

# Citation Report 2013

## Nursing Home Citations in California with Summaries & Fines Issued

A SPECIAL REPORT BY:

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## 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](http://www.nursinghomeguide.org)) in order to inform consumers about enforcement actions taken against California nursing homes.

## Explanatory Notes

In an effort to provide concise yet meaningful information about fines (“citations”) received by California’s ~1,235 nursing homes, CANHR has summarized the citations issued by the Licensing and Certification Division of the Department of Public Health to nursing homes in 2013.

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, 1432, and 1280.15 and Welfare & Institutions Code §14126.022

## Citation Classes

<b>Class AA</b>	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.
<b>Class A</b>	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.
<b>Class B</b>	Class B citations carry fines from \$100 to \$2,000 and are issued for violations which have a direct or immediate relationship to health, safety or security, but do not qualify as A or AA citations.
<b>WMF or WMO</b>	<b>Willful Material Falsification</b> or <b>Willful Material Omission</b> in the health record of a resident carries a fine from \$2,000 to \$20,000 for each citation.
<b>R/D</b>	Civil penalties for <b>Retaliation</b> or <b>Discrimination</b> 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.
<b>AN (or AP NHPPD)</b>	An <b>Administrative Penalty</b> for failure to provide each resident a minimum of 3.2 hours of skilled nursing care on a daily basis. Carries a fine of \$15,000 for failure to meet the requirement for 5 to 49% of the audited days and \$30,000 for failure to meet the requirement for more than 49% of the audited days.
<b>FTR (or FB, FP)</b>	<b>Failure to Report</b> any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information to the affected patient or the patient's representative and/or to the Dept. of Public Health.

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

Citations can be appealed. The type of appeal and the outcome can be of the following types: Arbitration, Judicial, 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**

Bedsore 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 bedsore.

- 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	→	<b>Amador County</b>	
Current facility name	→	<b>Kit Carson Nursing &amp; Rehabilitation Center</b> 811 Court Street, Jackson, CA 95642	
Name at time of citation	→	Kit Carson Nursing & Rehabilitation Center	Class
Date of citation	→	9/26/2013	DPH "Type"
Fine	→	\$1,000	CANHR categories
CANHR's summary of the citation	→	A care plan entry dated 7/16/10, indicated that a resident was at risk for skin breakdown. On 8/1/10, a stage III pressure sore was found on the resident's right heel. On 8/11/10, the resident was admitted to the acute care hospital for wound care related to the pressure sore. The facility was cited for failure to provide skin assessments as ordered and provide treatment as ordered when the pressure sore developed. Citation # 030010156.	Citation Number

### Citations for Deaths

California law permits DPH to issue Class AA fines of up to \$100,000 when a resident's death has occurred due to nursing home violations. In practice, however, DPH often issues much smaller fines for neglect leading to the death of a nursing home resident. In a number of cases where death occurred, the Department issued Class B citations – which are supposed to be reserved for the least serious violations – with fines as low as \$1,000. This appalling practice sends the message that DPH considers the lives of nursing home residents to have little value.

#### 2013 - Citations issued for incidents in which a death occurred.

Class	Number	Fines as Issued
AA	10	\$860,350
A	11	\$215,000
B	7	\$11,000
Totals	28	\$1,086,350

### Citation Collections

DPH collects only a fraction of the fines it imposes against nursing homes. According to its records as of March 2014, DPH assessed slightly over \$2.7 million in penalties in 2013 and collected about \$1.2 million on those citations, well less than half of the penalties. Nursing homes have multiple opportunities to appeal citations and often obtain reductions through this process. Nursing homes are also rewarded if they don't appeal citations, earning an automatic 35 percent reduction in the fine. These reductions further diminish the impact of the citations, which rarely provide justice for the harm and suffering residents endure due to facility neglect and abuse.

Class	Number	Penalty as Issued	Penalty Offset	Penalty minus Offset	Collected Amount
AA	10	\$860,350	-\$21,000	\$839,350	\$39,000
A	47	\$894,400	-\$130,900	\$763,500	\$374,500
B	209	\$321,450	-\$75,233	\$246,218	\$217,018
AN	38	\$645,000	\$0	\$645,000	\$595,000
WF	3	\$6,000	-\$1,400	\$4,600	\$4,600
FTR	3	\$7,000	-\$1,750	\$5,250	\$5,250
Totals	310	\$2,734,200	-\$230,283	\$2,503,918	\$1,235,368

Source:

California Department of Public Health (CDPH), Licensing and Certification Program (L&C) Electronic Licensing Management System (ELMS), data as of March 13, 2014

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(Counties that do not appear had no citations.)

## Alameda County

### Alameda Hospital D/P SNF

2070 Clinton Ave, Alameda, CA 94501

Alameda Hospital D/P SNF

10/21/2013     **A**  
**\$16,000**     Medication     Medication

#### **Death Occurred**

A female resident who was admitted on 8/15/12 was on Coumadin, a blood thinning medication requiring close monitoring to prevent severe bleeding episodes. On 9/26/12, the resident was found unresponsive and was transferred to a hospital where she died the next day of brain hemorrhaging. A lab report showed the resident had blood clotting time six times the normal range. The facility had failed to perform basic blood tests to ensure the resident's blood was not too thin. A number of nurses failed to properly monitor the resident's blood. The facility was cited for failing to ensure the resident was spared unnecessary drugs. Citation # 020010227.

### Oakgrove Springs Care Center

309 MacArthur Blvd., Oakland, CA 94610

Oakgrove Springs Care Center

2/19/2013     **AN**  
**\$15,000**     Administrative     Staffing  
Penalty - Staffing  
Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 8 days out of 24 randomly selected days. Citation # 020009737.

### Oakhill Springs Care Center

3145 High Street, Oakland, CA 94619

Oakhill Springs Care Center

10/10/2013     **AN**  
**\$15,000**     Administrative     Staffing  
Penalty - Staffing  
Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 7 days out of 24 randomly selected days. Citation # 020010175.

### Oakland Healthcare & Wellness Center

3030 Webster St., Oakland, CA 94609

Oakland Healthcare & Wellness Center

6/26/2013     **AN**  
**\$15,000**     Administrative     Staffing  
Penalty - Staffing  
Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 3 days out of 24 randomly selected days. Citation # 020009961.

### Park Central Care & Rehabilitation Center

2100 Parkside Drive, Fremont, CA 94536

Park Central Care & Rehabilitation Center

7/22/2013     **B**  
**\$2,000**     Patient Care     Infection

#### **Death Occurred**

On 1/24/13, a 76 year old resident was admitted to the hospital with a digestive track bacterial infection (C-diff). On 1/31/13, the resident died of complication from the infection. Family members who had visited the resident told investigators that the resident had been having episodes of diarrhea. A review of the facility's nurses' notes from 1/3 to 1/24/13 showed no documentation of diarrhea or loose stool at any point during the resident's stay at the facility. The facility was cited for failure to assess and respond to the changes in the resident's condition. Citation # 020010021.

### St John Kronstadt Convalescent Center

4432 James Avenue, Castro Valley, CA 94546

St John Kronstadt Convalescent Center

2/4/2013     **AA**  
**\$60,000**     Accidents     Other

#### **Death Occurred**

On 7/18/12, three residents were taken to a baseball game by two staff members as part of a facility outing. The residents were given hot dogs. One resident choked and died. The resident had known dysphagia (difficulty swallowing) and had had a previous choking incident and was on a special diet to prevent choking. Nonetheless, the staff members who took the resident to the baseball game were not informed of his special needs. The facility was cited for failing to ensure the resident's dietary restrictions were followed while on a facility outing. Citation # 020009728.

**Amador County****Kit Carson Nursing & Rehabilitation Center**

811 Court Street, Jackson, CA 95642

Kit Carson Nursing &amp; Rehabilitation Center

9/26/2013      **B**  
**\$1,000**      Patient Care      Decubiti (Bedsores)  
    Patient Care

A care plan entry dated 7/16/10, indicated that a resident was at risk for skin breakdown. On 8/1/10, a stage III pressure sore was found on the resident's right heel. On 8/11/10, the resident was admitted to the acute care hospital for wound care related to the pressure sore. The facility was cited for failure to provide skin assessments as ordered and provide treatment as ordered when the pressure sore developed. Citation # 030010156.

Kit Carson Nursing &amp; Rehabilitation Center

11/19/2013      **AN**  
**\$30,000**      Administrative      Staffing  
                                  Penalty - Staffing  
                                  Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 12 days out of 24 randomly selected days. Citation # 030010257.

**Butte County****Cypress Healthcare Center**

1633 Cypress Lane, Paradise, CA 95969

Cypress Healthcare Center

2/20/2013      **A**  
**\$10,000**      Patient Care      Fall

On 9/9/11, a 76 year old resident who was assessed as unstable while walking and being a risk for falling, fell while attempting to use her bedside commode. The fall opened a gash in her head and caused bleeding in her brain. The resident was transported via helicopter to a medical facility where she received aggressive treatments for her brain injury. The injury left her substantially diminished, without the ability to perform many of the functions she was capable of doing for herself prior to the fall. The facility was cited for failure to ensure the safety of the resident by not providing assistance with toileting. Citation # 230009708.

Cypress Healthcare Center

4/17/2013      **B**  
**\$2,000**      Patient Care      Dignity  
    Retaliation Against  
    Resident

A resident, who was rehabilitating after a right hip fracture repair, was in constant pain and received pain medication. The resident states that the pain medications he receives help lower his level of pain from severe to moderate levels. On 11/16/11, the resident claimed that the LVN told him that if he does not start behaving, she will see to it that he gets his medications last. The resident stated, "It hurt my feelings." The facility failed to provide respect and dignity to the resident by speaking in a rude and threatening manner. This failure resulted in the resident experiencing a loss of dignity, emotional distress, and isolation from staff. Citation # 230009330.

Cypress Healthcare Center

4/17/2013      **B**  
**\$2,000**      Patient Care      Dietary Services  
    Medication

Facility failed to follow a resident's ordered wine diet, resulting in increased sedation, weakness and heavy bladder incontinence. The resident was given permission by a physician to have four ounces of wine with his Thanksgiving dinner. During a Thanksgiving luncheon on 11/19/11, the resident was given more than one glass of wine, as well as several medications that should not be taken with alcohol, as it may lead to oversedation. That night, he experienced extreme lethargy, slurred speech and heavy urinary incontinence. On 11/20/11 around 1:30 am, a nurse answered the resident's call light and found him sitting on the side of his bed. He said his legs gave out and he fell to the floor. Between midnight and 6 am on 11/20/11, the resident was unable to use an inhaler he takes every six hours for wheezing, due to oversedation. Many nurses described the resident as "over medicated" during the night of 11/19/11 and the morning of 11/20/11. Citation # 230009421.

Cypress Healthcare Center

7/15/2013 AN Staffing  
 \$15,000 Administrative  
Penalty - Staffing  
Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 4 days out of 24 randomly selected days. Citation # 230009995.

**Twin Oaks Post Acute Rehab**

1200 Springfield Dr, Chico, CA 95928

Twin Oaks Post Acute Rehab  
 4/8/2013 B  
 \$2,000 Patient Care Fall  
 Injury

On 5/13/11, a resident at risk for falls due to low blood pressure and dialysis treatments, fell and fractured his hip. The facility was cited for failure to monitor and supervise the resident. Citation # 230009415.

**Calaveras County**

**Mark Twain Convalescent Hospital**

900 Mountain Ranch Road, San Andreas, CA 95249

Mark Twain Convalescent Hospital  
 10/4/2013 B  
 \$1,000 Patient Care Patient Care

The facility failed to ensure that the resident's environment remain free from accident hazards when a resident suffered a fall while being transported in the facility's van while in his wheelchair. While the van was transporting the resident, the driver accelerated abruptly while on a hill. The resident's wheelchair was not properly tied down, causing the wheelchair to tip backwards and the resident to hit his head on the floor of the van. The resident was hospitalized for two days after suffering a laceration to the back of his head. Citation # 030010160.



## Contra Costa County

### Kindred Transitional Care and Rehabilitation-Walnut Creek

1224 Rossmoor Parkway, Walnut Creek, CA 94595

Kindred Transitional Care and Rehabilitation - Walnut Creek  
7/29/2013      **A**

\$20,000      Administration      Administration  
   Patient Care  
   Supervision

#### **Death Occurred**

An 81 year old female resident with respiratory failure was receiving respiratory therapy, involving a breathing tube with a valve (PMV) inserted into her neck, which she did not tolerate well. On 2/20/13, a nurse removed her neck breathing tube because the resident had bitten off the cuff balloon which keeps the valve on the breathing tube in place. Later that evening the respiratory notes stated she was stabilized and using a breathing collar, or mask covering the breathing hole in her neck. The next morning the tube was reinserted. About an hour later, she was found not breathing and CPR was performed. However, the resident died. The facility failed to closely supervise the resident after she was placed on the breathing tube that morning. Citation # 020010043.

### San Miguel Villa

1050 San Miguel Road, Concord, CA 94518

San Miguel Villa

12/6/2013

**B**

\$1,200      Patient Care      Patient Care

On 9/14/13, a 72 year-old resident, who was totally dependent on staff for all activities of daily living, was found unresponsive and transferred to the hospital. At the ER, it was noted that he was significantly constipated and had Urosepsis and Encephalopathy (a brain disorder secondary to sepsis and dehydration). It was also noted that his catheter was full of pus and not draining. When questioned by Department investigators about the catheter, the facility's Director of Nurses said there was no documentation showing that the catheter had been taken out or replaced during August or September of 2013, nor were there any records showing that the catheter was draining. It was determined that the clogged catheter contributed to the spread of a urinary tract infection into the resident's entire blood stream. The facility was cited for failure to properly maintain the resident's catheter and for failing to respond to his progressively worsening condition until he became unresponsive and needed to be sent to the hospital. Citation # 020010295.

### Shields Nursing Center

3230 Carlson Blvd., El Cerrito, CA 94530

Shields Nursing Center

11/20/2013

**B**

\$2,000      Patient Care

Between 4/17/13 and 8/27/13, three of seven sampled residents were transferred involuntarily from one facility to another in a town far away from their homes, social supports and familiar neighborhoods for the facility's convenience. The admissions coordinator stated, "I don't know anything about 30 day notices." The facility was cited for failure to give written notice of the impending transfers with a chance to appeal. Citation # 020010274.

### Windsor Rosewood Care Center

1911 Oak Park Blvd., Pleasant Hill, CA 94523

Windsor Rosewood Care Center

4/25/2013

**B**

\$2,000      Patient Rights      Transfer

On 8/22/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's Unit for more than 2 years and suffered from a severe cognitive impairment. The resident's responsible party reported the facility staff stated the Alzheimer's unit was closing and "told me that I had 30 days, not even that, to find a new placement..." Citation # 020009798.

Windsor Rosewood Care Center

4/25/2013

**B**

\$2,000      Patient Rights      Transfer

On 11/4/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for more than a year and suffered from advanced dementia. After being informed that the facility planned to close the Alzheimer's unit, the resident's responsible party reported feeling quite upset when she learned that the facility was planning to replace the Alzheimer's unit "with a more profitable population." Additionally, the responsible party said it was difficult to find a new placement because the resident suffered from severe sundowner syndrome. Citation # 020009854.

Windsor Rosewood Care Center

4/25/2013

**B**

\$2,000      Patient Rights      Transfer

On 9/7/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for a year and suffered from advanced dementia. The unlawful discharge increased the resident's risks of unmet needs, weight loss, and increased use of psychoactive drugs with potentially irreversible adverse side effects. Citation # 020009799.

Windsor Rosewood Care Center

4/25/2013

**B**

\$2,000      Patient Rights      Transfer

On 9/30/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for about 19 months and suffered from advanced dementia. After receiving a letter from the facility on 8/18/11 about plans to close the Alzheimer's unit, the resident's responsible party reported "I sorta freaked out when I read the letter. (The) resident was happy at the facility. I was scared and worried about what to do." Citation # 020009800.

## Windsor Rosewood Care Center

4/25/2013 **B**  
**\$2,000** Patient Rights Transfer

On 8/12/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for about 6 months and suffered from dementia and other impairments. After the facility stated it was closing the Alzheimer's unit and discharging the residents, the resident's responsible party reported "they sorta put pressure on me. I started to panic, trying to find a good place." Citation # 020009802.

## Windsor Rosewood Care Center

4/25/2013 **B**  
**\$2,000** Patient Rights Transfer

On 10/11/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for about three years and suffered from advanced dementia. The resident's responsible party stated that it was shocking to get notice from the facility in August that the Alzheimer's unit was closing and that the resident had to move by December. Citation # 020009811.

## Windsor Rosewood Care Center

4/25/2013 **B**  
**\$2,000** Patient Rights Transfer

On 10/7/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for about a year and suffered from advanced dementia. Upon learning of the facility's plan to close the Alzheimer's unit and discharge the residents, the resident's responsible party reported that she did not want the resident moved because the resident had a familiar routine and environment. Citation # 020009812.

## Windsor Rosewood Care Center

4/25/2013 **B**  
**\$2,000** Patient Rights Transfer

On 10/21/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for about three years and suffered from dementia and Parkinson's Disease. Upon learning of the facility's plan to close the Alzheimer's unit and discharge the residents, the resident's conservator reported feeling dismayed because the family had made a tremendous effort to settle the resident into the secured unit. Citation # 020009813.

## Windsor Rosewood Care Center

4/25/2013 **B**  
**\$2,000** Patient Rights Transfer

On 10/06/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for more than six years and suffered from advanced dementia. Upon learning that the facility was closing the Alzheimer's unit and wanted the resident out, the resident's responsible party and a family member reported they felt shocked and powerless because the resident was comfortable at the facility and did not respond well to change. Citation # 020009814.

## Windsor Rosewood Care Center

4/25/2013 **B**  
**\$2,000** Patient Rights Transfer

On 9/26/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for about three years and suffered from advanced dementia. The resident's conservator reported she was surprised when she learned the facility was closing the Alzheimer's unit and that the resident was really mad and upset about the move. Citation # 020009815.

## Windsor Rosewood Care Center

4/25/2013 **B**  
**\$2,000** Patient Rights Transfer

On 8/09/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for more than a year and suffered from dementia. The resident's responsible party reported she felt surprised when she learned that the facility planned to close the Alzheimer's unit and discharge the resident and was concerned because the resident did not adjust well to change. Citation # 020009816.

## Windsor Rosewood Care Center

4/25/2013 **B**  
**\$2,000** Patient Rights Transfer

On 8/2/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for more than seven years and suffered from advanced dementia. Upon learning that the facility planned to close the Alzheimer's unit and discharge the residents, the resident's responsible party reported the family was shocked and did not want the resident to be moved because it would be very traumatic. The resident was shaking while leaving on the day of discharge. Citation # 020009817.

## Windsor Rosewood Care Center

4/25/2013 **B**  
**\$2,000** Patient Rights Transfer

On 10/10/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for about a year and suffered from advanced dementia. The facility discharged the resident while closing the Alzheimer's unit, exposing the resident to increased risk of confusion, fear and distressful behaviors. Citation # 020009818.

## Windsor Rosewood Care Center

4/25/2013 **B**  
**\$2,000** Patient Rights Transfer

On 10/5/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for almost a year and suffered from advanced dementia. Upon learning that the facility planned to close the Alzheimer's unit and discharge the residents, the resident's responsible party reported the resident was upset and unable to understand why discharge was necessary. The responsible party was told that the facility would move the resident to a facility in Sacramento if she did not move the resident. Citation # 020009819.

## Windsor Rosewood Care Center

4/25/2013 **B**  
**\$2,000** Patient Rights Transfer

On 10/6/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for more than a year and suffered from advanced dementia. The resident's responsible person reported she was stressed by the facility's plan to close the Alzheimer's unit and discharge the residents. After subjecting the resident to confusion and distress by moving her, the facility sent a letter one month later inviting the resident to return. Citation # 020009820.

