Ending the California Hospital Dump

Nursing homes regularly evict residents illegally. No illegal eviction method is more frustrating than the hospital dump. In such a scenario, a nursing home has a resident transferred to a hospital for some acute care need. Once the resident has been hospitalized, the nursing home clears out her room, packs her belongings, and refuses to take her back, all without any advance warning. This process is as illegal as it is reprehensible. And the time has come for it to end.

Transfers to a Hospital – The Right to a Bed-Hold

Whenever a nursing home resident is transferred to a general acute care hospital, federal and state rules require her bed be held for up to seven days. If the hospitalization exceeds seven days, the facility must nonetheless provide the resident with the first available bed in the nursing home after she is cleared for return (Medi-Cal residents or residents who did not receive bed-hold notice only).

The purpose of the legally mandated bed-hold is obvious: residents who need to go to the hospital for acute care should not have to worry about losing their placement in their nursing home as a result. At the time of hospitalization, the resident likely has built relationships with the facility staff members who know the resident and her care needs. Those relationships, as well as therapeutic progress, would likely be lost if the resident were forced to start over in a new nursing home. In addition, for better or worse, nursing homes serve as the homes of their residents. Residents spend weeks, months, and sometimes years in their nursing homes. They receive mail, visitors, and meals, hang their pictures, store their personal belongings, and live their lives. A tenant in an apartment would never dream of losing her home because she went to the hospital for a few days.

Refusals to Honor Bed-Holds: Trauma Drama

Despite legally mandated nursing home bed-holds, facilities often refuse to readmit hospitalized residents, primarily because it’s so easy. The residents who are discarded are typically disabled, unfamiliar with their bed-hold rights and in no position to take on a nursing home that has locked the door behind them. The Department of Public Health, charged with enforcing state and federal nursing home rules has been nearly non-existent in protecting the rights of residents to have their beds held. In the vast majority of cases, the facility is issued no enforcement action whatsoever.

Perhaps the main reason for hospital dumping is that it’s highly profitable for nursing homes. Residents who are refused readmission following a hospitalization are almost uniformly Medi-Cal beneficiaries. Replacing a “Medi-Cal resident” with a resident whose stay is covered by Medicare can garner a facility tens of thousands of dollars in additional revenue over the course of a few months.

From the dumped resident’s perspective, they are utterly abandoned, not only losing their home but also their care services and the relationships they may have developed with staff members and other residents. The loss of the nursing home bed eviscerates the resident’s sense of safety, exploiting their vulnerability and powerlessness. The loss of one’s home, without warning or legal remedy, can cause incalculable upheaval and damage. Residents who are dependent on others for most or all of their care needs are particularly vulnerable to transfer trauma that can send their health spiraling downward and occasionally cause death.

Hospital Dump ....................continued on page 4)
Help CANHR Save Resources!

One way you can help CANHR save resources is by requesting your “Advocate” subscription be sent to you via email. Contact the CANHR office with your current email address and we can easily convert your subscription from paper to electronic. You still receive the same great newsletter, reduce printing and mailing costs, and the trees will thank you too!

Giving to CANHR

It’s Tax Time! Think about a Donation To CANHR

Find out how you may be able to get tax deductions while supporting a deserving organization like CANHR. Whether you donate immediately by check, donate appreciated stock, life insurance or through other donative options, you can potentially reduce your tax obligations through charitable gifts. Ask your tax consultant before April 15!

Make a donation without writing a check!

Did you know you could make a secure online donation to CANHR with your credit card?

Simply by clicking on the yellow “Donate Now” button on CANHR’s website at www.canhr.org, you can help us to continue to provide valuable services to resident’s of long term care and their families. Even better, you can even make a recurring donation and help through out the year!

If you select “I want to make a recurring donation”, you will be registering to make a credit card donation every month, 3 months, or year. After you complete this initial donation, future donations will be made automatically. For example, if you choose to make a recurring monthly donation of $10.00, your next donation of $10.00 will be automatically charged to your account one month from the date of your initial donation.

You will receive an email receipt for each recurring donation. As soon as you complete this initial donation, you will receive a separate email containing a password and a link to a site where you can review and change your donation options (amount, frequency, billing information) at any time. Of course, you will also be able to cancel your recurring donation at any point in the future.

Request a Speaker for Your Next Meeting or Event

A reminder to our readers that CANHR staff members are available to speak to groups of 20 or more about CANHR services and long term care issues. Contact our office if you would like to discuss having a CANHR speaker at your next meeting or event. CANHR does request an honorarium from professional groups to cover costs.
Standardized Admission Agreement Effective 3/29/12

Effective March 29, 2012 – almost 15 years after SB 1061 (Vasconcellos) was signed into law, all California long term care facilities will be required to use a standardized admission agreement approved by the Department of Public Health. The regulations governing these agreements (22 CCR §72516) were filed in September 2011 and were to become effective on March 29, 2012. CANHR’s SNF Admission Agreement fact sheet will be updated and available for downloading on the CANHR web site. Anyone having questions about the admissions agreement, please contact the CANHR office.

CANHR releases “In a Stupor: What California’s Antipsychotic Drug Collaborative Reveals About Illegal Nursing Home Drugging.”

On January 27, 2012, CANHR released a new report that analyzes the findings of the Department of Public Health’s Antipsychotic Drug Collaborative. So far, the Collaborative has investigated 24 nursing homes to look at their practices regarding the use of antipsychotic medications for residents. Those investigations have yielded 147 confirmed violations of state rules regarding antipsychotic drug and other drug use. Most of the violations involve a failure to obtain informed consent, the use of clinically unnecessary or contra-indicated drugs, and issues with consultant pharmacists. The consultant pharmacist problems were discussed in detail in a recent New York Times story. (http://www.nytimes.com/2012/01/27/health/nursing-homes-in-california-confront-pharmacists-errors.html?pagewanted=all)

The Department’s investigations confirm that misuse of antipsychotics is rampant in California nursing homes and deserves immediate remedial action. The report includes CANHR’s recommendations for state action to ameliorate the antipsychotic drug problem. The report can be viewed for free from the CANHR website at: http://canhr.org/reports/In_a_Stupor.pdf

Governor’s Managed Care Plan Draws Strong Protests

The Governor’s budget plan proposes sweeping changes to Medi-Cal that would force more than a million people who are on both Medicare and Medi-Cal (known as dual-eligible beneficiaries) into managed care plans over a three-year period. An additional 160,000 people who are only on Medi-Cal and receive long term care services would face the same fate. These people would need permission from the managed care plans to access long-term care services, including nursing home care and In-Home Supportive Services (IHSS).

