a female resident's hand, causing the resident extreme pain and discomfort. X-rays taken on 3/16/07 revealed an acute fracture to the left hand/wrist. The resident, who was admitted to the facility on 7/1/05, required extensive assistance with activities of daily living and suffered from short and long term memory problems. The facility was cited for failing to ensure a resident was not subjected to verbal or physical abuse of any kind. (Issued as Class B at \$1,000.) Citation #22176103951.

Laguna Honda Hospital & Rehabilitation Ctr D/P Snf
7/31/2007 **B** Comp.
\$1,000 Patient Care Hydration

Death Occurred

Due to a resident's frequent urinary tract infections (UTIs) and subsequent risk for urosepsis, his care plan stated he required 1,800cc-2200cc of fluid intake per day. There was no documentation that the resident's fluid intake was monitored. On 1/28/07, the resident was transferred to an acute ward with a UTI and dehydration. On 1/30/07, he was transferred to a hospital with acute renal failure. The resident died on 2/1/07. The facility was cited for failure to implement the resident's care plan to provide him with fluids to prevent dehydration. (Issued as Class B at \$1,000.) Citation #22173504135.

Laguna Honda Hospital & Rehabilitation Ctr D/P Snf
 9/5/2007 **A** Comp.
\$20,000 Patient Care Fall
 Injury
 Supervision
 Careplan

On 5/28/07, a resident drove his electric wheelchair through two open fire doors into a nonresident area and down three stairs, where the resident flew out of the wheelchair and landed face down on the floor. The resident sustained serious head and neck injuries and was no longer able to use the wheelchair for independent movement. The facility was cited because it failed to provide a safe environment when it left both fire doors open and failed to monitor the resident's wheelchair use as directed by his careplan. (Issued as Class A at \$20,000.) Citation #22210104227.

Laguna Honda Hospital & Rehabilitation Ctr D/P Snf
 12/10/2007 **A** Comp.
\$20,000 Patient Care Injury
 Neglect

On 6/10/07, a resident suffered 2nd and 3rd degree burns on his lower legs that required hospitalization for five surgeries. He returned to the facility bedridden with limited motion and excruciating pain. The resident suffered the burns when his pants caught on fire while he was lighting a cigarette. The facility was cited because it violated their own smoking policy by allowing the resident to smoke without supervision despite their assessment that the resident was an unsafe smoker. (Issued as Class A at \$20,000.) Citation #22210204493.

Sequoias San Francisco Convalescent Hospital

1400 Geary Blvd., San Francisco, CA 94109

Sequoias San Francisco Convalescent Hospital
 4/30/2007 **B** Comp.
\$1,000 Patient Care Fall
 Careplan

On 10/4/04, the resident suffered a fall from bed, breaking their right hip. The resident had a careplan that included using full side rails on the bed. The CNA in charge of the resident admitted that the left side rail had not been put up because the CNA did not think that all four side rails were necessary. The facility was cited for failing to implement the resident's careplan. (Issued as Class B at \$1,000.) Citation #22137203928.

San Joaquin County

A & C Health Care Services - Arbor

900 North Church St., Lodi, CA 95240

Arbor Convalescent Hospital
 6/14/2007 **B** Comp.
\$1,000 Patient Care Verbal Abuse
 Mandated Reporting

In January of 2007, a 68 year old resident asked for assistance from a CNA with being cleaned up after soiling the bed. The CNA told the resident to take care of it herself. The resident reported the incident to a LVN, but nothing was done. The facility was cited for failure to report an allegation of verbal abuse to the Department of Health Services within 24 hours. (Issued as Class B at \$1,000.) Citation #03167204030.

Beverly Healthcare Center

4545 Shelley Court, Stockton, CA 95207

Beverly Healthcare Center
 6/27/2007 **A** Comp.
\$20,000 Patient Care Transfer
 Administration
 Physical Environment

On 7/22/06, the facility's air conditioning unit malfunctioned and broke during an area heat wave. On 7/23/06, the facility's interim administrator, who had not received adequate training, did not follow the facility's disaster plan as needed to protect the residents when temperatures inside the facility reached the upper 80s. The facility failed to follow their "Dangerous Temperature Level" emergency action plan and failed to monitor or address the residents' responses to the increased temperature. Stockton Fire and Police Departments evacuated the facility, resulting in all 106 residents being unexpectedly moved from the facility during the early morning hours. All 106 residents were subjected to undue stress, anxiety/depression and transfer trauma. (Issued as Class A at \$20,000.) Citation #03156604048.

Beverly Healthcare Center
 6/27/2007 **AA** Comp.
\$80,000 Patient Care Physical Environment
 Neglect

Death Occurred

On 7/22/06, a 79 year old resident died within minutes of arrival at a local emergency room. The facility sent her there in full cardiac arrest with CPR being performed due to hyperthermia (abnormally high body temperature) caused by excessive heat in the facility. The facility failed to provide safe temperatures when it's air conditioning system malfunctioned during a heat wave and it failed to follow it's emergency action plan for dangerous temperature levels. Due to the excessive heat in the facility, the fire department initiated an evacuation of the facility beginning at 4:30 am on 7/23/06. (Issued as Class AA at \$80,000.) Citation #03156604050.

Beverly Healthcare Center
 6/27/2007 **A** Comp.
\$20,000 Patient Care Deterioration
 Patient Care
 Physical Environment

On 7/22/06, the facility's air conditioning unit broke and temperatures inside the facility reached into the upper 80s. The facility failed to provide a resident with adequate care during this time and the resident's temperature reached 111 degrees. Stockton Fire and Police Departments were called in and evacuated the facility. The resident was subsequently diagnosed with dehydration. (Issued as Class A at \$20,000.) Citation #03156604047.

Beverly LivingCenter - Chateau

1221 Rose Marie Lane, Stockton, CA 95207

Chateau Convalescent Hospital #568
 4/3/2007 **B** Comp.
\$1,000 Transfer Discharge planning

On 11/23/06, the facility discharged a 55-year-old resident without arranging necessary home health care services, causing her to go without needed services for three weeks. She did not have assistance with bathing, dressing, preparing meals, or transportation to physician appointments. The resident had diagnoses of diabetes, edema, chronic obstructive pulmonary disease, high blood pressure, depression and an indwelling urinary catheter. (Issued as Class B at \$1,000.) Citation #03173403865.

Beverly Manor of Stockton

2740 N. California Street, Stockton, CA 95204

Beverly Manor of Stockton
 3/22/2007 **B** Comp.
\$500 Abuse Mandated Reporting
 Fall

The facility failed to report a large bruise of unknown origin to the Department of Health Services when it was discovered on a resident's right hip on 10/9/06. On 10/25/06, when the resident reported to the DON that the bruise was from being dropped, the facility again failed to report the incident to the DHS within 24 hours. The facility was cited for failing to report an injury of unknown origin on 10/9/06, and failing to report the allegation of physical abuse within 24 hours to DHS. (Issued as Class B at \$500.) Citation #03179403790.

Crestwood Manor - Stockton

1130 Monaco Court, Stockton, CA 95207

Crestwood Manor - Stockton
 4/17/2007 **B** Comp.
\$1,000 Patient Care Fall
 Deterioration

It was reported to staff that a 54 year old male resident fell in his room on 3/5/06 at approximately 7 pm. Vital signs were checked and it was noted that his blood pressure had fallen, his right side was drooping and his speech was slurred. The facility doctor was called. The RN asked if the resident should be transferred to an acute care hospital, but the doctor said no since he had checked on the patient a few hours ago (approximately 5 pm) and everything was fine. The resident was checked up on every 15 minutes and by approximately 10 pm his vitals had plummeted so much the RN called an ambulance despite having no doctor's order. Resident was diagnosed with a large hemorrhage on the left side of his brain and required two neuro-surgeries to repair. Facility was cited for failure to ensure the resident maintained his highest practicable level of well-being by not providing aggressive medical interventions. This failure resulted in the resident not being transferred to the hospital in a timely manner and him ultimately becoming ventilator-dependent indefinitely. It is not known if the facility filed a complaint against the doctor. (Issued as Class B at \$1,000.) Citation #03173403891.

Delta Valley Convalescent Hospital

1032 N. Lincoln Street, Stockton, CA 95203

Delta Valley Convalescent Hospital
 10/1/2007 **B** Comp.
\$1,000 Patient Care Careplan
 Injury
 Physical Environment

On 7/23/07 at 7 am, a resident was discovered by staff as missing from the facility. The resident had a history of elopement and his careplan called for frequent monitoring and use of safety devices, such as alarms and wander guard. The alarm on an exit door near the resident's room had been turned off. The resident was found about a half mile from the facility sitting down on the street and was taken to the emergency room, where he was diagnosed with an altered level of consciousness and fracture of the left hip. The facility was cited for failure to protect the resident, implement his careplan and to maintain necessary safety equipment. (Issued as Class B at \$1,000.) Citation #03166204298.

Elmhaven Care Center

6940 Pacific Avenue, Stockton, CA 95207

Elmhaven Care Center

7/24/2007 **B** Comp.
\$800 Patient Care

On three different occasions (12/6/06, 12/9/06, and 12/13/06), a 69 year old male resident with a history of escape attempts eloped from his facility. The first two attempts he was found right outside of the facility; the third time he was found 9.3 miles from the facility and intoxicated. When the resident was initially admitted to the facility, his elopement risk was not properly evaluated nor were his subsequent attempts at eloping followed up with appropriate changes in his careplan. The facility was cited for failure to develop an appropriate careplan and provide adequate supervision for the resident. (Issued as Class B at \$800.) Citation #03188604112.

Fairmont Rehabilitation Hospital

950 S. Fairmont Ave, Lodi, CA 95240

Fairmont Rehabilitation Hospital

10/29/2007 **B** Comp.
\$1,000 Patient Care Decubiti (Bedsore)

An 85 year old man was admitted to the facility on 4/4/07 and was identified as "at risk" for pressure sores. There is no documented evidence the resident received a pressure reducing device for his wheelchair or daily skin inspections. The resident began developing "abrasions" on his skin that were not measured or documented on a regular basis. On 7/1/07, the resident was transferred to a general acute care hospital due to increased weakness, lethargy and paleness of skin. The hospital documented two Stage III bedsore and one Stage II bedsore on the resident. The facility was cited for failing to prevent the resident from developing pressure sores and failing to document and measure the pressure sores. (Issued as Class B at \$1,000.) Citation #03166204395.

Hampton Care Center

442 Hampton Street, Stockton, CA 95204

Hampton Care Center

4/19/2007 **A** Comp.
\$18,000 Patient Care Decubiti (Bedsore)

On 4/11/06, a 69 year old resident was admitted to an acute care hospital with a Stage IV coccyx pressure sore, a necrotic left heel and sepsis. He underwent surgical debridement and aggressive wound care management for the coccyx sore and a Stage III heel pressure sore. At the time of his admittance, the resident had been assessed as a high risk for pressure sores and an extensive careplan had been developed for his care at the facility. The facility was cited for failure to provide the resident with treatment and services necessary to promote healing and prevent infections from pressure sores. (Issued as Class A at \$18,000.) Citation #03169903899.

Manteca Care And Rehabilitation Center

410 Eastwood Avenue, Manteca, CA 95336

Manteca Care And Rehabilitation Center

3/26/2007 **B** Comp.
\$800 Abuse Dignity

On 1/22/07, an 89-year-old female resident requested that she be assisted to the bathroom. A CNA responded to her call and told the resident to urinate into her incontinent brief because "that's what it's for." When the resident insisted on using the bathroom, the CNA roughly pulled the resident from her bed, causing neck pain and a bruise. The facility was cited for failing to keep the resident free from physical abuse and failing to treat the resident with dignity. (Issued as Class B at \$800.) Citation #03169903836.

Meadowood A Health & Rehabilitation Center

3110 Wagner Heights Road, Stockton, Ca 95209

Meadowood A Health & Rehabilitation Center

9/26/2007 **B** Comp.
\$1,000 Injury of Careplan
 unknown origin Patient Care

On 8/28/07, an 81 year old resident with osteoporosis had several x-rays performed. Several fractures were discovered in her left knee and hip bone. An investigation by the Department of Public Health revealed the facility failed to implement the resident's careplan on a consistent basis regarding transfer services. The resident's careplan directed staff to use an assistance device/mechanical lift during transfers; instead, staff members transferred the resident manually without any mechanical assistance. The facility failed to implement the resident's careplan. (Issued as Class B at \$1,000.) Citation #03148804283.

New Hope Care Center

2586 Buthmann Road, Tracy, Ca 95376

New Hope Care Center

5/10/2007 **B** Comp.
\$1,000 Patient Care Fall
 Careplan

On 5/12/06 around 9:40 am, a 97 year old resident fell out of her Hoyer lift resulting in cuts to the right side of her head and eyebrow. She was taken to the ER for stitches and observation. The facility was cited for failure to follow the careplan, which called for two person transfers. (Issued as Class B at \$1,000.) Citation #03166203933.

New Hope Care Center

10/30/2007 **B** Comp.
\$1,000 Patient Care Hydration
 Medication

A resident who was at risk for dehydration secondary to chronic diarrhea and colitis was transferred to the acute care hospital on 9/1/04, due to weakness, poor appetite and low blood pressure. She was treated for dehydration. The physician had prescribed prednisone for the colitis but the resident had not received the medication for 27 days. The facility was cited for failure to assess the resident regarding hydration, develop a care plan, monitor the resident's fluid intake, administer medication as prescribed and implement the facility's policy and procedure on hydration. (Issued as Class B at \$1,000.) Citation #03162204400.

Palm Haven Care Center

469 East North Street, Manteca, CA 95336

Palm Haven Care Center

10/1/2007	B	Comp.
\$1,000	<u>Abuse</u>	Physical Abuse Verbal Abuse Retaliation Against Resident Mandated Reporting

On 7/1/7 at 11 am, the manager of the day observed a CNA threaten to hit a resident with a folded rubber strap, then sit on his lap to restrain him. The manager did not intervene or promptly report the abuse. The facility was cited for failure to protect the resident from abuse, follow its own policies and procedures for reporting abuse, and for failure to report the abuse immediately or within 24 hours to the licensing agency. (Issued as Class B at \$1,000.) Citation #03188604295.

Sunbridge Heritage Care Center

9107 N. Davis Road, Stockton, CA 95209

Sunbridge Heritage Care Center

6/27/2007	B	Comp.
\$800	<u>Abuse</u>	Verbal Abuse Mandated Reporting

On 1/28/07, a CNA heard a nurse tell a resident, "You're the one with the problem. It's all in your damn head." The incident was not reported for 24 hours. The facility was cited for failure to report an alleged incident of abuse, report as a mandated reporter to the local law enforcement or ombudsman and failure to implement a portion of their "Resident Abuse Prohibition" policy. (Issued as Class B at \$800.) Citation #03144804044.

Sunbridge Heritage Care Center

6/27/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Fall Notification

On 2/4/07, a resident experienced an increase in body temperature from 99.5 degrees to 102.3 degrees. The resident fell out of his bed due to shaking and sustained a laceration to his head. The resident was admitted to the emergency room for the head wound, but ended up having a ten day stay with a diagnosis of pneumonia. The facility failed to notify the attending physician of the sudden change in the resident's condition and failed to identify the resident's care needs based on continual assessment with input from the resident's attending physician. (Issued as Class B at \$1,000.) Citation #03148804043.

Sunbridge Heritage Care Center

9/21/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Careplan Patient Care Supervision

On 9/01/07, a 74 year old resident fell from his wheelchair and fractured a bone in his right arm. The resident was considered high risk for falls and, according to his careplan, required assistance walking. The resident was left unsupervised, even though staff had seen him trying to get up multiple times earlier that day. The facility failed to provide adequate supervision of the resident. (Issued as Class B at \$1,000.) Citation #03148804281.

Sunbridge Heritage Care Center

9/21/2007	B	Comp.
\$1,000	<u>Abuse</u>	Administration Mandated Reporting Neglect

On 9/01/07, a resident attempted to rise from his wheelchair three times while under supervision. On the fourth attempt to rise he was no longer being supervised, fell and sustained a right shoulder fraction. The facility failed to implement their policy on resident abuse prohibition by failing to identify "neglect" as "failure to provide the care necessary to avoid physical harm," as well as by failing to report the incident and notify the Department of Health within 24 hours. (Issued as Class B at \$1,000.) Citation #03148804282.

Tracy Convalescent and Rehabilitation Center

545 West Beverly Place, Tracy, CA 95376

Tracy Convalescent and Rehabilitation Center

10/8/2007	B	Comp.
\$650	<u>Abuse</u>	Careplan Dignity Mental Abuse Physical Abuse Verbal Abuse

On 9/4/07, a CNA placed a 72 year old female resident roughly in a chair and spoke to her in a harsh manner, causing the resident shortness of breath and anxiety. The resident said she felt unsafe being treated by CNA. The facility failed to protect the resident from physical, mental and verbal abuse, and to implement its Abuse Prevention Plan that abuse of any kind would not be tolerated. (Issued as Class B at \$650.) Citation #03163704317.

Valley Gardens Health Care & Rehabilitation Center

1517 Knickerbocker, Stockton, CA 95210

Valley Gardens Health Care & Rehabilitation Center

6/19/2007	B	Comp.
\$800	<u>Patient Care</u>	Careplan Fall Supervision

An 80 year old resident experienced falls on 12/24/05, 4/18/06 and 5/20/06. Resident was assessed with high risk for falls before the first fall. After the second fall on 4/18/06, her care plan was updated with the instruction to staff to never leave her alone in the bathroom. However, on 5/20/06, the resident was left unattended in the bathroom and suffered her third fall. She suffered a deep laceration to her right eyebrow, bruising and swelling on her face. The facility failed to provide adequate supervision and assistance for toileting and failed to implement resident's updated care plan after 4/18/06. (Issued as Class B at \$800.) Citation #03188604027.

Valley Gardens Health Care & Rehabilitation Center

6/27/2007	B	Comp.
\$800	<u>Patient Care</u>	Physical Restraints

On 2/14/07, the housekeeping supervisor saw three residents tied to their wheelchairs with bed sheets. The facility was cited for failure to ensure the residents were not physically restrained due to convenience. (Issued as Class B at \$800.) Citation #03148804042.

Whispering Hope Care Center

5/10/2007 **B** Comp.
\$1,000 Abuse Physical Abuse
 Verbal Abuse

On 3/19/07 at 2:45 am, the charge nurse heard a CNA yelling at a resident and observed the CNA rolling and yanking the resident from one side of the bed to the other and slamming a bag down on the bed near the resident's foot. The 88 year old resident was screaming. The facility was cited for failure to protect the resident from physical and verbal abuse. (Issued as Class B at \$1,000.) Citation #03166203935.