## Windsor Rosewood Care Center

4/25/2013 **B**  
**\$2,000** Patient Rights Transfer

On 10/8/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for more than 30 months and suffered from advanced dementia. After learning that the facility planned to close the Alzheimer's unit and discharge the residents, the resident's responsible party reported, "We were given no choice" about moving, and that the resident did not like being moved. Citation # 020009821.

## Windsor Rosewood Care Center

4/25/2013 **B**  
**\$2,000** Patient Rights Transfer

On 10/18/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had recently been admitted to the facility's secured Alzheimer's unit and suffered from advanced dementia. After being notified that the facility planned to close the Alzheimer's unit, the resident's responsible party reported the facility social worker told him to find a new home or the resident would be discharged to a facility in Stockton. Citation # 020009822.

## Windsor Rosewood Care Center

4/25/2013 **B**  
**\$2,000** Patient Rights Transfer

On 9/28/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for more than 30 months and suffered from advanced dementia. After learning that the facility planned to close the Alzheimer's unit, the resident's responsible party reported feeling troubled by the discharge decision, the process of finding a new facility and the facility's plan to discharge the resident to an unsecured facility. Citation # 020009823.

## Windsor Rosewood Care Center

8/13/2013 **B**  
**\$2,000** Patient Rights Evictions  
 Transfer

On 8/2/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 3/9/04. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010079.

## Windsor Rosewood Care Center

8/13/2013 **B**  
**\$2,000** Patient Rights Evictions  
 Transfer

On 10/10/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 10/17/10. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010080.

## Windsor Rosewood Care Center

8/13/2013 **B**  
**\$2,000** Patient Rights Evictions  
 Transfer

On 10/5/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 11/3/10. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010081.

## Windsor Rosewood Care Center

8/13/2013 **B**  
**\$2,000** Patient Rights Evictions  
 Transfer

On 10/6/11, the facility violated a resident's rights by discharging the resident without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 7/23/10. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010082.

Windsor Rosewood Care Center

8/13/2013 **B**  
**\$2,000** Patient Rights Evictions  
 Transfer

On 10/8/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 2/7/09. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010084.

Windsor Rosewood Care Center

8/13/2013 **B**  
**\$2,000** Patient Rights Evictions  
 Transfer

On 10/18/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 9/15/11. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010085.

Windsor Rosewood Care Center

8/13/2013 **B**  
**\$2,000** Patient Rights Evictions  
 Transfer

On 8/22/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 5/7/09. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010062.

Windsor Rosewood Care Center

8/13/2013 **B**  
**\$2,000** Patient Care Evictions  
 Transfer

On 11/4/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 8/18/10. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010065.

Windsor Rosewood Care Center

8/13/2013 **B**  
**\$2,000** Patient Rights Evictions  
 Transfer

On 9/7/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 9/9/10. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010066.

Windsor Rosewood Care Center

8/13/2013 **B**  
**\$2,000** Patient Rights Evictions  
 Transfer

On 9/30/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 2/15/10. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010067.

Windsor Rosewood Care Center

8/13/2013 **B**  
**\$2,000** Patient Rights Evictions  
 Transfer

On 8/12/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 2/17/11. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010069.

Windsor Rosewood Care Center

8/13/2013 **B**  
**\$2,000** Patient Rights Evictions  
 Transfer

On 10/11/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 10/8/08. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010070.

Windsor Rosewood Care Center

8/13/2013

**B**

\$2,000

Patient Rights

Evictions  
Transfer

On 10/7/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 10/20/10. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010071.

Windsor Rosewood Care Center

8/13/2013

**B**

\$2,000

Patient Rights

Evictions  
Transfer

On 10/21/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 12/22/08. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010073.

Windsor Rosewood Care Center

8/13/2013

**B**

\$2,000

Patient Rights

Evictions  
Transfer

On 10/6/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 6/13/05. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010075.

Windsor Rosewood Care Center

8/13/2013

**B**

\$2,000

Patient Rights

Bed Hold  
Evictions  
Patient Rights  
Transfer

On 9/16/11, the facility transferred a resident to the hospital for treatment of a hip fracture caused by a fall at the facility. Following hospital treatment, the facility refused to readmit the resident because it was closing the Alzheimer's unit where the resident had lived since 3/3/10. The facility was cited because it failed to issue a bed hold notice at the time of hospitalization and failed to readmit the resident after hospitalization as required. Citation # 020010076.

Windsor Rosewood Care Center

8/13/2013

**B**

\$2,000

Patient Rights

Evictions  
Transfer

On 9/26/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 8/18/08. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010077.

Windsor Rosewood Care Center

8/13/2013

**B**

\$2,000

Patient Rights

Evictions  
Transfer

On 8/9/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 6/29/10. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010078.

Windsor Rosewood Care Center

8/14/2013

**B**

\$2,000

Patient Rights

Evictions  
Transfer

On 9/28/11, the facility violated a resident's rights by transferring the resident to another skilled nursing facility without a proper written discharge notice 30 days in advance. The resident had been living in the facility's Alzheimer's Unit since 1/8/09. The facility sent letters to the resident's representative, stating that it was converting the dementia unit to a sub-acute unit, but it failed to give a legal reason for the transfer, failed to advise the resident of appeal rights and failed to identify when and where the resident would be transferred, as required. Citation # 020010086.

**El Dorado County****Gold Country Health Center**

4301 Golden Center Drive, Placerville, CA 95667

Gold Country Health Center

11/14/2013      **B**  
**\$2,000**      Patient Care      Fall  
    Patient Care  
    Supervision

On 9/16/11 a female resident with dementia fell in her room after getting out of bed undetected by staff. A physician ordered xray revealed a fracture to her leg. The bed alarms were supposed to be checked weekly and the CNA on duty did not have a record of the alarm status for this resident's alarm. The CNA indicated that she was aware that her alarm may not have been working. The facility failed to ensure her bed alarm was in place and working properly to alert staff when she got out of bed without assistance. Citation # 030010251.

**Fresno County****Golden Living Center - Hillcrest**

3672 N. First Street, Fresno, CA 93726

Golden Living Center - Hillcrest

3/13/2013      **B**  
**\$2,000**      Physical      Physical Environment  
    Environment

The facility was cited for failing to provide a safe, functional and sanitary environment for residents, staff and public when there was a sewage backflow, foul odor and a plumbing leak due to a broken plumbing pipe. The bathroom toilet between rooms 2 and 3 was not available for one month due to the sewage leakage. This violation had a direct or immediate relationship to the health, safety, or security of residents. Citation # 040009782.

**Healthcare Centre of Fresno**

1665 'M' Street, Fresno, CA 93721

Healthcare Centre of Fresno

6/13/2013      **AN**  
**\$15,000**      Administrative      Staffing  
    Penalty - Staffing  
    Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 2 days out of 24 randomly selected days. Citation # 040009930.

**Manning Gardens Care Center, Inc.**

2113 E. Manning Ave., Fresno, CA 93725

Manning Gardens Convalescent Hospital

1/23/2013      **AN**  
**\$15,000**      Administrative      Staffing  
    Penalty - Staffing  
    Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 7 days out of 24 randomly selected days. Citation # 040009525.

## Glenn County

### Willows Care Center

320 North Crawford St., Willows, CA 95988

Willows Care Center

2/14/2013      AN  
**\$15,000**      Administrative      Staffing  
                          Penalty - Staffing  
                          Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 6 days out of 24 randomly selected days. Citation # 230009528.

## Imperial County

### Valley Convalescent Center

1700 S. Imperial Ave, El Centro, CA 92243

Valley Convalescent Center

5/20/2013      AN  
**\$15,000**      Administrative      Staffing  
                          Penalty - Staffing  
                          Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 5 days out of 24 randomly selected days. Citation # 090009890.

**Kern County**

**Bakersfield Healthcare Center**

730 34th Street, Bakersfield, CA 93301

Bakersfield Healthcare Center

2/19/2013 AN  
 \$15,000 Administrative Staffing  
Penalty - Staffing  
Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 5 days out of 24 randomly selected days. Citation # 120009736.

**Corinthian Gardens Health Care Center**

1611 Height Street, Bakersfield, CA 93305

Corinthian Gardens Health Care Center

10/23/2013 B  
 \$2,000 Abuse/Facility Mandated Reporting  
Not Self Reported

The facility failed to report an allegation of resident to resident abuse within 24 hours to the Department of Public Health, as required by the facility's policy. On 10/2/2013, a resident grabbed another resident's wrist. The abused resident said the grab was so hard that she thought her wrist would be fractured. The two staff members who broke up the incident did not document or report it. Citation # 120010212.

**Delano District Skilled Nursing Facility**

1509 Tokay Street, Delano, CA 93215

Delano District Skilled Nursing Facility

10/23/2013 B  
 \$2,000 Abuse/Facility Mandated Reporting  
Not Self Reported

The facility failed to report to the California Department of Public Health (DPH) an allegation of fiduciary abuse towards a resident within 24 hours of the allegation, as required by the facility's policy. On 6/12/2012, a resident reported a loss of \$200. The facility ran an investigation, but did not report the incident to the DPH because it did not appear to be an abuse case. Citation # 120010176.

**Golden Living Center - Shafter**

140 E.Tulare Ave, Shafter, CA 93263

Golden Living Center - Shafter

9/16/2013 B  
 \$1,000 Abuse / Facility Patient Care  
Not Self Reported

On 2/5/11, a resident who suffered from Alzheimer's kicked another resident who was being pushed in a wheelchair past her room. The resident in the wheelchair was being pushed by a family member who then complained to the facility about the incident. Upon investigation it was determined that the offending resident had a history of striking other residents who wandered into her area and had "territorial issues." The facility was cited for failing to follow procedures to prevent that resident from kicking other residents. Citation # 120008991.

**Parkview Healthcare Center**

329 North Real Road, Bakersfield, Ca 93309

Parkview Healthcare Center

9/16/2013 B  
 \$2,000 Patient Care Mandated Reporting  
 Sexual Abuse

Nurses' notes dated 1/23/12 indicated that at 2:30 pm the resident had been observed touching a female resident's thigh. There was no information indicating that the Department had been notified of the incident. The facility was cited for failing to report an allegation of abuse to the Department with 24 hours. Citation # 120009509.

Parkview Healthcare Center

9/16/2013 B  
 \$1,000 Patient Care Physical Abuse  
 Retaliation Against  
 Resident  
 Verbal Abuse

On 09/06/09, following a complaint made by a female resident to the nurse supervisor about the call light not being answered at night, a CNA came into the resident's room and yelled at her in a very threatening manner, "You quit accusing me of things, I'm sick and tired of it, and you better shut up." As a result, the facility was cited for failing to protect a resident from verbal and physical abuse from a CNA. Citation # 120007933.



## Lake County

### Evergreen Lakeport Healthcare

1291 Craig Avenue, Lakeport, CA 95453

Evergreen Lakeport Healthcare

5/16/2013

AA

\$100,000

Medication

Medication

#### **Death Occurred**

On 8/8/11, a female resident was given methadone that was not ordered by a physician. The licensed nurse confused the resident for a different resident. The nurse discovered her error about 15 minutes later. Despite the resident's declining functioning, the staff did not call 911 until eight hours later and she died shortly after. The staff had decided to monitor vital signs instead of sending the resident to the hospital or seeking treatment with a reversal agent. The facility was cited for giving the resident the wrong medication and failing to transfer the resident to the hospital after the error was discovered. The violations were a direct proximate cause of the resident's death. Citation # 110008617.

## Lassen County

### Country Villa Riverview Rehabilitation and Healthcare Center

2005 River Street, Susanville, CA 96130

Country Villa Riverview Rehabilitation and Healthcare Center

12/31/2013

B

\$1,000

Problem Transfer

Bed Hold

In March of 2012, a resident was transferred to a mental health facility for temporary care. When the social services worker attempted to place the resident back into the original facility, the resident was denied re-admittance on several occasions. The Director of Nursing stated they had a "verbal agreement" that the mental health facility would find alternate placement for the resident. When it was explained that without a written agreement the facility would have to take him back, the resident was readmitted on 6/8/12. The facility was cited for failure to readmit the resident. Citation # 230009387.

## Los Angeles County

### Allen Care Center, Inc.

201 Allen Ave., Glendale, Ca 91201

Allen Care Center, Inc.

4/12/2013      **A**  
 \$20,000      Patient Care      Careplan Neglect

#### **Death Occurred**

On 1/28/10, a resident was hospitalized after his blood sugar levels reached life-threatening levels, and he died three days later from “severe diabetic ketoacidosis.” Prior to his hospitalization, the resident was admitted to the Allen Care Center with a diagnosis of uncontrolled diabetes. However, the facility had not been checking his blood sugar levels. The facility was cited because it failed to provide effective care to manage the resident’s diabetes and did not promptly notify his physician of significant changes in his condition. Citation # 920007870.

Allen Care Center, Inc.

7/19/2013      **AN**  
 \$15,000      Administrative Penalty - Staffing Audit      Staffing

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility’s records, they were found to be out of compliance with this requirement for 11 days out of 24 randomly selected days. Citation # 920010008.

### Bay Crest Care Center

3750 Garnet Avenue, Torrance, CA 90503

Bay Crest Care Center

5/15/2013      **B**  
 \$2,000      Patient Care      Fall

On 9/10/2009, an 82 year-old wheelchair bound resident tried to get out of the facility by exiting through an emergency door that was not alarmed. The resident tumbled down the stairs suffering skin lacerations and abrasions to his head, hand, and knee. The resident was found on the ground floor still strapped into his wheelchair. The facility was cited for failure to ensure that the resident’s environment was safe from accident hazards. Citation # 910009904.

Bay Crest Care Center

5/15/2013      **B**  
 \$2,000      Patient Care      Fall

On 6/3/09, a severely impaired resident fell from his bed after a CNA left the side rail down. The fall resulted in the resident being sent to the emergency hospital with a large hematoma on the right side of his head above the eye and knee injuries. The resident’s care plan called for his bed rails to be up and secure while the resident was in bed. The facility was cited for failure to implement the resident’s care plan to keep the rails up and secure. Citation # 910009897.

### Bel Tooren Villa Convalescent Hospital

16910 Woodruff Ave., Bellflower, CA 90706

Bel Tooren Villa Convalescent Hospital

9/12/2013      **B**  
 \$2,000      Abuse/Facility Not Self Reported      Physical Abuse

The facility failed to protect a resident’s right to be free from abuse and also failed to investigate an alleged instance of abuse immediately. In June of 2013, a resident reported that he was punched in the face by another resident in the facility. The resident reported the alleged abuse to staff members but an investigation was not conducted immediately in accordance with facility abuse reporting procedures. Citation # 940010146.

Bel Tooren Villa Convalescent Hospital

9/16/2013      **B**  
 \$2,000      Administration      Physical Abuse

The facility failed to report within 24 hours an incident of alleged abuse against a resident as required by law. In June of 2013, a resident reported that another resident punched him in the face in the facility. The resident reported the alleged abuse to staff members, but staff failed to report to the Department State Survey and Certification Agency as required by law. Citation # 940010149.

### Bellflower Convalescent Hospital

9710 E. Artesia Ave., Bellflower, CA 90706

Bellflower Convalescent Hospital

4/2/2013      **AN**  
 \$15,000      Administrative Penalty - Staffing Audit      Staffing

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility’s records, they were found to be out of compliance with this requirement for 7 days out of 24 randomly selected days. Citation # 940009797.

### Bloomfield East

3615 Imperial Hwy, Lynwood, CA 90262

Bloomfield East

1/25/2013      **B**  
 \$2,000      Patient Care      Infection Mandated Reporting Patient Care

The facility was cited for failing to establish and maintain an infection control program. The facility failed to notify the department within 24 hours of a gastroenteritis outbreak affecting 17 out of 91 residents. Failure to report the outbreak resulted in delayed control of the gastroenteritis outbreak. Citation # 940009719.

**Brier Oak On Sunset**

5154 Sunset Blvd., Los Angeles, CA 90027

Brier Oak On Sunset

2/21/2013	<b>B</b>	
<b>\$1,500</b>	<u>Patient Care</u>	Careplan Notification

Nurse's notes indicated that on 12/12/10, a resident with congestive heart failure had a drop in blood pressure and heart rate. There was no indication that the physician was notified. On 12/14/10, the resident's condition changed again and he was transferred to the acute hospital and admitted to the cardiac care unit. The facility was cited for failure to notify the primary physician and responsible party of a drop in blood pressure and heart rate, and failure to closely monitor the resident's vital signs. Citation # 920009752.

**Broadway Healthcare Center**

112 E. Broadway, San Gabriel, CA 91776

Country Villa Broadway Healthcare Center

12/10/2013	<b>A</b>	
<b>\$20,000</b>	<u>Patient Care</u>	Notification Patient Care

**Death Occurred**

According to a complaint on 2/12/12, a resident was having phlegm and a cough that required suctioning. A family member made several requests for the resident to be suctioned and the physician to be notified. Facility policy indicated that the physician be notified of a change in condition. The resident had been complaining of headache and dizziness. Facility staff failed to suction the resident and the physician was never contacted. Six hours later the resident was found unresponsive and expired shortly thereafter. The facility was cited for failure to notify the physician of a change of condition and failure to provide suctioning. Citation # 950010234.

**California Convalescent Center 1**

909 S Lake Street, Los Angeles, CA 90006

California Convalescent Center 1

12/30/2013	<b>AN</b>	
<b>\$15,000</b>	<u>Administrative Penalty - Staffing Audit</u>	Staffing

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 10 days out of 24 randomly selected days. Citation # 910010327.

**Casa Bonita Convalescent Hospital**

535 E Bonita Ave., San Dimas, CA 91773

Casa Bonita Convalescent Hospital

8/12/2013	<b>B</b>	
<b>\$2,000</b>	<u>Patient Care</u>	Injury

On 4/8/12, a female resident with osteoporosis broke her foot when she struck it against a door while being pushed in a wheelchair by a CNA. The resident thought the CNA was going to attempt to open the door by slamming the wheelchair's footrests into it so she lifted her feet to avoid contact. The CNA told a different story: she pushed the door open with her hand but as she was pushing the resident through the doorway, the door closed, striking the resident's foot. The facility was cited for failing to follow its care plan for protecting the resident from fractures. Citation # 950010089.

**Centinela Skilled Nursing & Wellness Centre West**

950 Flower Street, Inglewood, CA 90301

Centinela Skilled Nursing &amp; Wellness Centre West

8/19/2013	<b>WMF</b>	
<b>\$2,000</b>	<u>Medication</u>	Patient Records

Two licensed nurses in the facility fraudulently noted they had provided an 86 year old male resident's physician-ordered potassium sodium phosphate on 4/11/13 and 4/12/13 when they had not. An investigation revealed the facility had not had any potassium sodium phosphate on hand during that time. The facility was cited for making a willful material false entry in the resident's records. Citation # 910010102.

**Century Villa, Inc.**

301 N Centinela Ave, Inglewood, CA 90302

Century Skilled Nursing Care

6/25/2013	<b>B</b>	
<b>\$2,000</b>	<u>Patient Care</u>	Fall Injury

On 2/23/2010, the facility failed to ensure a resident who was at risk for falls was safely transferred from her wheelchair to her shower chair. The CNA assisting the resident did not notice the breaks of the shower chair's wheels were unlocked, and the resident slipped, fell, and injured her left foot and right knee. Citation # 910009971.

**Chatsworth Park Care Center**

10610 Owensmouth Ave., Chatsworth, CA 91311

Chatsworth Park Care Center

3/11/2013

**A****\$19,000**Patient CareDecubiti (Bedsore)  
Nutrition**Death Occurred**

A resident with Parkinson's Disease was admitted to the facility on 10/16/10. The resident's admission assessment indicated he needed extensive assistance with eating and many other daily activities and had a risk for skin breakdown. The resident was not placed on an assisted feeding program. By 12/22/10, the resident had stage II bedsores on his coccyx and buttocks. The resident was ordered to receive nutritional supplements to prevent bedsores, but his records did not include evidence that the supplements were given. The bed sores continued to worsen to stage IV and the resident was transferred to a hospital where he was diagnosed with malnutrition. He died on 2/4/11. The facility was cited for failing to prevent the development of bedsores, provide proper nutrition, and provide proper wound evaluation and care. Citation # 920009694.