Under current law, the Department of Health Care Services (DHCS) is authorized to implement a demonstration project in four counties that would require these beneficiaries to enroll in managed care plans. The Governor’s proposal would rapidly speed up the transition to managed care, allowing DHCS to implement this system in up to 10 counties next year and extend it statewide by 2015.

The plan’s aggressive timeline drew almost universal criticism from consumers and advocates because it moves forward before the authorized demonstration project has been conducted and before any lessons learned from it can be considered. The nonpartisan Legislative Analyst’s Office (LAO) echoed these concerns, calling the plan premature and advising the Legislature to reject it.

The Governor’s plan is also creating fresh fears about the future of the In-Home Supportive Services program, which has been continuously on the chopping block in recent years. People on IHSS are very concerned that their services or access to caregivers of their choice will be cut or curtailed if this program is put under the control of private managed care companies.

Motion Picture Home Reopens its Doors

Three years after a highly controversial decision to close the nursing home at its Woodland Hills Campus, the Motion Picture and Television Fund (MPTF) reversed itself in February by announcing that it would reopen its doors to new residents and readmit former residents who had been transferred to other facilities. The landmark nursing home has operated for generations to serve members of the motion picture industry who need long term care.

Due to an impassioned campaign to save it by residents, families and many supporters, the Motion Picture Home never actually closed. About two dozen residents who lived there at the time of the January 2009 closure announcement remain. They are excited about the decision to readmit old friends and new residents.

Long Term Care News .................. continued on page 4
The decision to reopen the Motion Picture Home was quickly followed by a February 23rd press conference where the MPTF announced it is launching a $350 million campaign to sustain its charities. Jeffrey Katzenberg reported that he already had $200 million in pledges and donations from Hollywood luminaries such as George Clooney, Steven Spielberg, Tom Cruise and David Geffen.

CANHR applauds the MPTF for reopening the home and its renewed commitment to its historic mission, “Taking Care of Our Own.”

**San Mateo Board of Supervisors Rejects Pleas to Save Burlingame Long Term Care Facility**

The news was not so kind in San Mateo County, where the Board of Supervisors voted unanimously on February 14th to close its public nursing home – the Burlingame Long Term Care Facility – and transfer its 230 residents. In so doing, the Board ignored tearful pleas and persuasive arguments from hundreds of residents, families, staff, ombudsman, CANHR and other supporters to keep the facility open.

The Board of Supervisors gave highly debatable reasons for closing the facility, including financial problems, an aging building and other priorities. Contrary to its representations, Medi-Cal has not cut Burlingame’s rate, which exceeds $400 per day per resident. As a hospital-affiliated nursing home, Medi-Cal pays Burlingame more than twice the average rate it pays to freestanding skilled nursing facilities. The Board even rejected an offer by the building’s owner to reduce its rent.

Many of those attending the meeting complained the Board of Supervisors had already made up its mind beforehand and was just going through the motions. One attendee said “It was just the appearance of democracy.” It is almost a certainty that some of the residents will end up being moved to different counties and all of them will be exposed to transfer trauma, which occurs when frail elderly or disabled individuals are separated from families, friends, caregivers and familiar surroundings.

CANHR condemns this action and urges the Board of Supervisors to immediately reconsider its decision.

**Hospital Dump..........................(cont. from page 1)**

The illegal dumping of nursing home residents into hospitals is also a tremendous drain on state resources. Residents who needlessly sit in hospitals often spend weeks or even months in residential limbo, while running up an expensive bill paid for by the state.

**BUDGET BUSTER:**

**STATE COSTS IN A HOSPITAL DUMP CASE**

- Nursing home reimbursement rate: $150 - $200 per day
- Hospital Administrative Day rate: $351 per day
- DHCS Administrative Fair Hearing cost: $4,600

Total state costs for 30 days of wrongful refusal to readmit: $4,600 + ($175/day x 30 days) = $9,880.

**Dumping on the Rise**

Data obtained from the state unequivocally demonstrate that nursing home bed-hold abuse and illegal evictions are on the rise. The number of nursing home eviction appeal hearings held by the state has drastically risen over the past decade, more than tripling from 53 in 2000 to 186 in 2011. A significant number of these hearings are held when a resident has been dumped into a hospital but has the wherewithal to seek an appeal.

While 95% of all residents who are dumped into hospitals prevail at their hearing, fewer and fewer are getting readmitted. Facilities have learned that the state will take no additional action to ensure that a resident is actually readmitted following a successful appeal. The total lack of enforcement is an invitation to recalcitrance.

**AB 1752 – Taking the Profit Out of Hospital Dumping**

To end the illegal refusal to readmit nursing home residents, CANHR is sponsoring AB 1752 (Yamada), the Bed-Hold Protection Act of 2012. AB 1752 relies on one simple premise: meaningfully penalize nursing homes that abandon residents in hospitals. The bill will impose stiff mandatory and daily fines on any nursing home that illegally refuses to readmit a resident following a successful state appeal. The fines will realign the warped profit-incentive facilities have to illegally evict poor residents on Medi-Cal. Most importantly, AB 1752 sends a message to nursing homes that callously dumping residents into hospitals will no longer be tolerated in California.

For more information about bed-hold issues or AB 1752, please contact Anthony Chicotel, CANHR Staff Attorney, at tony@canhr.org.
**CANHR Sponsored or Co-sponsored Bills:**

**AB 1752 (Yamada): Illegal Dumping of Nursing Home Residents**
This bill would require the Department of Health Care Services to assess a per diem civil monetary penalty against a nursing home that refuses to readmit a resident following a hospital stay when readmission is ordered on appeal and require the Department to request that the Attorney General seek injunctive relief and damages against the facility.

**SB 1170 (Leno): VA Benefit Scams/Senior Insurance**
This bill would expand the definition of advertisement related to the sale and marketing of insurance products to seniors; add veterans organizations and the Department of Veterans Affairs to the list of those entities that cannot be used in deceptive or misleading advertising; and add the term “veteran” to those words deemed a senior designation.

**SB 1184 (Corbett): Veterans Benefits/Senior Insurance**
This bill would prohibit an insurance broker or agent from participating in, being associated with, or employing any party that participates in, or is associated with, the obtaining of veterans benefits for a senior, unless the insurance agent or broker maintains procedural safeguards designed to ensure that the agent or broker transacting insurance has no direct financial incentive to refer the policyholder or prospective policyholder to any government benefits program.

**SB 345 (Wolk): Long Term Care Ombudsman**
This bill would strengthen the role and independence of the state long term care ombudsman office by requiring it to represent the interests of long-term care facility residents before governmental agencies and calling for the office to submit an annual advocacy report describing how it has carried out these duties and its future plans to do so.