Whispering Hope Care Center

9/17/2007 **B** Comp.
\$1,000 Patient Care Physical Restraints

During the night on 6/17/07, a certified nursing assistant tied a restless 88 year old resident to her bed with a vest restraint without a physician order, causing the resident to yell and scream. During the same night, the nursing staff also administered ordered psychoactive medications, Haldol and Ativan. The facility was cited because it applied the vest restraint without physician's order. (Issued as Class B at \$1,000.) Citation #03166204245.

Whispering Hope Care Center

10/22/2007 **B** Comp.
\$1,000 Patient Care Nutrition

The facility failed to ensure a 54 year old male resident did not have an unintended weight loss of 17 pounds from 3/8/07 to 4/17/07 and an unintended weight loss of 10 pounds from 5/8/07 to 6/21/07. The facility also failed to ensure the resident was weighed weekly for four weeks, as ordered, on 4/25/07 and weighed within 24 hours when he experienced a weight loss of more than five pounds in one month, as per their policy. The facility also failed to ensure the resident received a protein shake with each meal and three times a day, as recommended. (Issued as Class B at \$1,000.) Citation #03166204379.

Wine Country Care Center

321 W. Turner Road, Lodi, Ca 95240

Wine Country Care Center

9/7/2007 **B** Comp.
\$1,000 Injury of Unknown Origin Injury

An untimed "Nurses Notes" entry dated 7/18/07 disclosed that a 93 year old nonverbal stroke victim had a shoulder swelling. An x-ray later determined the shoulder was dislocated and fractured. The facility made no determination of how her shoulder became injured. However, one interviewed CNA stated "that sometimes when you get her up with the Hoyer lift her arm gets trapped behind her." Although required to report the incident to the Department within 24 hours, the facility didn't notify it until 7/30. The facility was cited for failing to follow the state reporting requirement. (Issued as Class B at \$1,000.) Citation #03148804242.

San Luis Obispo County

Danish Care Center

10805 El Camino Real, Atascadero, Ca 93422

Danish Care Center

1/11/2007 **B** Comp.
\$1,000 Patient Care Medication

On 7/26/06, a resident "was vomiting, pale, cool/clammy to the touch, and stated 'I am sick.'" Half an hour later, the resident was transported to the acute hospital. An investigation revealed that the resident was given her husband's blood pressure and cholesterol medications. The facility failed to ensure that the resident was provided with proper care. (Issued as Class B at \$1,000.) Citation #05132503627.

Danish Care Center

1/11/2007 **B** Comp.
\$1,000 Patient Rights Physical Abuse
 Mental Abuse

On 10/3/06, a resident attacked another resident with a coat hanger. The victim suffered injuries to his forehead, neck, chest, and hands. The facility was cited for failing to ensure that a resident was not subjected to physical and mental abuse. (Issued as Class B at \$1,000.) Citation #05144803628.

Mission View Health Center

1425 Woodside Drive, San Luis Obispo, CA 93401

Mission View Health Center

1/25/2007 **B** Comp.
\$1,000 Patient Care Sexual Abuse

On 11/6/06, an 85-year-old female resident reported that a male CNA had touched her inappropriately several times. She stated that he would touch her shoulder, then her breast, then her genitals. The CNA would laugh at her and refuse to stop touching her. The facility was cited for failure to ensure that each resident is treated with dignity and not subjected to physical abuse. (Issued as Class B at \$1,000.) Citation #05144803660.

Mission View Health Center

1/25/2007 **B** Comp.
\$800 Patient Care Dignity
 Verbal Abuse

On 12/5/06, a resident stated that a staff member spit on her while changing her and also made rude comments such as, "that's what pigs do," "aren't you embarrassed or ashamed," and "I have to clean you up." The facility was cited for failing to ensure that the resident was treated with dignity and respect. (Issued as Class B at \$800.) Citation #05144803661.

Mission View Health Center

1/25/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Patient Care Injury

On the morning of 11/11/06, a resident was discovered to have a hematoma on her forehead, two black eyes and bruising across the bridge of her nose. Facility staff did not witness an accident, however, the facility concluded that the resident most likely fell asleep and struck her head on the bedside table. The resident is fully dependent on staff, unable to reposition herself and has a history of falling asleep while sitting up in her bed. The facility was cited for failing to identify the resident's risk for injury and plan care to ensure her safety. (Issued as Class B at \$1,000.) Citation #05144803662.

San Mateo County**Atherton Healthcare**

1275 Crane Street, Menlo Park, Ca 94025

Canaan Health Care Center		
3/9/2007	B	Comp.
\$1,000	<u>Abuse</u>	Mandated Reporting

On 11/17/06, Resident #1 pushed Resident #2, who fell to the floor. Resident #1 then brandished a three-hole puncher in the air. Nursing staff intervened and called the police. The police report stated that the two residents were "continuously fighting," and that Resident #1 was "always the main aggressor in the argument." The Director of Nurses stated the facility had not reported the incident to the Department of Health Services because there had been a fire in the laundry room that required their attention. The facility was cited for failing to report the incident of alleged or suspected abuse on Resident #2 by Resident #1 to DHS within 24 hours. (Issued as Class B at \$1,000.) Citation #22141203765.

Linda Mar Care Center

751 San Pedro Terrace Road, Pacifica, Ca 94044

Linda Mar Care Center		
1/9/2007	B	Comp.
\$1,000	<u>Patient Rights</u>	Verbal Abuse

During an interview with a resident on 10/17/06, it was determined the administrator of the facility had confronted a wheelchair bound resident and began screaming at her for having notified her roommate that her belongings were being packed up while she was in the hospital. The administrator placed his hands on both armrests of her wheelchair and had his face less than 10 inches from her face while he was yelling at her. The facility was cited for the administrator's conduct because it was likely to cause significant humiliation, indignity, anxiety or other emotional trauma to residents. (Issued as Class B at \$1,000.) Citation #22163403622.

Linda Mar Care Center		
1/9/2007	B	Comp.
\$1,000	<u>Abuse</u>	Mental Abuse Verbal Abuse Mandated Reporting

On 1/24/06, a resident reported the facility administrator screamed at her in public, causing her to cry because she felt demeaned and humiliated. Two licensed nurses reported that the administrator was yelling at the resident while leaning on her wheelchair, just inches from her face. One nurse said the administrator "screamed at people frequently, never apologizing or expressing remorse." The facility was cited because the nurses did not report the witnessed verbal and mental abuse to the Department of Health Services as required by law and the facility failed to investigate the abuse. (Issued as Class B at \$1,000.) Citation #22163403623.

Linda Mar Care Center
2/7/2007 **B** Comp.
\$1,000 Patient Rights Verbal Abuse
Administration

On 10/12/05, a female resident reported that the day before, her roommate, an 87-year-old female resident was verbally abused by a staff member. The staff member yelled at the resident twice in the same evening. When the employee's personnel file was reviewed, it revealed that the file was missing significant parts, including verification of citizenship and reference checks. The facility was cited for failure to ensure that a resident is free from verbal abuse and mental suffering, and for failure to screen potential employees and checking appropriate certification boards. (Issued as Class B at \$1,000.) Citation #22163403696.

Linda Mar Care Center
3/15/2007 **B** Comp.
\$1,000 Abuse Physical Abuse
Injury
Mandated Reporting

On 2/2/07, a resident suffered purplish/bluish discoloration of her eye and skin abrasions on her arms. Facility staff reported they suspected the injuries were caused by another resident, her roommate. The facility was cited because its staff failed their duties to report the suspected abuse to the Department of Health Services within 24 hours and failed to conduct a thorough investigation. (Issued as Class B at \$1,000.) Citation #22143803812.

Linda Mar Care Center
3/16/2007 **B** Comp.
\$1,000 Patient Care Medication
Patient Care

On 10/15/06, a licensed nurse attempted to administer medications to a resident four hours before the prescribed time. Later the same day, the licensed nurse attempted to have the husband of the resident administer his wife's treatment. She also administered medications to the resident without crushing them and mixing them with applesauce, but rather gave the resident water, although it was documented she was not to have thin liquids. The LVN also did not administer evening medications to five other residents and failed to sign her name on the Medication Administration Record. The facility failed to ensure that facility residents receive care and services as prescribed by the physician. (Issued as Class B at \$1,000.) Citation #22163403829.

Linda Mar Care Center
3/28/2007 **B** Comp.
\$1,000 Abuse Mandated Reporting

On 1/31/97, staff witnessed one resident punching another in the jaw three times. The law requires the facility to report such incidents to the proper authorities within 24 hours. The facility was cited for waiting a week before making the necessary report. The facility was cited for failure to ensure that the resident who was attacked was free from physical harm. (Issued as Class B at \$1,000.) Citation #22143803813.

Linda Mar Care Center
6/12/2007 **B** Comp.
\$1,000 Patient Care Physical Abuse

On 11/3/06, a cognitively alert elderly resident who had been admitted to the facility after shoulder surgery had a physical altercation with a CNA who removed her call light from her hand and hit her hand causing a bruise. The resident stated after the incident the CNA returned with a sheet over his head in an attempt to mask his identity and pulled the call light cord from the wall. The facility was cited for failure to protect the resident and failure to properly report the incident (Issued as Class B at \$1,000.) Citation #22184104016.

Linda Mar Care Center
8/2/2007 **B**
\$1,000 Abuse Mandated Reporting
Physical Abuse

On 3/5/07, a resident complained of "rushed/rough" handling by a CNA. The administrator admitted the incident was not reported to the Ombudsman or the Department of Health Services. The facility was cited for failure to notify the Department of an allegation of physical abuse and the facility staff failed to act as mandated reporters. (Issued as Class B at \$1,000.) Citation #22202604157.

Linda Mar Care Center
8/2/2007 **B** Comp.
\$1,000 Patient Rights Patient Rights

On 4/8/07, a female resident who repeatedly exhibited combative and aggressive behavior threatened another female resident and hit her repeatedly on the leg. The facility was cited for failure to ensure the resident was protected from physical abuse and the right to be treated with dignity and respect. (Issued as Class B at \$1,000.) Citation #22176104154.

Linda Mar Care Center
8/15/2007 **B** Comp.
\$1,000 Patient Care Fall

On 3/24/07, an 80 year old female resident fell from a mechanical lift, fracturing her right hip. The resident was extremely frail and dependent upon others for daily living activities. She required two people to transfer her and was at a high risk for falling. Regardless of this information, a CNA attempted to move the resident alone, resulting in the fall. The facility was cited for failing to develop individual care plans for its residents. (Issued as Class B at \$1,000.) Citation #22182704188.

Magnolia Gardens Care Center --- CLOSED

1609 Trousdale Drive, Burlingame, CA 94010

Magnolia Gardens Care Center

3/19/2007

B

\$1,000

Patient RightsPhysical Abuse
Verbal Abuse

On 11/10/04, a female resident with severe cognitive impairment was observed with skin discoloration on her right hand. The resident's roommate stated on the previous night she observed a staff member roughly handling the resident. The resident screamed in pain, and the staff member said, "Oh, you're not hurting--I have other patients to take care of." The facility was cited for failing to ensure that a resident was free from verbal and physical abuse. (Issued as Class B at \$1,000.) Citation #22169603795.

Magnolia Gardens Care Center --- CLOSED ---

12/6/2007

B

\$1,000

Problem Transfer

Comp.

Notification
Administration
Transfer

The facility discharged 50 residents without medical assessments by a physician. The above violation directly affected the health, safety, and/or security of the residents. (Issued as Class B at \$1,000.) Citation #22143804504.

Millbrae Serra Convalescent Hospital

150 Serra Avenue, Millbrae, CA 94030

Millbrae Serra Convalescent Hospital

8/28/2007

B

\$1,000

Patient Care

Comp.

Patient Care

On 2/23/07, a resident complained of leg pain. The resident continued to complain of pain, but was not seen by a physician for 12 days. An X-ray revealed a broken hip. The facility was cited for failure to assess the resident, update the care plan to address the pain and notify the resident's physician in a timely manner. (Issued as Class B at \$1,000.) Citation #22202604219.

Pacifica Nursing And Rehab Center

385 Esplanade Street, Pacifica, Ca 94044

Pacifica Nursing And Rehab Center

3/19/2007

B

\$1,000

Patient CarePatient Care
Careplan**Death Occurred**

An 83 year old male resident was admitted to the facility on 7/20/01. His Dehydration Assessment stated he was at "low risk" for dehydration, even though it showed him "unable to ask for fluids due to cognition problems." On 8/10/01, the resident was transferred to the hospital with a decreased level of consciousness, severe dehydration, a UTI, and a Stage II bedsore. The resident died on 12/17/01. The facility was cited for failing to identify and assess the resident's risk for dehydration and develop a care plan to prevent it. (Issued as Class B at \$1,000.) Citation #22173503819.

San Mateo Convalescent Hospital, Inc.

453 N. San Mateo Drive, San Mateo, CA 94401

San Mateo Convalescent Hospital, Inc.

8/22/2007

B

\$1,000

Patient Care

Comp.

Hydration

A resident who was taking a diuretic medication was admitted to the facility on 2/9/07. Nurse's notes indicate the resident's fluid output exceeded intake for 10 consecutive days. The resident was transferred to the hospital on 2/19/07, because of a change in mental status due to dehydration. The facility was cited for failure to identify factors that put the resident at risk for dehydration and failure to provide adequate fluids. (Issued as Class B at \$1,000.) Citation #22163504200.

San Mateo Medical Ctr.Long Term Care Serv. D/P

222 West 39th Avenue, San Mateo, CA 94403

San Mateo Medical Ctr.Long Term Care Serv. D/P Snf

2/21/2007

B

\$1,000

Patient Rights

Comp.

Mental Abuse

On 1/2/07, an 86-year-old female resident was resting her feet in a pan of warm water to alleviate pain. She asked a Medical Staff Assistant (MSA) to take the pan after the water became cold. The MSA forcibly pulled the pan and demanded that the resident clean the spilled water. The facility was cited because the MSA used an angry tone and taunted the resident, treating her with extreme disrespect and causing significant emotional trauma. (Issued as Class B at \$1,000.) Citation #22165503734.

Seton Medical Center - Coastside D/P SNF

600 Marine Boulevard, Moss Beach, CA 94038

Seton Medical Center - Coastside D/P SNF

1/22/2007

A

\$20,000

Patient Rights

Comp.

Sexual Abuse

On 12/4/06, a licensed nurse informed the resident's physician that the resident had verbalized, "They raped me, followed by striking and hitting, saying bitch, bitch, bitch." There was no documented evidence of the physician's response and no physical assessment was done by the facility. The following day, the resident was transferred to the hospital, and was found to have bruises on her arms. An investigation by the Sheriff's Department revealed that the resident had been sexually abused through digital penetration. The facility was cited for failing to protect the resident from mental and physical abuse. (Issued as Class A at \$20,000.) Citation #22169603650.

Seton Medical Center D/P SNF

1900 Sullivan Ave., Daly City, CA 94015

Seton Medical Center D/P SNF

1/8/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Physical Abuse

During the week of 10/23/06-10/27/06, a CNA roughly handled an 88-year-old resident by pulling a gown over her head ripping out her pierced earring, tearing her left ear lobe, and causing bleeding. The lobe could not be repaired. The facility was cited for not protecting the resident from abuse and not reporting the event. (Issued as Class B at \$1,000.) Citation #22183803624.

Seton Medical Center D/P SNF

3/21/2007	B	
\$1,000	<u>Patient Care</u>	Patient Care Physical Abuse

On 2/21/07, a resident was having trouble breathing and asked for his tracheotomy opening to be suctioned. The respiratory therapist (RT) attended him. The resident became upset with the RT and he called the RT stupid and she said, "Treatment is over." The RT disconnected his tubing and a tube came undone on the ventilator sounding an alarm. The resident said he could not breath and but the RT told him he was fine. Other staff attended him and the RT left the room. Afterwards, the resident complained of muscle pains and a headache, and stated that he was now afraid of the RT. The facility was cited for failing to protect a resident from physical and emotional abuse. (Issued as Class B at \$1,000.) Citation #22165503838.

Santa Barbara County**La Cumbre Senior Living Concepts**

3880 Via Lucero, Santa Barbara, CA 93110

La Cumbre Senior Living Concepts

1/18/2007	B	Comp.
\$1,000	<u>Medication</u>	Medication

On 10/31/06, a resident was taken to the acute hospital in an altered mental state after being given narcotic medications that were never prescribed by her physician. At the ER, a urine toxicology screen was performed and it was positive for the presence of both morphine and diazepam, neither of which should have been given to the resident. The facility was cited for giving medication that was not ordered by her physician. (Issued as Class B at \$1,000.) Citation #05144003644.

La Cumbre Senior Living Concepts

5/23/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Fall

On 6/1/06, a resident who had problems with balance and was at risk for falls was left unattended while on the toilet. As a result, the resident fell forward, struck her head and sustained a laceration that required treatment at the local hospital. The facility was cited for failure to ensure the resident was provided with adequate supervision and assistance devices to prevent accidents. (Issued as Class B at \$1,000.) Citation #05137103735.

La Cumbre Senior Living Concepts

7/12/2007	A	Comp.
\$18,000	<u>Patient Care</u>	Fall

On 4/28/07, a resident who was at risk for falls was left unattended in the bathroom. Although both the resident's roommate and the CNA reported a large crash from the bathroom, the CNA denied the resident fell. The resident was transported to an acute care hospital on 4/29/07, where she underwent surgery for a left hip fracture. The facility was cited for failure to provide adequate supervision to prevent accidents. (Issued as Class A at \$18,000.) Citation #05205203971.

La Cumbre Senior Living Concepts

8/30/2007	A	Comp.
\$10,000	<u>Patient Care</u>	Careplan Injury Fall

On 10/16/06 around 8:45 pm, a resident wandered from the facility and was not found until 9 am the next morning. He was found several miles from the facility and taken to the ER with a fever, vomiting and chest pain. He had a previous incident of elopement on 7/30/06, also resulting in hospitalization. The facility was cited for failure to follow the careplan, which required monitoring every 30 minutes and the use of a Wanderguard system that had been ordered, but not installed. (Issued as Class A at \$10,000.) Citation #05177604173.

Lompoc Skilled & Rehabilitation Center

1428 W. North Avenue, Lompoc, Ca 93436

Lompoc Skilled & Rehab Center

1/18/2007 **B** Comp.
\$300 Failure to Report Mandated Reporting

On 11/20/06, a CNA witnessed a resident to resident abuse and reported it to the charge nurse. The facility was cited for failing to report the abuse to the Department of Health Services until 11/28/06. (Issued as Class B at \$300.) Citation #05144003640.

Lompoc Skilled & Rehab Center

1/18/2007 **B** Comp.
\$600 Patient Care Mandated Reporting

On 10/26/06, Resident A wandered into Resident B's room and attempted to use the restroom. When Resident B tried to redirect Resident A out of her room, Resident A grabbed Resident B around the neck as if to choke her. Resident B notified the charge nurse of the incident, but the charge nurse did not notify the administrator as required by the facility's policy and procedure for abuse. The facility was cited for failing to ensure that all allegations of resident abuse are immediately reported to the facility administrator in accordance with the facility's policy and procedure. (Issued as Class B at \$600.) Citation #05144003641.