**Coast Care Convalescent Center**

14518 E. Los Angeles, Baldwin Park, CA 91706

Coast Care Convalescent Center

2/8/2013

**B****\$2,000**Physical  
Environment

Administration

The facility was cited for failure to comply with a California Health and Safety code requirement to post the Medicare and Medicaid overall facility rating information in areas visible to the public, areas for employee breaks, and areas used for communal functions. Citation # 950009735.

**Country Villa Belmont Heights Healthcare Center**

1730 Grand Ave, Long Beach, CA 90804

Country Villa Belmont Heights Healthcare Center

5/21/2013

**AA****\$75,000**Patient Care

Patient Care

**Death Occurred**

On 1/26/10, a resident had a gastrostomy tube (GT) surgically inserted through her skin and stomach wall to provide nutrition and medications. On 1/27/10, the resident pulled the GT out. The facility's procedures dictated that a GT was only to be inserted per a physician's orders. Disregarding the procedures, a facility LVN reinserted a new GT and resumed the feeding formula. On 1/28/10, the resident began vomiting, had an elevated temperature and rapid heartbeat, and low blood pressure. The resident was transferred to the ER where she was diagnosed with acute peritonitis, which was caused by the GT being improperly inserted into the peritoneal cavity, causing septic shock. The resident died nine days after being admitted to the hospital. There was no documented evidence of the CNA having any training related to GT care. The facility was cited for not providing appropriate treatment and services. Citation # 940009762.

**Country Villa Glendale Healthcare Center**

1208 S. Central Ave., Glendale, CA 91204

Country Villa Glendale Healthcare Center

10/10/2013

**B****\$1,800**Patient CareCareplan  
Notification  
Patient Records  
Physical Abuse

The facility failed to monitor a resident for symptoms of complications, pain and discomfort after a fall on 9/5/2011, as required by his careplan. When he complained of hip pain that increased over time after the fall, the nursing staff failed to stop his physical therapy exercises and failed to evaluate if his hip pain was related to the preceding fall. The resident was also administered pain medication without documentation of pain assessment, medication administration or tolerance for physical therapy; and his physician was not notified of changes in his pain intensity. Citation # 920010179.

**Country Villa Mar Vista Nursing Center**

3966 Marcase Ave, Los Angeles, CA 90066

Country Villa Mar Vista Nursing Center

8/15/2013

**A****\$14,000**Patient Care

Fall

On 1/12/13, a 63 year old stroke resident who had a history of falls was found on the floor. The facility's records indicated that this was the third time that resident had been found on the floor. On 1/14/13, the resident was again found on the floor, this time with head injuries and a laceration on her forehead. The facility was cited for failing to adequately supervise and address the needs of a resident who was at high risk for falling. Citation # 910010093.

**Country Villa Pavilion Nursing Center**

5916 West Pico Blvd, Los Angeles, CA 90035

Country Villa Pavilion Nursing Center

8/16/2013

**B****\$1,800**Patient Care

Fall

On 6/8/09, a 90 year old resident, totally dependent others, fell off of a Hoyer lift and sustained a head injury and was sent to the ER. Upon investigation into the incident, it was determined that the staff person operating the lift was using an improper sling. The sling that was being used was designed for a different machine. The facility was cited for the employee's incorrect use of equipment. Citation # 910010101.

**Country Villa Rehabilitation Center**

340 S. Alvarado St., Los Angeles, CA 90057

Country Villa Rehabilitation Center

8/16/2013	<b>B</b>	
<b>\$2,000</b>	<u>Patient Care</u>	Patient Care

On 10/3/12 a female resident reported that a CNA had threatened to choke her with the call light cord if she called for help again. On 9/10/12, the CNA was disciplined for refusing to care for the resident. However, the CNA stated she was not allowed to care for the resident because the family filed a complaint against her for being too rough. However, there was no documentation of a complaint by the family. The facility failed to ensure an abuse allegation was thoroughly investigated, and failed to prevent further abuse from occurring by continuously assigning the CNA for 19 days after the resident complained and family members requested not to assign the CNA to the resident. Citation # 910010098.

Country Villa Rehabilitation Center

11/13/2013	<b>A</b>	
<b>\$20,000</b>	<u>Patient Care</u>	Fall

**Death Occurred**

On 6/20/13, a resident fell when a CNA improperly transferred the resident without assistance of another staff member while using a mechanical lift. The resident sustained a gash to the left side of the forehead, had pinpoint pupils, vomited, required CPR, and was transferred by paramedics to the general acute care hospital where she subsequently expired due to heart disease. The facility was cited for not adequately supervising and assisting devices to prevent accidents and ensuring that the resident environment remains as free from accident hazards as possible. Citation # 910010192.

**Country Villa Westwood Healthcare Center**

12121 Santa Monica Blvd, Los Angeles, CA 90025

Country Villa Westwood Cvlr Center

3/14/2013	<b>A</b>	
<b>\$20,000</b>	<u>Patient Care</u>	Patient Care

On 2/1/09, a 64 year old male resident was found unresponsive and transferred to a hospital where he was treated for respiratory failure and diabetic shock. The resident had been admitted to the facility on 1/28/09 and was noted to have diabetes, but there were no physician orders to control or monitor it. The resident's admissions paperwork noted he had diabetes that was very difficult to control. The resident's roommate reported that the resident had been sleeping all day prior to his emergency hospitalization. The facility was cited for failing to ensure the resident's diabetes was monitored and assessed; failing to ensure the physician's orders were clarified regarding the resident's condition; and failing to promptly report the resident's change in condition. Citation # 910009764.

**Driftwood Healthcare Center**

4109 Emerald Avenue, Torrance, CA 90503

Driftwood Healthcare Center

5/14/2013	<b>A</b>	
<b>\$19,000</b>	<u>Patient Care</u>	Medication Careplan

The facility administered unnecessary drugs to a resident, which resulted in the resident having low blood pressure and a slow heart rate. She was transferred to an acute hospital in critical condition, and was admitted to the intensive care unit. She was diagnosed with kidney failure, dehydration, and digoxin toxicity (poisoning from excess doses of dogoxin, a drug used to slow and strengthen the heart rate for fibrillation of the heart's atrium). This could have been avoided if the resident's physician and facility staff followed the pharmacy's recommended careplan, and if the staff notified the physician of the resident's change of condition. Citation # 910009863.

**El Monte Convalescent Hospital**

4096 Easy Street, El Monte, CA 91731

El Monte Convalescent Hospital

4/18/2013	<b>B</b>	
<b>\$2,000</b>	<u>Patient Care</u>	Infection

Twenty residents developed vomiting and/or diarrhea between 11/17/2012 and 12/4/2012, including one who tested positive for Norovirus and one who tested positive for C. difficile. The facility was cited for not promptly reporting the gastrointestinal outbreak to the Department of Public Health once it was evident that there was an outbreak. Citation # 950009844.

**El Rancho Vista Health Care Center**

8925 Mines Avenue, Pico Rivera, CA 90660

El Rancho Vista Health Care Center

11/19/2013	<b>B</b>	
<b>\$2,000</b>	<u>Patient Care</u>	Patient Care

On 9/5/13, a resident was readmitted to the facility with skin itching and rashes. The resident was not seen by a dermatologist until 9/30/13. As a result, 13 other residents and 6 staff members contracted scabies. The facility failed to implement established infection control policies and procedures by failing to consult the dermatologist promptly, place the resident in isolation to protect the other residents, and develop a tracking record of patients with onset of signs and symptoms and exposures. Citation # 940010271.

**Elmcrest Care Center**

3111 Santa Anita Ave, El Monte, CA 91733

Elmcrest Care Center

7/1/2013      **B**  
**\$2,000**      Patient Care      Notification

On 2/22/2012, the facility failed to promptly notify a resident's physician of critical laboratory results from a blood test. A staff member attempted to contact the physician, but the physician could not be reached, so the staff member left a message. The facility's medical director is required by facility policy to be notified if the physician cannot be reached, but the medical director was not notified. The physician was not notified until 2/29/2012, which delayed treatment, including administering medication for anemia and transfer to the acute hospital for blood transfusion to prevent further bleeding. Citation # 950009987.

**Emeritus at San Dimas**

1740 San Dimas Avenue, San Dimas, Ca 91773

Emeritus at San Dimas

7/3/2013      **B**  
**\$2,000**      Medication      Careplan  
    Medication

A female resident was experiencing elevated potassium levels in the blood, which can lead to irregular heartbeat or cardiac arrest. The facility failed to notify the physician promptly, thus the resident received three unnecessary doses of potassium chloride, likely worsening the resident's high potassium levels. The facility failed to develop a care plan to monitor for an increase in the resident's potassium blood levels. The facility also failed to notify the physician promptly, when the situation required prompt medical intervention and could lead to serious harm. Citation # 950009849.

**Flower Villa, Inc.**

1480 S. La Cienega, Los Angeles, CA 90035

Flower Villa, Inc.

7/19/2013      **AN**  
**\$30,000**      Administrative      Staffing  
                                  Penalty - Staffing  
                                  Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 13 days out of 24 randomly selected days. Citation # 940009801.

**Four Seasons Healthcare & Wellness Center, LP**

5335 Laurel Canyon Blvd., North Hollywood, CA 91607

Four Seasons Healthcare &amp; Wellness Center, LP

6/20/2013      **AN**  
**\$15,000**      Administrative      Staffing  
                                  Penalty - Staffing  
                                  Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 4 days out of 24 randomly selected days. Citation # 920009955.

**Gardena Convalescent Center**

14819 S Vermont, Gardena, CA 90247

Gardena Convalescent Center

10/17/2013      **B**  
**\$2,000**      Physical      Physical Environment  
                                  Environment

The facility was cited for failing to maintain a comfortable hot water temperature range for its residents. A facility maintenance report documented that there was no hot water in facility for three days, and housekeeping staff said that the hot water and the water heater was "off and on, not working" when he was working during the week. Citation # 910010214.

Gardena Convalescent Center

11/26/2013      **A**  
**\$20,000**      Patient Care      Fall  
    Injury  
    Supervision

On 4/8/13, a resident at risk for falls and wandering was found on the ground outside the facility with a right arm fracture. The facility was cited for failure to develop a plan of care to prevent wandering. Citation # 910010261.

Gardena Convalescent Center

11/26/2013      **B**  
**\$2,000**      Patient Care      Fall  
    Mandated Reporting

On April 1, 2013, facility front office staff heard a loud bang and found a 91 year old resident with dementia lying at the bottom of a ramp outside of the building. The resident was transferred to the emergency room and found to have a broken arm. The facility did not report the fall to the Department, and was cited for failing to report an unusual occurrence to the Department within 24 hours that resulted in the resident's unwitnessed fall and injury. Citation # 910010259.

**Genesis**

723 E 9th Street, Long Beach, CA 90813

Villa Maria Care Center

2/11/2013      **A**  
**\$17,000**      Patient Care      Careplan

The facility's staff failed to follow the resident's careplan after hospital treatment on 11/28/12 for fecal impaction (large mass of hard stool in rectum due to chronic constipation), thus putting the resident at risk of further fecal impaction. Citation # 940009709.

**Glendora Grand, Inc.**

805 West Arrow Highway, Glendora, CA 91740

Glendora Grand, Inc.

5/1/2013 **B**  
**\$2,000** Patient Care Physical Abuse

On 12/17/11, an 89 year old resident who suffers from dementia was discovered with a skin tear to the face, a swollen nose, and discoloration on the jaw, right upper thigh, and right upper arm. The resident was transferred to the hospital, but the facility failed to notify the Department about the resident's injuries. It was not determined how the resident received her injuries. The facility was cited for failure to immediately report the incident to the Department. Citation # 950009868.

Glendora Grand, Inc.

8/22/2013 **B**  
**\$2,000** Physical Environment Supervision

The facility was cited for failing to provide adequate supervision for a resident who was assessed as an unsafe smoker. As a result the resident accidentally started a fire in the facility bathroom caused by a cigarette in the trash can. Citation # 950010116.

**Goldstar Rehabilitation and Nursing Center of Santa Monica**

1340 15th Street, Santa Monica, CA 90404

Goldstar Rehabilitation and Nursing Center of Santa Monica

8/22/2013 **B**  
**\$2,000** Patient Care Physical Abuse

A resident's family member noticed the resident's eye was red and swollen on 8/28/10. The resident was able to identify a staff member as the person who had hit him. The police were called and determined the resident had suffered physical trauma. The facility was cited for failing to protect the resident from physical abuse by the staff. Citation # 910010100.

**Grand Park Convalescent Hospital**

2312 W 8th Street, Los Angeles, CA 90057

Grand Park Convalescent Hospital

8/1/2013 **B**  
**\$2,000** Patient Rights Injury  
 Physical Abuse

On 4/19/10, a 70 year old resident's finger was broken when his hand was held down against his will to perform a blood sugar test. The facility was cited for failing to honor the resident's right to refuse treatment. Citation # 910010049.

**Greenfield Care Center Of Gardena**

16530 S Broadway, Gardena, CA 90248

Greenfield Care Center Of Gardena

10/17/2013 **B**  
**\$2,000** Patient Care Patient Care

On 11/9/2011, the facility failed to investigate a bruise of unknown origin in the middle of a resident's forehead, which is required by the facility's own policy on Care of Accident and Incident. The facility also failed to report the injury to the Department of Public Health. Citation # 910010197.

**Hyde Park Convalescent Hospital**

6520 West Blvd, Los Angeles, CA 90043

Hyde Park Convalescent Hospital

12/30/2013 **AN**  
**\$15,000** Administrative Staffing  
Penalty - Staffing  
Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 2 days out of 24 randomly selected days. Citation # 910010303.

**Imperial Convalescent Hospital**

11926 La Mirada Blvd, La Mirada, CA 90638

Imperial Convalescent Hospital

5/9/2013 **AN**  
**\$15,000** Administrative Staffing  
Penalty - Staffing  
Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 2 days out of 24 randomly selected days. Citation # 940009867.

**Inglewood Health Care Center**

100 S. Hillcrest Blvd, Inglewood, CA 90301

Inglewood Health Care Center

5/16/2013 **AN**  
**\$15,000** Administrative Staffing  
Penalty - Staffing  
Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 2 days out of 24 randomly selected days. Citation # 910009881.

**Intercommunity Care Center**

2626 Grand Avenue, Long Beach, CA 90815

Intercommunity Care Center

1/7/2013      **AN**  
**\$15,000**      Administrative      Staffing  
                          Penalty - Staffing  
                          Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 9 days out of 24 randomly selected days. Citation # 940009686.

Intercommunity Care Center

2/27/2013      **B**  
**\$750**              Administration      Administration  
    Mandated Reporting  
    Supervision

On 12/24/12, a male resident with dementia went missing from the facility where he resided. The police department was notified and a missing person report was filed. On 2/7/13, the resident had yet to be found. The facility had a policy to report within 24 hours an unusual occurrence to the local health officer and Department of Health Services. However the administrator and the director of nursing were unable to provide evidence the Department was notified of the missing resident. Citation # 940009760.

**Ivy Creek Healthcare & Wellness Centre**

115 Bridge Street, San Gabriel, CA 91775

Ivy Creek Healthcare & Wellness Centre

4/8/2013      **B**  
**\$2,000**              Patient Care              Careplan  
    Decubiti (Bedsore)  
    Patient Records

The facility failed to prevent a resident from developing pressure sores by not developing a proper careplan after she was assessed as being at risk of developing pressure sores on 9/14/12. The facility also failed to conduct weekly body checks for pressure sores, implement the Activities of Daily Living plan of care to turn and reposition the resident every two hours, and document the healing of previous sores. This caused the resident to develop two stage II pressure sores on her left and right buttocks, which were found on 12/12/12. Citation # 950009830.

**Kennedy Post Acute Care Center**

619 N. Fairfax Avenue, Los Angeles, CA 90036

Kennedy Post Acute Care Center

5/16/2013      **A**  
**\$20,000**              Patient Care              Fall  
    Injury

A resident at risk for falls fell twice between 7/19/13 and 7/24/13. The second fall resulted in a fractured hip requiring hospitalization and surgery. The facility was cited for failure to provide adequate assistance during transfers. Citation # 910008788.

**Kindred Transitional Care and Rehabilitation-Foothill**

401 W. Ada Ave., Glendora, Ca 91741

Kindred Transitional Care and Rehabilitation-Foothill

1/24/2013      **B**  
**\$2,000**              Patient Care              Careplan  
    Neglect  
    Notification

A 78 year old female resident with swallowing problems was rushed to the hospital on 1/30/11 for dehydration, pneumonia, urinary tract infection, and muscle wasting. The resident had a history of poor nutritional intake that had significantly worsened in the days prior to the hospitalization. The facility was cited for failing to create a careplan for the resident's possible dehydration, for failing to follow the physician's orders to monitor the resident for poor nutritional intake, and for failing to consult with the physician regarding the resident's declining appetite. Citation # 950009714.

**La Paz Geropsychiatric Center**

8835 Vans Avenue, Paramount, CA 90723

La Paz Geropsychiatric Center

12/23/2013      **B**  
**\$1,000**              Patient Care              Careplan  
    Neglect  
    Patient Care

On 11/6/2013, a resident complained that the nurses had been neglecting her and had not provided the necessary care in treating her rashes. It was observed that the resident had various rashes and multiple sores in various degrees throughout her back, buttocks, arms, breasts, stomach, lower legs, and under arm area. The resident was not being adequately treated for the rash for over 40 days, which caused mental anguish, severe itching and inability to sleep at night. On 11/11/2013, the resident's dermatologist diagnosed the resident with scabies. The facility was cited for not implementing its policy related to abuse and neglect, by not providing the care necessary to prevent neglect. Citation # 940010357.

La Paz Geropsychiatric Center

12/23/2013      **B**  
**\$1,500**              Patient Care              Patient Care

On 11/6/13 a 49 year old female resident complained about not getting treatment for a back rash. She told the staff she was diagnosed at another facility for having a bug under her skin and was being treated with hydrocortisone. Consequently, the rash spread to other residents. On 11/11/13 she was diagnosed with scabies. The supervisor at the CDPH/Communicable Disease stated she did not know why the staff were not following the policy that was given to them as they had recently been trained by her staff. The facility failed to maintain an Infection Control Program to identify or track rashes and prevent the spread of scabies. The facility also failed to treat a reddened rash with itching for over 40 days, or provide surveillance to prevent the spread of scabies. Citation # 940010297.



**Lakeview Terrace Special Care Center**

9601 Foothill Blvd, Lakeview Terrace, CA 91342

Lakeview Terrace Special Care Center

10/17/2013     **B**  
**\$2,000**         Patient Care         Careplan  
    Security  
    Supervision

The facility failed to prevent a resident from leaving the locked perimeter four times without permission between 5/16/2011 and 9/17/2011, twice while under one to one (1:1) monitoring, and failed to follow the resident's careplan for 1:1 monitoring. The resident had been assigned 1:1 monitoring after the first incident, but the Interdisciplinary Team (IDT) later recommended reducing the resident's 24-hour 1:1 monitoring to 3 pm to 7 am, with only hourly checks from 7 am to 3 pm. While the resident was under 24-hour supervision after the second incident, he managed to leave the facility unsupervised because his assigned monitor wanted to give him a moment of privacy in his room. Citation # 920009102.

**Lakewood Healthcare Center**

12023 S. Lakewood Blvd, Downey, CA 90242

Lakewood Healthcare Center

8/6/2013         **B**  
**\$2,000**         Abuse

On 5/21/2013, the facility failed to ensure a resident was safe from verbal and physical abuse from a staff member. While changing the resident's diaper, a CNA struck the resident on the head with an open hand and again with his diaper. He also called the resident multiple profane terms. Citation # 940010074.