**SB 924 (Price, Walters and Steinberg): Direct Access to Physical Therapy**
This bill would specify that patients may access physical therapy treatment directly, and would, in those circumstances, require a physical therapist to refer his or her patient to another specified healing arts practitioner if the physical therapist has reason to believe the patient has a condition requiring treatment or services beyond that scope of practice, to disclose to the patient any financial interest he or she has in treating the patient, and, with the patient’s written authorization, to notify the patient’s physician and surgeon, if any, that the physical therapist is treating the patient. The bill would prohibit a physical therapist from treating a patient beyond 30 business days or 12 visits, whichever occurs first, unless the physical therapist receives a specified authorization from a person with a physician and surgeon’s certificate.

**Watch:**

**AB 2066 (Monning): RCFE Closures**
This bill would eliminate the requirement that an RCFE licensee comply with the relocation provisions on the basis of the revocation of a license. The bill would instead require the department to make every effort to minimize trauma for residents of the facility, including allowing a facility a closure date of 60 days following the revocation of the license, except as specified.

**Consumer Alert**

**Beware of Misleading Property Notices from “Local Records Office”**

Homeowners in Contra Costa County and throughout California have recently received notices from an organization out of Norwalk called “Local Records Office.” Although the notices include the required statements that it is “not government affiliated” and is “not affiliated with the county in which your deed is filed,” the notices are set up to look like an official document from the county recorder’s office. For a mere $89, the notice states, you can get a copy of your property profile and a copy of a deed to your property. In extremely small print at the bottom of the notice, it reads: *This is not a bill this is a solicitation you are under no obligation to pay the amount stated, unless you accept this offer.*

In fact, a copy of a deed from the Contra Costa County Recorder’s office will cost you $1 per page. If you want it certified, it’s $2.50 per document. So a copy of a certified deed to your property would cost about $5.50. Most county recorders offices charge similar fees. You can download a property profile from various websites like Zillow for free.

Clearly, mass mailings like this from organizations like Local Records Office are done for one reason only – in the hope that enough homeowners will be distracted, confused, or fearful enough to send them $89 for a document that would cost less than $10.
I've been looking for the perfect board and care for my mom. Recently, I have visited lots of facilities with six or fewer beds. They seem to be cheaper than the larger facilities and are within my budget. However, many of the bedrooms in these homes seem to be too small for the amount of people living there. Are there rules about room size or the number of people who can live in a room?

Sincerely,
Its a Small World in Saratoga

Dear Its a Small World,

There are definitely regulations regarding your concerns, and the California regulations at CCR Title 22 § 87307(a)(2), outlines them:

(2) Resident bedrooms shall be provided which meet, at a minimum, the following requirements:

(A) Bedrooms shall be large enough to allow for easy passage between and comfortable usage of beds and other required items of furniture specified below, and any resident assistant devices such as wheelchairs or walkers.

(B) No room commonly used for other purposes shall be used as a sleeping room for any resident. This includes any hall, stairway, unfinished attic, garage, storage area, shed or similar detached building.

(C) No bedroom of a resident shall be used as a passageway to another room, bath or toilet.

(D) Not more than two residents shall sleep in a bedroom.

Debunking the Myths of Short Term Stay Beds

It is a common nursing home myth that beds are designated as either long term or short term. This is simply untrue! The fact is, if a nursing home is licensed in California, it must meet California nursing home standards. Nursing home facilities are able to perpetuate this myth by improperly discharging residents as their Medicare coverage expires, using common reasons such as the resident no longer needs rehabilitation services or the facility is not a long term care facility.

If you are being discharged from the facility while still being covered under the 100-day Medicare benefit period, you have a right to appeal. Before you are discharged, the facility is required to provide you with the Important Message from Medicare. This notice will explain how to file an appeal. You can stay in the facility and continue to get Medicare coverage if you file the appeal before you are discharged.

If you do not win the appeal and your Medicare coverage is terminated, you should not be forced to leave the facility. You may stay. However payment must be arranged, as the resident is then financially responsible for services received. If the facility accepts Medi-Cal and you qualify, the facility will be prohibited from discharging/evicting you once the Medi-Cal application has been submitted.
CCRC Corner

Who Does the IRS Ruling 72-124 Protect: CCRC Residents or the CCRC Industry?

By Lillian L. Hyatt, M.S.W

Recently I read the wording of the IRS Ruling–72-124 on the subject in my headline. The ruling states that in order for a CCRC to qualify for tax exempt status, it must operate in a manner designed to satisfy the three primary needs of aged persons. These are the need for housing, the need for health care, and the need for financial security. The need for financial security, i.e., the aged person’s need for protection against the financial risks associated with later years of life, will generally be satisfied if two conditions exist. First, the organization must be committed to the established policy, whether written or in actual practice, of maintaining in residence any persons who become unable to pay their regular charges. Secondly, the organization must operate so as to provide its services to the aged at the lowest feasible cost, taking into consideration such expenses as the payment of indebtedness, maintenance of adequate reserves sufficient to insure the life care of each resident, etc.

The reason I looked up the ruling is because I have reached the upper limit of my ability to pay my monthly care fee of $4,401 and meet my other obligations i.e. taxes, fees for services needed by a legally blind, disabled resident. The upkeep of the expensive technology for the blind and for the technicians required to install and maintain this equipment is costly but essential to do my columns. The CCRC is supposed to keep a resident functioning at the highest level possible. My working as a journalist helps me to be mentally alert at 87 years of age. These specialized expenses are not covered by the CCRC. I also have other living expenses, such as dental, medical and prescription costs, Medigap insurance premiums and personal care expenses. I am certainly not alone in this; I hear similar worries from fellow residents too timid to speak up in protest and reveal, as did the old fairy tale that the emperor has no clothes!

I am convinced that if I continue to pay all the monthly care fee increases demanded yearly by the management of the CCRC where I live, I would be unable to survive financially and pay all of my other financial obligations. If I live even another few years, I cannot accept the fantasy that CCRC marketers sell which is, “If you run out of money we will support you for your lifetime.”

I wrote the following paragraph in the January 2007 issue of the California News, but I did not know there was going to be such a severe meltdown of the housing market, which today profoundly affects the ability of seniors to buy into a CCRC. Mortgages are impossible to get, so homeowners cannot sell their homes and are coming into CCRCs with loans. It is impossible to run a CCRC with its huge staff, large debt load and the lack of the entrance fees that financed the CCRC operations in the past. The column began:

“Seniors considering buying into a CCRC should heed the ancient warning, ‘Buyer Beware,’ or face the consequences of their failure to investigate the financial underpinnings of the chosen CCRC. Since each contract involves hundred of thousands of dollars, seniors should consult an accountant as well as an attorney and social worker. For example, one facility’s corporate management claimed to have a cash reserve of millions, but failed to disclose a huge debt borrowed to do capital improvements. If a major disaster occurred–an earthquake or fire–new residents could not be admitted and the CCRC would lose millions in entrance fees, which it needs to maintain its reserves. Borrowing to repair the damage then becomes most difficult if not impossible.”