Lompoc Skilled & Rehab Center

1/18/2007 **B** Comp.
\$1,000 Failure to Report Physical Abuse

On 10/36/06, a resident who had a history of wandering and physical aggression towards other residents wandered into another resident's room and grabbed her around the neck. The charge nurse was informed of the episode but did not notify the administrator and the resident's careplan was not revised to prevent further incidents of abuse of other residents. On 11/20/06, the resident wandered into another resident's room and struck her. The facility was cited for failure to keep residents free from physical abuse. (Issued as Class B at \$1,000.) Citation #05144003642.

Lompoc Skilled & Rehab Center

3/1/2007 **B** Comp.
\$500 Patient Rights Patient Care
Supervision

On 2/8/07, a resident wandered into another resident's room, grabbed the resident's hands and arms and shook her. The facility was aware that the resident had a history of wandering and physically aggressive behavior towards other residents, and determined that she required one on one staff at all times. The facility was cited for failing to consistently provide the resident with one-on-one staff. (Issued as Class B at \$500.) Citation #05144803742.

Lompoc Skilled & Rehab Center

11/1/2007 **B** Comp.
\$800 Patient Care Fall
Patient Care

On 8/13/07, a resident fell while climbing out of her bed and sustained a fracture of her right shoulder, requiring surgical repair. The resident suffered severe dementia and was diagnosed as "a 100% fall risk." The facility failed to provide the resident with adequate supervision and assistive devices to protect the resident from an accident. (Issued as Class B at \$800.) Citation #05203304315.

Samarkand Skilled Nursing Facility

2566 Treasure Drive, Santa Barbara, Ca 93105

Samarkand Skilled Nursing Facility

7/12/2007 **B** Certif.
\$1,000 Abuse Physical Abuse
Notification

On 9/9/06, a male resident stated he had been hit by a male CNA. The resident had swelling on his leg between his knee and his hip with yellow areas on the thigh and small bruises on the temple. The incident was reported to the Assistant Director of Nursing, but was not reported to the Department of Health Services until 9/11/06, three days after the incident occurred. The facility was cited for failure to report alleged abuse of the resident to the Department immediately or within 24 hours. (Issued as Class B at \$1,000.) Citation #05203304083.

Samarkand Skilled Nursing Facility

7/12/2007 **B** Comp.
\$900 Abuse Mandated Reporting

On 4/27/06, a female resident, completely dependent upon staff for all daily activities, complained of neck pain and headaches. Investigation revealed fractures in two bones on her neck. The suspected abuse was not reported until 5/1/06, four days after the fracture was discovered. On 4/9/07, another female resident dependent upon staff for all her daily activities was discovered to have two fractured toes from unknown causes. There was no record the facility reported this suspected abuse. The facility was cited for failure to report all incidents of alleged or suspected abuse of a resident to the department immediately or within 24 hours. (Issued as Class B at \$900.) Citation #05177804094.

Santa Barbara Convalescent Hospital

2225 De La Vina Street, Santa Barbara, CA 93105

Santa Barbara Convalescent Hospital

3/6/2007 **B** Comp.
\$1,000 Patient Rights Physical Abuse

On the evening of 11/12/06, a resident was struck by his roommate with a shoe. The resident sustained a large, painful bruise from his elbow to his wrist. The facility was cited for failure to protect the resident from physical abuse. (Issued as Class B at \$1,000.) Citation #05136803731.

Valle Verde Health Facility

900 Calle De Los Amigos, Santa Barbara, CA 93105

Valle Verde Health Facility

7/12/2007	A	Certif.
\$8,000	<u>Patient Care</u>	Fall

On 3/1/07, a female resident, diagnosed with Parkinson's and dementia, fell from her wheelchair while being wheeled to the dining room. The CNA moving her failed to attach the footrest to the wheelchair and the resident's feet got stuck under the wheelchair, causing her to fall forward out of the chair. The resident broke her upper arm in the fall. The facility was cited for failure to ensure that each resident receives adequate supervision and assistive devices to prevent accidents. (Issued as Class A at \$8,000.) Citation #05109104064.

Valle Verde Health Facility

8/2/2007	A	Comp.
\$8,000	<u>Patient Care</u>	Fall Transfer

The facility failed to ensure a resident received adequate supervision and assistance devices to prevent an accident on 6/15/06, when a CNA attempted to transfer a resident without assistance from another aide and the use of a mechanical lift. The CNA was from an agency, but was made aware the resident required assistance for transfers by another CNA and the nursing coordinator. Ignoring this, the CNA attempted to transfer the resident alone and the resident fell and sustained injuries, including skin tears and a fractured hip. (Issued as Class A at \$8,000.) Citation #05144803728.

Villa Maria Healthcare Center

425 E Barcellus Ave, Santa Maria, Ca 93545

Villa Maria Healthcare Center

10/31/2007	A	Comp.
\$5,000	<u>Medication</u>	Medication

On 3/6 and 3/7/07, a nurse administered excessive doses of insulin to a resident, resulting in the resident's transfer to the emergency room with a hypoglycemic reaction. The nurse administered 100 units of insulin each day, five times the physician ordered dose of 20 units. On 3/7/07, the resident was found unresponsive and sweating with a low blood sugar of 53 (a normal range is 80 to 120). The medication error put the resident in danger of death or serious harm. (Issued as Class A at \$5,000.) Citation #05137103910.

Santa Clara County**Almaden Health And Rehabilitation Center**

2065 Los Gatos-Almaden Road, San Jose, CA 95124

Almaden Health And Rehabilitation Center

6/11/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Patient Care

On 4/7/07, after speaking to a resident at 7:30 am, a family member called the facility and asked them to call the paramedics because the resident was disoriented, confused and had a temperature of 104 degrees. The resident was usually alert and oriented, but had a persistent cough since 3/26/07. The resident was not transported to the acute care hospital until 12 hours later, where she was admitted for a 13 day stay for treatment of pneumonia. The facility was cited for failure to identify the resident's care needs and conduct a continuing assessment of her vital signs. (Issued as Class B at \$1,000.) Citation #07129104015.

Amberwood Gardens

1601 Petersen Avenue, San Jose, Ca 95129

Amberwood Gardens

5/31/2007	B	Comp.
\$700	<u>Medication</u>	Mandated Reporting

On 5/17/07, an 83 year old female resident was transferred from the facility to an acute care hospital. The hospitalization was the result of a staff member giving the resident medications that were ordered for another resident. The medications administered included treatment for diagnoses including diabetes, depression, and hypertension, none of which the resident suffered from. The facility was cited for failure to report an unusual occurrence involving a significant medication error to the Department of Health Services within 24 hours of the incident. (Issued as Class B at \$700.) Citation #07170303998.

Amberwood Gardens

5/31/2007	A	Comp.
\$14,000	<u>Medication</u>	Medication

On 5/17/07, an 83 year old female resident was transferred from the facility to an acute care hospital. The hospitalization was the result of a staff member giving the resident medications prescribed to another resident. The medications administered included treatment for diagnoses including diabetes, depression, and hypertension, none of which the resident suffered from. Shortly after being administered the inappropriate medications, the resident suddenly suffered abnormally low blood pressure, dizziness, low blood sugar, and hypotension. The facility was cited for failure to ensure residents are free from any significant medication errors. (Issued as Class A at \$14,000.) Citation #07170303989.

Amberwood Gardens
 9/4/2007 **B** Comp.
 \$850 Medication Medication

The facility failed to follow their Policy and Procedures on medications brought to the facility by resident or family member when the facility failed to verify a resident's medications brought from home with a pharmacist or physician to ensure the actual medications were correct prior to administering them. The medications were administered to the resident from 5/11 to 5/24/07. The facility also failed to follow their Policy and Procedures on discharge medications when the facility did not obtain a physician's order to provide the resident his medications at discharge. The facility failed to verify the labels of discharge medications for accuracy by checking them against the most recent physician orders and placed the resident at risk by giving him medications belonging to another resident. (Issued as Class B at \$850.) Citation #07177504089.

Courtyard Care Center

340 Northlake Drive, San Jose, CA 95117

Courtyard Care Center
 1/8/2007 **B** Comp.
 \$800 Patient Care Medication

On 9/16/06, a resident was admitted to the facility with a newly diagnosed heart condition. The condition, which required an anti-coagulant medication, was not mentioned in the hospital transfer summary. It was, however, mentioned in the hospital laboratory records. On 10/4/06, the resident had a stroke, fell, and hit her head on the floor. The cause was a blood clot that had been the result of the resident not receiving the anti-coagulant medication. The facility was cited for failing to ensure that the services provided met professional standards of quality. (Issued as Class B at \$800.) Citation #07129103595.

Courtyard Care Center
 12/20/2007 **B** Comp.
 \$1,000 Abuse Physical Abuse

On 11/7/07, a male resident reported to a licensed staff member that another staff member had kicked him in the left leg. Nurse's notes indicate the presence of a bump where he had allegedly been kicked and the resident complaining of pain when it was touched. On 11/16/07, the staff member stated the resident had reported to her previously regarding alleged abuse by another staff member, but she did not report the incident to her supervisor because she did not think a nurse would do such a thing. The facility was cited for failure to report all incidents of alleged or suspected abuse of a resident of the facility to the department immediately or within 24 hours. (Issued as Class B at \$1,000.) Citation #07105504495.

Courtyard Care Center
 12/20/2007 **B** Comp.
 \$1,000 Abuse Reporting
 Physical Abuse

On 11/7/07, a male resident reported to a licensed staff member that a staff member had kicked him in the left leg. Nurse's notes reflect the incident as well as indicating the presence of pain and a bump where he had allegedly been kicked. Another licensed staff member reported in an interview on 11/16/07 that the resident had reported to her previously regarding alleged abuse by this specific staff member, but she did not report the incident to her supervisor because she did not think a nurse would do such a thing. The facility was cited for failure to report immediately or as soon as possible and by written report sent within two days of allegations of abuse to the ombudsman or the local law enforcement agency. (Issued as Class B at \$1,000.) Citation #07105504496.

Courtyard Care Center
 12/20/2007 **B** Comp.
 \$1,000 Patient Rights Theft & Loss

On 8/22/07, a resident who had difficulty understanding others because of her hearing loss was admitted into the facility. The day after her admission she lost her hearing aid and complained to the administration. A search of the laundry and trash was unsuccessful and the resident was told that, "...corporate office has to approve before we can order a new hearing aid." On 10/4/07, a progress note documented, "Finally approved by Vice-Pres to pay for hearing aid..." The facility was cited for failing to resolve the resident's grievance promptly. (Issued as Class B at \$1,000.) Citation #07105504497.

Courtyard Care Center
 12/20/2007 **B** Comp.
 \$1,000 Patient Rights Physical Abuse

On 10/25/07, a male resident experienced three separate incidents of physical abuse from a CNA assigned to him. He reported the incidents the next day to the activity director, who then had him inform the administrator and the director of nursing. He was still emotional regarding the experience during his interview on 10/25/07. The CNA allegedly hit him in the head, then lifted his legs so far over his head his back hurt as a result, and finally she flipped him over so quickly his face hit the side rail. The facility was cited for failure to ensure the resident was free from verbal, physical, and mental abuse, corporal punishment, and involuntary seclusion. (Issued as Class B at \$1,000.) Citation #07105504531.

Empress Care Center, Llc

1299 S. Bascom Avenue, San Jose, Ca 95128

Empress Care Center, Llc

3/6/2007

B**\$1,000**Patient Care

Fiduciary

On 11/16/06 a resident informed staff member B that staff member A was a co-signer on his checking account. On 11/22/06, staff member A denied she opened a checking account with the resident. In an interview with bank staff on 11/28/06, it was confirmed that staff member A was a co-signer on the resident's checking account. It was verified that staff member A had withdrawn \$16,500 from the resident's checking account in four separate cash withdrawals. Staff member A said this went towards the purchase of a wheelchair for the resident, but the wheelchair was purchased by Medi-Cal and Medi-Care. The facility's failure to ensure the resident was free from the misappropriation of property had a direct relationship to the resident's safety and security. (Issued as Class B at \$1,000.) Citation #07129103684.

Empress Care Center, Llc

3/6/2007

B**\$1,000**Patient Care

Comp.

Patient Rights

On 6/6/06, the facility failed to provide medically related social services associated with discharge planning and transportation arrangements which negatively impacted a resident from attaining or maintaining the highest practicable physical, mental, and psychological well-being and either jointly, separately, or in any combination had a direct or immediate relationship to the resident's health, safety and security. (Issued as Class B at \$1,000.) Citation #07129103766.

Empress Care Center, Llc

3/6/2007

B**\$1,000**Patient Care

Comp.

Dignity

On 5/22/06, a staff member yelled at a resident in a degrading and humiliating manner regarding the length of time the resident spent in the shower. The resident's left leg was amputated from the knee down, causing him to take longer in the shower than other residents. It was not within the staff members responsibilities to set up the shower schedule or to speak to the resident about the length of his showers. Facility was cited for failure to protect and promote the resident's rights under circumstances likely to cause humiliation, indignity or other emotional trauma to residents. (Issued as Class B at \$1,000.) Citation #07129103767.

Gilroy Healthcare And Rehabilitation Center

8170 Murray Avenue, Gilroy, Ca 95020

Gilroy Healthcare And Rehabilitation Center

10/25/2007

B**\$600**Patient Rights

Comp.

Dignity

On 10/15/07, a female resident with impaired cognition was yelled at by a CNA to "get out of here, get out of here," as the resident walked toward some food trays. The resident's diaper was around her ankles but the CNA did not help her adjust it. The facility was cited for violating the resident's right to be treated with dignity and respect. (Issued as Class B at \$600.) Citation #07170304393.

Gilroy Healthcare And Rehabilitation Center

12/10/2007

B**\$750**Patient Care

Injury

On 11/5/07, an x-ray determined a male resident with cognitive impairment and memory problems had a dislocated shoulder. Since the resident required assistance for transfers and repositioning, the injury could have occurred at anytime, and additionally he could not have dislocated it himself. He began experiencing pain and swelling in his arm a few days prior to the x-ray, but no pain medication was administered. The facility was cited for failure to ensure the resident's environment remained free from hazards and that he received adequate supervision and assistance devices to prevent accidents. (Issued as Class B at \$750.) Citation #07203904498.

Gilroy Healthcare And Rehabilitation Center

12/10/2007

A**\$18,000**Patient Care

Certif.

A female resident with no history of bed sores developed a pressure ulcer on her right heel on 3/8/07. She refused physician's orders to wear a pressure relieving boot, but the physician was never informed. She was never provided alternative treatments or weekly documentation of wound progression. In 3.5 months from the initial development of the pressure sore, it had progressed into a severely infected pressure wound, black in color, foul smelling, with necrotic tissue through to the bone. Her right leg was amputated below the knee on 7/18/07. The facility was cited for failing to ensure the resident remained free from pressure sores and failure to provide appropriate care for the development of the sores. (Issued as Class A at \$18,000.) Citation #07177504505.

Gilroy Healthcare And Rehabilitation Center

12/10/2007

A**\$20,000**Patient Care

Certif.

Death Occurred

On 10/28/07, a female resident complained of severe left shoulder pain. Her pain was coupled with uncontrollable sweats, a slowed heart rate and unobtainable blood pressure; all signs of a heart attack. Her physician was never informed, nor was 911 called. The resident was finally transferred to the hospital the next day, but her condition had degenerated to the point that her heart stopped beating. The facility was cited for failure to provide prompt medical care for a resident, who then passed away as a result. (Issued as Class A at \$20,000.) Citation #07177504506.

Golden Livingcenter - San Jose

401 Ridge Vista Avenue, San Jose, CA 95127

Beverly Livingcenter - San Jose

6/4/2007	B	Comp.
\$600	<u>Patient Care</u>	Patient Rights

On 5/3/07, a 58 year old male resident diagnosed with schizophrenia was moved to the visitor's lounge where he stayed, involuntarily, for over 3 hours, without any concern for his personal needs. The lounge lacked a toilet which resulted in the resident urinating and defecating on himself. The resident was placed in the lounge after his behavior became agitated and too much for the staff to handle. Staff did not follow procedure and instead placed him in seclusion. The facility was cited for failure to ensure its residents are treated with consideration, respect and full recognition of dignity and individuality. (Issued as Class B at \$600.) Citation #07170303981.

Homewood Care Center

75 N. 13th Street, San Jose, CA 95112

Homewood Care Center

2/26/2007	AA	Comp.
\$100,000	<u>Patient Care</u>	Neglect Notification

Death Occurred

On 10/17/06, a 67-year-old resident with diabetes died after the facility failed to identify and respond to the signs and symptoms of hypoglycemia. Tests taken that morning revealed his blood sugar was dangerously low, but the facility did not contact his physician and ignored his pleas for help and requests for an ambulance. He was left in bed and died before 1 pm. The facility failed to provide prompt medical and emergency treatment when the resident became non-responsive, leading to his eventual death. (Issued as Class AA at \$100,000.) Citation #07131603702.

Homewood Care Center

2/26/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Medication

Death Occurred

On 10/17/06, a 67-year-old male resident became non-responsive due to a low blood sugar level. The facility staff obtained an emergency order for Glucagon to be given immediately. Rather than obtaining the order from the physician, though, the facility obtained it from the physician's office manager, who was not authorized to give a medical order. The office manager frequently acted as a conduit between nursing staff and the physician, and gave orders on the physician's behalf. The resident's condition declined and he died on 10/17/06. The facility was cited for failing to obtain direct intervention, medical care and treatment for a resident. (Issued as Class B at \$1,000.) Citation #07131603757.

Idylwood Care Center

1002 W. Fremont Avenue, Sunnyvale, CA 94087

Idylwood Care Center

8/30/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Physical Abuse

On 7/16/07, a resident, diagnosed with schizophrenia and mixed personality disorder and a history of violence toward other residents, approached a female resident sitting by herself and began harassing her. He then hit her in the nose and she had to go to the emergency room, with visible swelling and a hematoma. The facility failed to ensure the resident was treated with dignity and respect and not subjected to physical abuse. (Issued as Class B at \$1,000.) Citation #22141204224.

Lifehouse San Jose

180 Jackson Avenue, San Jose, CA 95116

Emmanuel Convalescent Hospital of San Jose

3/6/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Careplan Injury

The facility failed to provide as assistive device, specifically bed side rail padding, on 2/13/07, when a resident sustained left facial injuries during an accident in the resident's room while in the custody of a hospice agency aid. The side rail padding was requested by both the resident's physician and family members. (Issued as Class B at \$1,000.) Citation #07170303772.