**Lakewood Manor North**

831 S Lake Street, Los Angeles, CA 90057

Lakewood Manor North

5/9/2013         **AN**  
**\$30,000**         Administrative         Staffing  
    Penalty - Staffing  
    Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 12 days out of 24 randomly selected days. Citation # 910009872.

**Lancaster Health Care Center**

1642 W Avenue J, Lancaster, CA 93534

Lancaster Health Care Center

9/26/2013         **A**  
**\$15,000**         Patient Care         Careplan  
    Fall  
    Injury  
    Physical Environment

On 1/15/2012, a resident fell while getting out of bed unassisted, sustaining multiple injuries, including a broken shoulder, broken elbow, and facial lacerations requiring ten stitches. The facility failed to prevent a resident with a history of falls from sustaining an injury by not following it's own policy of creating a careplan to prevent such an incident. The facility also failed to properly install an alarm pad into the resident's mattress as prescribed by the physician. Citation # 920010030.

**Landmark Medical Center**

2030 N. Garey Ave., Pomona, CA 91767

Landmark Medical Center

6/25/2013         **B**  
**\$2,000**         Abuse/Facility not     Sexual Abuse  
    self reported

On 9/12/2012, the facility failed to protect a Schizophrenic resident from sexual assault by an employee. The employee came into the resident's room at 3:58 am while she was asleep and kissed her. The resident was awakened by the employee and could not go back to sleep. She later asked the employee to hug her because she was nervous about going to court in the morning. The employee hugged her and kissed her on the forehead, then on the lips, and then he hugged her tightly and tried to "give [her] tongue." She could not get away because he held her too tight. Citation # 950009975.

**Lighthouse Healthcare Center**

2222 Santa Ana Blvd, Los Angeles, CA 90059

Lighthouse Healthcare Center

9/4/2013         **AN**  
**\$15,000**         Administrative         Staffing  
    Penalty - Staffing  
    Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 6 days out of 24 randomly selected days. Citation # 940010110.

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**Long Beach Care Center**2615 Grand Avenue, Long Beach, CA 90815

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Long Beach Care Center

2/11/2013

**A**

\$18,000

Patient Care

Injury

Physical Environment

On 9/13/12, a resident fell from her broken shower chair with a non-fitting safety bar, fracturing both of her knees. Her Care Area Assessment notes from 6/30/12 indicated she was at risk for falls/injuries due to lack of mobility, cardiac medication use, and incontinence. The facility failed to provide safety from injury for the resident by not providing her with a shower chair large enough for the safety bar to fit around her, strong enough to support her weight, and able to support her lower extremities with a foot rest. Citation # 940009696.

Long Beach Care Center

6/13/2013

**AN**

\$15,000

Administrative  
Penalty - Staffing  
Audit

Staffing

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 3 days out of 24 randomly selected days. Citation # 940009939.

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**Longwood Manor Convalescent Hospital**4853 W. Washington Blvd., Los Angeles, CA 90016

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Longwood Manor Convalescent Hospital

6/27/2013

**WMF**

\$2,000

Patient Records

Patient Care

Patient Records

The facility was cited after a staff member falsified the records of a resident stating that the resident had received treatment exercises as ordered by the doctor when he had not. In 2/2013 the 42 year old resident, paralyzed from the waist down, was ordered to be provided with exercises to improve his mobility five times a week, and on several occasions the facility RNA falsely signed off that treatment had been provided.  
Citation # 910009979.

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**Los Palos Convalescent Hospital**1430 W 6th Street, San Pedro, CA 90732

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Los Palos Convalescent Hospital

9/13/2013

**B**

\$2,000

Patient Care

Injury

Patient Care

On 6/11/2009, a facility CNA failed to ask for assistance, as instructed by her superior, and failed to use a transfer assistance device to transfer a resident from the shower chair to her bed. This resulted in the resident twisting her ankle and fracturing two bones in her lower left leg. Citation # 910010141.

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**Lotus Care Center**6011 West Blvd, Los Angeles, CA 90043

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Lotus Care Center

6/18/2013

**A**

\$20,000

Patient Care

Injury

Supervision

On 8/9/2010, a 67 year old resident with mild mental retardation suffered fractures to his hip and wrist and a head injury when he fell outside of the facility. He was not supervised at the time and lacked a cane or other supportive device, contrary to his care plan. Due to his injuries, he was hospitalized for 14 days, admitted into intensive care, required orthopedic surgery, and suffered pain daily. The facility was cited because it failed to provide needed supervision to keep the resident safe and failed to update his assessment and care plan after an earlier fall. Citation # 910009911.

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**Maclay Healthcare Center**12831 Maclay Street, Sylmar, CA 91342

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Maclay Healthcare Center

6/20/2013

**AN**

\$15,000

Administrative  
Penalty - Staffing  
Audit

Staffing

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 6 days out of 24 randomly selected days. Citation # 920009840.

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**Mayflower Gardens Convalescent Hospital**6705 W Avenue M, Lancaster, Ca 93536

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Mayflower Gardens Convalescent Hospital

2/4/2013

**B**

\$700

Physical  
Environment

Physical Environment

The facility's maintenance staff made several alterations to the building without the approval of the Office of Statewide Health Planning and Development (OSHPD). Citation # 920009726.

**Mid-Wilshire Health Care Center**

676 S Bonnie Brae, Los Angeles, CA 90057

Mid-Wilshire Health Care Center

6/26/2013      **B**  
**\$2,000**      Patient Care      Fall  
    Injury  
    Patient Care

On 10/20/10, while attending the morning activity in the activity room, a resident nodded off to sleep then fell from her wheelchair and hit her head on another resident's wheelchair. The resident sustained lacerations and required stitches. The resident's records indicated that she had been complaining for several months that she was having trouble sleeping at night which was causing her to be lethargic during the day, and interfered with her ability to participate in recreational programs. There was no documented assessment of the resident's inability to sleep at night or documented nap schedules. The facility was cited for failing to ensure that the resident's complaints of not being able to sleep at night and being lethargic during the day were addressed. Citation # 910009972.

Mid-Wilshire Health Care Center

7/5/2013      **B**  
**\$2,000**      Patient Care      Fall  
    Other  
    Patient Care

On 5/4/13, a CNA attempted a solo Hoyer Lift bed to shower chair transfer of a 92 year old dementia resident. During the shower the resident complained of pain in her leg which was swelling. The CNA reported the resident's complaint of pain to the registered nurse. An x-ray of the resident indicated a non-displaced fracture of the knee cap. The CNA said that he had help transferring the resident from another CNA but an investigation determined that the CNA's statement was false. The facility was cited for staff performing an improper transfer. Citation # 910009997.

**Mountain View Convalescent Hospital**

13333 Fenton Avenue, Sylmar, CA 91342

Mountain View Convalescent Hospital

10/2/2013      **B**  
**\$1,200**      Patient Care      Careplan  
    Injury  
    Patient Records

On 4/15/2011, a resident sustained a deep laceration on her right shin that required 12 stitches. There were no records to report the cause of the laceration, nor were there any records indicating protective clothes were provided as ordered by the resident's careplan. The facility failed to follow the resident's careplan, failed to take initiative to prevent further skin tears, and failed to update the careplan with approaches directed to eradicate the cause of the patient's injuries. Citation # 920010177.

**Olive Vista A Center For Problems Of Living**

2335 S. Towne Avenue, Pomona, CA 91766

Olive Vista A Center For Problems Of Living

4/3/2013      **B**  
**\$2,000**      Patient Care      Physical Abuse  
 x3     Verbal Abuse

The facility failed to provide an environment free of verbal and physical abuse. On April 21, 2010, a 31 year old resident diagnosed with schizophrenia was held down on his bed by the wrists and arms by a staff member who also swore at the resident after he refused to take his blood glucose reading. While the staff member alleged that the resident attacked him first, the staff member failed to use techniques for dealing with resident behaviors as suggested during the facility's Assault Crisis Training. Citation # 950009828.

**Pacific Care Nursing Center**

3355 Pacific Place, Long Beach, CA 90806

Pacific Care Nursing Center

9/26/2013      **B**  
**\$2,000**      Physical      Physical Environment  
    Environment

The facility was cited for failure to ensure residents were provided safe hot water temperature below 120 degrees Fahrenheit in 39 of 40 resident's bedrooms and in 4 out of 4 shower rooms. The unsafe hot water placed all 86 residents in the facility at risk for burn, scalding and tissue damage. Citation # 940010164.

**Palos Verdes Health Care Center**

26303 S. Western Ave, Lomita, Ca 90717

Palos Verdes Health Care Center

3/29/2013      **B**  
**\$1,500**      Abuse      Dignity  
    Mandated Reporting  
    Verbal Abuse

The facility was cited for failing to report an incident of alleged employee to resident abuse within 24 hours. On 03/14/10, an employee allegedly got mad and threw a book on the floor close to the resident when the resident asked for pain medication. The employee yelled and got mad at the resident a second time that day when the resident requested medication. Citation # 910009809.

Palos Verdes Health Care Center

3/29/2013      **B**  
**\$1,500**      Patient Care      Verbal Abuse

On 3/14/10, a resident who receives medication for pain and muscle spasms asked the charge nurse for her medications. She also asked why the other nurses gave her all her medications together. The nurse got angry, yelled, and threw a big book on the floor near the resident. The resident indicated that it happened twice that day. The facility was cited for failing to ensure that the resident was not verbally abused by staff. Citation # 910009808.



**Santa Anita Convalescent Hospital**

5522 Gracewood Avenue, Temple City, CA 91780

Santa Anita Convalescent Hospital

4/26/2013

**A****\$10,000**Patient CareCareplan  
Medication  
Neglect  
Patient Care

On 01/17/13, a female resident was admitted to general acute care hospital because her heart muscle was damaged due to a heart attack. During the hospital admission, her physician changed her anticoagulant medication from Plavix to Xarelto. The resident was readmitted from 01/2013 to 01/27/13, and again from 01/28/13 to 02/12/13. However when the resident was readmitted on 01/28/13, the resident's medical administration records showed no evidence that she received Xarelto to prevent further heart incidences. The physician's progress note indicated the resident was taking an anticoagulant medication due to an irregular and rapid heart rhythm. The resident was not given Xarelto until the physician was notified on 02/12/13. The facility failed to ensure that the resident was provided an anticoagulant to prevent further blood clots from forming for a total of 24 days. Citation # 950009824.

**Santa Monica Health Care Center**

1320 20th Street, Santa Monica, CA 90404

Santa Monica Health Care Center

2/14/2013

**B****\$1,000**Physical Environment

Physical Environment

The facility failed to maintain all essential mechanical equipment in safe operation condition by not complying with the requirements of the Office of Statewide Health Planning and Development. Two water heaters had no change in work status between 4/26/2011 and 1/17/2013. An additional, unapproved water heater was located directly under the residents' floor. All three water heaters had improper ventilation, improperly secured pipes, inadequate temperature regulating devices, and no insulation for the water pipes. The locations of the water heaters was meant to be temporary, yet they had not been moved since 5/18/2011. Citation # 910009748.

**Sharon Care Center**

8167 W 3rd Street, Los Angeles, CA 90048

Sharon Care Center

8/20/2013

**A****\$16,000**Patient CareCareplan  
Patient Care

Physician's orders and a resident's plan of care called for an abduction pillow (used to immobilize a person's legs after hip surgery) and left leg immobilizer to be in place for several days following his surgery. There was no documented evidence that the devices were used as ordered from 3/24/11 to 3/26/11. The resident was transferred to the acute care hospital on 3/26/13, due to being in great pain where he required surgery again to correct a malalignment of the joint and a dislocated hip. The facility was cited for failure to follow physician's orders and the resident's plan of care. Citation # 910010099.

**Skyline Healthcare Center-Los Angeles**

3032 Rowena Avenue, Los Angeles, CA 90039

Skyline Healthcare Center-Los Angeles

2/14/2013

**B****\$2,000**Patient CarePatient Care  
Security

On 10/15/12, a male resident who was diagnosed with difficulty walking, lack of coordination, seizure disorder, hypertension, difficulty swallowing, and wandering behavior; went missing from the facility and could not be located by staff. He was found the next day at noon wandering around a college campus. The physician's order indicated the resident was to wear a wander-guard bracelet at all times. The staff was to check for malfunctions every shift. The CNA, who had started her employment three days prior, said she did not know that the resident had a history of trying to leave the facility. She did not hear any alarms when he left and did not know that he had a wander-guard bracelet on. The failure of the facility to provide adequate supervision and monitoring resulted in the resident leaving the facility, which is a violation of the health, safety and security of the resident. Citation # 920009740.

**Sophia Lyn Convalescent Hospital**

1570 N. Fair Oaks Avenue, Pasadena, CA 91103

Sophia Lyn Convalescent Hospital

5/23/2013

**AN****\$15,000**Administrative  
Penalty - Staffing  
Audit

Staffing

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 10 days out of 24 randomly selected days. Citation # 950009888.

**South Pasadena Convalescent Hospital**

904 Mission Street, South Pasadena, CA 91030

South Pasadena Convalescent Hospital

4/22/2013

**B****\$2,000**Patient Rights

Patient Rights

The facility was cited for failure to follow written policy requiring that residents are readmitted immediately upon availability of a semi-private room. A resident was transferred to an acute hospital for head and back pain. After being discharged from the acute hospital, the facility refused to readmit the resident even though beds were available and the resident was eligible for Medicaid services. Citation # 950009850.

South Pasadena Convalescent Hospital

7/1/2013

**B****\$1,000**Physical Environment

Administration

The facility failed to comply with California Health and Safety Code by not posting complete information regarding their current overall facility rating information. During an annual rectification visit, an evaluator noticed the facility had posted their rating as determined by the Centers for Medicare and Medicaid Services (CMS), but did not include additional required information that provides consumers with available information in making informed choices about facilities. Citation # 950009988.



The Earlwood  
6/19/2013 **B**  
\$2,000 Patient Care Injury  
x3

On 2/9/09, a 92 year old resident suffered a deep laceration down to the bone on her foot after facility staff failed to transfer her according to her care plan, which required two-person assistance during transfers. The facility was cited for failure to provide adequate supervision and assistance, and for not providing an environment free from accident hazards. Citation # 910009957.

### The Rehabilitation Center on La Brea

505 N. La Brea Ave, Los Angeles, CA 90036

Hancock Park Rehabilitation Center  
1/30/2013 **B**  
\$2,000 Patient Care Patient Care

#### **Death Occurred**

At 9:10 a.m. on 7/12/12, during a physical therapy session, a resident became short of breath. She was checked for her oxygen saturation level. Oxygen saturation levels of lower than 95% indicate impaired cardiopulmonary function or abnormal gas exchange. Her level was 77%. The resident was back in her room where an attempt to take her blood pressure and oxygen saturation failed. The resident went to the ER in full cardiac arrest and was pronounced dead at 10:43 a.m. The facility was cited for failure to provide the resident with the necessary care. Citation # 940009724.

Hancock Park Rehabilitation Center  
1/30/2013 **B**  
\$500 Patient Care Physical Environment

The facility was cited for failing to provide supervision and maintain an environment free of hazards when the licensed nurses failed to lock the medication cart and secure a set of keys that provided access to the medicine cart, the medication room, the medical supply room, the fire alarm box, and two exits. As a result, a resident obtained seven medication packs, keeping them for two weeks. The resident also took the set of keys while they were left unattended, posing a risk for other unauthorized individuals to gain access to medications and the inability of staff to access the fire alarm. Citation # 940009723.

Hancock Park Rehabilitation Center  
2/12/2013 **B**  
\$2,000 Patient Care Careplan  
Neglect  
x3

On 10/11/12, a LVN failed to check the blood sugar level of four residents at the time of day ordered by their physician, and failed to give them insulin to control their blood sugar levels. The facility was cited for failing to provide necessary diabetic care to ensure blood sugar level monitoring and administration of insulin in accordance with the residents' assessment, plan of care, physician's orders, and facility's policy and procedures. Citation # 940009743.

Hancock Park Rehabilitation Center  
2/12/2013 **B**  
\$6,000 Patient Care Patient Care  
x3

On 10/11/12, during the midday medication pass, an LVN failed to check residents' blood sugar levels. The LVN also failed to administer insulin doses until after lunch started. This resulted in hyperglycemia for three residents and placed them at risk for hypoglycemia. A review of the LVN's assignment indicated that she had thirty-five residents under her care. Sixteen of the 35 residents were diabetic and required blood sugar checks by finger stick and insulin administration. Six of the 16 diabetic residents had G-Tubes and ten received oral diets. The facility was cited for failure to provide residents with the necessary diabetic care. Citation # 940009741.

Hancock Park Rehabilitation Center  
2/12/2013 **B**  
\$6,000 Patient Care Patient Care  
x3

On 10/11/12, an LVN who had 35 residents under her care failed to provide seven diabetic residents who received oral diets with the proper diabetic care. The LVN's failure placed these residents at risk of serious hypoglycemia. During an interview with the LVN she stated that a week prior to the incident she spoke with the director of nursing about her heavy workload. An interview with the LVN's supervising RN indicated that the RN did not recall any conversation about the LVN's workload. The facility was cited for failing to provide seven residents who received oral diets with the necessary diabetic care. Citation # 940009742.

Hancock Park Rehabilitation Center  
2/12/2013 **B**  
\$6,000 Patient Care Careplan  
Medication

The facility was cited for a failure to provide care in accordance with patients' assessments, care plans, and doctor's orders. On 10/11/12, a LVN failed to administer prescribed medications to five residents as required by their care plans. Resident's medications were prescribed to treat varying conditions such as hypertension, hypoglycemia, and other medical conditions. Citation # 940009744.

### The Rowland

330 W. Rowland Ave. , Covina, CA 91723

The Rowland  
5/13/2013 **AN**  
\$15,000 Administrative  
Penalty - Staffing  
Audit Staffing

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 2 days out of 24 randomly selected days. Citation # 950009882.

**Torrance Care Center East - CLOSED**

4315 Torrance Blvd., Torrance, CA 90503

Torrance Care Center East

7/2/2013	<b>B</b>	
<b>\$2,000</b>	<u>Abuse</u>	Mandated Reporting Physical Abuse

On 09/28/2010, a CNA assisted a 66-year-old male resident with a shower, the resident stated the CNA was being rough with him and he hit the CNA with the shower head and that was when the CNA allegedly choked the resident with a shower blanket. The facility failed to investigate or report this incident for six days from the date they knew the incident occurred and the accused staff member continued to provide care to the resident during that time. The facility was cited for failure to follow the facility's policy and procedure for Elder abuse reporting. Citation # 910009990.

**Two Palms Nursing Center, Inc.**

2637 E. Washington, Pasadena, CA 91107

Two Palms Nursing Center, Inc.

3/25/2013	<b>AN</b>	
<b>\$30,000</b>	<u>Administrative Penalty - Staffing Audit</u>	Staffing

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 18 days out of 24 randomly selected days. Citation # 950009786.

Two Palms Nursing Center, Inc.

4/22/2013	<b>B</b>	
<b>\$2,000</b>	<u>Patient Care</u>	Patient Rights Physical Restraints

A male resident was being physically restrained with a wheelchair lap belt. The facility claimed the restraint was needed due to poor safety judgment and for poor posture that led to sliding down from the chair. The resident's medical documentation did not include any evidence of attempts at less restrictive measure nor a referral to a physical therapist for assessment regarding positioning devices. The facility was cited for improper use of physical restraints. No mention was made about the resident's right to consent or refuse the restraint. Citation # 950009852.

**Valley Palms Care Center**

13400 Sherman Way, North Hollywood, CA 91605

Valley Palms Care Center

10/17/2013	<b>B</b>	
<b>\$500</b>	<u>Administration</u>	Administration

On 2/1/2013, the facility failed to post its overall five-star quality rating determined by the Centers for Medicare and Medicaid Services in the required areas for review by the residents, staff and visiting public. The facility's rating information was not posted in two dining rooms and in the employee lounge. Citation # 920010199.