The business model for the not-for-profit CCRC industry sells long term care insurance to its resident like an insurance company. It sells annuities and bonds like a brokerage house. How can this be called a not-for-profit business model? If it quacks like a duck and waddles like a duck–it’s a duck, and in my opinion, it is a for-profit business with the advantages of a not-for-profit business.

A corporate Vice President for Finance in one CCRC told me that a CCRC contract protects the resident but not the resident’s heirs. In other words, the whole family suffers financial loss if the CCRC strips a resident of nearly all the resident’s assets. Many times the resident suffers humiliation because they are no longer able to provide for themselves because they have spent all of their money and feel they have become a charity case as well.

(Ms. Hyatt is a resident of a CCRC and an AARP Policy Specialist on CCRCs.)
CANHR on the Move...

Past Speaking Engagements, Panel Discussions and Training Sessions

- **December 14:** Tony Chicotel went to Sacramento to provide a training for the Department of Social Services’ Community Care Licensing Division. The presentation featured resident capacity issues, surrogacy, and legal decision-making.

- **January 11:** Prescott Cole attended an All State Bar Association Meeting/Open Courts Coalition to explore options for court funding.

- **January 12:** Prescott Cole attended the NAPSA Elder Financial Exploitation Advisory Board Teleconference.

- **January 19:** Prescott Cole attended the Department of Insurance Senior Task Force.

- **January 24:** Prescott Cole gave a presentation at USF Law School.

- **January 30:** Tony Chicotel and Mike Connors visited Beatitudes in Phoenix to learn more about its acclaimed dementia care services.

- **February 9:** Tony Chicotel traveled to San Rafael to present to the Marin Council on Aging. He discussed “myths about long-term care.”

- **February 9:** Deborah Espinola, MSW Long Term Care Advocate, gave a presentation on CANHR services and Long Term Care Medi-Cal to a group from Sutter Visiting Nurses in Fairfield.

- **February 15:** Mike Connors participated in the family council meeting at the Motion Picture Home in Woodland Hills.

- **February 15:** Tony Chicotel presented “Hot Topics in Long-Term Care” to the Sonoma County Section on Aging in Santa Rosa.

- **February 16:** Tony Chicotel presented a webinar as part of the Legal Aid Association of California’s “Armchair Training” series. The topic was probate conservatorship defense in California.

**CANHR Upcoming Events**

**June 1, 2012: Pasadena SWAP Training:**
- CANHR will present a training for long term care professionals (non-lawyers) on Long Term Care Medi-Cal and Medi-Cal Recovery. The training will be held at the Western Justice Center Foundation, 55 South Grand Avenue in Pasadena, CA 91105. Come learn about CANHR services, understand the eligibility requirements for Long Term Care Medi-Cal, and ensure that your clients are accurately informed about Medi-Cal Recovery issues. For more information visit our website or contact Deborah Espinola at (415) 974-5171 or deborah@canhr.org.

**June 2, 2012: Burbank Attorney Training:**
- CANHR will present a one-day, 6.5 MCLE attorney training on Current Long Term Care Issues, including long term care insurance disputes, special needs trusts, and Medi-Cal eligibility and recovery concerns. The training will be held at Burbank Gardens and will include light breakfast, lunch and materials. Registration information will be posted on CANHR’s web site at www.canhr.org.
CANHR welcomes memorial and honorary gifts. This is a great way to honor a special person, or a loved one who has been a nursing home resident, while helping those who are nursing home residents. Recent gifts have been made in the names of the following persons:

**MEMORIALS**

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<td>Lynn Cooper</td>
<td>Judy Tiwalestwiwa</td>
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<td>Vivian C. Elorriaga</td>
<td>Virginia Spenceley</td>
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<td>Ronald Lozano</td>
<td>Judith Morrow</td>
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<td>Sabita Goswami</td>
<td>CANHR’s good work</td>
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<tr>
<td>Subrata Goswami</td>
<td>Susana Haake</td>
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**Alameda County**

**Silver Oak Manor**

788 Holmes Street, Livermore

**B $800 Careplan Fall Injury Transfer 11/30/2011**

On 9/24/11, a 97 year old non-ambulatory and wheelchair dependent resident was being transferred from the toilet to her wheelchair and fell, breaking her left ankle. An investigative interview noted that a CNA had attempted a solo transfer when there should have been two staff. The report stated that the resident had stood up from the toilet, held onto the grab bar with both hands, then tried to pivot to sit in the wheelchair. The report stated that the pivot caused her foot to break. The facility was cited for failure to implement the resident’s comprehensive care plan requiring two staff members for transfers. Citation # 020008754.

**Willow Tree Nursing Center**

2124 57th Ave., Oakland

**B $700 11/10/2011**

CitationWatch description will be published once citation is received. Citation # 020008733.

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**Butte County**

**Country Crest**

50 Concordia Lane, Oroville

**B $1000 Careplan Patient Care 10/20/2011**

On 8/25/11, an 81 year old resident who had suffered from a stroke and severe depression attempted suicide. She was found in her bed with her call light cord wrapped around her neck. During the ensuing investigation it was discovered that three weeks prior to the incident she had been expressing her desire to commit suicide. She had said she wanted to die and had several ideas about how to kill herself, including thoughts about wrapping a cord around her neck. A review of the resident’s records revealed that there were no interventions listed in her care plan that would prevent a suicide attempt. The facility was cited for failure to update her care plan to include necessary interventions to prevent the resident from attempting to kill herself. Citation # 230008640.

**Pine View Care Center**

8777 Skyway, Paradise

**B $1000 Careplan Fall Injury 06/30/2011**

A resident at risk for falls had physicians orders for “Pressure alarms in wheelchair and tabs unit in bed” to prevent falls. On 4/21/11, a CNA stated she transferred a resident from her bed to her wheelchair and did not connect the alarm. She was in the resident’s room when she heard the resident fall. The CNA stated she alerted a Licensed Nurse (LN) regarding the fall but 12 hours later the resident complained of pain during a transfer to bed and an x-ray revealed a broken hip. The LN stated she was not notified of the fall or she would have done the required assessment. The facility was cited for failure to carry out physician’s orders, follow the resident care
plan and ensure assessment by a licensed nurse after the fall. Citation # 230008336.

B $500 Injury Mandated Reporting 07/06/2011
The facility was cited for failure to report an injury that should have been classified as “injury of an unknown source”. The Administrative Nurse failed to report a bruise observed on 05/12/11. The resident had a dark and reddish purple bruise extending from under her chin, down the front of the neck and covering her entire chest and both breasts. Citation # 230008352.