Lincoln Glen Skilled Nursing

2671 Plummer Avenue, San Jose, CA 95125

Lincoln Glen Skilled Nursing

7/5/2007	B	Comp.
\$400	<u>Patient Rights</u>	Dignity Verbal Abuse

On 1/29/07, a CNA was witnessed yelling at a resident who required assistance going to the bathroom. The facility was cited for failure to ensure the resident was treated with dignity and respect. (Issued as Class B at \$400.) Citation #07206104071.

Lincoln Glen Skilled Nursing

7/5/2007	B	Comp.
\$500	<u>Administration</u>	Mandated Reporting

On 1/29/07, a CNA witnessed another CNA yelling at a resident. The abuse was not reported until 2/5/07 and investigation began, but the alleged abuser continued to work with residents until 2/4/07. The facility was cited for failure to follow procedure for mandated reporting of suspected abuse and implement the policy on protecting residents during an investigation. (Issued as Class B at \$500.) Citation #07206104072.

Lincoln Glen Skilled Nursing
7/5/2007 **B** Comp.
\$600 Administration Mandated Reporting

On 1/29/07, a CNA witnessed another CNA yelling at a resident. The alleged incident was not reported until 2/5/07. The facility was cited for failure to report an alleged incident of abuse to the Department within 24 hours. (Issued as Class B at \$600.) Citation #07206104073.

Manorcare Health Services

1150 Tilton Drive, Sunnyvale, CA 94087

Manorcare Health Services
2/28/2007 **B** Comp.
\$1,000 Patient Care Fall
Supervision

On 3/16/06, a 95-year-old resident passed by the receptionist's desk in her wheelchair and exited through the automatic front doors without being noticed because the receptionist was not at the front desk. She fell down the front stairs and suffered bruises, abrasions on her nose, right cheek and right eye, and a large lump on the right side of her face. She laid there until another resident noticed her. The facility was cited for failing to monitor the resident and prevent accidents. (Issued as Class B at \$1,000.) Citation #22116303748.

Mission De La Casa

2501 Alvin Avenue, San Jose, CA 95121

Mission De La Casa
7/12/2007 **B** Comp.
\$600 Administration Injury
Mandated Reporting

During a review of a resident's medical records, an X-ray report dated 8/31/06 indicated findings of a fracture of the resident's clavicle (collarbone). No documentation was found to indicate that an investigation was done to determine the cause. The facility was cited for failure to implement their policy and procedures on investigating and reporting accidents. (Issued as Class B at \$600.) Citation #07207704091.

Pacific Hills Manor

370 Noble Court, Morgan Hill, CA 95037

Pacific Hills Manor
8/8/2007 **B**
\$750 Medication Medication

The facility failed to transcribe a 6/29/07 doctor's order to reduce a resident's administration of Digoxin. As a result, the resident received twice the ordered level of Digoxin on eight occasions, causing toxicity and an abnormally low heart rate. The facility was cited for failing to ensure residents are free from significant medication errors. (Issued as Class B at \$750.) Citation #07177504142.

Pleasant View Convalescent Hospital

22590 Voss Avenue, Cupertino, CA 95014

Pleasant View Convalescent Hospital
4/3/2007 **AA** Comp.
\$100,000 Patient Care Fall

Death Occurred

On 2/4/07, a resident died after falling from a mechanical lift which was being used to transfer her from her bed to a recliner chair. The Medical Examiner's report indicated the cause of death was "blunt impact of torso with laceration of liver." A single CNA had attempted the transfer and had improperly placed the resident in the lift sling. The resident slid out of the sling and fell on her head and right side. The CNA left her on the floor and got another CNA to help place her in bed without contacting a nurse to assess her. The facility was cited for the CNA's failure to report the fall before moving the resident and for failure to follow the care plan. (Issued as Class AA at \$100,000.) Citation #22135803849.

San Jose Sub Acute & Skilled Care

1250 S. Winchester Boulevard, San Jose, CA 95128

San Jose Sub Acute & Skilled Care
8/16/2007 **B** Comp.
\$750 Patient Rights Physical Abuse

On 6/24/07, a male nursing assistant slapped a female resident twice on the back, allegedly because she soiled herself and he had to clean her up. The resident expressed fear that the nursing assistant would return and retaliate against her for reporting the abuse. The facility was cited because it failed to protect the resident from physical abuse. (Issued as Class B at \$750.) Citation #07205804088.

San Jose Sub Acute & Skilled Care
8/16/2007 **B** Comp.
\$600 Patient Care Physical Abuse

On 6/19/07, a resident reported an employee slapped her roommate on the hand for taking off her mittens, which she wore to prevent her from pulling out her tracheostomy tube. The resident who witnessed the abuse told the caregiver "not to do that and that was wrong." The facility was cited because it failed to protect the resident from physical abuse. (Issued as Class B at \$600.) Citation #07205804106.

San Jose Sub Acute & Skilled Care
9/6/2007 **A** Comp.
\$15,000 Patient Care Careplan

Death Occurred

A 60 year old female resident was admitted to the facility on 4/24/07, status post tracheostomy. The facility failed to ensure all of the resident's care needs were identified and continually assessed. The facility failed to reassess the resident's need for a more restrictive wrist restraint to protect the resident from pulling out her tracheostomy tube, which she did regularly. The 6/12/07 Physical Restraint Assessment documented a recommendation for protective mittens, which the resident continually removed with her teeth. On 7/1/07, the resident was found with her right mitten off and her tracheostomy tube removed. The resident expired at 5:14 am on 7/1/07. (Issued as Class A at \$15,000.) Citation #07129104183.

San Jose Sub Acute & Skilled Care
 11/8/2007 **B** Comp.
\$650 Patient Care

On 3/7/07, a resident with a gastrostomy tube was noted to have persistent abdominal distention, as well as food leakage. The staff failed to note whether it was monitoring abdominal pain, fluid characteristics, bladder functioning, nausea, abdominal symmetry, or girth measurements. The resident's feeding tube was not in his stomach and required surgical intervention on 3/22/07, resulting in a 72 day hospitalization. The facility was cited for poor identification of the resident's care needs. (Issued as Class B at \$650.) Citation #07129104291.

San Jose Sub Acute & Skilled Care
 11/8/2007 **B** Comp.
\$750 Patient Care Decubiti (Bedsores)

A male resident, with no prior history of skin breakdown, was admitted to a hospital on 8/7/07 with wounds of necrotic tissue on both heels, necessitating the amputation of one leg below the knee. Nurses notes indicate that on 5/28/07, one heel displayed redness. On 7/18/07, and again 7/25/07, pressure ulcers on the resident's heels were documented, indicating the skin was 90% necrotic (dead). However, from 5/28/07 to 8/7/07, when the resident entered the hospital, no changes were made to his careplan to treat the infection. The facility was cited for failing to identify the resident's needs based upon written and continuing assessment of his condition. (Issued as Class B at \$750.) Citation #07129104438.

Skyline Healthcare Center - San Jose
 2065 Forest Avenue, San Jose, CA 95128

Skyline Healthcare Center - San Jose
 7/5/2007 **B**
\$400 Administration

On 4/30/07, a CNA ran over the foot of a resident while simultaneously transporting two other residents down the hallway in their wheelchairs. The resident sustained pain and redness to her right foot. The facility was cited for failure to educate staff in measures for accident prevention and safety. (Issued as Class B at \$400.) Citation #07194004061.

Skyline Healthcare Center - San Jose
 10/12/2007 **B** Comp.
\$600 Patient Rights Physical Abuse

An 87 year old male resident was physically abused by his roommate on 5/24/07. The perpetrator had a history of violent behavior, but the facility had not actively sought alternative placement after a psychiatrist had recommended he be moved to a locked facility. On 5/24, the perpetrator was agitated and grabbed and violently twisted his roommate's private area. (Issued as Class B at \$600.) Citation #07203904303.

Terraces Of Los Gatos, The
 800 Blossom Hill Road, Los Gatos, Ca 95032

Terraces Of Los Gatos, The
 5/9/2007 **B** Certif.
\$500 Patient Care Physical Abuse
 Verbal Abuse
 Mental Abuse

On 3/15/07 after midnight, a resident asked a CNA for assistance in going to the bathroom. The resident was told, "Why don't you go in your diaper?" because her roommate was using the bathroom. The CNA handled her roommate roughly when putting her back to bed. A few hours later the resident asked the same CNA to change her wet diaper, and was told "Well why didn't you do that in the first place. You caused me a lot of trouble." When the CNA tripped over her shoes, she kicked the shoes and told the resident, "In my country anyone who needs shoes like that would have their feet cut off." The facility was cited for failure to protect residents from physical and verbal abuse. (Issued as Class B at \$500.) Citation #07168403931.

Valley House Care Center
 991 Clyde Avenue, Santa Clara, CA 95054

Valley House Care Center
 7/24/2007 **B** Comp.
\$1,000 Transfer Transfer

On 3/27/07, the facility transferred a resident who had lived there four years to another nursing home and arranged the transfers of three other residents without giving any of them 30-day written notice and without informing them in writing of their right to appeal the transfers. The facility was evicting the residents to make room for individuals who need short-term care. These actions were taken for the facility's convenience, which is not a legitimate reason to transfer a resident. (Issued as Class B at \$1,000.) Citation #22141204120.

Valley House Care Center
 11/30/2007 **B** Comp.
\$1,000 Transfer Evictions
 Patient Rights

On 3/21/07, a resident was transferred to an acute care hospital for emergency psychiatric services (EPS) after lashing out at two staff members and throwing objects around. The physician at EPS found no need for hospitalization and released the resident back to the facility on 3/22/07, but the facility refused to take the resident back. The facility was cited for failing to provide the resident the right to return to the facility after a one day stay in the hospital and for failing to issue a 30 day notice of discharge to the resident and his responsible party. (Issued as Class B at \$1,000.) Citation #22169604480.

Willow Glen Convalescent Hospital Rest Care

1267 Meridian Avenue, San Jose, CA 95125

Willow Glen Convalescent Hospital Rest Care Center

6/8/2007	B	Comp.
\$600	<u>Patient Care</u>	Verbal Abuse

On 2/21/07, a licensed staff member and a resident got into a verbal altercation in the hallway. The resident asked the staff member how much insulin he was going to be given and the staff member responded by telling him his blood sugar level. The resident then accused the staff member of not understanding English. The staff member responded in a way that might be construed as verbally abusive. In an interview later, the staff member said she regretted her tone and that she had apologized. The resident claims not to remember an apology about the incident. The facility was cited for failure to ensure that its residents are not subjected to verbal lecturing in a belittling manner from staff. (Issued as Class B at \$600.) Citation #07168404013.

Santa Cruz County**Country Villa Watsonville East Nursing Center**

535 Auto Center Drive, Watsonville, CA 95076

Watsonville Nursing Center East

5/16/2007	B	
\$900	<u>Patient Rights</u>	Physical Abuse

Around midnight of 3/3/07, a CNA handled a resident roughly when changing her diaper and slammed the door on the way out of the room. The resident had a recent hip surgery, and told her family the next day she was very upset and did not sleep well. The facility was cited for failure to protect the resident from abuse. (Issued as Class B at \$900.) Citation #07177503939.

Country Villa Watsonville Nursing Center East

8/28/2007	A	Comp.
\$15,000	<u>Patient Care</u>	Hydration

A resident was admitted to the facility on 6/22/07. During his brief stay at the facility, he consumed little or none of the nine meals he was served and was not evaluated for nutritional or fluid needs. The dehydration risk assessment for the resident was incomplete and inaccurate. After four days in the facility, he was sent to the acute care hospital with a high fever where he was diagnosed with dehydration. The facility was cited for failing to ensure the resident maintained adequate fluid intake to prevent dehydration. (Issued as Class A at \$15,000.) Citation #07160704164.

Driftwood Healthcare Center - Santa Cruz

675 24th Avenue, Santa Cruz, Ca 950604205

Driftwood Healthcare Center - Santa Cruz

4/18/2007	A	Comp.
\$2,000	<u>Patient Care</u>	Decubiti (Bedsore)

A resident who was at moderate risk for pressure ulcers was admitted to the facility with no skin problems. On 8/18/06, the physician ordered a knee immobilizer to be worn at all times. By 10/13/06, the resident had developed a Stage III pressure sore on her right ankle measuring 1" x 1.25" from the chaffing of the immobilizer. The facility was cited for failure to ensure the resident did not develop pressure sores. (Issued as Class A at \$2,000.) Citation #07141803898.

Golden Age Convalescent Hospital

523 Burlingame Avenue, Capitola, CA 95010

Golden Age Convalescent Hospital

11/1/2007	B	Comp.
\$650	<u>Physical Environment</u>	Physical Environment

After repairs to fix a shower room leak revealed underlying wood damage, the facility decided to overhaul the room on 10/9/07. For two weeks during the repairs, the facility provided showers in a utility room full of dirty mop water and a stained hopper bowl. The facility was cited for failing to notify the state of its construction work and for using an unsanitary and dangerous interim shower room. (Issued as Class B at \$650.) Citation #07209804417.

Pacific Coast Manor

1935 Wharf Road, Capitola, CA 95010

Pacific Coast Manor

11/7/2007	A	Comp.
\$20,000	<u>Patient Care</u>	Patient Rights

Death Occurred

A 71 year old female resident with metastasizing cancer was admitted on 9/11/07 with a full code status, stating she wanted to live. Her oncologist had recently written that she could live for years. The resident's mental condition rapidly deteriorated and she began to scream and refuse medications. Facility staff sought and received a doctor's order to change the resident's status to "no CPR or hospitalization." The facility did not follow state law for providing medical treatment when a resident is not capable of informed consent. The facility forcibly administered pain medication and withdrew other treatment, including hydration. The resident died on 9/16/07. (Issued as Class A at \$20,000.) Citation #07202404429.

Pacific Coast Manor

11/7/2007	AA	Comp.
\$100,000	<u>Patient Care</u>	Medication

Death Occurred

A 71 year old female resident with metastasizing cancer became agitated. The facility implemented a doctor's order for morphine and fentanyl on 9/15/07, despite the resident's noted opioid intolerance. The facility failed to monitor the resident for adverse side effects, despite her rapidly declining condition. She died on 9/16/07. The facility's failures presented an imminent danger to the resident and were a direct proximate cause of her death. (Issued as Class AA at \$100,000.) Citation #07202404430.

Santa Cruz Skilled Nursing Center

2990 Soquel Avenue, Santa Cruz, Ca 95062

Pleasant Care Rehab. And Nursing Center-Santa Cruz

1/24/2007	B	Comp.
\$1,000	<u>Abuse</u>	Mandated Reporting Sexual Abuse

On 12/23/06, a resident alleged to CNA 1 that CNA 2 inappropriately fondled her bottom. Although CNA 1 told the licensed nurse about the incident, she did not call the Ombudsman or fill out an abuse report. The facility was cited for failing to ensure that a mandated reporter immediately report an allegation of abuse by a CNA to the local ombudsman or law enforcement agency. (Issued as Class B at \$1,000.) Citation #07160703664.

Pleasant Care Rehab. And Nursing Center-Santa Cruz

4/18/2007	B	Comp.
\$900	<u>Patient Records</u>	Administration

On 3/17/07, a resident signed out on a pass without a physician's order. The resident did not document his expected return or destination and the leave of absence form was not signed by licensed staff. The resident had done this on 20 occasions but this time he did not return to the facility and the physician was not notified until the resident had been gone for 23 hours. The facility was cited for failure to follow their leave of absence procedures. (Issued as Class B at \$900.) Citation #07160703895.

Pleasant Care Rehab. And Nursing Center-Santa Cruz

7/10/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Fall

On 2/3/07 (Saturday), nurse's notes documented that a resident complained of right shoulder pain and stated he fell "last Wednesday." The resident fell while a CNA was assisting him in transferring to his wheelchair and the CNA never reported the fall. The resident had soreness in his arm and shoulder and was unable to perform his regular exercises. The facility was cited for failure to protect the resident from abuse and neglect. (Issued as Class B at \$1,000.) Citation #07177504014.

Valley Convalescent Hospital

919 Freedom Boulevard, Watsonville, CA 95076

Valley Convalescent Hospital

9/6/2007	B	Comp.
\$750	<u>Patient Care</u>	Infection Notification

The facility failed to develop and implement policies and procedures adequate to protect patients from harm during an outbreak of viral gastroenteritis. Specifically, the facility failed to report an outbreak of viral gastroenteritis within 24 hours after identifying two residents with nausea, vomiting, or diarrhea, and failed to cancel group activities as specified in the state guidelines for managing outbreaks of viral gastroenteritis. 16 residents were ultimately affected, and the virus sickened one resident enough to require hospitalization, and contributed to a second resident being hospitalized. (Issued as Class B at \$750.) Citation #07209804178.

Watsonville Nursing & Rehab Center West

525 Auto Center Drive, Watsonville, CA 95076

Watsonville Nursing & Rehab Center West

4/18/2007	B	Comp.
\$1,000	<u>Patient Records</u>	Administration

During a review of records on 3/27/07 through 3/29/07, it was found that monthly reviews of physicians' orders were not signed by the physician or noted by a licensed nurse as required by regulations for 13 out of 26 residents. The facility was cited for failure to ensure that physician order recaps were signed and dated by a physician and noted by a licensed nurse at least every 45 days. (Issued as Class B at \$1,000.) Citation #07160703873.

Watsonville Nursing & Rehab Center West

4/18/2007	B	Comp.
\$1,000	<u>Administration</u>	Administration

During an interview on 3/28/07, it was found that two recently hired employees had not had health examinations or TB tests as required by regulations. The facility was cited for failure to ensure that new employees did not have any health condition that would create a hazard for fellow employees or residents. (Issued as Class B at \$1,000.) Citation #07160703874.

Shasta County

Applewood Inn

201 Hartnell Ave., Redding, CA 96002

Applewood Inn

3/14/2007 **B** Comp.
\$1,000 Patient Care Fall
 Careplan

A female resident fell five times in her first six days at the facility (10/5/05-10/11/05) and sustained a fractured wrist during the fourth fall. All falls were documented, yet no corrections were made to the resident's careplan. The facility was cited for failure to provide adequate supervision and assistive devices to prevent a resident from falling. (Issued as Class B at \$1,000.) Citation #23150803706.

Applewood Inn

3/29/2007 **B** Comp.
\$1,000 Patient Care Careplan
 Neglect

On five occasions in June of 2006, a family member observed a resident had soaking wet incontinent pads and/or bowel movement smeared on her bedrails, clothes, linen and hands. An Ombudsman observed this on 6/20/06 after the family member complained, and photographs were taken that showed feces under and around the patient's fingernails, on the bedrails and linen. Facility staff acknowledged there was no plan of care developed to prevent the patient from shredding the incontinent pads or smearing her bowel movements, for which they were cited. (Issued as Class B at \$1,000.) Citation #23101603805.