**Verdugo Vista Health Care Center**

3050 Montrose Avenue, La Crescenta, CA 91214

Verdugo Vista Health Care Center

3/19/2013	<b>AN</b>	
<b>\$15,000</b>	<u>Administrative Penalty - Staffing Audit</u>	Staffing

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 2 days out of 24 randomly selected days. Citation # 920009769.

**Vista Cove Care Center at San Gabriel**

909 W Santa Anita, San Gabriel, Ca 91775

Vista Cove Care Center at San Gabriel

2/28/2013	<b>B</b>	
<b>\$2,000</b>	<u>Patient Care</u>	Patient Care

Between 10/17/12 and 10/19/12, four residents were treated for scabies. The unusual incident was not reported by telephone within 24 hours as required but instead notification was sent by regular mail. The facility was cited for failure to report the incident by telephone within 24 hours. Citation # 950009759.

Vista Cove Care Center at San Gabriel

7/15/2013	<b>AN</b>	
<b>\$15,000</b>	<u>Administrative Penalty - Staffing Audit</u>	Staffing

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 2 days out of 24 randomly selected days. Citation # 950009996.

**Westlake Convalescent Hospital**

316 S Westlake Ave, Los Angeles, CA 90057

Westlake Convalescent Hospital

9/16/2013	<b>B</b>	
<b>\$2,000</b>	<u>Patient Care</u>	Theft & Loss

The facility failed to ensure a resident's wallet was safe from theft from his room. On 3/29/2013, a CNA stole the resident's wallet and used his debit card to withdraw \$1,000 from his bank account. Not until after the incident did the facility install locks in the resident's drawer and closet. Citation # 910010148.



**Westside Health Care**

1020 S Fairfax Ave, Los Angeles, CA 90019

Westside Health Care

2/25/2013      **A**  
**\$10,000**      Patient Care      Injury  
    Neglect  
    Patient Care

The facility was cited for failing to keep a resident free from accidents and failing to provide adequate supervision and assistance to prevent accidents. On 5/6/09, a 91-year resident's tibia (leg bone) was fractured when her leg got stuck in the bed rail while two CNAs moved her from her bed to the shower chair. Citation # 910007214.

Westside Health Care

12/10/2013      **A**  
**\$20,000**      Patient Care      Careplan  
    Injury  
    Patient Records

The facility failed to develop a comprehensive nursing assessment and plan of care to address a resident's right arm contractures (permanent tightening or shortening of a body part, such as muscle, tendon or skin), and failed to develop approaches to providing daily care, especially when dressing the resident. This resulted in a CNA lifting the resident's arm while dressing her on 4/17/2012, causing a distal humerus fracture in her elbow. The facility had no documentation of contraction in the resident's arm between her admission on 3/30/2012 and the incident date. Citation # 910010265.

**Whittier Hills Health Care Center**

10426 Bogardus, Whittier, CA 90603

Whittier Hills Health Care Center

8/7/2013      **B**  
**\$2,000**      Abuse/Facility      Verbal Abuse  
    Not Self Reported

On 5/18/2013, the facility failed to ensure that an intellectually disabled resident was not verbally abused by a CNA. The CNA swore down the hallway at the resident and yelled "shut up" after the resident repeatedly said, "It's a Saturday morning," while moving down the hallway. Another resident witnessed the incident, which made her feel unsafe and insecure. Citation # 940010090.

**Madera County**

**Oakhurst Healthcare & Wellness Centre**

40131 Hwy 49, Box 2349, Oakhurst, CA 93644

Oakhurst Healthcare & Wellness Centre

7/25/2013      **B**  
**\$2,000**      Patient Care      Infection  
    Patient Care

The facility failed to maintain a safe and sanitary environment to prevent the transmission of infections. Staff did not properly wash their hands after coming into contact with residents, did not consistently follow proper cleaning guidelines, did not follow proper guidelines for glove and gown use, and did not properly handle contaminated linens. These violations resulted in 7 residents testing positive for C. Difficile, a contagious gastrointestinal bacterial resulting in diarrhea and severe illness. Citation # 040010032.

**Marin County****Northgate Care Center**

40 Professional Center Parkway, San Rafael, CA 94903

Northgate Care Center

7/16/2013

**B****\$1,000**Administration

Administration

On 6/7/13, a resident made an allegation of abuse to facility staff. The facility did not report the allegation to the Department of Health (DPH) until 6/9/13. The facility was cited for failure to contact DPH within 24 hours as required by law. The facility administrator stated that the reason for not reporting in a timely manner was because the resident was out of the facility on 6/8 and 6/9. The citation did not indicate the nature of the allegation. Citation # 110009981.

**Pine Ridge Care Center**

45 Professional Center Parkway, San Rafael, CA 94903

Pine Ridge Care Center

1/8/2013

**AN****\$15,000**Administrative  
Penalty - Staffing  
Audit

Staffing

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 2 days out of 24 randomly selected days. Citation # 110009527.

Pine Ridge Care Center

12/30/2013

**A****\$20,000**Patient CareCareplan  
Patient Care  
Security  
Supervision

The facility failed to provide a resident adequate supervision to prevent elopement from the facility after the resident was able to leave undetected and drive away in his own car. The resident was later found after a car accident in which the car went down a steep ravine and the resident was ejected from the car and had to be rescued by the fire department. The resident had a long history of noncompliance and elopement from previous facilities, and on several occasions had failed to sign in and out of the facility or turn over his car keys. The resident was able to leave the facility despite care plan instructions which included 15 minute visual checks on his whereabouts and loss of his "pass privileges" for leaving without signing out. The resident's elopement was not discovered until an hour and 15 minutes after he left the facility. Citation # 110009715.

**Mariposa County****Avalon Care Center-Sonora**

19929 Greenley Road, Sonora, Ca 95370

Avalon Care Center-Sonora

12/11/2013

**AN****\$15,000**Administrative  
Penalty - Staffing  
Audit

Staffing

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 3 days out of 24 randomly selected days. Citation # 030010317.

## 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

7/9/2013

**B**

\$2,000

Patient Rights

Careplan  
Physical Abuse  
Supervision

The facility failed to ensure that Resident 1 was safe from physical abuse by Resident 2, and failed to follow the facility's elder abuse policy, and Resident 2's careplan, by administering proper supervision to prevent such an event. On 5/25/12, Resident 2 hit Resident 1 in the back of the head with an open hand. On 7/19/12, Resident 2 tried to choke Resident 1 by pulling on the back of her bib while no staff was present in the room. Part of Resident 2's careplan, developed on 9/19/11, was to closely observe him and keep him away from other residents, as he had a history of aggressive outbursts towards other residents and staff. Citation # 230010002.

## Napa County

### Napa Valley Care Center

3275 Villa Lane, Napa, CA 94558

Napa Valley Care Center

2/8/2013

**A**

\$20,000

Patient Care

Fall  
Supervision

On 8/3/10, a 90 year old resident with dementia and osteoporosis suffered her fourth serious fall while at the facility and her second in two days. The fourth fall caused a cervical spine fracture of the second vertebrae. The resident was known to have serious fall risks but did not have a careplan that included effective measures for preventing the resident from getting out of her wheelchair unassisted and providing adequate supervision to prevent accidents. These failures were found to present an imminent danger of death or serious harm. Citation # 110009733.

## Orange County

### Fullerton Post Acute Care

2222 N. Harbor Blvd., Fullerton, Ca 92835

Fullerton Post Acute Care

12/19/2013	<b>B</b>	
<b>\$2,000</b>	<u>Abuse/Facility not self reported</u>	Administration Neglect Physical Abuse Sexual Abuse

Two female residents reported separate incidents of a male CNA inappropriately touching them on various occasions to facility staff and administrators. The facility was cited for failure to investigate these accusations properly, allowing the CNA to continue working with vulnerable female residents, including an additional female resident who also eventually reported unwanted sexual touching by the male CNA. Citation # 060010335.

Fullerton Post Acute Care

12/19/2013	<b>B</b>	
<b>\$2,000</b>	<u>Patient Care</u>	Patient Care

A female resident who suffered from glaucoma, had not seen an eye doctor in 16 months. Eventually she lost her sight. Another resident was not assisted with financial matters until her home was in danger of being auctioned off. Another resident's hearing aids broke, but the facility failed to make arrangements to have them repaired. She cannot hear what people are saying to her and she cannot read lips. Another resident was scheduled for cataract surgery on her left eye in February 2012. The surgery did not take place and there was no documentation of a follow up. This resident states she is now blind in her left eye. The facility failed to provide medically related social services for residents needing eye appointments, hearing aids, and financial assistance. Because of this, the residents' quality of life have been greatly diminished. Citation # 060010334.

### Parkview Healthcare Center

1514 E. Lincoln Avenue, Anaheim, CA 92805

Parkview Healthcare Center

3/8/2013	<b>B</b>	
<b>\$1,500</b>	<u>Medication</u>	Chemical Restraints Medication Patient Records

On 1/16/13, records of the Physicians Orders List showed the facility had 20 of 29 residents on psychotherapeutic drugs. Of ten sampled residents, the facility failed to present any behavior data of seven residents to the prescriber of psychoactive medications. The facility failed to produce clinical records of monitoring of any behaviors associated with the need for antipsychotic medications, antidepressant medications and anti-anxiety medications or documentation showing an attempt for gradual dose reductions. Citation # 060009777.

### Seal Beach Health and Rehabilitation Center

3000 N Gate Road, Seal Beach, CA 90740

Seal Beach Health and Rehabilitation Center

8/26/2013	<b>B</b>	
<b>\$1,000</b>	<u>Administration</u>	Administration Privacy

The facility failed to secure the personal and confidential medical privacy of 56 residents when documents identifying names, health conditions and treatments were found in a trash can in a public area by an unauthorized person. Citation # 060010117.

## Placer County

### Auburn Oaks Care Center

3400 Bell Road, Auburn, CA 95603

Auburn Oaks Care Center

7/8/2013 **B**  
**\$1,000** Patient Rights Careplan  
 Sexual Abuse  
 Supervision

On 7/27/09, a male resident with a history of sexually inappropriate behavior who was to be supervised at all times, placed a female resident's hand in his lap. On 2/22/10, the male resident had been found in the activities area fondling the breasts of another resident, while his hand was down in her pants. On 3/13/10, the male resident wandered into another female resident's room and placed one hand in her blouse while he was holding her other hand in his pants. The facility was cited for failing to prevent abuse and protect the dignity of three female residents or to fully implement the abuse policy. Citation # 030009992.

Auburn Oaks Care Center

8/1/2013 **A**  
**\$20,000** Patient Care Injury  
 Patient Care

An 84 year old female resident had cerebral vascular disease that had led to a loss of functioning in her left arm and leg. On 1/16/10, the resident began to complain of pain in her legs which intensified over two days. On 1/18/10, the resident was hospitalized and her right leg required amputation due to loss of blood flow and subsequent gangrene. The facility nurses had failed to properly evaluate the possible causes of the resident's leg pain and had failed to update the physician about her condition. Citation # 030010045.

Auburn Oaks Care Center

8/13/2013 **B**  
**\$800** Patient Rights Dignity  
 Physical Abuse

The facility was cited for failing to protect a 69 year old female's rights by not subjecting her to abuse when a male CNA purposefully sprayed the resident with cold water during a shower. The resident stated she told the CNA to stop because of the cold water. She then told the CNA the cold water spray was "on purpose" and he replied, "Maybe." As a result, the CNA was terminated for abuse. Citation # 030010068.

Auburn Oaks Care Center

8/29/2013 **B**  
**\$500** Abuse/Facility Mandated Reporting  
Not Self Reported

On 3/21/11, a resident complained to a nurse about neglect by a CNA. The nurse notified the Ombudsman, but failed to notify the Department because she was unaware that the Department was supposed to be notified. The nurse stated that the DON "does that part and we didn't have [a DON]." The facility was cited for failing to report the alleged abuse of a resident by a CNA to the Department within 24 hours as required by law. Citation # 030010113.

Auburn Oaks Care Center

8/29/2013 **B**  
**\$800** Patient Rights Neglect  
 Physical Abuse

On 3/20/11, a CNA made the resident wait an extended period of time to change her absorbent underwear, and then threw the bed control and call light at the resident after the resident kept calling for assistance. The facility was cited for failing to protect a resident from neglect and abuse by a CNA. Citation # 030010115.

### Lincoln Meadows Care Center

1550 Third Street, Lincoln, CA 95648

Lincoln Meadows Care Center

3/21/2013 **AA**  
**\$100,000** Patient Care Careplan  
 Medication  
**Death Occurred**

A male resident received a doctor's order for a blood thinner on 5/12/11. No anticoagulation monitoring was documented. On 5/26/11, the resident fell and sustained injuries to his head and face. The resident was hospitalized for a brain hemorrhage four days later. His blood test results showed excessive blood thinning by a factor of 18 times normal and six times the therapeutic range. He died on 6/4/11. The facility was cited for failing to keep the resident free from unnecessary drugs and for failing to prepare a care plan and monitor blood levels when the blood thinner was ordered. Citation # 030009792.

Lincoln Meadows Care Center

7/19/2013 **B**  
**\$800** Patient Rights Physical Abuse

On 5/24/10, a licensed nurse administered a rectal suppository to a resident after the resident stated that she did not want the suppository. The Director of Nursing stated that the staff "made a mistake," and that "It was abuse." The facility was cited for violating the resident's rights by failing to protect her from physical abuse. Citation # 030009989.

### Pine Creek Care Center

1139 Cirby Way, Roseville, CA 95661

Pine Creek Care Center

9/17/2013 **B**  
**\$1,000** Abuse/Facility Mandated Reporting  
Not Self Reported Physical Abuse  
 Verbal Abuse

On 10/13/10, a CNA physically abused an 81 year old resident, yanking him roughly around in his bed, and spoke to him in a very loud, harsh manner. The abuse is the subject of a separate citation. In this citation, the facility was cited for failing to report the abuse to the Department of Public Health (DPH) in a timely manner. It did not report the abuse to DPH until five days after it was observed. Citation # 030010123.

## Pine Creek Care Center

9/17/2013 **B**  
**\$1,000** Patient Rights Physical Abuse  
 Verbal Abuse

On 10/13/2010, a CNA verbally and physically abused an 81 year old resident. Two other CNAs witnessed the abuse. One reported the CNA was yanking the resident around in bed, causing him pain, and speaking to him in a very harsh, loud manner. The resident was screaming, "Don't let her touch me," "You're hurting me," and "Stop hurting me." The facility was cited for failing to prevent abuse of the resident. Citation # 030010122.

## Rock Creek Care Center

260 Racetrack Street, Auburn, CA 95603

## Rock Creek Care Center

5/9/2013 **B**  
**\$1,000** Patient Care Verbal Abuse

On 5/8/10, while a LVN and another staff member were assisting a 75 year old non-ambulatory resident who had short and long term memory impairment, another LVN came in and shouted at the resident, scolding him saying that he should have a Norco patch (narcotic pain medication). The LVN who had been assisting the resident noted that the resident was terribly confused and near tears because he didn't know what he did that was wrong. The facility was cited for failing to ensure that the resident was free from mental abuse. Citation # 030009884.

## Roseville Care Center

1161 Cirby Way, Roseville, CA 95661

## Roseville Care Center

10/2/2013 **B**  
**\$1,000** Patient Care Medication  
 Patient Care

**Death Occurred**

A resident was admitted to the facility for comfort (end of life) care on 11/25/11, with medical orders for intravenous (IV) morphine for end-stage respiratory failure with pneumonia. The family elected to admit him to the facility because they were told it was the only skilled nursing facility in the area with the ability to administer IV fluids and medications. The DON indicated in an interview that there was a facility policy they could not give morphine intravenously but there was no written documentation of the policy. The resident received no medication for his persistent coughing and died at 3:40 am on 1/26/11. The facility was cited for accepting a resident for whom it could not provide adequate care. Citation # 030010172.

## Riverside County

## AFVW Health Center

17050 Arnold Drive, Riverside, Ca 92518

## AFVW Health Center

11/14/2013 **A**  
**\$5,000** Patient Care Fall  
 Injury  
 Patient Care

On 6/26/08, an 85 year old female resident was admitted to the facility for physical therapy rehabilitation after fracturing her hip at home. The resident fell in the bathroom four days later. On 7/16/08, the resident was receiving toileting assistance by a CNA. The CNA told the resident to use her call light when she was finished and then left the resident alone to assist another resident. When the CNA returned, she found the resident on the floor. The resident was found to have a fracture around her right hip replacement at the acute care hospital requiring additional surgery. There were no indications in the resident's care plan that it was safe to leave the resident alone. The facility failed to develop a comprehensive plan of care based on the continual assessment of care needs for the resident. This failure resulted in the resident falling and re-fracturing her hip. Citation # 250010258.

## Blythe Nursing Care Center

285 W. Chanslor Way, P.O. Box 850, Blythe, Ca 92226

## Blythe Nursing Care Center

12/16/2013 **AN**  
**\$15,000** Administrative Staffing  
Penalty - Staffing  
Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 2 days out of 24 randomly selected days. Citation # 250010300.

## Centinela Grand, Inc.

2225 North Perris Blvd., Perris, Ca 92370

## Centinela Grand, Inc.

7/25/2013 **B**  
**\$1,000** Abuse / Facility Mandated Reporting  
Not Self Reported

The facility was cited after an investigation discovered that staff failed to properly report an incident of alleged abuse as required by law. On 11/23/12 a resident called the police to report that he felt threatened by a staff member, and the call was reported to the facility Administrator. The administrator waited until 11/29/12 to report the alleged abuse to the CA Dept. of Public Health, much longer than the 24 hours required by law. Citation # 250010018.

**Chapman Convalescent Hospital**

4301 Caroline Court, Riverside, CA 92506

Chapman Convalescent Hospital

8/15/2013

**B**

\$500

Patient CareCareplan  
Fall  
Injury  
Supervision

On 7/15/09, a resident with a high fall risk was left unattended on the toilet and fell, breaking her hip. A CNA had assisted the resident onto the toilet and then left to assist another resident despite an order to assist the resident with all transfers. The facility was cited for failing to implement the resident's careplan. Citation # 250010061.

**Emeritus At Rancho Mirage**

72-201 Country Club Drive, Rancho Mirage, Ca 92270

Emeritus At Rancho Mirage

10/15/2013

**B**

\$1,000

Patient CareCareplan  
Fall  
Staff (Inservice)  
Training

The facility failed to follow a resident's careplan for safety from falls, and failed to ensure the staff had the necessary training to operate the patient's HI/LO bed to keep it in the low position as ordered by his careplan. On 11/5/2010, the resident accidentally raised his bed and fell on the floor, fracturing his neck. Upon investigation, it was discovered that the bed's on/off switch had been left switched on. Had it been switched off, the resident would not have been able to raise his bed. Staff members responsible for the resident's care did not know about the on/off switch. Citation # 250010204.

**Manorcare Health Services-Hemet**

1717 West Stetson Avenue, Hemet, Ca 92545

Manorcare Health Services-Hemet

10/14/2013

**FB**

\$4,700

Failure to Report

Mandated Reporting

The facility was cited for failure to report an unlawful or unauthorized access to, or use or disclosure of a patient's medical information within five business days of the date the unlawful or unauthorized access, use or disclosure was detected. Citation # 250010203.

**Manorcare Health Services-Palm Desert**

74-350 Country Club Dr, Palm Desert, CA 92260

Manorcare Health Services-Palm Desert

5/7/2013

**B**

\$1,000

Abuse

Physical Abuse

The facility was cited for failure to implement the facility Abuse Policy and Procedure to conduct a timely, thorough and objective investigation of all allegations of abuse, neglect and mistreatment. The facility failed to immediately investigate an allegation of a staff member throwing the resident on the bed. Citation # 250009834.

**Miller's Progressive Care**

8951 Granite Hill Dr, P.O. Box 3156, Riverside, Ca 92519

Miller's Progressive Care

3/7/2013

**B**

\$200

Abuse

Physical Abuse

On 7/11/09, a resident with schizoaffective disorder walked over to another resident during a movie activity and grabbed some popcorn from another resident. A nearby CNA went over to that resident and slapped her twice on the arm. The facility was cited for failure to protect the resident from the facility staff's physical abuse. Citation # 250009731.