Contra Costa County

Antioch Convalescent Hospital
1210 A Street, Antioch

A $7000 Careplan Hydration 11/18/2011
A resident normally able to participate in assisting with his own activities of daily living became totally dependent on staff beginning 12/19/10. On 1/11/10, the resident who was in a lethargic but responsive state, began vomiting and was transferred to the acute care hospital. There was no record of assessment or care plan adaptation related to the change in condition during this time period when the resident ceased to eat or participate in his own care. A fax was sent to the physician regarding the change in condition, but no follow up was performed when the physician failed to respond. The hospital reported that the resident was found to have severe dehydration, “multi-organ shutdown,” sepsis, and was described as, “pretty much terminal.” The facility was cited for failure to assess the resident, plan care for the change in condition and notify the physician. Citation # 020008758.

Kindred Nursing and Rehabilitation - Ygnacio Valley
1449 Ygnacio Valley, Walnut Creek

B $800 Careplan Fall Injury Supervision Transfer 11/30/2011
On 5/21/11, a resident was admitted to the facility from a hospital. The hospital physician gave discharge instructions that she is to be provided with “fall precautions”, and the facility would need to assist the resident when being transferred from her bed and to turn and position her in bed. On 6/4/11, the resident fell and fractured her hip while she was being transferred from the wheelchair to the bed. The facility was cited for failing to provide supervision to ensure the resident’s safety and avoid an accident during transfer, and to develop or update the resident’s care plan to ensure that two staff assisted the resident during transfers. Citation # 020008751.

Pittsburg Care Center, Inc.
535 School Street, Pittsburg

B $750 Bed Hold 12/19/2011
On 9/21/11, a quadriplegic resident with a bladder/bowel dysfunction, who had been refusing to eat and was experiencing constipation, was sent to the ER. On 9/22/11, the hospital Medical Social Worker indicated that the resident was ready to be discharged back to the facility. The facility refused to readmit the resident, stating that there was no bed hold. The facility was cited for failure to provide the resident with written information about the bed hold policy and the resident’s right to return and resume residence in the nursing facility. Citation # 020008828.

El Dorado County

Gold Country Health Center
4301 Golden Center Drive, Placerville

B $1000 Fall Injury Supervision Transfer 08/26/2011
On 3/3/09, while being transported to a medical appointment, the resident rolled himself backwards while seated on his walker and its wheels got caught in the space between the lift and the bus. He then fell on the floor of the van, and his portable oxygen compressor fell onto his ribs, causing severe pain. The resident stated that the RNA was not standing on the lift with him at the time. The facility was cited for failing to ensure that the resident environment remains as free from accident hazards as possible, and that the resident received adequate supervision and assistance devices to prevent the accident. Citation # 030008501.

Glenn County

Willows Care Center
320 North Crawford St., WILLOWS

B $1000 Careplan Fall Injury Patient Care Supervision 10/14/2011
The facility was cited for failing to implement the resident’s care plan, which indicated the resident should not be left unattended in his bedroom, unless in bed. On 9/8/11, the resident was left unattended in his wheelchair. This resulted in the resident falling out of his wheelchair and sustaining a fractured hip. Citation # 230008635.

Lassen County

Country Villa Riverview Rehabilitation & Healthcare Center
2005 River Street, Susanville

B $800 04/07/2011
CitationWatch description will be published once citation is received. Citation # 230008122.

B $500 04/07/2011
CitationWatch description will be published once citation is received. Citation # 230008121.

B $800 Mandated Reporting Physical Abuse Verbal Abuse 08/11/2011
Resident council minutes dated 12/15/10 and 1/20/11 documented four incidents of alleged abuse that included yelling at residents, rough handling of residents, and rudeness to residents. None of these incidents were reported to the Department of Public Health within 24 hours as required. The facility was cited for failure to report the alleged abuse to the Department. Citation # 230008441.
### Modoc County

**Modoc Medical Center D/P SNF**  
228 W. McDowell Avenue, Alturas

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<th>Citation</th>
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CitationWatch description will be published once citation is received. Citation # 230008785.

**Surprise Valley Community Hospital D/P SNF**  
741 N. Main Street, Cedarville

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<td>B $1000</td>
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The facility was cited for failing to establish procedures ensuring the safe procurement, storage, distribution and use of the fentanyl skin patch in agreement with the FDA required box warnings. This resulted in a resident being exposed to the potential risk of severe hypoventilation or death by a potential overdose of a fentanyl skin patch. Citation # 230008638.

### Monterey County

**Ave Maria Convalescent Hospital**  
1249 Josselyn Canyon Road, Monterey

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<th>Citation</th>
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<td>B $650</td>
<td>08/01/2011</td>
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On 7/9/11, a resident became too weak to stand, began to fall, and eventually grabbed hold of the recliner. However, the CNA (CNA1) assigned to the resident did not attempt to assist the resident at all. Another CNA witnessed the incident and immediately called for help. When assistance came, CNA1 told them, “Don’t help him! Let him sit down by himself so he won’t call us anymore!” CNA1 then told the resident, “Stop acting like an old man...a baby!” The facility was cited for failing to treat the resident with respect and full recognition of dignity and individuality. Citation # 070008429.

### Nevada County

**Crystal Ridge Care Center**  
396 Dorsey Drive, Grass Valley

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<th>Citation</th>
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During a bath on 2/8/11, a male resident fell from a mechanical lift and landed in an empty tub, causing a broken neck and head lacerations. The resident was paralyzed, suffered respiratory failure, and passed away four days later. The facility's mechanical lift policy required two staff members perform transfers but only one CNA was operating the lift when the resident fell. The CNA was a hospice aide who had little experience or training in operating mechanical lifts. The facility was cited for failing to provide supervision and assistance to residents to prevent accidents. Citation # 230008564.

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### Plumas County

**Country Villa Quincy Healthcare Center**  
50 Central Avenue, Quincy

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On 10/6/11, a male resident refused to take a pain pill crushed in yogurt. An administrative staff member attempted to force the yogurt into the resident’s mouth. The resident also asked to stay in bed but was forced to sit in a wheelchair with a physical restraint. The facility was cited for failing to treat the resident with dignity and respect. Citation # 230008702.

**Eastern Plumas Hospital-Portola Campus D/P SNF**  
500 First Street, Portola

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<td>B $500</td>
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In January of 2011, a CNA observed but did not immediately report another CNA's inappropriate massage of a 75 year old totally dependent resident. The CNA waited until six months had passed before notifying the Department of the alleged incident. The facility was cited for failure to report the alleged abuse within 24 hours as required by law. Citation # 230008498.