Applewood Inn

3/29/2007 **B** Comp.
\$1,000 Abuse Mandated Reporting
 Physical Abuse

The facility was cited for failure to report an incident of alleged or suspected abuse within 24 hours to the California Department of Health Services. On 10/14/06, a female resident was sitting in her wheelchair in the lobby when another resident rolled his wheelchair close to her and a resident who was next to her. The female resident asked the male resident to be careful and not run over the other resident's feet. The male resident kicked the female resident in the shin, which resulted in a four-inch bruise. The facility waited 14 days after discovery to report the incident. (Issued as Class B at \$1,000.) Citation #23101603707.

Applewood Inn

4/3/2007 **B** Comp.
\$0 Patient Rights Dignity
 Privacy

On 10/30/05, a CNA pushed a female resident in a wheelchair down the hallway to the shower room. The resident was completely naked and had no clothes or covering. Other staff observed that the resident had her arms folded over her chest in an attempt to cover her breasts. In an interview on 10/20/06, the resident stated she asked to be covered up with a bath blanket, but the CNA explained the shower room was only 20 feet away and the resident did not need covering. The facility was cited for failing to treat residents with dignity, respect and privacy. (Issued as Class B at \$0.) Citation #23101603850.

Applewood Inn

4/3/2007 **B** Comp.
\$0 Administration Administration

On 10/20/06, an investigator for the Department of Health Services attempted to access employees' records, but the administrator refused to allow him to do so, which is a misdemeanor under the Health and Safety Code. (It is a misdemeanor for any person to willfully prevent the examination of relevant records in the conduct of official duties.) When asked for the records, the administrator said "no" and excused himself and left the room. The surveyor was later told by a staff person that the administrator had left the facility to "catch a plane". (Issued as Class B at \$0.) Citation #23101603851.

Applewood Inn

10/18/2007 **B** Comp.
\$1,000 Abuse Fiduciary
 x3 Mandated Reporting

A missing property report indicated two residents had their credit cards stolen on 8/8/07, although a police report indicated one resident's card was stolen on 8/7/07. The facility did not report the suspected financial abuse to the department until nine days later, on 8/16/07. The facility was cited for failing to report an incident of suspected abuse to the department within 24 hours. (Issued as Class B at \$1,000.) Citation #23198904340.

Applewood Inn

10/18/2007 **B** Comp.
\$800 Other Administration
 Mandated Reporting
 Theft & Loss

On 8/07/07 and 8/08/07, police were notified of stolen credit cards and fraudulent charges made by an employee against two residents. The facility failed to conduct an investigation regarding the suspected abuse and failed to promptly report the incidents to the State Department of Public Health and Ombudsman, as required by its policy and procedure. (Issued as Class B at \$800.) Citation #23198904341.

Applewood Inn

10/18/2007 **B** Comp.
\$1,000 Patient Care Notification
 Patient Care

Death Occurred

On 12/04/06, a 92 year old female resident developed a temperature of 100 degrees, a high pulse rate and acute respiration. The resident did not receive medical treatment until 11 hours later, because the night shift nurse failed to notify the legal representative of the resident's change in condition to determine if she wished for the resident to be transferred to the acute care hospital. The resident died the following day. The facility failed to notify the physician and the resident's legal representative of her change in condition. (Issued as Class B at \$1,000.) Citation #23199204334.

Beverly Living Center - Redding

1836 Gold Street, Redding, CA 96001

Beverly Health And Rehabilitation Center
 5/16/2007 **B** Comp.
\$750 Medication Medication

On 6/8/06, an 80 year old resident was mistakenly given another resident's medication. The nurse who was preparing the medication stated she had been distracted at the time by another resident and ended up making the error. The resident receiving the wrong medication was taken to the ER for observation. The facility was cited for making a medical error which caused an adverse consequence to the resident. (Issued as Class B at \$750.) Citation #23101603956.

Canyonwood Nursing And Rehab Center

2120 Benton Drive, Redding, CA 96003

Canyonwood Nursing And Rehab Center
 3/26/2007 **B** Comp.
\$1,000 Patient Rights Neglect
 Dignity
 Mandated Reporting
 Patient Rights

During the night shift of 1/7/07, a resident called for assistance in toileting and was told by the CNA "go ahead and go in your diaper." The facility was cited for failure to report abuse to the licensing agency within 24 hours. (Issued as Class B at \$1,000.) Citation #23187003826.

Canyonwood Nursing And Rehab Center
 3/26/2007 **B** Comp.
\$1,000 Patient Rights Sexual Abuse
 Mandated Reporting

In the resident's clinical records, there was a nurse's note dated 5/31/06 stating that she observed a male resident sitting next to the bed of a female resident with his hand up her blouse and "messing around with her." This incident was not reported to the licensing agency for a six-month period of time. The facility was cited for failure to report an alleged incident of sexual abuse to the Department of Health Services within 24 hours. (Issued as Class B at \$1,000.) Citation #23086103827.

Canyonwood Nursing And Rehab Center
 3/29/2007 **B** Comp.
\$1,000 Patient Care Medication
 Dignity

A 72-year-old female resident suffered severe constipation as a result of the nurses failing to properly administer physician prescribed laxatives. For eight consecutive days from 7/14/06 to 7/22/06, the resident was unable to move her bowels, complaining of discomfort and stomach pain. The facility was cited for failure to administer medication as it is prescribed. (Issued as Class B at \$1,000.) Citation #23101603797.

Canyonwood Nursing And Rehab Center
 4/12/2007 **B** Comp.
\$1,000 Patient Care Verbal Abuse
 Patient Care

On 2/16/07, an 88-year-old resident with a broken right hip used the call light because she needed assistance using the restroom. The CNA came into the resident's room and pulled on her leg to see if she was wet. The resident's roommate, tried to tell the CNA that the resident had a broken hip, but the CNA was unkind and stated that she knew that. The resident had increased right hip pain afterwards. The facility was cited for failing to ensure that the residents remain free from verbal and physical abuse. (Issued as Class B at \$1,000.) Citation #23199203887.

Canyonwood Nursing And Rehab Center
 5/16/2007 **B** Comp.
\$1,000 Patient Care Fall

On 11/19/06, a 56 year old resident with a history of multiple strokes, diabetes and blindness fell off her bed and fractured her hip. Although she complained of pain, the staff failed to properly assess her and it wasn't until 33 hours later that she was taken to the hospital where she underwent surgery to repair the fracture. The facility was cited for failure to develop a care plan that addressed the residents fall and pain. (Issued as Class B at \$1,000.) Citation #23179303953.

Canyonwood Nursing And Rehab Center
 10/18/2007 **B** Comp.
\$1,000 Staffing Staffing

The facility failed to provide the minimum number of nursing hours per patient per day (3.2 hours) required for 20 days out of a total of 55 days, which resulted in diminished care and services to the residents. (Issued as Class B at \$1,000.) Citation #23154604330.

Canyonwood Nursing And Rehab Center
 10/18/2007 **B** Comp.
\$800 Patient Care Patient Care

An 86 year old resident, who was not able to make her needs known, was found to have swelling in her left foot on 5/18/06. On 5/20, a LVN notified the physician and obtained an order for Vicodin, but was refused an x-ray request. On 5/31, 11 days later, an order for an x-ray was obtained. On 6/1, the x-ray revealed two large fractures in the resident's lower left leg. The facility was cited for failing to attain timely services to treat two fractures of a resident's lower leg, resulting in the resident experiencing considerable pain for 15 days. (Issued as Class B at \$800.) Citation #23154604331.

Canyonwood Nursing And Rehab Center
 10/18/2007 **B** Comp.
\$1,000 Abuse Physical Abuse
 x3

On 6/4/07, two CNAs were providing care to a 76 year old male resident. The resident grabbed one of the CNA's breast and, in response, the CNA bit the resident on his left arm. Nurses notes on 6/5 and 6/19/07 documented the resident had visible red marks on his left forearm from the incident. The facility was cited for failing to ensure residents were free from physical harm. (Issued as Class B at \$1,000.) Citation #23199204332.

Canyonwood Nursing And Rehab Center
 12/21/2007 **B** Comp.
\$1,000 Patient Care Dignity
 Medication
 Physical Abuse

On 9/29/07, two licensed nurses held down a 65 year old resident so they could administer an intramuscular injection (for agitation). The injection was administered against the resident's will. The facility was cited for failing to ensure the resident was treated with dignity and not subjected to physical abuse. (Issued as Class B at \$1,000.) Citation #23208504517.

Mayers Memorial Hospital D/P SNF
 43563 Hwy 299 E, P.O. Bx 459, Fall River Mills, CA 96028

Mayers Memorial Hospital D/P SNF
 10/18/2007 **B** Comp.
\$1,000 Administration Verbal Abuse
 Mandated Reporting

On 7/4/07, a CNA overheard another CNA make inappropriate sexual remarks to a 94 year old female resident with Alzheimer's disease. The CNA waited two days to tell another CNA what she overheard, and that CNA waited until 7/19/07 (15 days after the original incident) to tell her charge nurse. The facility was cited for failing to report an alleged incident of verbal abuse to the Department of Health Services within 24 hours of the incident. (Issued as Class B at \$1,000.) Citation #23199204360.

Mayers Memorial Hospital D/P SNF
 10/18/2007 **B** Comp.
\$1,000 Patient Rights Sexual Abuse
 Verbal Abuse

On 7/4/07, a CNA overheard another CNA making inappropriate sexual comments to a 94 year old female resident with Alzheimer's disease. He heard the CNA say to the resident, "Drink your milk. It's cum... You need to drink it because it took me all day to make it." He then overheard the CNA laugh. The facility was cited for failing to ensure the resident remain free from verbal, mental, sexual, or physical abuse. (Issued as Class B at \$1,000.) Citation #23199204356.

Shasta Healthcare
 3550 Churn Creek Road, Redding, CA 96002

Shasta Healthcare
 10/18/2007 **B** Comp.
\$800 Failure to Report Mandated Reporting

A CNA witnessed alleged abuse of a resident by another CNA on 5/12/07. The incident was not reported to Licensing until 5/14/07. The abusive CNA reportedly was handling a resident too roughly. While the alleged abuse complaint was not substantiated, the facility was cited for failing to notify Licensing within 24 hours of the alleged abuse. (Issued as Class B at \$800.) Citation #23200104354.

Windsor Redding Care Center
 2490 Court Street, Redding, CA 96001

Redding Care Center
 2/8/2007 **B** Comp.
\$1,000 Patient Care Patient Care

On 10/9/05, a 68-year-old resident who had a knee replacement in May 2005, was found on the floor in front of a wheelchair. She experienced severe pain from the fall and asked the charge nurse for pain medication. Although the resident had a physician's order to receive additional pain medication should she need it, the nurse refused to give her any. The resident said the nurse was being a "smart aleck." The facility was cited for failing to provide the necessary care and services. (Issued as Class B at \$1,000.) Citation #23101603685.

Redding Care Center
 2/8/2007 **B** Comp.
\$1,000 Staffing Staffing

During the period from 9/16/06 to 9/30/06, the facility did not meet the minimum 3.2 staff per resident per day ratio for 6 of 15 days. Inadequate staffing resulted in residents experiencing discomfort and wetting or soiling themselves because they had to wait too long to be taken to the bathroom. Food was served late. The facility was cited for failure to meet the minimum staffing requirements. (Issued as Class B at \$1,000.) Citation #23179303687.

Redding Care Center
 6/8/2007 **B** Comp.
\$1,000 Patient Care Verbal Abuse

A resident reported that a nurse "flipped out" and started yelling at him on 4/15/07, describing it as a "super heavy verbal attack." The resident expressed fear of the nurse, who had pointed her finger at him in a threatening manner. Three other employees witnessed the incident, which led to the nurse's employment being terminated by the facility. The facility was cited because it subjected the resident to verbal abuse. (Issued as Class B at \$1,000.) Citation #23198904003.

Redding Care Center
 6/22/2007 **B** Comp.
\$3,000 Patient Care Physical Abuse
 x3 Supervision
 Careplan

On 2/28/07, a resident picked up a wet floor sign and used it to strike another resident. Due to previous incidents, the nursing home had assigned an aide to watch the abusive resident, but the aide neglected to supervise him during this incident. Instead of watching the resident, she was on the phone when the abuse occurred. Another altercation between the same residents occurred on 3/5/07 when the assigned aide was again on the phone instead of watching the resident. (Issued as Class B at \$3,000.) Citation #23198904008.

Redding Care Center
7/3/2007 **B**
\$1,000 Patient Care Physical Abuse
Verbal Abuse
Dignity

On the evening of 12/19/06, a CNA handled a resident roughly when returning him to his bed after taking him to the toilet. The resident complained that the CNA was rude and "turned me roughly, like a sack of potatoes." The same CNA during the night shift, on 12/18/06, refused to clean up a different resident who had a bowel movement because she was not assigned to that resident. The facility was cited for failure to protect a resident from physical and verbal abuse, and to treat residents with dignity. (Issued as Class B at \$1,000.) Citation #23198804054.

Redding Care Center
7/5/2007 **B** Comp.
\$1,000 Patient Care Injury
Transfer

On 12/10/05, a 50 year old male resident requiring assistance in all activities of daily living was transferred from his wheelchair to the toilet by a CNA. The resident had splints on both arms and a fractured leg, therefore he required two person transfers. When the CNA attempted to transfer him by herself, the resident got caught between the toilet and the wheelchair. He twisted his leg and hit his arm as he was thrown backward onto the toilet, which caused him significantly more pain. The facility was cited for failure to ensure that each resident receives adequate supervision and assistance to prevent accidents. (Issued as Class B at \$1,000.) Citation #23190504051.

Siskiyou County

Shasta View Nursing Center 445 Park Street, Weed, Ca 96094

Shasta View Nursing Center
7/5/2007 **B** Comp.
\$750 Administration Dietary Services
Mandated Reporting

During breakfast on 4/8/07, a CNA acted in anger against a resident, verbally threatening the resident, moving her roughly in her chair, and placing her in isolation. The facility was cited for failure to report elder abuse immediately or within 24 hours to the licensing agency as required by law. (Issued as Class B at \$750.) Citation #23148404052.

Shasta View Nursing Center
7/5/2007 **B** Comp.
\$750 Patient Rights Verbal Abuse
Physical Abuse
Retaliation Against
Resident
Patient Rights

During breakfast on 4/8/07, a resident threw orange juice at a CNA, hitting her in the face. The CNA responded in anger, and roughly grabbed the resident's geri-chair, and pulled the resident backwards into another room. The CNA was observed putting the resident's plate and silverware down with force and saying, "Sit there in solitary." The facility was cited for failure to protect the resident from verbal abuse and involuntary confinement. (Issued as Class B at \$750.) Citation #23148404053.

Shasta View Nursing Center
7/18/2007 **B** Comp.
\$1,000 Patient Care Sexual Abuse
Careplan

The facility failed to ensure a female resident was free from sexual abuse when a male resident placed his hand on her genital area on 7/14/06 and repeated this behavior by placing his hand on the same female resident's genital area and on top of her incontinent brief again on 12/16/06. Following the first incident, each residents' careplan was updated to keep these residents away from each other. The facility failed to follow and fully implement the approaches listed on these careplans. (Issued as Class B at \$1,000.) Citation #23198904078.

Shasta View Nursing Center
7/18/2007 **B** Comp.
\$1,000 Patient Rights Physical Restraints
Patient Rights

The facility failed to ensure its own policy and procedure regarding restraints was followed when it applied a mitt to an 85 year old male resident, causing a decrease in his mobility. The physician's order for the mitt was not in compliance with the policy because it did not contain the medical diagnosis/symptom, how often the device was to be used or the frequency of checking and removing the device. No appropriate alternatives to the mitt were attempted or documented in the careplan prior to the consideration of the restraint. (Issued as Class B at \$1,000.) Citation #23198904077.

Vallejo Care Center

2200 Tuolumne, Vallejo, CA 94590

Vallejo Care Center

3/8/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Infection

Between 10/19/06 and 10/24/06, the facility encountered two lab confirmed cases of scabies. The facility did not report the outbreaks to the state licensing agency or Public Health within 24 hours. The facility was cited for failure to implement their infection control policies and procedures in tracking, monitoring and reporting the outbreak of a highly infectious communicable skin disease which created a risk for delay in diagnosis and treatment. In addition, these failures created a risk for residents to contract and spread scabies to other residents, staff and visitors. (Issued as Class B at \$1,000.) Citation #11187103498.

Winsor House Convalescent Hospital

101 S. Orchard Street, Vacaville, CA 95688

Winsor House Convalescent Hospital

2/5/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Careplan

On 2/23/05, an 87-year-old resident was admitted to the facility with diagnoses of advanced Alzheimer's Disease and Aortic Stenosis. On 5/18/05, a physician's order called for use of a merry walker. On 6/05/05, staff observed the "Resident lose balance and land on his groin on the straps." After multiple falls it was revealed that there was no provision for fatigue while the merry walker was in use. As a result, the resident's groin and genitalia became swollen. The facility was cited for failing to assess the resident's risk for falls on an ongoing basis. (Issued as Class B at \$1,000.) Citation #11136603679.

Winsor House Convalescent Hospital

3/14/2007	B	License
\$1,000	<u>Administration</u>	Administration

The Department of Health Services sent the facility three requests for accurate and up to date ownership and licensee information. The facility failed to respond to written requests or phone calls. The facility was cited for failure to comply with the Department's request. (Issued as Class B at \$1,000.) Citation #11125703799.

Winsor House Convalescent Hospital

3/26/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Physical Abuse Supervision

On 7/28/06, Resident 1 was observed hitting Resident 2 with a shoe. The next week, Resident 1 pushed Resident 3's bedside table into her leg, causing bruising. Resident 3 transferred to another facility out of fear of Resident 1. During the surveyor's visit to the facility on 8/5/06, Resident 1 was observed wandering into a resident's room, unbeknown to facility staff. Resident 1 was started on a psychotic medication on 6/21/06, but her behavior was not being monitored or documented. The facility was cited for failing to assess, monitor and document Resident 1's behaviors, which resulted in two residents being assaulted. (Issued as Class B at \$1,000.) Citation #11168503274.

Winsor House Convalescent Hospital

3/26/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Neglect

During a visit on 8/5/06, a surveyor found that the facility had violated the rights of four residents by failing to provide them with incontinent care. Three residents were visibly upset about being left wet with urine and two residents voiced complaints about being left to sit in urine soaked sheets and clothing for hours. The facility was cited for failing to keep residents clean and dry and failing to ensure that the residents' ability to use the toilet would not diminish. (Issued as Class B at \$1,000.) Citation #11168503275.