**Ramona Manor Convalescent Hospital**

485 W. Johnston Ave., Hemet, CA 92343

Ramona Manor Convalescent Hospital

7/25/2013

**B**

\$1,000

Abuse/Facility not self reported

Mandated Reporting

The facility failed to report an alleged incident of abuse to the California Department of Public Health (CDPH) within 24 hours of the incident, as required by law. On 12/7/2012, a resident reported to a LVN that she had been sexually assaulted by a physical therapist. The Director of Nursing determined the incident did not require reporting, but the Administrator submitted a report to the CDPH on 12/18/2012. Citation # 250010019.

**The Springs At The Carlotta**

41-505 Carlotta Drive, Palm Desert, Ca 92211

The Springs At The Carlotta

9/4/2013

**B**

\$1,000

Patient RightsPhysical Abuse  
Verbal Abuse

The facility failed to protect a resident from physical and verbal abuse from a staff member. On 9/10/2008, an occupational therapist (OT) gave unwanted treatment to the resident who said she had chest pain. During a meeting between the resident's daughter and the discharge planner, the OT interrupted and contradicted everything the discharge planner had said and told her what was going to happen. The OT also threatened to take away the resident's oxygen because he was tired of carrying it behind her, and insisted she use a walker she didn't like because he "[knew] best." Citation # 250010072.

The Springs At The Carlotta

9/4/2013

**B**

\$1,000

Patient RightsMental Abuse  
Verbal Abuse

The facility failed to protect a resident from verbal and mental abuse from a staff member. On 9/10/2008, an occupational therapist told a resident to go somewhere else if she didn't like the treatment she was receiving, and that she needed to respect him and not treat him like a puppet. He also took her personal sling, dangling it in her face before returning it to her, because they had disagreements on treatment for her broken shoulder. Citation # 250010083.

**The Springs At The Carlotta**

9/4/2013

**B****\$1,000**Abuse/Facility not self reported Mandated Reporting Verbal Abuse

On 9/10/08, the facility's Social Service Coordinator (SSC) reported to the DON that she witnessed an occupational therapist verbally abusing a resident. Later, a resident's daughter called to report that the same therapist had been verbally abusive to her mother. When confronted and terminated, the therapist was verbally abusive to the facility director. None of the incidents were reported to the Department. The facility was cited for failure to follow policy and procedure and report the verbal abuse to the Department as required. Citation # 250010087.

**Vista Cove Care Center at Corona**

2600 S. Main Street, Corona, Ca 92882

Vista Cove Care Center at Corona

7/30/2013

**B****\$1,000**Physical Environment Physical Environment

On 12/20/2010, the facility failed to maintain a safe, functional, sanitary and comfortable environment for residents, staff and the public by not repairing severe roof leaks, which led to hazards throughout the facility, including damage to the ceiling, walls and floor, leaks coming out of and near electrical equipment, wetness in a resident's bed, and the development of molds that can cause pneumonia. Buckets and towels left on the floor to catch the water were tripping hazards. Citation # 250009918.

**Vista Pacifica Center**

3674 Pacific Avenue, Riverside, CA 92509

Vista Pacifica Center

7/25/2013

**B****\$1,000**Abuse / Facility Not Self-Reported Mandated Reporting

The facility failed to report the allegation of resident abuse to the California Department of Public Health (CDPH) within 24 hours. On 5/10/2012, Resident 1 reported to a Mental Health Counselor (MHC) that Resident 2 tried to touch her chest the day before. The MHC determined that Resident 1 was delusional because she claimed to be "raped" when the event she described sounded more like assault. The alleged incident was not reported to the CDPH until 5/17/2012 (seven days later). Citation # 250010020.

**Sacramento County****Applewood Care Center**

1090 Rio Lane, Sacramento, Ca 95822

Applewood Care Center

5/17/2013

**B****\$1,000**Patient Care Patient Care Careplan Injury

On 6/12/11, the facility failed to assess and consult with appropriate health professionals to determine whether a quadriplegic resident could be safely transferred using a sit to stand lift. The facility also failed to update the resident's careplan in regards to safe transfer from one surface to another after she was diagnosed with paraplegia. This led to a dismal fracture of the resident's femur, as well as moderate soft tissue swelling in her knee, which was first noticed on 8/9/11. Citation # 030009910.

**Asian Community Nursing Home**

7801 Rush River Drive, Sacramento, CA 95831

Asian Community Nursing Home

7/3/2013

**AA****\$80,000**Patient Care Dietary Services**Death Occurred**

On 1/9/12, the facility failed to ensure a resident consumed food in a form that she could safely swallow during a facility sponsored outing, which caused her die from choking on a large piece of meat. On 6/7/11, the resident was evaluated to have moderate impairment with the oral phase of swallowing and recommended to have intermittent meal supervision with a diet of soft chopped solids. A careplan for this diet was initiated on 6/13/11. The resident became unconscious from choking on her food and died of asphyxiation in a hospital on 1/10/12. Citation # 030009946.

**Carmichael Care & Rehabilitation Center**

8336 Fair Oaks Blvd., Carmichael, CA 95608

Carmichael Care &amp; Rehabilitation Center

3/8/2013

**B****\$500**Abuse Mandated Reporting

On 7/30/11, the facility failed to report the observed abuse of a resident within 24 hours of the observation. As the resident struggled to breathe and tried to get up, two facility aides pushed her back onto her bed. One of them held or sat on her legs, while the other pushed her down on the bed. A quarter-sized bruise developed on the resident's cheek. The Director of Nurses claimed to not be familiar with the incident, and the Social Services Assistant said that the Administrator handles the reports and that she was "only asked to get a statement from the witness." The administrator did not file a report to the Department of Public Health until the Department told him he had to on 8/5/11. Citation # 030009775.



Carmichael Care & Rehabilitation Center

5/16/2013 **B**  
**\$1,000** Patient Care Security

On 11/28/10, the facility failed to prevent a resident with Alzheimer's disease from leaving the facility unnoticed. The resident was found outside with a body temperature of 96.5 degrees Fahrenheit. Her admission assessment on 10/11/10 described her as "Exit seeking/wandering," and a physician's order from 10/12/10 called for an exit alarm device to be attached to her body to alert staff of any unassisted leaving. This could have been avoided if the resident had not unplugged wires to the exit alarm system about one month prior to the incident, and if the maintenance supervisor had kept records of repairs needed while he was on leave. He said that the housekeeping supervisor covered his job during his leave. Citation # 030009887.

Carmichael Care & Rehabilitation Center

5/16/2013 **A**  
**\$20,000** Patient Care Patient Care

**Death Occurred**

On 3/13/11 a female resident was found not breathing. A physician's order dated 1/19/11 ordered to attempt CPR. The supervisor was informed that the resident was already dead. However, facility policy did not empower nurses to pronounce the death of a resident, therefore CPR should have been initiated and 911 should have been called. The facility failed to perform CPR for a resident with orders for full resuscitation measures. The facility also failed to have the licensed nurse provide proof of current CPR training. Citation # 030009885.

Carmichael Care & Rehabilitation Center

10/30/2013 **A**  
**\$20,000** Patient Care Fall

**Death Occurred**

A male resident, admitted on 12/28/10 with a history of falls, fell from the toilet on 1/11/11. His physician ordered a bed and wheelchair alarm be used to prevent falls. On 1/12/11, the resident fell and broke his upper arm. His alarm was not in use. The broken arm may have caused a pulmonary emboli which led to the resident's death on 1/14/11. The facility was cited for failing to implement the resident's plan of care for a personal alarm and failing to provide adequate supervision to prevent a fall. Citation # 030010237.

**Casa Coloma Health Care Center**

10410 Coloma Road, Rancho Cordova, CA 95670

Casa Coloma Health Care Center

11/14/2013 **B**  
**\$500** Abuse/Facility Not Self Reported Mandated Reporting

The facility failed to report an allegation of abuse toward a resident to the Department of Public Health within 24 hours of the allegation, as required by the facility's policy. On 9/30/2013, a resident complained that a "black" staff member threw pillows at her. On 10/2/2013, the resident complained that five personal items were missing, including \$580. The Director of Nurses said that she did not believe the resident at first because she found no "black" staff members on duty during the incident, but made the report on 10/7/2013 because the resident kept complaining. Citation # 030010252.

**Double Tree Post-Acute Care Center**

7400 24th Street, Sacramento, Ca 95822

Double Tree Post-Acute Care Center

10/22/2013 **B**  
**\$1,000** Abuse/Facility Not Self Reported Mandated Reporting

The facility failed to report an allegation of suspected abuse to the Department of Public Health (DPH) within 24 hours of being notified of the allegation, as required by law. On 6/7/2011, a resident entered another resident's room uninvited and sexually assaulted her. The facility was unable to provide any documentation that they had reported the incident/allegation to the DPH. Citation # 030010222.

**Eskaton Care Center Greenhaven**

455 Florin Road, Sacramento, CA 95831

Eskaton Care Center Greenhaven

3/12/2013 **B**  
**\$1,000** Patient Care Careplan  
Death Occurred Dietary Services  
Hydration  
Neglect  
Patient Care

A resident at risk for dehydration and nutritional status was admitted to the facility on 3/12/10, and lost 17 pounds in two months. During an interview with the DON on 3/30/11, she confirmed she was unable to locate documentation that the resident was assessed for dietary intake and hydration status. On 5/13/10, the resident was showing a decreased level of consciousness and transferred to the hospital. The emergency department report showed that the resident had multidrug resistant urinary tract infection, dehydration, elevated sodium levels and kidney failure. The resident died on 5/15/10 from cardiopulmonary arrest and septic shock. The facility was cited for failure to assess and provide necessary food and fluids and follow procedures on documenting intake and output. Citation # 030009780.

**Eskaton Care Center Manzanita**

5318 Manzanita Avenue, Carmichael, CA 95608

Eskaton Care Center Manzanita

1/11/2013 **B**  
**\$1,000** Patient Rights Mental Abuse  
Patient Care  
Patient Rights  
Physical Abuse

The facility failed to ensure that two residents were free from abuse. A CNA was accused of alleged abuse on the following four occasions: 1) On 3/3/09, the CNA was given a warning for scolding a resident with an episode of incontinence, 2) On 4/30/09, the CNA was accused of throwing a call cord at the resident, 3) On 6/17/09, the CNA was accused of raising her voice in a rude manner, and 4) On 8/4/09, the CNA threw toilet paper and a small coin purse at the resident. The CNA was terminated on 08/07/09. The facility was also cited for failure to report the alleged abuse to the Department of Public Health. Citation # 030009697.

## Eskaton Care Center Manzanita

11/14/2013 **B**  
**\$1,000** Medication Medication

From 4/4/11 through 4/13/11, a resident received 18 doses of Bactrim (an antibiotic) despite the facility's knowledge that she was allergic to it. She suffered serious side effects including drowsiness, nausea, fever, pain, and rash. On 4/13/11 she was sent to the hospital emergency room after her doctor became aware of the allergic reaction. The resident reported she expressed concern to facility nurses on multiple occasions that she might be allergic to the antibiotic, but they continued to give her the drug. The facility was cited for failing to prevent a serious medication error. Citation # 030010243.

**Gramercy Court**

2200 Gramercy Drive, Sacramento, CA 95825

Gramercy Court  
 7/8/2013 **B**  
**\$500** Abuse/Facility Notification  
Not Self Reported Patient Care

A resident with severe mobility limitations due to a stroke, in need of regular repositioning in her bed, was not repositioned for a total of 6 hours on 5/5/13. After 4 hours without being repositioned, the resident put on her call light for assistance from facility staff. Staff did not respond to her call light until 2 hours later, causing the resident to experience pain and discomfort. The facility failed to report the resident's allegation of abuse to the Department of Public Health within the 24 hour period required by law. Citation # 030009993.

## Gramercy Court

11/19/2013 **B**  
**\$2,000** Patient Care Fall  
 Medication

During the evening on 1/21/12, a resident fell twice from her wheelchair, with the second fall causing head and facial injuries that required treatment in the emergency room. In the days prior to the falls, the resident had experienced increased confusion. Although her doctor had ordered an antibiotic to treat a urinary tract infection, the facility did not notify the doctor that the resident had been refusing her medications for several days prior to the fall. The facility was cited for failing to notify the doctor and for failing to ensure that her doctor's order for a wheelchair alarm was implemented. Citation # 030010254.

**Manorcare Health Services (Citrus Heights)**

7807 Uplands Way, Citrus Heights, CA 95610

Manorcare Health Services (Citrus Heights)  
 8/14/2013 **B**  
**\$1,000** Patient Care Injury

On 7/23/10, a 62 year old male resident was admitted to the facility for rehabilitation following a foot surgery. During a walk with the physical therapist, the resident attempted to sit down in his wheelchair while assisted by the physical therapist. The resident fell face forward and hit his face against the hallway rails. As a result, the resident sustained multiple facial fractures and soft tissue swelling around both eyes and his sinuses. The facility was cited for failing to follow the gait belt policy to use the assistive device during therapy services. Citation # 030010044.

**McKinley Park Care Center**

3700 H Street, Sacramento, Ca 95816

## McKinley Park Care Center

10/30/2013 **FP**  
**\$1,100** Patient Rights Mandated Reporting  
Failure to Report Patient Records

On 7/9/2013, the facility failed to notify Resident 1's responsible party (RP) when Resident 1's personal health information was accidentally given to Resident 2. The facility did not notify Resident 1 or their RP within five business days as required by law. In Resident 2's discharge packet, Resident 2's family member found Resident 1's observation report, which included diagnoses and a note of "difficult adjustment" to the facility. Resident 1's RP was not notified until 8/6/2013. Citation # 030010189.

## McKinley Park Care Center

10/30/2013 **FB**  
**\$1,200** Patient Rights Mandated Reporting  
Failure to Report Patient Records

The facility failed to report unauthorized access of Resident 1's medical information to the Department of Public Health (DPH) within five business days after becoming aware of the issue. The facility accidentally sent a letter to the family member of Resident 2 that included some of Resident 1's medical documents. The family member hand delivered the documents to the facility on 7/19/2013, but the facility did not report their mistake to DPH until 8/7/2013. Citation # 030010188.

**Norwood Pines Alzheimers Center**

500 Jessie Avenue, Sacramento, CA 95838

## Norwood Pines Alzheimers Center

12/13/2013 **B**  
**\$1,000** Patient Care Injury  
 Patient Care

A resident with Alzheimer's Disease was found to have seven different injuries over the course of two months, including skin tears and bruises on his back, ribcage, forearm, hands and eyelid. The facility's policy is to report any alleged or suspected abuse immediately and investigate these reports. However there were no incident reports completed nor any investigations conducted as to how these injuries occurred. The facility failed to implement its policy to report and investigate the cause of seven significant injuries to determine if abuse had occurred. Citation # 030010296.

**Rosewood Post Acute Rehabilitation**

6041 Fair Oaks Blvd., Carmichael, CA 95608

Rosewood Post Acute Rehabilitation

10/23/2013

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

Elopement

On 10/23/10, the Sheriff's Department returned an elderly man with cognitive impairment to the facility after finding him attempting to cross a street in his wheelchair. Facility staff did not see the resident leave the building and were unaware that he was missing until he was brought back to the facility. The resident was admitted with a diagnosis of altered mental status, and his care plan instructed facility staff to "Be Alert regarding resident's whereabouts." The facility was cited for failing to ensure that the resident received adequate supervision to prevent him from leaving the facility. Citation # 030010206.

Rosewood Post Acute Rehabilitation

11/13/2013

**AA****\$100,000**Medication

Medication

**Death Occurred**

A female resident was admitted to the facility on 12/15/06 for rehabilitation following femur fracture surgery. She was prescribed Warfarin, a blood thinning medication, and ordered to receive periodic blood tests to ensure her blood to clot ratio was therapeutic. On 12/18/06, the resident's applicable blood test was 2.09, within the reference range of 2-3. By 12/26/06, the measure had jumped to 5.48, which is a "high panic" result. There was no evidence the facility staff informed the resident's physician. On 1/1/07, the resident became nonresponsive and was rushed to the hospital. Her blood test measure was over 13. She was diagnosed with bleeding in the brain and died that day. Facility records showed that the resident's Warfarin had not been given from 12/26 to 12/30 but no reason was given. Nurses interviewed shortly after the resident died stated they had given Warfarin to the resident in those days. The records may have been altered. The facility was cited for failing to develop a care plan, failing to notify the doctor of the dangerous blood levels, and maintaining records to professional standards. Citation # 030010256.

**Whitney Oaks Care Center**

3529 Walnut Avenue, Carmichael, CA 95608

Whitney Oaks Care Center

6/10/2013

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

Physical Abuse

The facility failed to prevent a resident from being physically abused by another resident. The abusive resident's most recent assessment, dated 4/28/2010, indicated he was moderately impaired with decision making and required supervision. On 5/25/2010, a CNA found the abusive resident with his hands in the abused resident's underpants. Citation # 030009931.

Whitney Oaks Care Center

6/10/2013

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

Patient Rights

On 8/26/09, Resident 1, a 70 year old who suffered from dementia, depression, and angry outbursts, threw a four pound (dumbbell) weight at Resident 2, injuring his lower leg. A review of Resident 1's records showed he was assessed as having verbal abuse behaviors towards others, being socially inappropriate at times, and documented as resisting care from the staff. The Department questioned a LVN about what measures were in place to protect residents from Resident 1 and was told, "We have 30 minutes checks of Resident 1". When asked about the time the 30 minutes checks began, the LVN said she couldn't recall. The facility was cited for failing to protect residents from possible harm. Citation # 030009914.

**Windsor Care Center of Sacramento**

501 Jessie Avenue, Sacramento, CA 95838

Windsor Care Center of Sacramento

5/31/2013

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

Patient Care

On 11/26/10 a male resident with congestive heart failure had developed severe swelling on his feet. His physician ordered a diuretic to remove fluid. On 12/17/10 tests showed a high level of dehydration with convulsions, irritability, and dry mucous membranes. On 12/23/10 the Registered Dietician indicated that the resident had lost nine pounds since his admission to the facility 25 days prior. The facility failed to identify the resident's care needs, implement a care plan, ensure sufficient fluids were provided to maintain hydration and ensure lab tests were completed as ordered by the physician. Citation # 030009893.

**Windsor El Camino Care Center**

2540 Carmichael Way, Carmichael, CA 95608

Windsor El Camino Care Center

10/11/2013

**B****\$1,000**Patient CareMandated Reporting  
Patient Rights  
Sexual Abuse

The facility was cited for failure to thoroughly investigate a resident's allegation made on 5/4/10. The resident claimed a CNA was too "touchy-feely" and requested that the CNA no longer be assigned to her. The facility failed to follow the facility's abuse prevention and reporting policies and placed all patients at risk for unwanted sexual encounters. This resulted in two additional incidences of sexual abuse to occur to two additional residents. Citation # 030010193.

**Windsor Elk Grove Care and Rehabilitation Center**

9461 Batey Avenue, Elk Grove, CA 95624

Windsor Elk Grove Care and Rehabilitation Center

5/29/2013

**B****\$1,000**Fire Safety

Physical Environment

The facility had the fire alarm system turned off for a total of 5 hours and 18 minutes on 12/13/11 and 6 hours and 25 minutes on 12/14/11. The facility failed to initiate a fire watch during the time the alarm system was turned off. This failure had the potential to delay an evacuation in case of a fire. Citation # 030009920.

**Woodside Healthcare Center**

2240 Northrop Avenue, Sacramento, CA 95825

Woodside Healthcare Center

12/3/2013

**B**

\$1,000

Patient Care

Careplan

Patient Records

**Death Occurred**

On 7/24/2010, the facility failed to assess and provide timely pain management for a resident, follow the resident's careplan for pain, and follow the resident's physician ordered treatment of constipation. This resulted in fecal impaction, for which the staff did not indicate in the nurses' progress notes. The resident died five days later. Citation # 030010280.