### Sacramento County

**Whitney Oaks Care Center**  
3529 Walnut Avenue, Carmichael

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The facility was cited for failing to follow their own hydration policies and procedures and for failing to prevent the severe dehydration of a resident. The resident was transferred from the facility to the hospital on 3/6/09 due to decreased level of consciousness and lack of response to verbal stimuli. He stayed in the hospital until 3/14/09. The resident was diagnosed with profound dehydration, acute renal failure, likely inadequate blood circulation or perfusion to the kidneys and elevated serum sodium levels. Citation # 030008634.

### San Joaquin County

**Arbor Nursing Center**  
900 North Church St., Lodi

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On 4/27/09, a CNA reported that a resident alleged she had been hit while the CNA was repositioning her. The charge nurse on duty did not believe it was abuse so she “didn’t go any further.” The facility was cited for failure to report the alleged abuse to the Department within 24 hours. Citation # 030008603.

**Manteca Care And Rehabilitation Center**  
410 Eastwood Avenue, Manteca

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On 7/4/10, a resident wanted to be wheeled to the dining room for an activity. The CNA who was taking care of the resident asked her to put her feet on the footrests, but the resident preferred not to use them. While being
wheeled to the dining room, the resident’s left leg got caught underneath the wheelchair, and suffered an acute leg fracture. The facility was cited for failing to prevent the resident from injury. Citation # 030008489.

**Santa Clara County**

**Amberwood Gardens**
1601 Petersen Avenue, San Jose

**B $750 Careplan Hydration 01/25/2012**
On 12/18/11, a resident was transferred to the acute care hospital and diagnosed with sepsis and acute urinary tract infection. The resident was unable to drink on her own and had been prescribed a diuretic medication. The facility was cited for failure to update the resident’s care plan when she required assistance taking fluids; failure to monitor the resident’s fluid intake, and failure to monitor her condition to ensure she received adequate hydration. Citation # 070008939.

**Gilroy Healthcare And Rehabilitation Center**
8170 Murray Avenue, Gilroy

**B $600 Physical Abuse 09/08/2011**
On 8/27/11, one staff member was observed by another staff member slapping a resident in the face. The resident had been agitated and struck the staff member in the face and the staff member responded by slapping the resident. The facility was cited for failing to keep the resident free from physical abuse. Citation # 070008552.

**Milpitas Care Center**
120 Corning Ave., Milpitas

**A $20000 Careplan Injury Physical Environment Supervision 12/09/2011**
The facility was cited for failing to provide a hazard free environment due to inadequate supervision for a resident who had a long history of elopement. It was also known by staff that the resident knew how to disarm the door alarms. On 11/18/11 at 8:30 pm, a CNA noticed the resident was missing and the facility notified the police. The police report dated 11/18/11, indicated there was a possibility the resident was hit by a car and was admitted to the Intensive Care Unit, suffering multiple pelvis fractures trauma to the face, shoulders and hips. Citation # 070008781.

**Pacific Hills Manor**
370 Noble Court, Morgan Hill

**B $600 Dignity Physical Abuse 06/09/2011**
On 5/21/11, a resident reported that a CNA was rough with her during her shower. The resident stated, “I was hurt and I cried.” The facility was cited for failure to treat the resident with dignity and respect. Citation # 070008280.

**Skyline Healthcare Center - San Jose**
2065 Forest Avenue, San Jose

**B $1000 01/23/2012**
CitationWatch description will be published once citation is received. Citation # 070008934.

**Willow Glen Center**
1267 Meridian Avenue, San Jose

**B $600 Dignity Supervision 10/21/2011**
On 9/22/11, a resident with severe cognitive impairment went into two other residents’ rooms multiple times and exposed his private parts. On 9/24/11, the resident pulled down his pants and fondled his male organ in another resident’s room. The facility was cited for failing to prevent the resident from making unwanted visits and gestures to other residents. Citation # 070008653.

**Santa Cruz County**

**Cresthaven Nursing Home**
740 17th Avenue, Santa Cruz

**B $750 Medication 06/21/2011**
On 5/27/11, the facility cook mixed medication into the food of a resident without any supervision by the medication nurse. The facility was cited for failure to ensure the medication was administered correctly to the resident by the licensed nurse who had poured the medication. Citation # 070008286.

**B $600 Physical Abuse Verbal Abuse 10/26/2011**
A CNA was reported by several residents to have verbally abused them and other residents. One resident was allegedly sprayed in the face with window cleaner and another resident was photographed while in the shower. The facility was cited for failing to conduct a timely, thorough investigation of the allegations against the CNA. Citation # 070008670.

**B $500 Other 10/26/2011**
Seventeen of twenty-two employees working in the facility lacked required health examinations. The facility practice was to have a nurse do cursory vital sign checks and the medical director would falsely certify that he had examined the employee and found him or her in good health and free from contagious disease. The facility was cited for failing to implement its health examination policy. Citation # 070008673.

**Driftwood Healthcare Center - Santa Cruz**
675 24th Avenue, Santa Cruz

**B $800 Dignity Neglect Patient Care Patient Rights 08/25/2011**
During an interview on 8/12/11, the resident reported having problems with the CNA assigned to her. The resident stated when she would ring her call bell, the CNA would come to the room and sometimes just turn off the bell, or tell the resident that she was too busy to help her. The resident also stated she would have to wait 90 minutes to receive assistance from the CNA to go to the bathroom. Sometimes she would soil herself while waiting, and feel humiliated. Other staff reported residents’ call bells would be out of the residents’ reach, or residents would be left waiting for assistance while this CNA was working. The facility was cited for failing to ensure the resident was treated with dignity and respect, and free from abuse. Citation # 070008506.
B $900 Careplan Injury Patient Care Physical Restraints Transfer 01/23/2012
The resident sustained a fracture to her upper left leg, however the staff could not determine how it happened. During an investigation, the medical director stated the resident’s leg may have been caught in her wheelchair. Prior to the fracture, staff knew the resident dragged her feet while being transported in her wheelchair, but a care plan was never developed to address the problem. The facility was cited for failing to develop a care plan to address the resident’s behavior of dragging her feet, and for failing to use footrests while transporting the resident. Citation # 070008901.

Santa Cruz HealthCare Center
1115 Capitola Road, Santa Cruz
B $1000 01/18/2012
CitationWatch description will be published once citation is received. Citation # 070008820.

Santa Cruz Skilled Nursing Center
2990 Soquel Avenue, Santa Cruz
B $600 Dignity Sexual Abuse 09/09/2011
On 7/31/11, a CNA was observed by multiple staff members kissing and inappropriately touching a resident. The resident had schizophrenia and believed that she and the CNA were to be married as prince and princess. The facility was cited for failing to ensure the resident was treated with respect. Citation # 070008476.