Winsor House Convalescent Hospital

7/25/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Fall

On 10/9/06, a female resident was found lying on the floor by the door of her room. Although she was uninjured, her careplan should have been modified to reduce her risk of falling. Her fall risk was not updated, a tab alarm was not placed by her bed, nor did the staff implement the policies designed to lower residents risk for falls. The facility was cited for failure to provide continued assessment of a resident at risk for falls. (Issued as Class B at \$1,000.) Citation #11139303982.

Winsor House Convalescent Hospital

8/16/2007	AA	Comp.
\$100,000	<u>Patient Care</u>	Fall Injury Supervision

Death Occurred

On 3/10/06, an 88 year old resident who had Alzheimer's disease fractured his skull and spine after falling while using a Merry Walker (enclosed framed wheeled walker with a seat). He was hospitalized and died the next day. The Coroner determined the cause of death was blunt force head and neck injuries. The resident had a long history of falls while using the Merry Walker, having suffered five such falls at the facility since 2005, with the last three falls causing injuries. The facility was cited for its failure to provide adequate supervision and to follow the manufacturer's safety recommendations led to the resident's death. (Issued as Class AA at \$100,000.) Citation #11187203860.

Sonoma County

Apple Valley Convalescent

1035 Gravenstein Ave., Sebastopol, CA 95472

Apple Valley Convalescent

5/10/2007 **A**
\$18,000 Patient Care Hydration
 Infection

A male resident with a risk of dehydration was admitted to the facility on 4/20/05. From 4/20/05 - 6/24/05, the facility failed to adequately monitor the resident's fluid intake and output as required by his careplan. On 6/24/05, the resident's blood pressure dropped to 96/60, and he became verbally non-responsive. He was sent to an acute hospital where he was found to be severely dehydrated with a UTI. The facility was cited for failing to ensure that a resident was adequately hydrated, as well as for failing to continually monitor his condition. (Issued as Class A at \$18,000.) Citation #11168503907.

Apple Valley Convalescent

5/10/2007 **A** Comp.
\$18,000 Patient Care Fall

A cognitively impaired resident admitted to the facility on 4/24/06 was assessed to have a very high risk for falls. On 5/1/04, a licensed nurse observed the resident attempting to climb out of bed over her siderails. The LN was unaware of the resident's risk for falls, so she took none of the precautions that would have normally been taken in the situation (such as putting a personal alarm on the resident and monitoring the resident every 15-20 minutes). Later that day, the resident was found on the floor next to her bed. She had fallen after climbing over the siderails and she re-injured her neck. She was transferred to an acute hospital, and she later underwent spinal surgery. (Issued as Class A at \$18,000.) Citation #11168503889.

Beverly Livingcenter - London House Sonoma

678 2nd Street West, Sonoma, CA 95476

London House Convalescent Hospital - Sonoma

6/6/2007 **B** Comp.
\$1,000 Patient Care Sexual Abuse

The facility failed to implement their abuse prohibition policy to protect residents against further potential abuse after a facility employee was accused of sexually abusing a resident on 10/1/06. The facility allowed the employee to render direct supervision to residents prior to the completion of the investigation of the allegation. (Issued as Class B at \$1,000.) Citation #11148904017.

London House Convalescent Hospital - Sonoma

6/6/2007 **B** Comp.
\$1,000 Patient Care Bed Hold
 Transfer

On 10/24/06, a resident was sent to an acute care hospital for evaluation, but the facility refused to readmit him the same day. The facility was cited for failure to issue a proper transfer and discharge notice and to inform the resident of his bed hold rights. (Issued as Class B at \$1,000.) Citation #11187203576.

Beverly LivingCenter - Petaluma

101 Monroe St., Petaluma, Ca 94952

Beverly LivingCenter - Petaluma

11/29/2007 **B** Comp.
\$1,000 Patient Care Supervision

A female resident with senile dementia and a Wanderguard alert bracelet exited the facility unescorted on 9/9/07. The resident was found in the parking lot by a CNA on break smoking a cigarette. The wander alert system was defective. The facility was cited for failing to ensure the resident received adequate supervision. (Issued as Class B at \$1,000.) Citation #11187204407.

Cloverdale Healthcare Center

300 Cherry Creek Rd., Cloverdale, Ca 954252714

Cloverdale Healthcare Center

10/18/2007 **B** Comp.
\$1,000 Patient Care Physical Abuse
 Supervision

From 10/16/07 through 10/30/07, a resident who was physically abusive without being aware was abusive to, or was hit by, other residents in five incidents. The facility was not providing one on one supervision for the resident as indicated in her careplan. The facility was cited for failure to protect the residents from physical abuse. (Issued as Class B at \$1,000.) Citation #11168504373.

Country Villa Petaluma Healthcare Center

523 Hayes Lane, Petaluma, CA 94952

Pleasant Care Convalescent - Petaluma

1/31/2007 **A** Comp.
\$20,000 Physical Environment Fall

On 4/5/06, a resident with impaired cognition and wandering issues fell down stairs while strapped in a wheelchair. The resident had wandered unnoticed through the facility business office, despite the presence of staff, and went through a door leading to the stairs. The resident suffered a bruised leg and broken collarbone. The facility was cited for failing to secure the door, resulting in the resident's fall. (Issued as Class A at \$20,000.) Citation #11185003620.

Pleasant Care Convalescent - Petaluma

1/31/2007 **A** Comp.
\$18,000 Patient Care Physical Restraints
 Injury
 Supervision
 Fall

On 8/20/06, a resident who suffers from dementia was found face down on the floor after a table topper was not applied securely to her wheelchair, allowing her to stand up and fall. She required emergency treatment for injuries to her face that caused large black and purplish-blue areas around both eyes and her forehead. Four days after the fall, an investigator observed her restrained in a geri-chair in the hallway, and later alone on the patio, without supervision. The facility was cited because it failed to ensure the resident was free from physical restraints used for purposes of staff convenience, and did not provide adequate supervision to prevent accidents. (Issued as Class A at \$18,000.) Citation #11179203635.

Pleasant Care Convalescent - Petaluma
 6/25/2007 **AA** Comp.
\$100,000 Patient Care Neglect
 Infection

Death Occurred

At the insistence of her family, a 76 year old resident was transferred to a hospital on 3/4/07 due to a high fever and large swelling of her neck. These symptoms were caused by an infection resulting from varying levels of decayed teeth. She died 8 days later. The resident did not have a routine dental exam between admission on 8/18/05 and her hospital admission on 3/4/07. The facility was cited because it failed to provide routine dental care, which led to her death. (Issued as Class AA at \$100,000.) Citation #11136603834.

Pleasant Care Convalescent - Petaluma
 8/9/2007 **A** Comp.
\$20,000 Patient Care Patient Care
 x3

On 3/22/07, a resident with Alzheimer's, dementia and episodes of unauthorized exits was found wandering on a city street by a passerby. The passerby who took the resident back to the facility stated that the nurse he spoke to had no idea the resident had been missing, nor did she even recognize him as a resident of the facility. The facility was cited for failure to implement a comprehensive care plan and for failure to prevent repeated wandering. (Issued as Class A at \$20,000.) Citation #11179203867.

Pleasant Care Convalescent - Petaluma
 12/19/2007 **B** Comp.
\$800 Patient Care Supervision

The facility was cited for several enumerated instances where cognitively impaired residents were observed wandering unsupervised outside of the facility and smoking in the patio area when no staff were present. The investigation focused on three cognitively impaired residents who, in August of 2007, were observed in the parking lot without staff knowledge and at other times smoking on the patio without staff supervision. One of the cognitively impaired residents was identified as at risk for elopement and the other two had no careplans to prevent possible elopements. (Issued as Class B at \$800.) Citation #11135104085.

Pleasant Care Convalescent - Petaluma
 12/19/2007 **B** Comp.
\$800 Abuse Physical Abuse

On 6/24/07, a resident was barricaded in the bathroom by another resident. The resident that did the barricading had a history of blocking bathroom doors and a history of verbal and physical abuse. Her records documented that she threatened, screamed at, cursed at, hit, shoved, scratched, and sexually abused others. The facility was cited for not properly assessing and devising a proper care plan for the resident. (Issued as Class B at \$800.) Citation #11135104087.

Creskide Convalescent & Mental Health Rehab

850 Sonoma Ave, Santa Rosa, CA 95404

Creskide Convalescent & Mental Health Rehab Prgrm
 3/14/2007 **B** License
\$1,000 Administration Administration

From 6/23/06 to 2/2/07, the facility failed to comply with Sections 1265 to 1267.5 of the Health and Safety Code, which pertains to license and ownership information. The facility failed to respond to repeated requests for the information. (Issued as Class B at \$1,000.) Citation #11125703798.

Healdsburg Senior Living Community

725 Grove Street, Healdsburg, CA 95448

Healdsburg Senior Living Community
 7/12/2007 **B** Comp.
\$1,000 Patient Care Dignity
 Neglect

On 4/10/07, it was observed that the call bell system did not function for five residents. One resident stated her system had not worked for three weeks, resulting in soiling herself, embarrassment and missing activities. The facility was cited for failure to maintain a functioning call bell system, resulting in putting residents at risk and violating their dignity. (Issued as Class B at \$1,000.) Citation #11203804086.

Healdsburg Senior Living Community
 8/14/2007 **A** Comp.
\$18,000 Patient Care Fall
 Careplan
 Physical Environment

On 4/14/07, the facility failed to implement nursing interventions and/or adequate supervision to prevent a fragile and confused resident, with a recent fall and fracture history, from falling out of bed, over a full bed side rail, striking a wheelchair and the floor, and sustaining a fractured left shoulder and a laceration to the forehead that required suturing. The facility failed to ensure the resident's environment remained as free from accident hazards as possible. Just prior to the fall, the nurse assessed the resident's behavior was suggestive of being at high risk for falls, but no additional fall prevention approaches were developed and/or implemented, nor was enhanced supervision provided to prevent falls and injuries. The full side rails posed a safety hazard to the resident and contributed to his fall and injuries. (Issued as Class A at \$18,000.) Citation #11172403918.

Palm Drive Nursing and Rehabilitation Center

477 Petaluma Ave, Sebastopol, CA 95472

Palm Drive Nursing and Rehabilitation Center
 9/11/2007 **A** Comp.
\$18,000 Patient Care Neglect
 Supervision
 Injury

A severely confused and blind 79 year old resident with dementia wandered from the facility on 1/19/07. A passerby found him on the ground a short distance away and took him to the hospital, where he was treated for an injury to his hand. The facility was cited because it neglected to adequately identify the resident's need for supervision, placing him at imminent danger of death or serious harm. (Issued as Class A at \$18,000.) Citation #11198303712.

Palm Drive Nursing and Rehabilitation Center
 9/11/2007 **B** Comp.
\$1,000 Patient Care Supervision
 Careplan
 Physical Abuse

During dinner on 1/17/07, a resident begin pulling on another resident's hair and clothes. The aggressive resident had a history of combative behaviors, especially in the evening, and a careplan requiring one on one supervision and eating away from other residents. On the previous day of 1/16/07, there was an incident of verbally and physically abusing his roommate. The facility was cited for failure to implement the careplan and to prevent physical abuse. (Issued as Class B at \$1,000.) Citation #11198304228.

Palm Drive Nursing and Rehabilitation Center
 9/11/2007 **B** Comp.
\$1,000 Administration Mandated Reporting

On 1/17/07 during dinner, a resident pulled the hair and clothes of another resident. The facility was cited for failure to report this incident of resident to resident abuse immediately or within 24 hours to the licensing agency and to either the Ombudsman or law enforcement as required by law. (Issued as Class B at \$1,000.) Citation #11198304229.

Sonoma Acres
 765 Donald Avenue, Sonoma, CA 95476

Sonoma Acres
 1/26/2007 **B** Certif.
\$1,000 Dietary Dietary Services

On 5/24/06, it was discovered the facility failed to clearly label leftover food items, store foods in a manner that prevented cross contamination, ensure foods were stored in a manner to inhibit the growth of organisms associated with food borne illness, provide consistent sanitation of food production surfaces with food safe products, and maintain dishwashing equipment as recommended by the manufacturer which resulted in putting residents at risk for food borne illness. (Issued as Class B at \$1,000.) Citation #11166103648.

Sonoma Acres
 1/26/2007 **A** Certif.
\$18,000 Patient Care Nutrition
 Dietary Services

From January of 2006 until May 2006, a resident experienced progressive and consistent weight loss of a total of 20 pounds, or 12.4% in six months. The facility was cited for failure to ensure the resident maintained acceptable weight parameters, implement ordered interventions, evaluate the effectiveness of interventions and to conduct a medication assessment for the resident who was taking a medication with a known side effect of decreased appetite. (Issued as Class A at \$18,000.) Citation #11166103652.

Sonoma Acres
 2/9/2007 **A** Comp.
\$18,000 Patient Care Medication

On 12/27/02, a resident was admitted to the facility with diagnoses of dementia and constipation. Admission orders documented treatment and suppositories, as necessary. On 11/8/05, the resident stated that "a certain nurse gave (her) a suppository every day and would get a boy to hold me down and I would scream." A written statement from another resident dated 10/28/05, revealed that a staff was called into that residents room to insert two suppositories without checking for constipation. The facility failed to ensure that suppositories were administered as prescribed to both residents. (Issued as Class A at \$18,000.) Citation #11184903670.

Sonoma Acres
 6/25/2007 **A** Comp.
\$18,000 Patient Care Sexual Abuse

On 6/4/06, a staff member witnessed another staff member in the room of a cognitively impaired female resident while passing out medication. The staff member had barricaded the door with a bed and his pants and boxer shorts were down to his mid thigh. The resident was completely naked yelling, "Stop it, stop it." The facility was cited for failure to treat the resident with dignity and respect and protect her from physical abuse of any kind. (Issued as Class A at \$18,000.) Citation #11159203937.

Sonoma Developmental Center D/P SNF
 P.O. Box 1493, Eldridge, CA 95431

Sonoma Developmental Center D/P SNF
 2/20/2007 **B** Comp.
\$700 Patient Rights Physical Abuse

On 11/15/06, a PT became frustrated while changing a resident and said "You are f***ing difficult" before she slapped the resident on the buttock. The facility was cited for failing to keep the resident free from mental and physical abuse. (Issued as Class B at \$700.) Citation #15102203693.

Sonoma Developmental Center D/P SNF
 8/13/2007 **AA** Comp.
\$90,000 Patient Rights

Death Occurred

On 10/22/05, a totally dependent 25 year old resident who was confined to a special wheelchair, had highly impaired vision, limited use of both arms and partial loss of voluntary movement died after swallowing two plastic-handled cotton-tipped swabs. The plastic punctured his internal organs and he bled to death. The swabs were being used for oral hygiene. It was not clear how the resident came to have swallowed the swabs. Comments in the Autopsy findings noted it was very unlikely that he put the swabs in his own mouth due to his limb deformities. (Issued as Class AA at \$90,000.) Citation #15111603148.

Spring Lake Village

5555 Montgomery Drive, Santa Rosa, CA 95405

Spring Lake Village

3/14/2007	B	License
\$1,000	<u>Administration</u>	Administration

The facility was cited for failure to disclose ownership information to the Department of Health Services. The facility was given three notices to do so, beginning on 6/23/06, and had failed to respond as of the date of the citation. (Issued as Class B at \$1,000.) Citation #11125703802.

Stanislaus County**Acacia Park Nursing & Rehab Center**

1611 Scenic Drive, Modesto, CA 95355

Acacia Park Nursing & Rehab Center

3/30/2007	B	Comp.
\$1,000	<u>Abuse</u>	Physical Abuse

On 4/15/06 and 4/16/06, a CNA was observed hitting and verbally abusing a female resident. The incident was reported anonymously to the facility administration and was not reported to Licensing until 4/18/06. The facility was cited for failing to report verbal and physical abuse within 24 hours and for failing to ensure the abused resident was protected. (Issued as Class B at \$1,000.) Citation #03148803863.

Acacia Park Nursing & Rehab Center

6/1/2007	B	Comp.
\$1,000	<u>Abuse</u>	Verbal Abuse

On 1/26/07, a verbal incident occurred between a female resident and a CNA regarding stolen property. The CNA, feeling accused by the resident, then shouted, "I've never been accused of stealing! I've been working here 12 years and never been accused of stealing and you're not going to start now." The resident began to cry and later stated she is afraid of the CNA. The incident was not reported to the Department of Health Services. The facility was cited for failure to report to the Department within 24 hours of an alleged incident of verbal or physical abuse as well as failure to ensure that the resident was treated with dignity and respect. (Issued as Class B at \$1,000.) Citation #03144803990.

Crestwood Manor - Modesto

1400 Celeste Drive, Modesto, CA 95355

Crestwood Manor

12/13/2007	A	Comp.
\$15,000	<u>Patient Care</u>	Fall Careplan

The facility failed to identify the safety needs of a resident when she fell five times, between 11/10/06 and 3/10/07, in order to ascertain the cause of her falling and to prevent future falls and injury. The facility failed to update the resident's careplan with input from other professionals and failed to implement the resident's careplan by ascertaining the cause of the five falls to prevent further falls and prevent physical harm. The facility also failed to implement their Policy & Procedure regarding falls each time the resident fell. (Issued as Class A at \$15,000.) Citation #03167704512.

Elness Convalescent Hospital

812 West Main Street, Turlock, CA 95380

Elness Convalescent Hospital

7/19/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Fall

On 5/15/07, an 88 year old male resident with a history of falls was found sitting on the floor by his bed. No changes were made to his careplan to avoid possible future incidents, nor was the fall noted in his tracking log. Subsequently, on 5/31/07, the resident fell from his bed again at 6:30 a.m., fracturing his right hip. The facility was cited for failure to implement policies and procedures following the resident's fall on 5/15/07. (Issued as Class B at \$1,000.) Citation #03184504111.

Evergreen Rehabilitation Care Center

2030 Evergreen Avenue, Modesto, CA 95350

Evergreen Rehabilitation Care Center

8/6/2007	B	Comp.
\$1,000	<u>Abuse</u>	Physical Abuse

On 11/16/06, a 78 year old female resident, incontinent of bowel and bladder, reported an incident that occurred on 11/14/06 while the CNA assigned to her was changing her after a bowel movement. She reported that the CNA moved her roughly, told her to "move her fat ass over" and, after rolling her onto her back, rammed his fist into her vagina. Her roommate, a 62 year old female, corroborated the story. No social service intervention followed the incident and the CNA was not disciplined. The facility failed to thoroughly evaluate an abuse allegation, to follow through with appropriate disciplinary action for the CNA involved, and to provide appropriate social services intervention for the resident who reported the abuse. (Issued as Class B at \$1,000.) Citation #03169904141.

Garden City Healthcare Center

1310 West Granger Ave, Modesto, CA 95350

Garden City Healthcare Center

11/14/2007	B	Comp.
\$1,000	<u>Patient Care</u>	

CitationWatch description will be published once citation is received. Citation #03207204416.