**San Bernardino County**

**Hillcrest Nursing Home**

4280 Cypress Drive, San Bernardino, CA 92407

Hillcrest Nursing Home

9/4/2013

**AN**

\$15,000

Administrative  
Penalty - Staffing  
Audit

Staffing

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 4 days out of 24 randomly selected days. Citation # 240010111.

**Sky Harbor Care Center**

57333 Joshua Lane, Yucca Valley, CA 92284

Sky Harbor Care Center

7/3/2013

**AN**

\$15,000

Administrative  
Penalty - Staffing  
Audit

Staffing

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 2 days out of 24 randomly selected days. Citation # 240009962.

**Vista Cove Care Center At Rialto**

1471 S. Riverside, Rialto, CA 92376

Vista Cove Care Center At Rialto

5/15/2013

**B**

\$2,000

Patient Care

Injury  
Patient Care

On 10/10/11, a resident was taken to the acute care hospital with a scrotal injury that was bleeding. The facility investigation determined that the resident most likely caused the injury to himself by scratching. A physical therapist stated that the resident was unable to use his hands and a CNA stated the resident's arthritis was so bad it took two people to pry his arms away from his body. There was no documentation that the resident had and skin breakdown/problems to the scrotal area prior to 10/10/11. The internal medicine team at the hospital diagnosed scrotal avulsion (tearing away or separation of the skin from the scrotum) and suspicion of elder abuse. The attending physician stated that the type of injury the resident had, "doesn't just happen." He further stated that "...no way the resident could do that to himself; someone cut his scrotum." The facility was cited for failure to check the resident every two hours for prompt, proper incontinence care. Citation # 240009891.

**San Diego County****Brighton Place Spring Valley**

9009 Campo Road, Spring Valley, CA 92077

Brighton Place Spring Valley

4/19/2013

AN

\$15,000

Administrative  
Penalty - Staffing  
Audit

Staffing

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 4 days out of 24 randomly selected days. Citation # 090009839.

**Escondido Post Acute Rehab**

421 E. Mission Ave., Escondido, CA 92025

Escondido Post Acute Rehab

4/17/2013

B

\$2,000

Patient CareCareplan  
Supervision

On 1/20/13, a resident with a history of wandering was found by the police 1.3 miles from the facility with his front wheel walker and his pants around his ankles. He had no wrist band identification as required by his care plan. On 2/21/13, another resident was found by the police over 2 miles from the facility confused, and also had no identification. The facility was cited for failure to provide adequate supervision, ensure the residents wore identification bands, and ensure the wanderguards were working. Citation # 080009842.

Escondido Post Acute Rehab

11/26/2013

B

\$2,000

Quality of Care  
/Treatment

Patient Care

**Death Occurred**

On 10/14/13, A 75 year old male resident fell on the floor. When the nurse discovered him unresponsive, she failed to check his pulse as required per facility policy. Therefore, no one initiated CPR in accordance with the resident's wishes. When paramedics arrived they administered CPR, but the resident was pronounced dead at the scene. The facility failed to ensure that a resident be immediately assessed when found on the floor. In addition, the facility failed to ensure the emergency cart had an Ambu bag, or device used to assist with breathing in an emergency, was available for CPR. Citation # 080010278.

**Palomar Vista Healthcare Center**

201 N. Fig Street, Escondido, CA 92025

Palomar Vista Healthcare Center

1/17/2013

AN

\$15,000

Administrative  
Penalty - Staffing  
Audit

Staffing

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 5 days out of 24 randomly selected days. Citation # 080010313.

**Poway Healthcare Center**

15632 Pomerado Road, Poway, CA 92064

Poway Healthcare Center

2/1/2013

B

\$2,000

Patient CareInjury  
Patient Care

The facility failed to transfer a resident with two-person assistance and the use of a mechanical lift (Hoyer). As a result, the resident sustained a left femur (thigh) fracture during the transfer and suffered severe pain. Twelve days after the injury the resident was transferred to the acute hospital and required surgical repair of the fractured thigh. Citation # 080009727.

Poway Healthcare Center

12/2/2013

B

\$2,000

Patient CareDecubiti (Bedsore)  
Patient Care

A resident at risk for skin breakdown on his heels was not given heel protectors by the facility as required by his care plan, dated 3/16/13, and developed stage III pressure sores on both heels. He was transferred to a different facility on 4/17/13 for treatment of the sores and was not released until 5/18/13. The facility was cited for failure to provide heel protectors per the care plan. Citation # 080010173.

**Shea Family Care South Bay**

553 F Street, Chula Vista, CA 92010

Shea Family Care South Bay

11/7/2013

B

\$1,600

Patient Rights

Bed Hold

On 1/4/13, a resident was sent to a general acute care hospital for evaluation. On 1/9/13, the resident was refused readmission by the DON. During the time of the admission refusal the resident become very anxious, had complaints of chest pain, and was sent back to the general acute care hospital. The DON denied being contacted by the hospital and receiving information and paperwork to readmit the resident. The facility administrator stated that the bed hold should have been honored upon return to the facility and acknowledged that the miscommunication on the facility's part lead to the denial of the readmission. The facility was cited for failure to honor their bed-hold policy. Citation # 090010183.

**Veterans Home Of California - Chula Vista**

700 East Naples Court, Chula Vista, Ca 91911

Veterans Home Of California - Chula Vista

6/28/2013

B

\$1,600

Patient CarePatient Care  
Supervision

On 4/11/2013, a resident with severe dementia and multiple incidents of falls was left unattended while using the toilet, and found on the floor, face down, with blood on the floor. The resident suffered a laceration to the left eyebrow and a broken wrist. The resident's care plan identified that she was at risk for falls related to dementia, balance gait disturbance, and lack of safety awareness, but did not include interventions given her prior history of three falls. The facility was cited for failing to provide the resident with proper supervision, and failing to revise her care plan to include necessary interventions to address her high risk for falls. Citation # 170009974.

**Veterans Home Of California - Chula Vista**

7/15/2013      **B**  
**\$2,000**      Administration      Administration  
    Infection

From February through April 2013, the governing body of the facility failed to ensure that a dental clinic operating inside the facility met professional standards for sterilization of equipment and infection control practices. Seven equipment sterilization tests failed during this time period, exposing 112 patients seen in the clinic to potential exposure to bloodborne infectious diseases. The facility was cited for failing to ensure that the machine used to sterilize dental instruments was properly maintained, sterilization test results were reported and reviewed, and infection control practices were established and implemented.

Citation # 170009991.

**Villa Rancho Bernardo Care Center**

15720 Bernardo Center Drive, San Diego, CA 92127

Villa Rancho Bernardo Care Center

3/13/2013      **AA**  
**\$100,000**      Dietary      Dietary Services

**Death Occurred**

On 10/28/12, a 61 year old male resident with dementia choked to death after he was given uncut pancakes and sausage patties despite having orders for chopped food because of his aggressive and compulsive eating. The facility cook, food line checker, licensed nurse and a CNA all failed to catch the mistake despite handling the resident's food tray. The food line checker claimed that she was quite busy because she also answers the phones on Sundays, while the licensed nurse said she was in a hurry too. No findings were made regarding the facility's sufficiency of staffing. The facility was cited for failing to follow the physician's orders for a chopped food diet. Citation # 080009783.

**Vista Healthcare Center**

247 E. Bobier Drive, Vista, Ca 92084

Vista Healthcare Center

12/19/2013      **B**  
**\$2,000**      Patient Rights      Evictions

On 7/21/2013, the facility failed to allow a resident to return to the facility after she left for a routine outing with her family. When she returned from the outing, her belongings were packed and she was discharged from the facility against medical advice. With nowhere to go, the resident developed chest pain, called 911, and was admitted to a hospital. The hospital physician noted that the eviction could have caused the resident emotional or psychological trauma, which could have caused her chest pain. Citation # 080010344.

**Windsor Gardens Convalescent Center Of San Diego**

220 E. 24th St., National City, Ca 91950

Windsor Gardens Convalescent Center Of San Diego

10/1/2013      **B**  
**\$1,800**      Patient Care      Decubiti (Bedsore)  
    Neglect

According to a skin assessment performed on a resident at admission on 8/24/12, she was at high risk for pressure sores but none were present at that time. According to facility documentation the resident's skin was clear on 10/31/12 and 11/7/12. No documentation could be found for subsequent dates. The resident was discharged to the General Acute Care Hospital where admission notes indicated six pressure sores, four of which were considered "unstageable" (full thickness tissue loss in which the depth of the wound cannot be determined.) When observed at the hospital on 12/7/12, the resident had a feeding tube, and was receiving intravenous antibiotics and hemodialysis. The facility was cited for failure to prevent skin impairment and failure monitor and assess skin condition to identify wounds in early stages to provide appropriate measures for healing. Citation # 090010170.

## San Francisco County

### California Pacific Medical Center - California East Campus Hospital D/P SNF

3698 California Street, San Francisco, CA 94118

California Pacific Medical Center - California East Campus Hospital D/P SNF

8/1/2013

**B**

\$2,000

Patient Care

Careplan

Patient Care

#### **Death Occurred**

An 88 year old resident admitted to the facility following hip surgery was noted to have a poor appetite and lost over 21 pounds in the two weeks after her admission. She had irregular bowel movements and began to exhibit nausea and abdominal distention. On 2/15/12, the resident began vomiting "copious amounts of dark-brown fecal-smelling fluid from her mouth and nose" exceeding 1000 milliliters. The patient lost consciousness and died. The resident's family indicated that the resident's stomach had grown so large it appeared she was pregnant. The facility was cited for failing to follow its policy to assess and review significant changes in condition, plan care appropriately, or document physician notifications regarding resident changes in condition. Citation # 220010042.

### Sequoias San Francisco Convalescent Hospital

1400 Geary Blvd., San Francisco, CA 94109

Sequoias San Francisco Convalescent Hospital

9/17/2013

**A**

\$20,000

Patient Care

Fall

Notification

Patient Care

#### **Death Occurred**

On 3/7/12 a resident, who had a high risk for falls, was found lying on the floor and sustained lacerations from broken glass. He was taken to the acute care hospital where he was treated for lacerations and blood loss. On 3/22/12, he was found on the floor again and had removed his alarm device and his Continuous Positive Air Pressure breathing device. He was taken to the acute care hospital to be treated for a laceration to his head. It was discovered that he had a subdural hematoma that needed to be drained under the site of the laceration. The family opted to not have the resident treated. The resident died on 4/8/12 due to head trauma with subdural hemorrhage suffered in a fall. Never was a physician notified of the falls or the increase in agitation. The facility failed to provide proper supervision through appropriate care planning and implementation, as well as to provide a safe environment. Citation # 220010147.

## San Joaquin County

### Arbor Nursing Center

900 North Church St., Lodi, CA 95240

Arbor Nursing Center

3/7/2013

**B**

\$1,000

Patient Care

Careplan

Fall

During an investigation on 6/21/11, the facility was found to have failed to update a resident's care plans after several falls and injuries. The facility also failed to follow the doctor's orders for dressing changes for a laceration sustained after a fall. Assessments indicated the resident was at "high risk" of falling. A physician's order called for a "Seat belt with alarm." One review after a fall and injury shows no updates to the resident's care plan, except "just keep a close eye on her." Citation # 030009761.

### Bethany Home Society San Joaquin Co.

930 West Main Street, Ripon, CA 95366

Bethany Home Society San Joaquin Co.

8/8/2013

**A**

\$20,000

Patient Care

Fall

On 6/14/10, a 73 year-old resident was being transferred from her wheelchair to her bed and a front clip on one corner of the transfer sling became dislodged, causing the resident to fall face first to the floor. The resident was sent to the ER where it was determined that she had fractured her spine at the second cervical vertebra (neck). She had also fractured her right femur, which required surgery. On 6/16/10, the lift was examined and it was determined that the sling was very worn, in poor condition, and had stitching coming out. The facility was cited for failure to ensure that the lift's sling was in good condition. Citation # 030010063.

### Delta Rehabilitation & Care Center

1334 South Ham Lane, Lodi, Ca 95242

Delta Rehabilitation & Care Center

5/20/2013

**B**

\$1,000

Abuse / Facility  
Not Self Reported

Mandated Reporting

On 4/28/10, the facility received a Grievance Complaint Report from a family member about a CNA who was mean to a resident on 4/26/10. The report stated that the CNA told the resident she didn't have time to take her to the bathroom and left the resident sitting in diarrhea. Also, when the CNA came to change the resident she talked mean to her and was very rough. The Department did not receive the complaint until 5/18/10. The facility was cited for failing to notify the Department of an allegation of neglect of a resident within 24 hours as required by law. Citation # 030009898.

**Delta Rehabilitation & Care Center**

7/19/2013 **B**  
**\$1,000** Patient Care Elopement  
 Supervision

A resident at risk for elopement wore an armband to alert staff in the event she left the facility. A family member who was not the responsible party for the resident removed his mother from the facility on 10/22/10, without setting off any alarms. Investigation revealed two exit doors were not equipped with alarms. The facility was cited for failure to provide adequate supervision. Citation # 030010006.

**Delta Rehabilitation & Care Center**

11/27/2013 **A**  
**\$10,000** Patient Care Hydration  
 Medication  
 Patient Care

On 11/29/10, a resident developed diarrhea related to a Clostridium difficile, or C-diff, infection resulting in unrelenting diarrhea for 18 days and episodes of nausea and vomiting, all of which resulted in the resident being unable to retain food and fluids in her system to maintain fluid and electrolyte balance. The situation was also aggravated by the continuation of a diuretic medication, further reducing her fluid volume. The resident was transferred to the Acute Care Hospital on 12/17/10, where she was treated for kidney failure related to severe dehydration and dangerously low sodium levels. The facility was cited for failure to provide necessary care to ensure adequate hydration. Citation # 030010281.

**Golden Living Center - Hy-Pana**

4545 Shelley Court, Stockton, CA 95207

**Golden Living Center - Hy-Pana**

7/3/2013 **B**  
**\$1,000** Medication Medication

An 81 year old patient was given the wrong medication which caused sedation and confusion in the patient, who eventually was transferred to an acute care hospital after additional medication to counteract the effects were administered. The patient, who under doctor's orders was not to receive any sedative medications, was given 90 milligrams of Avinza, an extended release Morphine Sulfate Bead. The facility was cited for failure to properly administer prescribed medication. Citation # 030009986.

**Golden Living Center - Portside**

2740 N. California Street, Stockton, CA 95204

**Golden Living Center - Portside**

4/25/2013 **B**  
**\$1,000** Patient Care Patient Care  
 Security  
 Supervision

On 2/26/11 a female resident with memory problems wandered from the facility and was found 1.8 miles away. She had a departure alert system bracelet that was supposed to be checked for placement every shift. The resident had stated in the past that she wanted to go home. A nurse had discovered that the resident was able to take her bracelet off. However, the resident's care plan did not address this fact. The facility failed to provide adequate supervision to prevent accidents. Citation # 030009836.

**Kindred Transitional Care & Rehab-Valley Gardens**

1517 Knickerbocker, Stockton, CA 95210

**Kindred Transitional Care & Rehab-Valley Gardens**

11/13/2013 **B**  
**\$1,000** Patient Care Notification  
 Physical Environment  
 Supervision

The facility failed to ensure a resident received adequate supervision and assistive devices to prevent an accident, and failed to ensure the resident's physician was consulted immediately when the potential for medical intervention was indicated. On 6/30/2011, the diabetic resident fell off her bed, injuring the amputation below her knee. A nurse dressed the wound, but did not report the change in condition to a physician until 7/2/2011. On 7/7/2011, a surgeon observed gangrene in the wound and determined that an amputation above the knee would be necessary for healing. Citation # 030010244.

**St. Jude Care Center**

469 East North Street, Manteca, CA 95336

**St. Jude Care Center**

1/15/2013 **B**  
**\$1,000** Patient Care Fall  
 Injury  
 Mandated Reporting  
 Patient Care

The facility was cited for failing to ensure that a staff person reported an incident to supervisory staff when a resident fell while being assisted. The resident complained of severe pain and was not assessed for eleven hours before being transferred to the emergency room for evaluation and treatment. The resident sustained a fractured ankle. Citation # 030009691.

**Wagner Heights Nursing And Rehabilitation Center**

9289 Branstetter Place, Stockton, CA 95209

**Wagner Heights Nursing And Rehabilitation Center**

8/20/2013 **A**  
**\$16,000** Patient Care Deterioration

On 4/11/10, an 81 year-old resident, who was dependent on staff for eating and drinking, went to the ER in an altered mental state. It was determined that she was profoundly dehydrated and had acute renal failure due to the lack of hydration. The resident remained hospitalized for seven days. The facility was cited for failure to ensure that the resident was being given sufficient fluids to maintain hydration. Citation # 030010094.

**Windsor Hampton Care Center**

442 Hampton Street, Stockton, CA 95204

**Windsor Hampton Care Center**

5/31/2013 **B**  
**\$800** Patient Rights Injury  
 Physical Abuse

On 2/1/11, the facility failed to ensure a resident was safe from physical abuse, which led to bruising on his left wrist. A CNA roughly pulled on the resident's arm while helping him transfer from his bed to the toilet. Citation # 030009917.



Windsor Hampton Care Center

7/25/2013      **B**  
**\$1,000**      Patient Care      Decubiti (Bedsores)  
    Patient Care

On 3/23/10, a physician order indicated a male resident was to be monitored for changes to a pressure sore on his left heel for 14 days and then re-evaluated. The resident developed pressure sores on his left and right heels that were described by the doctor as unstageable and gangrenous and a Stage III pressure sore on his buttocks. On 5/3/10, the resident's left heel was described as Stage IV. On 5/22/10 he had both legs amputated. The facility failed to ensure that the resident received necessary care and treatment to promote the healing of an existing pressure sore and to ensure that the resident did not develop additional pressure sores. Citation # 030010007.

Windsor Hampton Care Center

8/1/2013      **B**  
**\$1,000**      Problem Transfer      Patient Rights

On 1/12/12, the Department made an unannounced visit to the facility following up on a complaint that the facility had illegally transferred a number of residents who had failed to adhere to the facility's cigarette smoking policy. The County Ombudsmen told investigators that residents were being discharged for breaking the rules, and the facility was just "trying to push the smokers out," and that the facility's Administrator personally drove residents away in his own car. The Administrator stated that those residents left "voluntarily." When the department interviewed 14 residents who were smokers they said that they lived in fear of being sent away if they broke the facility rules. The facility was cited for transferring residents out of the facility for reasons other than those regulated by law. Citation # 030010024.

**Santa Barbara County**

**Lompoc Valley Medical Center Comprehensive Care Center D/P SNF**

216 North Third Street, Lompoc, CA 93436

Lompoc Valley Medical Center Comprehensive Care Center  
 D/P SNF

11/21/2013      **B**  
**\$1,000**      Quality of Care      Medication  
    /Treatment

On 1/14/13, a resident became unresponsive after being transferred to the hospital for tests. The resident was found to have three Fentanyl patches affixed to his body. Fentanyl is a narcotic used to control pain and carries a "Black Box Warning" (indicating significant risk of serious or life threatening adverse effects) indicating that the prior patch must be removed before placing a new patch. The facility was cited for failure to administer and monitor the patches according to the manufacturer's recommendations. Citation # 050009766.

## Santa Clara County

### Los Altos Sub-Acute And Rehabilitation Center

809 Fremont Avenue, Los Altos, Ca 94024

Los Altos Sub-Acute And Rehabilitation Center

10/18/2013      **A**  
**\$20,000**      Patient Care      Careplan  
    Patient Care

A female resident was to receive moist heat packs wrapped in two towels applied to her right shoulder. On 11/29/12, the resident was repositioned in bed, which put the heating pad she was using under her body. However, there was no physician order for a heating pad. The heating pad caused a second degree burn to her left back, resulting in severe pain and complex wound treatments. The facility did not have a policy and procedure for the use of heating pads. The facility failed to ensure a safe environment free of accident hazards, which resulted in second degree burns to the resident. Citation # 220010218.