Shasta County
Canyonwood Nursing And Rehab Center
2120 Benton Drive, Redding
B $1000 Dignity Patient Care 08/23/2011
On 6/15/11, a CNA was asked by a 65 year-old resident for assistance in getting off the commode, cleaning, pulling up briefs, and getting back into her bed. The CNA told the resident that she “could do it herself”. After saying that the CNA left the resident alone, sitting on the commode and sobbing. The facility was cited for failing to treat the resident with dignity and respect. Citation # 230008497.

B $1000 Fall Injury 11/07/2011
An 82 year old male resident was assessed as a moderate fall risk although he was in fact a high fall risk. He was prescribed Ambien, a sleeping pill that increases fall risks, and the resident fell on 1/5/11. He suffered a bump on the head and cuts on his wrist. The resident was not wearing special socks that had been ordered to reduce fall risks. The facility was cited for failing to properly assess the resident’s fall risk and for failure to implement its care plan. Citation # 230008693.

Golden LivingCenter - Redding
1836 Gold Street, Redding
B $1000 Physical Abuse Verbal Abuse 09/15/2011
On 5/22/11, a CNA slapped a resident in the mouth, restrained her arms and verbally reprimanded and threatened the resident. The facility was cited for failure to protect the resident from physical and verbal abuse. Citation # 230008554.

B $1000 Careplan Patient Care Supervision 10/10/2011
The facility was cited for failing to provide supervision for a resident resulting in the elopement of the resident for 45 minutes on 8/26/11. The resident traveled nearly a mile away from the facility and was in danger of being struck and injured by traffic. Citation # 230008606.

Marquis Care at Shasta
3550 Churn Creek Road, Redding
B $1000 11/29/2011
CitationWatch description will be published once citation is received. Citation # 230008701.

Mayers Memorial Hospital D/P SNF
43563 Hwy 299 E, P.O. Bx 459, Fall River Mills
B $750 Fiduciary Mandated Reporting 10/18/2011
On 7/9/11, a resident informed the nurse that $116 was missing from her wallet. The nurse completed an internal form and delivered the form to the administration office. The Department of Public Health was not notified until 7/18/11, nine days later. The facility was cited for failure to report the incident of alleged financial abuse to DPH within 24 hours, as required by law. Citation # 230008641.

Siskiyou County
Shasta View Nursing Center
445 Park Street, Weed
B $1000 Dignity 04/20/2011
In an interview on 2/7/11, a resident reported that an LN C had put her finger in the residents rectum to perform a manual fecal removal while the resident was suspended in a mechanical lift sling. The resident stated she “begged” to have the procedure done in her bed because the sling straps were too small and caused her pain. The LN C called said the resident was “faking” and called her a “drama queen.” The resident said the incident made her feel humiliated and caused her physical pain. The facility was cited for failure to treat the resident with dignity and respect. Citation # 230008164.

B $1000 Mental Abuse Physical Abuse Verbal Abuse 04/20/2011
On 8/14/10, a resident with behavioral problems such as altercations with other residents and trying to get into the...
beds of female residents with his pants down, was struck and verbally abused by another resident when he wandered into his room. The wandering resident received an injury to his nose which required treatment. Stop Guards to prevent his wandering into other resident’s rooms were not implemented consistently. The facility was cited for failure to protect the resident from physical and mental abuse. Citation # 230008162.

**Yolo County**

**Davis Healthcare Center**  
715 Pole Line Road, Davis  

B $1000 Medication 10/12/2011  
Between 2/9/09, and 2/13/09, a resident was given Zolpidem (a sleeping medication) four times without a physician’s order. The medication had been discontinued due to risk of the resident becoming hypoxic (inadequate oxygen in the blood) related to obesity and sleep apnea. On 2/13, the resident was found unresponsive and transferred to the acute care hospital with an oxygen saturation of 65-70%. The facility was cited for failure to ensure medications were not administered without a valid order. Citation # 030008633.

**Yuba County**

**Marysville Care Center**  
1617 Ramirez Street, Marysville  

B $100 11/30/2011  
CitationWatch description will be published once citation is received. Citation # 230008704.
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Fresno County

Willow Creek Healthcare Center
650 West Alluvia Avenue, Clovis

B $1000 Careplan 01/03/2012
The facility was cited for failing to implemented an 87 year old’s care plan to prevent falls. The plan called for a self-release belt while in a wheelchair to prevent leaning forward. On 9/27/11, a staff member who assisted her to the bathroom, turned her back and the resident fell out of the wheelchair, face to the floor and sustained a fractured nose and injuries to her left eye, arm, thumb and both knees. Citation # 040008876.

Los Angeles County

CORRECTION:
In the Winter 2011 edition of The Advocate, a Citation issued by the State of California Dept. of Public Health was incorrectly attributed to Dreier's Nursing Care Center in Glendale when the Citation was actually issued to another facility. Dreier's Nursing Care Center has not received any Citations in 2011. We apologize for this error.

Antelope Valley Healthcare
44445 N.15th St. West, Lancaster

B $750 Medication 11/10/2011
On 1/28/11 and 1/29/11, two LVNs administered Coumadin to a resident on separate occasions, although the physician ordered that they hold the Coumadin until further orders. The facility was cited for failing to comply with the physician’s orders. Citation # 920008737.

Bel Tooren Villa Convalescent Hospital
16910 Woodruff Ave., Bellflower

B $500 Mandated Reporting Sexual Abuse Supervision 09/26/2011
The facility was cited for failing to report an incident to the department of the alleged abuse within 24 hours. On 5/18/11, a resident (Resident 1) reported that she was awakened by another resident (Resident 2) entering her room and trying to kiss her on the mouth. This resident also reported that the offending resident also attempted to kiss another resident (Resident 3) and touched Resident 3’s breast. Citation # 940008590.

Coast Care Convalescent Center
14518 E. Los Angeles, Baldwin Park

B $800 Injury Supervision 09/07/2011
On 7/18/10, while an employee was lowering a resident’s bed the resident’s IV pole fell and struck the resident in the head causing a laceration. The facility was cited for failure to follow policy and procedure and provide adequate supervision to prevent injury. Citation # 950008528.

B $1000 Careplan Injury 10/06/2011
A 70 year old male resident with end-stage renal disease broke his wrist on 7/30/09. The resident was noted as highly prone to self-injury due to constant turning and rolling in bed. The facility wanted to use padded side rails but did not have the proper pads. Staff used pillows instead which the resident easily removed. The facility was cited for failing to implement the plan of care to use side rail padding to prevent injury. Citation # 950008618.