Hy-Lond Convalescent Hospital - Modesto

1900 Coffee Road, Modesto, Ca 95355

Hy-Lond Convalescent Hospital #548

8/6/2007	B	Comp.
\$1,000	<u>Abuse</u>	Physical Abuse

On 4/25/07, a 97 year old resident suffered pain and bruises to her forearms when a CNA physically restrained and roughly handled her while two other employees were changing her incontinent brief. The other aides reported the CNA grabbed the resident's hands and arms and pulled them across the resident's body, and bound the resident's hands. The resident responded by stating, "Stop, you're hurting me." The facility was cited because it failed to protect the resident from physical abuse. (Issued as Class B at \$1,000.) Citation #03169904147.

Oak Valley Care Center D/P SNF

275 South Oak Avenue, Oakdale, CA 95361

Oak Valley Care Center D/P SNF

8/6/2007	B	Comp.
\$1,000	<u>Abuse</u>	Sexual Abuse Mandated Reporting

The facility failed to implement their Abuse Prohibition Policy by not initiating a physical assessment of a female resident for injury after another female resident was found touching her vagina on 5/21/06. The facility failed to notify both residents' physicians of the incident in a timely manner. The incident was not reported to the Department of Health Services and the facility did not conduct an investigation into the incident of alleged resident-to-resident sexual abuse. (Issued as Class B at \$1,000.) Citation #03169904137.

Oak Valley Care Center D/P SNF

9/28/2007	B	Comp.
\$800	<u>Abuse</u>	Feeding Mental Abuse Physical Abuse Sexual Abuse Verbal Abuse

Between October 2006 and May 2007, a CNA called a 58 year old female resident names, force fed her and slapped her buttocks with an open hand. The verbal and physical abuse lasted for seven months. The resident feared for her life, suffered emotional and physical abuse, humiliation and anguish. The facility failed to protect her from these abuses. (Issued as Class B at \$800.) Citation #03193004241.

San Luis Convalescent Hospital

709 N Street, Newman, CA 95360

San Luis Convalescent Hospital

10/8/2007	B	Comp.
\$1,000	<u>Abuse</u>	Physical Abuse

On 8/11/07, a CNA was observed hitting a 95 year old female resident on the shoulder. A review of the CNA's personnel file demonstrated a list of abusive and neglectful care that had not been reported to Licensing. The facility was cited for failing to appropriately intervene to ensure that its residents were protected from abuse. (Issued as Class B at \$1,000.) Citation #03163704329.

Turlock Nursing And Rehabilitation Center

1111 E. Tuolumne Road, Turlock, Ca 95380

Turlock Nursing And Rehabilitation Center

2/7/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Medication

On 6/09/05, the resident was admitted to the facility with a diagnoses of dementia, diabetes, depression, and a recent hip surgery. On 6/09/05, the physician ordered Contin pain medication every eight hours and Vicodin, as needed. The nursing staff did not clarify which pain medication should be given for mild, moderate, or severe pain. Additionally, the order for Morphine was not added to the resident's plan of care. The facility was cited for failing to ensure pain alleviation and implementation of their own policy. (Issued as Class B at \$1,000.) Citation #03156603686.

Turlock Nursing And Rehabilitation Center
 10/26/2007 **B** Comp.
\$1,000 Patient Care Fall

An 85 year old female resident suffered four falls within a two month period. The fourth fall resulted in three fractured ribs. An investigation revealed that the facility failed to assess the resident for falls upon admission, failed to properly note her fall risk on her door, and failed to note the use of a preventive clip alarm. The resident's call light cord was also found out of her reach. The facility was cited for failing to identify the resident's needs and implementing her careplan. (Issued as Class B at \$1,000.) Citation #03207204392.

Vintage Faire Nursing And Rehabilitation Center
 3620 B Dale Road, Modesto, CA 95356

Vintage Faire Nursing And Rehabilitation Center
 7/2/2007 **B** Comp.
\$1,000 Patient Care Injury
 Patient Care

On 1/18/07, an 82 year old resident suffered a fracture to her right leg caused by an aide turning her in bed without noticing that the resident's right knee and leg were caught between the side rail and the bed. As she turned the resident, the aide heard a "pop" sound and saw that the resident's foot was turned outward. An X-ray taken the next day revealed the fracture. The facility was cited because it failed to provide adequate assistance to prevent accidents. (Issued as Class B at \$1,000.) Citation #03188604056.

Sutter County

Live Oak Manor, Inc.

9000 Larkin Road, Live Oak, CA 95953

Live Oak Manor, Inc.
 3/7/2007 **B** Comp.
\$1,000 Patient Rights Physical Abuse

On 12/6/06, a 93-year-old resident was struck struck by a staff member on the back with an open hand. An employee witnessed the incident and said it occurred in the dining room after dinner when the resident knocked into a food tray which splashed liquid on a staff person's uniform. The facility was cited for failure to keep the resident free from physical abuse. (Issued as Class B at \$1,000.) Citation #23150803754.

Live Oak Manor, Inc.
 5/14/2007 **B** Comp.
\$1,000 Patient Rights Verbal Abuse

On 10/22/06, two CNAs observed a registered nurse tell a 93 year old resident if she did not take her medication "I'll pour it down your throat." The facility was cited for failing to ensure the resident was not verbally abused. (Issued as Class B at \$1,000.) Citation #23149903946.

Live Oak Manor, Inc.
 6/13/2007 **B** Comp.
\$750 Abuse Mandated Reporting
 Physical Abuse

The facility failed to ensure an incident of alleged or suspected abuse was reported to the California Department of Health Services within 24 hours. Documentation showed that on 12/23/06, two residents were involved in a resident to resident altercation where it was described that "Resident 1 ran into Resident 2's wheelchair and Resident 2 became upset, yelling and attempted to pull on Resident 1's wheelchair to direct him around her. Staff responded, but before staff could intervene Resident 1 grabbed onto Resident 2's arm and began striking out at Resident 2." The incident was reported to the Department on 12/26/07, more than 78 hours after the incident. (Issued as Class B at \$750.) Citation #23191303984.

Live Oak Manor, Inc.
 6/13/2007 **B** Comp.
\$750 Abuse Mandated Reporting
 Physical Abuse

On 10/13/06, a female resident reported to nursing staff that her roommate had slapped her across the face. The resident's roommate was interviewed and admitted to slapping the resident and stated "What would you do if your child became disobedient?" The facility did not report the incident to the California Department of Health Services until 10/16/06, more than 65 hours after the incident. The facility was cited for failure to report incidents of alleged or suspected abuse to the Department within 24 hours. (Issued as Class B at \$750.) Citation #23191303983.

Live Oak Manor, Inc.
 6/13/2007 **B** Comp.
 \$500 Patient Rights Physical Abuse

A nurse at the facility stated she was at the nurse's station on 12/28/06 around 9:00 am when she heard a resident's family member yelling from the resident's room. The nurse stated she went to the resident's room and saw the family member standing over the resident yelling "shut up." The nurse also witnessed the family member slap the resident on the face. The facility was cited for failure to ensure that a resident was free from mental and physical abuse. (Issued as Class B at \$500.) Citation #23191303985.

Live Oak Manor, Inc.
 6/13/2007 **B** Comp.
 \$750 Abuse Mandated Reporting
 Physical Abuse
 Verbal Abuse

On 10/15/06, a nurse assistant observed another aide tell a resident to "shut up" and changed the resident against her will. The facility was cited because it waited more than 48 hours before reporting the alleged abuse to the Department of Health Services instead of reporting it within 24 hours as required by law. (Issued as Class B at \$750.) Citation #23191303986.

Live Oak Manor, Inc.
 6/13/2007 **B** Comp.
 \$750 Patient Rights Dignity
 Patient Care

An 87 year old female resident was admitted to the facility on 7/6/05, with diagnosis of dementia, arthritis and depression. On 1/3/07, a CNA witnessed the resident yelling that she did not want to be changed while another CNA changed her. The CNA who witnessed this told the CNA who was changing the resident that the resident didn't have to be changed if she didn't want to. The CNA doing the changing told the resident to "shut up" and proceeded changing her. The facility was cited for failing to ensure the resident was treated with dignity and respect. (Issued as Class B at \$750.) Citation #23191303987.

Yuba City Care Center
 1220 Plumas St., Yuba City, CA 95991

Yuba City Care & Rehabilitation Center
 3/7/2007 **B** Comp.
 \$1,000 Patient Care Verbal Abuse

On either 7/15/06 or 7/16/06, the facility failed to ensure that a female resident was not subjected to verbal abuse when a CNA verbally threatened her, by telling her she would put her in her room, in the dark, and turn off her TV. The facility was cited for failure to keep a resident free from verbal abuse. (Issued as Class B at \$1,000.) Citation #23179303752.

Yuba City Care & Rehabilitation Center
 3/7/2007 **B** Comp.
 \$1,000 Failure to Report Mandated Reporting
 Verbal Abuse

On either 7/15/06 or 7/16/06, a resident was in the dining room and a CNA told the resident to be quiet or she would put her in her room, in the dark and turn her TV off. The facility was cited because a CNA who witnessed the event did not report the incident to administration until 7/20/06. (Issued as Class B at \$1,000.) Citation #23179303704.

Yuba City Care & Rehabilitation Center
 3/7/2007 **B** Comp.
 \$1,000 Patient Care Mandated Reporting

On 8/6/06, a resident hit another resident with a metal reaching stick, causing a six cm skin tear. The facility was cited for failing to report an incident of abuse to the Department of Health Services. (Issued as Class B at \$1,000.) Citation #23148403705.

Yuba City Care & Rehabilitation Center
 9/20/2007 **B** Comp.
 \$1,000 Patient Rights Verbal Abuse
 Dignity

On 9/26/06, an 80 year old female resident reported that a CNA yelled at her the night prior. The resident called for help because her roommate was yelling for help from the restroom. The CNA said, "Shut up, be quiet, we know that your call light is on" when she responded to resident's calls. This was the second time the CNA had been accused of verbal abuse. The facility failed to prevent resident from being verbally abused by staff. (Issued as Class B at \$1,000.) Citation #23148404249.

Yuba City Care Center
 10/19/2007 **B** Comp.
 \$1,000 Medication Medication

From 1/23/07 to 1/25/07, licensed nurses administered five times the prescribed dose of insulin to an 85 year old resident. The facility was cited because it failed to administer the medication in accordance with the physician's order on three separate occasions. (Issued as Class B at \$1,000.) Citation #23190804376.

Yuba City Care Center
 10/26/2007 **B** Comp.
 \$800 Staffing Staffing
 x3

The facility was cited because it failed to provide at least 3.2 nursing hours per resident (California's minimum staffing requirements) on 1/1/07, 1/7/07 and 1/14/07. (Issued as Class B at \$800.) Citation #23148404375.

Yuba Skilled Nursing Center

521 Lorel Way, Yuba City, CA 95991

Emmanuel Health Care Center

3/27/2007 **B** Comp.
\$1,000 Patient Care Injury
 Physical Abuse

During the early morning hours of 1/17/07, a CNA handled a resident roughly while administering care causing bruising on the right wrist and the top of the left hand. The CNA did not speak English well and did not understand the resident or the instructions for care. The facility was cited for failure to prevent physical abuse. (Issued as Class B at \$1,000.) Citation #23187003818.

Emmanuel Health Care Center

4/4/2007 **B** Comp.
\$1,000 Patient Care Patient Care
 Neglect

On 12/1/06, a resident was left sitting in his wheelchair in clothing smelling of urine and stool from 3 pm until 9 pm. Two nurses and another CNA all asked the responsible CNA to change her. A staff member even reported to the responsible CNA that the resident was observed trying to drink from his dirty urine container. The responsible CNA repeatedly replied that the "resident is independent and can take care of himself." The facility was cited for failing to protect the resident from neglect when the resident was left sitting in urine and stool for six hours. (Issued as Class B at \$1,000.) Citation #23198803855.

Emmanuel Health Care Center

4/4/2007 **B** Comp.
\$1,000 Failure to Report Mandated Reporting

On 3/10/07, a resident reported to a CNA that another CNA had hit her. The CNA reported the incident to the charge nurse. The facility manager determined that the resident had acquired a bruise to her right shin on the transfer pole during a transfer from her wheelchair to bed. The facility was cited for failing to report the incident of alleged abuse to the Department of Health Services within 24 hours. (Issued as Class B at \$1,000.) Citation #23200103856.

Emmanuel Health Care Center

4/11/2007 **B** Comp.
\$1,000 Patient Care Decubiti (Bedsores)
 Neglect
 Patient Care

On 5/3/06, the resident was admitted to the facility without pressure sores. By 10/3/06, the resident had developed four severe pressure sores. The facility failed to follow their own pressure sore policy regarding the use and assessment of pressure reduction devices, weekly assessments of the pressure sores, and continuous inservice training. Moreover, the facility failed to follow physician orders for proper treatment of pressure sores. The facility was cited for failing to keep the resident free from pressure sores, and failure to continually assess the resident and implement their pressure sore policy. (Issued as Class B at \$1,000.) Citation #23132603882.

Emmanuel Health Care Center

5/23/2007 **B** Comp.
\$1,000 Abuse Neglect

A resident reported that on 8/2/06 a CNA had placed her call light out of reach, during which time she suffered a nose bleed and "messed her pants" because she was not able to call for help. An Ombudsman report indicated the incident had been reported to the director of staff development, but no action was taken and the director stated he did not remember the incident. The facility was cited for failure to report the allegation of abuse to the Department of Health Services and for not suspending the staff person pending the outcome of the investigation. (Issued as Class B at \$1,000.) Citation #23121403967.

Emmanuel Health Care Center

10/23/2007 **B** Comp.
\$1,000 Abuse
 x3

During a complaint investigation on 5/31/07, an administrative staff member stated that although an allegation had been made that on 5/20/07 a CNA was observed force feeding a resident, an internal investigation had been completed and no evidence of abuse was found. The Department was unable to substantiate the alleged abuse. However, the facility was cited for failign to report an incident of alleged abuse to the Department of Public Health within 24 hours of the allegation. (Issued as Class B at \$1,000.) Citation #23199204366.

Emmanuel Health Care Center

11/30/2007 **B** Comp.
\$1,000 Patient Care Physical Abuse
 x3

On 6/2/07, a CNA witnessed two residents slapping and hitting each other. The resident who initiated the altercation had a history of fighting. The facility was cited for failing to control the aggressive behavior of the resident, which had a direct relationship to the health, safety, and security of residents. (Issued as Class B at \$1,000.) Citation #23198804464.

Emmanuel Health Care Center

11/30/2007 **B** Comp.
\$1,000 Patient Care Physical Abuse

On 8/27/07, a 77 year old female resident who had been diagnosed with a recent pelvic fracture, chronic respiratory disease, arthritis and osteoprosis was given a full body skin assessment. The turning and position during the assessment procedure caused the resident to have excruciating pain and the staff ignored the resident's screams for them to stop. The resident also complained that afterwards the staff didn't respond to her call light when she tried to get pain medication. The facility was cited for failing to treat the resident with dignity and respect. (Issued as Class B at \$1,000.) Citation #23150804454.

Tehama County**Brentwood Skilled Nursing & Rehabilitation Center**
1795 Walnut Street, Red Bluff, CA 96080

Brentwood Skilled Nursing & Rehabilitation Center
3/23/2007 **B** Comp.
\$1,000 Patient Care Physical Abuse

On 6/19/06, two CNAs were taking a 90-year-old resident with dementia to the toilet. One CNA failed to tell the resident what she was going to do, and reached for the resident's glasses as the resident pushed the CNA's hand away from her face. The CNA proceeded to grab the glasses aggressively. The resident reacted to the aggressiveness and tried to push the CNA off of her. The CNA slapped the resident on the left side of her face twice. Afterwards the resident was upset and cried and the CNA smirked and laughed. The facility was cited for failing to protect the resident from physical abuse. (Issued as Class B at \$1,000.) Citation #23190503753.

Red Bluff Health Care Center

555 Luther Road, Red Bluff, CA 96080

Sunbridge Care & Rehabilitation
3/2/2007 **B** Comp.
\$1,000 Patient Care Infection
 Neglect
 Supervision

On the night shift of 6/10/06, a resident with a catheter and history of urinary tract infections produced a urinary output of only 60 cc's, versus a usual 600 cc's. The resident experienced nausea and vomited after the noon meal. Resident was observed at 3 pm with an evaluated temperature and labored breathing and was sent to the ER at 4 pm. The resident was diagnosed with a urinary tract infection, sepsis and MRSA bacteria in the urine caused by a blocked catheter. Records show the catheter had been changed only once in 6 months, although a doctor's order required monthly changes. In addition, the resident's scrotum area was filthy with bowel matter and his ears were red, swollen and "full of crusty gunk." The facility was cited for failure to assess and monitor the resident and to maintain basic hygiene. (Issued as Class B at \$1,000.) Citation #23076303700.

Trinity County**Trinity Hospital D/P SNF**

410 N. Taylor St., P.O. Bx 1229, Weaverville, Ca 96093

Trinity Hospital D/P SNF
4/3/2007 **B** Comp.
\$800 Patient Care Neglect
 Careplan

An 88 year old resident was admitted to the facility's skilled nursing facility unit on 7/15/06, following a 5 day stay in it's medical surgical unit. It's initial assessment failed to identify she had not had a bowel movement in at least five days. She continued not to have a bowel movement for three more days, for a total of 8 days, resulting in constipation and discomfort. Records indicated she did not receive any medication for the constipation until 7/19/06. (Issued as Class B at \$800.) Citation #23191303848.

Tulare County

Kaweah Manor Convalescent Hospital

3710 West Tulare Ave, Visalia, CA 93277

Kaweah Manor Convalescent Hospital
1/17/2007 **B** Comp.
\$1,000 Patient Rights Verbal Abuse

On 12/19/06, a 74-year-old female resident asked a CNA for assistance in getting ready for bed. The CNA refused and no one responded to the resident's subsequent call light. When the CNA finally returned, she yelled at the resident. The facility was cited for failure to protect the resident from verbal abuse. (Issued as Class B at \$1,000.) Citation #12186803621.

Sierra Valley Rehabilitation Center

301 West Putnam, Porterville, CA 93257

Sierra Valley Rehabilitation Center
3/28/2007 **B** Comp.
\$1,000 Patient Rights Bed Hold

On 11/6/07 and 11/12/07, a resident was transferred to the hospital because of "combative behavior." On both occasions, the facility failed to inform the resident's responsible party of the hospitalization or the right to a seven-day bed hold. On both occasions the facility refused to readmit the resident. The facility was cited for failing to afford the resident a seven-day bed hold. (Issued as Class B at \$1,000.) Citation #12172003844.