### Mountain View Healthcare Center

2530 Solace Place, Mountain View, CA 94040

Mountain View Healthcare Center

4/23/2013      **B**  
**\$2,000**      Medication      Medication

On 3/15/12 a resident was given 100 units of a diabetic medication instead of 14 units and was given 100 units of another medication instead of six units. This resulted in an overdose of diabetic medications. The overdose resulted in low blood sugar which was treated with two cups of orange juice and one milligram injection of a sugar substance. The resident reported feeling wheezy and was transferred to an acute care hospital, followed by a one night stay at the hospital intensive care unit. Citation # 220009846.

### O'Connor Hospital D/P SNF

2105 Forest Avenue, San Jose, CA 95128

O'Connor Hospital D/P SNF

3/5/2013      **AA**  
**\$65,000**      Patient Care      Patient Care

#### **Death Occurred**

A female resident with amyotrophic lateral sclerosis died after her ventilator, used to provide breathing assistance, was left in standby mode. On 12/26/12, the resident's respiratory therapist performed his regular tracheostomy care, placing the ventilator in standby mode. Shortly after he left, the resident was found nonresponsive and without a pulse. The resident's ventilator was still in standby mode, meaning it was not providing any air. The resident was transferred to the intensive care unit where she passed away two days later. The facility was cited for failing to ensure its environment remained free of accident hazards. Citation # 070009756.

### San Jose Healthcare Center

180 North Jackson Avenue, San Jose, CA 95116

San Jose Healthcare Center

10/10/2013      **AN**  
**\$30,000**      Administrative      Staffing  
    Penalty - Staffing  
    Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 14 days out of 24 randomly selected days. Citation # 070010174.

### Skyline Healthcare Center - San Jose

2065 Forest Avenue, San Jose, CA 95128

Skyline Healthcare Center - San Jose

11/15/2013      **B**  
**\$800**      Patient Care      Administration  
    Careplan  
    Patient Care  
    Security  
    Supervision

A facility was cited after it failed to adequately supervise and prevent a resident from leaving the facility without staff knowledge. Although the resident's written care plan included the use of a WanderGuard system (door alarms activated by bracelets worn by a resident) the facility had not yet purchased or installed such a system. The resident was able to leave unobserved by staff from one of six unlocked exit doors. The resident, diagnosed with diabetes and dementia, was later found 2.7 miles from the facility, 25 hours after leaving the facility. During the time period the resident was missing from the facility the outside temperature dropped to a low of 40 degrees. Citation # 070010263.

### Willow Glen Center

1267 Meridian Avenue, San Jose, CA 95125

Willow Glen Center

10/14/2013      **B**  
**\$1,300**      Patient Rights      Patient Rights  
    Physical Abuse

The facility failed to provide an environment free of mental and physical abuse. On 10/2/13, a resident was slapped on the face by a staff member during lunchtime. The staff member failed to use techniques for dealing with resident behaviors and was likely to cause significant humiliation, anxiety, or other emotional trauma to the resident. Citation # 070010190.

## Santa Cruz County

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

2990 Soquel Avenue, Santa Cruz, Ca 95062

Hearts & Hands, Post Acute Care & Rehab Center

2/11/2013

**AN**

**\$15,000**

Administrative Staffing  
Penalty - Staffing  
Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 3 days out of 24 randomly selected days. Citation # 070009161.

### Kindred Nursing and Transitional Care-Santa Cruz

1115 Capitola Road, Santa Cruz, Ca 95062

Kindred Nursing and Transitional Care-Santa Cruz

12/4/2013

**B**

**\$1,500**

Medication Medication

On 11/17/2013, the facility failed to ensure that a resident was free from a significant medication error. Two patches of fentanyl (a narcotic pain medication applied to the skin) were applied to the resident instead of one, as ordered by her physician. This error caused an overdose in the resident, who experienced difficulty breathing the next day and was transferred to a hospital. She was diagnosed with a urinary tract infection and over medication syndrome, which are symptoms of overmedication. Citation # 070010287.

## Shasta County

### Marquis Care at Shasta

3550 Churn Creek Road, Redding, CA 96002

Marquis Care at Shasta

4/26/2013

**B**

**\$2,000**

Patient Care Injury  
Neglect  
Patient Care

On 8/8/12, a female resident who required total assistance with transfers was transferred with a Medicare Stand. However, the resident's care plan stated that transfers should use total lift with two staff members. During this transfer, the resident suffered a skin tear and bruising as well as a right shoulder fracture that went undiscovered until 8/11/12. A total lift is done with a Medicare Lift, not a Medicare Stand. The CNA stated that she always used the Medicare Stand alone and did not look at the resident's care plan. On 8/10/13, the records showed that the physician had not been notified of the resident's complaints of severe pain and change in condition. The physician was not informed until the resident requested to go to the hospital. The facility failed to ensure that complaints of pain were assessed by a registered nurse and reported to a physician in a timely manner. Citation # 230009575.

## Siskiyou County

### Shasta View Nursing Center

445 Park Street, Weed, Ca 96094

Shasta View Nursing Center

4/29/2013

**B**

\$1,000

Patient Care

Notification  
Patient Care  
Physical Abuse

On 10/26/12 and 10/28/12, a resident was reported to have hit another resident on the arm with a closed fist. The facility had a policy to inform the California Department of Public Health within 24 hours of an incident as required by State and Federal regulations as well as the facility's abuse policy. However the incident that occurred on 10/26/12 was not reported until 10/29/12. This failure to report the incident endangered the health and safety of the resident. Citation # 230009590.

## Solano County

### Fairfield Post-Acute Rehab

1255 Travis Blvd., Fairfield, Ca 94533

Fairfield Post-Acute Rehab

4/10/2013

**A**

\$18,000

Patient Care

Careplan  
Fall  
Injury

A resident experienced a fall on 7/9/10, and a second fall on 8/2/10, sustaining a major laceration to a newly operated right knee requiring a second operation to repair the damage caused by the fall. The facility was cited for failure to revise the resident's careplan to prevent falls. Citation # 110009374.

Fairfield Post-Acute Rehab

10/10/2013

**B**

\$1,000

Administration

Administration  
Patient Care

After an observation at the facility in July of 2013, a citation was issued for failure to post a recently-issued "A" citation. Health and Safety Code regulations state that such a level of citation should be prominently posted in plain view of residents and visitors for up to 120 days. Failure to post a copy of the citation had the potential for residents, visitors, employees, and the public to not be aware of facility practices that could impact patient care. Citation # 110010028.

### Orchard Post Acute Care

101 S. Orchard Street, Vacaville, CA 95688

Orchard Post Acute Care

12/12/2013

**A**

\$20,000

Patient Care

Patient Care  
Supervision

The facility was cited for failure to keep the resident environment free of accident hazards after a 79 year old resident fell from her wheelchair on two separate occasions while unsupervised. The resident had previously been identified at risk for falling due to poor balance and limited mobility. These falls resulted in the resident suffering a Hematoma to the forehead and a probably brain bleed. Citation # 110009258.

## Sonoma County

### Cloverdale Healthcare Center

300 Cherry Creek Rd., Cloverdale, Ca 95425

Cloverdale Healthcare Center

2/15/2013      **B**  
**\$1,000**      Failure to Report      Mandated Reporting

The facility staff failed to report an alleged incident of sexual abuse within 24 hours of the incident. This lack of warning put other residents at risk of abuse. An anonymous complaint said that facility staff witnessed a resident being sexually inappropriate with another resident on multiple occasions. One unlicensed staff member said that she saw the accused resident masturbating in the presence of the abused resident on 11/24/11, and told two official staff that day and the day after. The California Department of Public Health received no report of sexual abuse. Citation # 110009477.

Cloverdale Healthcare Center

2/15/2013      **B**  
**\$1,000**      Patient Rights      Patient Rights  
Sexual Abuse

On 11/24/11, a male resident with a history of masturbating in front of other residents was seen masturbating under his pants while holding the hand of the other resident in his room. He was removed to another room with a resident who was alert and able to voice concerns. No report had been made to the Ombudsman. After the incident, checks every 15 minutes were started and discontinued on 12/9/11. The nursing plan of care and the facility policy and procedure for "Abuse Prevention" did not ensure how the facility staff would protect all residents from this resident's inappropriate sexual behaviors. The failure to continuously monitor, ensure protection and prevent resident abuse put the other resident and others at risk for further abuse. The violation of this regulation had a direct relationship to the health, safety, and security of the residents. Citation # 110009476.

### EmpRes Post Acute Rehabilitation

300 Douglas Street, Petaluma, CA 94952

EmpRes Post Acute Rehabilitation

2/21/2013      **B**  
**\$1,000**      Abuse      Mandated Reporting  
Sexual Abuse

On 2/9/11, licensed staff saw two residents in bed fully clothed. The staff pulled the curtains for privacy, checked the residents every 15 minutes for safety, and both residents ended up naked. The department was notified on 2/18/11, nine days after the event. The facility was cited for failure to report an incident of sexual abuse as required by federal or state statute. Citation # 110009717.

EmpRes Post Acute Rehabilitation

2/21/2013      **B**  
**\$1,000**      Failure to Report      Mandated Reporting  
Sexual Abuse

On 2/9/11, two residents were observed in the same bed and licensed staff pulled the privacy curtain. This caused one of the residents, who suffers from dementia, to become agitated and punch in the code for the dining room alarm. The resident showed increased anxiety and was irritated requiring one to one supervision. The facility was cited for failure to protect the resident from sexual abuse. Citation # 110009718.

EmpRes Post Acute Rehabilitation

7/29/2013      **B**  
**\$1,000**      Patient Care      Careplan  
Supervision

The facility failed to follow Resident 1's careplan, which involved supervising Resident 1 to prevent him from continuing a pattern of hitting other residents. On 3/6/2010, the facility planned to keep Resident 1 away from residents involved in previous altercations with him, and to enhance observation. Between 4/4/2010 and 5/12/2010, Resident 1 hit three other residents unsupervised, injuring two of them. Another bedbound resident complained of being afraid and feeling unsafe at night due to Resident 1's pattern of wandering into other residents' rooms and hitting them. Citation # 110007167.

### Golden Living Center - London House Sonoma

678 2nd Street West, Sonoma, CA 95476

Golden Living Center - London House Sonoma

2/6/2013      **B**  
**\$1,000**      Patient Rights      Patient Rights

During a State interview on 1/8/13 it was observed that the facility had not posted its overall rating in an employee's break room. Failure to post has the potential for staff not being informed of a facility's overall rating. The facility was cited for this violation. Citation # 110009712.

## Stanislaus County

### Country Villa Modesto Nursing & Rehabilitation Center

159 E Orangeburg, Modesto, CA 95350

Country Villa Modesto Nursing & Rehabilitation Center

10/22/2013 **B**  
**\$2,000** Patient Care Patient Rights

The facility was cited when it failed to provide adequate care and equipment to ensure a safe environment in order to prevent falls, which stated that a mechanical lift should be used for all transfers between the bed and chair in a safe manner to prevent falls. On 3/2/13, during transfer from the bed to the chair, a resident fell from the lift's sling and hit his head on the floor, sustaining a subdural hematoma brain injury. Citation # 040010229.

### Crestwood Manor

1400 Celeste Drive, Modesto, CA 95355

Crestwood Manor

8/15/2013 **B**  
**\$800** Patient Care Careplan  
 Fall  
 Injury

On 12/4/2012, the facility failed to ensure that a resident was transferred by two people as ordered by her careplan. A CNA attempted to transfer a resident from her wheelchair to her bed without additional assistance. The resident fell and injured her shoulder. An x-ray report conducted later that day indicated the resident's shoulder was fractured in the fall. Citation # 040010097.

Crestwood Manor

10/3/2013 **B**  
**\$2,000** Patient Rights Dignity  
 Mental Abuse  
 Physical Abuse  
 Verbal Abuse

Between 10/2012 and 12/2012, three CNAs stated that they observed another CNA harass, curse at, pinch and slap a resident. The resident stated that the CNA mistreated him, "All the time," and that she would move the call light out of his reach. The facility was cited for failure to ensure the resident was free from verbal, physical and mental abuse. Citation # 040010178.

## Evergreen Nursing & Rehabilitation Care Center

2030 Evergreen Avenue, Modesto, CA 95350

Evergreen Nursing & Rehabilitation Care Center

5/20/2013 **AA**  
**\$100,000** Medication Medication

### **Death Occurred**

On 10/26/12, a resident on hospice care was mistakenly given twenty times his prescribed dose of morphine sulfate and overdosed and died. The resident had an order for five mg of morphine every six hours. At noon, a nurse gave the resident 100 mg. The nurse realized her error about an hour later when doing documentation. The facility did not have a policy for signing drug accountability records before giving a narcotic medication nor did it have a policy for nurses to have a high alert medication double-checked by another nurse. At 3:00 pm, a hospice nurse administered Narcan to counter the morphine. By 6:00 pm, the resident was unresponsive. He was briefly hospitalized, returned to the facility, and died at 12:55 am on 10/27/12. His cause of death was morphine intoxication. Citation # 040009912.

### Riverbank Nursing Center

2649 West Topeka, Riverbank, CA 95367

Riverbank Nursing Center

2/14/2013 **AA**  
**\$80,000** Staff Development Fall

### **Death Occurred**

A 90 year old female resident with Alzheimer's Disease and osteoporosis fell while being transferred from her wheelchair to her bed on 2/19/12. Two CNAs were using a Hoyer lift for the transfer but failed to secure the apparatus and a sling became disengaged. The resident fell on her head and face, hitting the legs of the lift. She sustained multiple facial fractures and a brain hemorrhage and died two days later. Further investigation revealed the facility had failed to provide adequate instruction to its staff regarding the proper usage of the lift. Citation # 040009746.

## Trinity County

### Trinity Hospital D/P SNF

60 Easter Avenue, Weaverville, Ca 96093

Trinity Hospital D/P SNF

5/7/2013      **B**  
**\$1,000**      Patient Care      Verbal Abuse

The facility was cited for failure to ensure that a resident diagnosed with Alzheimer's was not subjected to physical and verbal abuse. On 7/30/12, a CNA grabbed the resident by both wrists and shouted at her in her face after the resident became combative with another staff member. The CNA did not follow the facility's written procedures for dealing with residents who have dementia in a calm and soothing manner. Citation # 230009534.

## Tulare County

### Sierra Valley Rehabilitation Center

301 West Putnam, Porterville, CA 93257

Sierra Valley Rehabilitation Center

7/18/2013      **A**  
**\$20,000**      Patient Care      Neglect

#### **Death Occurred**

On 6/11/11, after suffering a stroke, a 119 pound woman was sent to the facility for rehab. The resident died on 9/2/11 weighing less than 103 pounds. An investigation was conducted to determine if the resident's weight loss was due to inadequate care. The records indicated that in July her average meal consumption was between 40-50% and that in August that dropped down to 24% with 0% consumption for at least one meal per day. There was no documented evidence that the physician was notified when the resident's average meal consumption dropped to 25%. The facility was cited for failing to ensure that the resident maintained acceptable nutritional parameters. Citation # 120009044.

Sierra Valley Rehabilitation Center

9/16/2013      **B**  
**\$2,000**      Patient Rights      Physical Abuse

On 12/12/12, a 71 year old resident with Chronic Obstructive Pulmonary Disease was receiving physical therapy when her oxygen tank became empty. She became short of breath and was taken back to her room by the Occupational Therapist (OT). When the resident reached her room, she tried to get the OT to hurry up and connect her to a new oxygen tank. She was told by the OT to do it herself then turned to exit the room. Before the OT exited, the resident called her a "bitch", where upon the OT turned, came back to the resident, and slapped her. This was witnessed by the resident's roommate. The facility was cited for failure to protect a resident from being physically abused by an employee. Citation # 120010127.

**Ventura County****Ojai Gardens Nursing Center**

601 N Montgomery Avenue, Ojai, CA 93023

Los Robles Care Center

3/13/2013

**AN****\$15,000**Administrative Staffing  
Penalty - Staffing  
Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 4 days out of 24 randomly selected days. Citation # 050009774.

**Vista Cove Care Center At Santa Paula**

250 March Street, Santa Paula, CA 93060

Vista Cove Care Center At Santa Paula

3/19/2013

**AN****\$15,000**Administrative Staffing  
Penalty - Staffing  
Audit

The minimum number of nursing hours per patient per day required in a skilled nursing facility is 3.2 hrs. Through an audit of the facility's records, they were found to be out of compliance with this requirement for 3 days out of 24 randomly selected days. Citation # 050009785.

**Yolo County****Alderson Convalescent Hospital**

124 Walnut Street, Woodland, CA 95695

Alderson Convalescent Hospital

2/7/2013

**B****\$800**Patient Rights Patient Rights  
Physical Abuse

On 11/8/10, a CNA bruised the forearm and upper arms of a resident by grabbing the resident and holding the resident down. The resident stated that the CNA grabbed her arm and started to "wring it like a towel," and then held her down on the bed. An interview with the DON acknowledged the bruising found on the resident's arms was indicative of having been grabbed with some force. The facility was cited for failing to ensure the resident did not suffer physical abuse from a staff member. Citation # 030009730.

**Cottonwood Healthcare Center**

625 Cottonwood Street, Woodland, CA 95695

Cottonwood Healthcare Center

3/7/2013

**B****\$500**Patient Rights Physical Abuse

On 11/2/10 a facility CNA put both of her hands over a resident's mouth, telling him to stop screaming. The facility failed to ensure the resident was free from physical abuse. Citation # 030009770.

**Courtyard Health Care Center**

1850 East 8th Street, Davis, Ca 95616

Courtyard Health Care Center

1/18/2013

**B****\$1,000**Abuse Notification  
Physical Abuse

Nine cases of resident-on-resident physical abuse occurred at the facility between 5/27/08 and 7/4/09, but they were not reported to the Department of Public Health within the required 24 hour window. The facility was cited for failure to report all incidents of alleged abuse or suspected abuse of a resident to the Department of Public Health within 24 hours. Citation # 030009698.



**Davis Healthcare Center**

715 Pole Line Road, Davis, CA 95616

Davis Healthcare Center

8/27/2013      **A**  
**\$20,000**      Patient Care      Fall

***Death Occurred***

A female resident was readmitted to the facility from the hospital on 1/24/10 after sustaining a hip fracture in a fall at the facility. The resident was totally dependent on staff for transferring to and from her bed and wheelchair. On 5/24/10, the resident fell again, while transferring out of her bed with the aid of a CNA. The CNA had helped the resident to her bedside and then turned away to retrieve a lift and the resident fell from the bed. Facility policy required two staff people when using the lift. The resident fractured her hip, requiring surgery, and she died the next day. The facility was cited for failing to prevent the resident's fall. Citation # 030010112.

**Woodland Skilled Nursing Facility**

678 Third Street, Woodland, CA 95695

Woodland Skilled Nursing Facility

2/11/2013      **B**  
**\$1,000**      Patient Rights      Patient Care  
    Patient Rights  
    Physical Abuse  
    Verbal Abuse

On 2/1/10, a resident with a chronic muscular disorder and receiving hospice care reported that she was hit by a CNA at the facility. A treatment nurse reported that she heard the resident hollering and it was a different yell than she was used to hearing. She went to the resident's room and found her lying towards the foot of the bed in a defensive position. The resident's roommate also said that the CNA was rough with her and was pulling on her. However, the CNA stated that she hit the resident and that she may have spoken abruptly to her. The CNA was counseled regarding her communications. The facility failed to ensure the resident rights were not violated when she was physically and verbally abused. Citation # 030009721.

Woodland Skilled Nursing Facility

6/25/2013      **B**  
**\$1,000**      Patient Rights      Physical Abuse  
    Verbal Abuse

On 5/3/10, the facility failed to ensure that a resident was safe from verbal or physical abuse from a staff member. In an interview on 7/2/10, two residents said a CNA had "spoken rudely" to them and physically handled them "roughly." Citation # 030009944.