Visalia Nursing And Rehabilitation Center

1925 East Houston Avenue, Visalia, Ca 93292

Visalia Nursing And Rehabilitation Center
4/11/2007 **B** Comp.
\$1,000 Abuse Mandated Reporting
Physical Abuse

Interviews with staff and review of nurses notes revealed four incidents of resident-to-resident abuse from 2/10/06 to 2/20/06 went unreported. The facility was cited for failure to report four allegations of abuse to the State survey and certification agency. (Issued as Class B at \$1,000.) Citation #12144103617.

Visalia Nursing And Rehabilitation Center
4/11/2007 **B** Comp.
\$1,000 Patient Rights Physical Abuse
Supervision

On 2/20/06, a 79 year old resident, who was on one-to-one observation, was punched several times in his nose, back and arms by his 82 year old roommate. The CNA who was watching the 79 year old resident stated she had been instructed to sit in a chair by the door while the residents were in the room together. The facility was cited for failing to ensure a resident was free from physical abuse. (Issued as Class B at \$1,000.) Citation #12144103618.

Visalia Nursing And Rehabilitation Center
4/11/2007 **A**
\$20,000 Patient Rights Sexual Abuse

On 2/15/06 and 2/16/06, a resident was observed in his roommate's bed attempting to sexually assault him. In the first incident, the resident was found naked from the waist down, attempting to open his roommate's legs. The next day, he was found again in his roommate's bed with feces on his exposed penis. The CNA who found them said he was very concerned for the victim, "because he couldn't scream or say anything or defend himself." The victim was moved, however there was no evidence the physician was notified, or that he received a sexual assault examination. The facility was cited for failing to ensure a resident was free from repeated episodes of probable sexual abuse. (Issued as Class A at \$20,000.) Citation #12144103619.

Visalia Nursing And Rehabilitation Center
7/3/2007 **A** Comp.
\$20,000 Patient Care Neglect
Injury
Careplan
Fall

On 11/1/06, a 98 year old resident fractured her ankle when she fell from her wheelchair and was found lying on the floor of her room. The facility neglected to apply a seat belt as ordered by the resident's physician to prevent falls. The facility was cited because its failure to follow the resident's plan of care resulted in serious injury. (Issued as Class A at \$20,000.) Citation #12162303541.

Visalia Nursing And Rehabilitation Center
12/19/2007 **A** Comp.
\$20,000 Patient Care Physical Abuse
Supervision

On 7/5/06 at 9 am, an 84 year old male resident struck a 90 year old female resident in the mouth, causing several lacerations. On the same date, a second altercation occurred at 10:45 am, when the male resident pushed the female resident to the floor, causing a small laceration and a bruise to the back of her head. The facility was cited for failing to ensure a confused and physically aggressive resident on the Alzheimer's unit was supervised adequately to prevent two separate incidents of physical aggression toward the same peer. (Issued as Class A at \$20,000.) Citation #12144103544.

Westgate Gardens Convalescent Center

4525 W. Tulare Avenue, Visalia, CA 93277

Westgate Gardens Convalescent Center
8/3/2007 **AA** Comp.
\$100,000 Patient Care Neglect
Dietary Services

Death Occurred

On 8/4/06, a 77 year old resident who had difficulty swallowing was hospitalized in critical condition after she choked on whole grapes served to her by facility staff. The resident died one week later on 8/11/06. The facility's neglect caused an imminent danger of death when it served her whole fruits forbidden by her diet and by its failure to follow her careplan to carefully monitor her food intake. (Issued as Class AA at \$100,000.) Citation #12171903543.

Tuolumne County**Sonora Regional Medical Ctr D/P Snf (Unit 6 & 7)**
179 S. Fairview/538 Ponderosa Drive, Sonora, CA 95370

Sonora Community Hosp D/P SNF (Unit 6 & 7)

8/1/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Fall Careplan Supervision

The facility failed to implement an 88 year old male resident's 6/12/06 careplan on 9/29/06 when a CNA placed the resident in a Geri-chair without an over-table securely in place to prevent rising and a subsequent fall, which resulted in the resident breaking his back. Facility also cited for failure to provide adequate supervision and assistive devices. (Issued as Class B at \$1,000.) Citation #03179404126.

Ventura County**Brighton Gardens Of Camarillo**
6000 Santa Rosa Road, Camarillo, Ca 93012

Brighton Gardens Of Camarillo

7/13/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Fall Careplan

Between 5/30/04 and 5/21/06, nurse's notes revealed a female resident, requiring assistance in all daily activities, had seven falls, three of which she was found on the bathroom floor. Even after repeated incidents, there was no evidence the facility acknowledged and performed an assessment to address the repeated causes of the falls or to develop new interventions accordingly. The facility was cited for failure to continuously assess factors related to the resident's repeated falls and to update/ revise care plan interventions accordingly. (Issued as Class B at \$1,000.) Citation #05191503737.

Brighton Gardens Of Camarillo

7/13/2007	A	Comp.
\$18,000	<u>Patient Care</u>	Decubiti (Bedsores)

On 6/23/06, a female resident was fitted for a leg brace that left her at risk for developing pressure sores and dependent upon staff for bathing, dressing and personal hygiene. Her skin condition was not monitored nor was it inspected beneath the brace. On 8/17/06, the nurse assigned to the resident discovered a Stage IV wound on her right ankle, requiring transfer to an acute hospital for aggressive treatment. The facility was cited for failure to prevent a resident from developing pressure sores. (Issued as Class A at \$18,000.) Citation #05191503738.

Camarillo Healthcare Center

205 Granada Street, Camarillo, CA 93010

Camarillo Healthcare Center

3/21/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Decubiti (Bedsores) Careplan

On 10/20/06, a resident was admitted to the facility with multiple diagnoses including a high risk for skin breakdown with a careplan that included antibiotics plus dressing and treatment orders for her wounds. On 11/10/06, the resident was moved to an outpatient wound care center for treatment and was assessed to have multiple areas of skin breakdown and Stage II bedsore. The facility was cited for failure to continually assess the needs of the resident. (Issued as Class B at \$1,000.) Citation #05136903736.

Camarillo Healthcare Center

3/21/2007	B	Comp.
\$1,000	<u>Patient Care</u>	Patient Care

On 10/20/06, a female resident requiring assistance in daily living activities, including toilet use and personal hygiene, was admitted to the facility. On 11/16/06, she was transferred to an acute hospital where photo documentation revealed that her hygiene was very poor and her genital area was red with areas of white fluid between the skin folds. The facility was cited for failure to provide the resident with proper personal hygiene. (Issued as Class B at \$1,000.) Citation #05136903833.

Camarillo Healthcare Center
5/29/2007 **B** Comp.
\$800 Patient Care Fall

A 96 year old female resident was incorrectly assessed to not be at a high risk for falls. Although her careplan indicated she be closely monitored and provided with a wedge cushion in her wheelchair, these preventative measures were never implemented. As a result, on 1/27/07, the resident fell and sustained a cut on her forehead and a bruise and skin tear on her leg. The facility was cited for failure to provide adequate supervision and assistance devices for its residents to prevent accidents. (Issued as Class B at \$800.) Citation #05190403991.

Camarillo Healthcare Center
7/6/2007 **B** Comp.
\$800 Patient Rights Dignity

On 3/27/07, a resident reported she wet the bed while sleeping. The nurse that answered the call light yanked the protective pad from under the resident and left her cold and wet. When the resident complained of being cold, the nurse brought her an old bedspread. The resident stated, "I've never been treated that way before." The facility was cited for failure to treat the resident with dignity and respect. (Issued as Class B at \$800.) Citation #05177803962.

Camarillo Healthcare Center
7/11/2007 **B** Certif.
\$800 Physical Environment Physical Environment

During an environmental tour of the facility on 3/28/07, a maintenance person indicated the facilities fire alarm system, including the smoke detectors that controlled the fire doors, had been inoperable for eight months. The facility was cited for failure to conform to the State Fire Marshal's standards for prevention of fire. (Issued as Class B at \$800.) Citation #05109303876.

Camarillo Healthcare Center
11/21/2007 **B** Comp.
\$1,000 Patient Care Fall
x3

On 10/6/07, a resident, who had paralysis of the left side of the body, was cognitively impaired and assessed to be a high risk for falls, was found on the floor after being left unattended on the toilet. The resident was later sent to ER with a fever, abrasion to the knee, discoloration of the shoulder, and a head injury. The facility was cited for failing to adequately supervise the resident. (Issued as Class B at \$1,000.) Citation #05205204396.

Country Villa Oxnard Manor Healthcare Center
1400 W Gonzales Rd, Oxnard, CA 93030

Country Villa Oxnard Manor Healthcare Center
8/10/2007 **B** Comp.
\$800 Patient Care Fall
Careplan

Despite a history of falls and staff awareness of changes in condition that placed a male resident at higher risk of injury, the facility failed to ensure his safety. The resident fell on 10/8/06 and sustained a head injury on or before 11/4/06. In both cases, the facility failed to identify the cause of the accident/injury and failed to develop and implement plans of care to prevent further accidents. (Issued as Class B at \$800.) Citation #05137103966.

Country Villa Oxnard Manor Healthcare Center
8/10/2007 **B** Comp.
\$500 Patient Care Notification
Careplan

Following the identification of a head injury on 11/4/06, staff obtained physician's orders and developed a plan of care with interventions including neurological assessments, monitoring for physical and mental changes, and notifying the physician if changes were identified. One staff identified physical changes on 11/5/06, and the resident's family and nursing staff noted mental changes on 11/6/06. For unknown reasons, two versions of the neurological assessments yielded conflicting data, rendering it difficult for nursing staff to identify mental changes. The resident's physician was not immediately notified of the physical and mental changes and possible need to alter treatment until 11/7/06. (Issued as Class B at \$500.) Citation #05137103974.

Country Villa Oxnard Manor Healthcare Center
8/10/2007 **B** Comp.
\$300 Patient Rights Physical Abuse

On 2/13/07, a physician attending to a female resident requiring assistance in daily activities treated her roughly and ignored her pleas for him to stop what he was doing. The resident's toenails were cut too short and her foot held too tightly. Although a CNA was in the room when the incident occurred and another CNA responded to the resident's cries, no one reported the incident and the administrators were not aware of the altercation. The facility was cited for failure to thoroughly investigate alleged abuse and to prevent further potential abuse. (Issued as Class B at \$300.) Citation #05137103975.

Country Villa Oxnard Manor Healthcare Center
8/10/2007 **B** Comp.
\$1,000 Patient Rights Patient Rights

On 2/13/07, a female resident requiring assistance in daily activities was being treated by a podiatrist, even though she had previously refused treatment. She attempted again to refuse by yelling and cursing at the doctor. The resident's toenails were painful and swollen as a result of the treatment. Although a CNA was in the room when the incident occurred and another CNA responded to the resident's cries, no one reported the incident and the administrators were not aware of the altercation between the resident and the physician. The facility was cited for failure to ensure that the resident's right to refuse treatment is upheld. (Issued as Class B at \$1,000.) Citation #05137103976.

Shoreline Care Center

5225 South J Street, Oxnard, Ca 93033

Shoreline Care Center

9/28/2007 **B** Comp.
\$700 Patient Rights Physical Abuse

On 1/20/07, a CNA entered a resident's room and witnessed another resident slapping her on the face. The resident sustained bruises to her right eye and right side of her face. The facility was cited for failure to protect the resident from physical abuse. (Issued as Class B at \$700.) Citation #05190404305.

Shoreline Care Center

12/13/2007 **B** Comp.
\$1,000 Patient Rights Physical Abuse

Two CNAs witnessed another CNA slap a 76 year old male resident, yell at him and use profanity. The facility was cited for failing to ensure the resident was not subjected to abuse. (Issued as Class B at \$1,000.) Citation #05136904452.

Thousand Oaks HealthCare Center

93 W. Avenida de Los Arboles, Thousand Oaks, CA 91360

Thousand Oaks HealthCare Center

10/17/2007 **B** Certif.
\$1,000 Staffing Staffing

During the facility's annual recertification survey, several residents and their family members complained of understaffing. An investigation revealed the facility had failed to provide the state law minimum of 3.2 nursing care hours per resident per day for a total of 20 days from February to July 2007. The understaffing led to a failure to provide adequate care to the facility residents. (Issued as Class B at \$1,000.) Citation #05204104272.

Twin Pines Health Care

250 March Street, Santa Paula, CA 93060

Twin Pines Health Care

3/20/2007 **B** Comp.
\$800 Patient Care Physical Abuse

On 12/18/05, a resident with a history of striking both staff and residents was observed hitting another resident repeatedly. The resident was hit with three hard blows to the left forearm, shoulder and back before staff intervened. She also expressed fear that she would be hit again by the resident. The facility was cited for failure to protect the resident from physical harm. (Issued as Class B at \$800.) Citation #05177803785.

Twin Pines Health Care

9/5/2007 **B** Certif.
\$1,000 Staffing Staffing

The facility failed to consistently meet the minimum nursing hours of 3.2 per resident per day from 1/1/07 through 6/27/07. The facility failed to ensure there was sufficient nursing staff to provide care, such as answering call bells timely, providing care at the time the resident chooses, completing activities of daily living, including hygiene, and providing incontinent care at the time it is reported. The facility also failed to consistently provide a registered nurse for eight consecutive hours per day, seven days a week, as required by federal regulations. (Issued as Class B at \$1,000.) Citation #05177804235.

Twin Pines Health Care

10/26/2007 **B** Comp.
\$1,000 Abuse Physical Abuse
Mandated Reporting

On 9/7/07, a resident and his sister informed the social services designee that a CNA had been rough when giving care and hit him on the back. The social services designee and director of nursing reported the abuse allegation to the administrator, who instructed them not to report it to the Department of Public Health. The facility was cited because it failed to report the alleged abuse to the Department of Public Health within 24 hours as required by law. (Issued as Class B at \$1,000.) Citation #05093004310.

Twin Pines Health Care

10/26/2007 **B** Comp.
\$1,000 Patient Care Neglect
Dignity

During the midnight shift on 9/25/07, an aide repeatedly ignored a resident's cries for help. Instead of helping the resident to the bathroom as requested, the aide told her, "No, no," and directed her to go in her diaper, causing the resident to cry. The neglected resident's roommate reported the sequence of events was repeated several times during the night. The next evening, the resident loudly cried, "Very cold," when the same aide left her naked and uncovered in an unmade bed. (Issued as Class B at \$1,000.) Citation #05093004311.

Victoria Care Center

5445 Everglades Street, Ventura, CA 93003

Victoria Care Center

2/1/2007 **A** Comp.
\$5,000 Patient Care Fall

On 9/2/05, a resident was found lying at the bottom of the stairs located at the front entrance of the facility. The resident was restrained in her wheelchair and had fallen down eight concrete stairs. She suffered multiple injuries including a fractured eye socket. The facility was cited for failing to provide the cognitively impaired resident with adequate supervision to prevent the resident from leaving the facility without staff supervision. (Issued as Class A at \$5,000.) Citation #05132503675.

Victoria Care Center
2/16/2007 **B** Comp.
\$800 Patient Care Careplan

On 7/19/05, a female resident was observed experiencing shortness of breath, increased respiration, wheezing, gagging, and coughing, while displaying anxious facial expressions. Although the resident had a careplan developed for respiratory distress, including identified interventions, the plan was not implemented at the time of the resident's distress. The facility was cited for failure to identify, assess, and evaluate the resident's condition and to promptly implement the treatment interventions. (Issued as Class B at \$800.) Citation #05177803714.

Victoria Care Center
3/1/2007 **B** Comp.
\$800 Administration Bed Hold

On 9/25/05, the resident experienced shortness of breath and was transferred to a local hospital. Hospital notes dated 9/26/05, indicated that the resident was informed of a seven day bedhold as of 9/25/05. The facility was cited for failing, upon discharge, to afford the resident with the right to exercise a seven day bedhold. (Issued as Class B at \$800.) Citation #05144003718.

Victoria Care Center
3/1/2007 **B** Comp.
\$500 Patient Rights Dignity

On 3/16/06, a resident's daughter arrived and found her mother sitting in a wheelchair in the hallway outside her room. The door to the room was closed, and there was a male voice inside the room yelling "Stop it, you're hurting me." Her mother was upset and confused about what was happening in her room. The resident's daughter opened the door and saw a naked male resident being showered by a staff member in the bathroom. The facility was cited for placing a resident with a private room in the hallway outside while staff showered a male resident in her bathroom. (Issued as Class B at \$500.) Citation #05144803725.

Victoria Care Center
3/9/2007 **B** Comp.
\$1,000 Abuse Sexual Abuse

On the morning of 2/22/06, a resident told two staff members that a male Occupational Therapist touched her inappropriately and made comments that made her uncomfortable. Although there was an internal investigation, the facility failed to report the alleged abuse immediately or within 24 hours to the licensing agency. (Issued as Class B at \$1,000.) Citation #05137103721.

Victoria Care Center
3/9/2007 **A** Comp.
\$10,000 Administration Sexual Abuse

On 2/22/06, a resident alleged that a Certified Occupational Therapy Assistant (COTA) had touched her inappropriately and had made inappropriate comments during previous treatment sessions. Although the aides reported the allegation to a charge nurse and supervisor, the facility failed to conduct a thorough investigation in accordance with their abuse prevention policies and procedures. The facility failed to suspend the COTA and the COTA was allowed to provide treatment to the resident that day. The facility was cited for failing to implement abuse prevention policies and procedures. (Issued as Class A at \$10,000.) Citation #05137103723.

Victoria Care Center
3/9/2007 **A** Comp.
\$20,000 Patient Rights Sexual Abuse

On 2/22/06, a resident alleged that a Certified Occupational Therapy Assistant (COTA) had touched her inappropriately and had made inappropriate comments during previous treatment sessions. Although the aides reported the allegation to a charge nurse and supervisor, the facility failed to conduct a thorough investigation in accordance with their abuse prevention policies and procedures. The facility failed to suspend the COTA and the COTA was allowed to provide treatment to the resident that day. The facility was cited for failing to protect the resident from sexual abuse. (Issued as Class A at \$20,000.) Citation #05137103724.

Victoria Care Center
3/9/2007 **B** Comp.
\$1,000 Administration Physical Abuse
Patient Rights

During the night shift on 5/27/06, a resident complained that she was handled roughly by a CNA. The resident was receiving rehabilitation for a broken right shoulder, but was turned on her right side against her wishes. The resident's daughter requested that the CNA be reassigned, but she continued to provide care for the nights of 5/28/06 and 5/29/06. The facility was cited for failure to report the incident to the administrator and to the licensing agency in violation of the law. (Issued as Class B at \$1,000.) Citation #05137103783.

Victoria Care Center
3/9/2007 **B** Comp.
\$1,000 Administration Physical Abuse
Staffing

On 12/20/06, a review of a CNA's personnel record revealed that the facility hired her on 12/29/04 without a reference check. On 5/27/06, a resident complained that the CNA had treated her roughly. The facility was cited for failure to ensure that the CNA was screened before the hire. (Issued as Class B at \$1,000.) Citation #05137103784.