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

A $19500 Medication 10/07/2011
On 9/15/09, a resident was transferred to the hospital because she became immobile and non-functional. It was determined that the resident’s health issues were in part due to the large dose of psychotropic medications. When they were discontinued, she improved considerably without recurrence of psychosis or any other adverse reaction. It was also documented that the resident in her condition was unable to give consent for use of the medications. The facility was cited for failing to ensure that the medications prescribed were necessary and used as indicated, the informed consent was obtained prior to the administration of psychotherapeutic medication and also for failing to ensure that the resident was free from psychotherapeutic drugs used for the purpose of discipline/staff convenience. Citation # 910008607.
B $950 Patient Rights 10/07/2011
On 10/1/09, the Department received an allegation from a family member with the Durable Power of Attorney (DPA) for an 84 year old dementia resident, that someone else had become the patient’s DPA during her stay at the facility. The complaint was that the resident had the capacity to make another appointment. It was noted in the resident records that on 11/6/08, the resident was completely disoriented and hallucinating. On 7/29/09, the resident signed the disputed DPA and with an “X” next to her printed name. The family member with the first DPA did not discover this change until she attempted to have the resident transferred to another nursing home. The facility was cited for failure to ensure a resident and/or her representative were fully informed regarding the appointment of a conservator for the resident’s health care needs. Citation # 910008621.

Downey Care Center
13007 South Paramount, Downey

AA $8000 01/24/2012
CitationWatch description will be published once citation is received. Citation # 940008718.

Fountain View Subacute And Nursing Center
5310 Fountain Ave., Los Angeles

AA $75000 Fall Injury 12/21/2011
On 9/6/2010, an 89 year old resident suffered a severe fatal brain injury from a fall that occurred a day after he was admitted to Fountain View Subacute. At the time of the fall, the resident was recovering from an earlier fall and was considered a very high risk for falls. He was found on the floor at 1 am with a bump on his head, which a family member described as the size of a goose egg. The facility had not taken necessary protective steps to prevent falls. His doctor ordered the facility to monitor his neurological status after the fall, but records indicated it did not do so. Hours after the fall, the resident lost consciousness, was transferred to an acute care hospital, diagnosed as having suffered a large subdural hematoma, and placed on life support in the intensive care unit. He died three days later due to blunt head trauma. The facility was cited because its failure to provide adequate supervision and necessary care led to the resident’s severe brain injury and death. Citation # 920008483.

Glendora Grand, Inc.
805 West Arrow Highway, Glendora

B $1000 Dignity Mental Abuse Patient Rights Physical Abuse Sexual Abuse Verbal Abuse 10/20/2011
On 8/30/09, a janitor who also worked in the kitchen at the facility, inappropriately touched a female resident’s legs, hands, and arms, and told her “I love you” and “You are beautiful”. The employee would also blow kisses, wink, and look at the resident with a “dirty” look on his face. The employee’s actions made the resident feel uncomfortable and “violated”. The resident stated these actions had been going on for two and a half months. The facility was cited for failing to ensure that the resident was free from verbal, sexual, physical, and mental abuse. The facility was also cited for failing to report the results of the investigation to the department within five days of the incident and take appropriate actions, and that the alleged violations were thoroughly investigated. Citation # 950008652.

Hawthorne Convalescent Center
11630 S. Grevillea Ave., Hawthorne

B $1000 Fiduciary Patient Records 05/09/2011
On 10/14/09, two employees purchased a 19 inch television, clothes, and accessories (totaling $605.33), from the resident’s trust account. However, there was no evidence that the resident ever had that television in her room.

Lakeview Terrace Special Care Center
9601 Foothill Blvd, Lakeview Terrace

B $1000 Dignity Mandated Reporting Patient Care Patient Rights Physical Abuse Verbal Abuse 10/13/2011
On 4/18/11, a CNA and a resident were yelling profanities towards each other. Later on in the evening, the CNA began slamming chairs because the resident kept turning on the light and going in and out of the bathroom. Then the CNA pushed the resident onto his bed and kicked his leg. Another CNA who witnessed the physical abuse, failed to report it. The facility was cited for failing to treat the resident with dignity and respect, and prevent physical and verbal abuse toward the resident. The facility was also cited for failing to report the physical and verbal abuse. Citation # 920008642.

Marlinda Nursing Home
3615 Imperial Hwy, Lynwood

B $1000 Careplan Fall Injury Transfer 09/27/2011
On 3/17/11, a resident suffered a fractured hip when a nursing assistant dropped him while attempting to transfer him from bed to chair. During the fall, the resident struck his right hip on the corner of the bedside table. The serious injury occurred because the nursing assistant ignored the resident’s request to get help and failed to follow his care plan and doctor’s order that he be provided two-person assistance with transfers via a mechanical lift. The facility was cited for these failures. Citation # 940008595.

Maywood Skilled Nursing & Wellness Centre
6025 Pine Avenue, Maywood

B $1000 Fall Injury 09/13/2011
A resident at high risk for falls fell five times between 3/7/09 and 4/10/09. The last fall resulted in a head injury requiring six sutures. The facility was cited for failure to apply a tab alarm as directed by the physician to notify
staff when the patient got out of bed unassisted, and failure to monitor the resident and provide adequate assistance to prevent falls. Citation # 940008565.

Motion Picture & Television Hospital D/P SNF
2338 Mulholland Dr., Woodland Hills

AA $80000 Fall Injury Supervision 12/29/2011
On 10/24/2010, a 90 year old resident with dementia died after sustaining fatal neck and spine injuries in a fall one week earlier on 10/17/2010. The facility reported that the resident, who had recently been moved to the 2nd floor, fell after wheeling herself into the stairwell. She and her wheelchair were found in the stairwell, where she complained of head, neck and back pain. She was hospitalized, where scans found that she suffered a burst fracture of her neck and spine. According to her death certificate, the cause of death was “Sequelae of Fall.” The resident suffered eight falls in a three year period at the facility, including a fall down the same flight of stairs in 2007 and another fall three days prior to the fall that led to her death. During the investigation, the facility stated its care plan for the resident did not address her wandering behavior or wheelchair alarm use and that its staff did not document concerns about her anxiety on the day of the fall and other factors that may have contributed to the fall. The facility was cited because it failed to provide a safe environment and adequate supervision to the resident. Which resulted in her death. Citation # 930008531.

The Rehabilitation Center of Santa Monica
1338 20th Street, Santa Monica

B $1000 Fall Injury 09/08/2011
On 9/2/08, a 48 year old resident who was totally dependent on staff for transfers, fell off of a gurney as she was being taken by two ambulance attendants to a dialysis center. The resident stated that she thought the ambulance crew were moving too fast, and when they came to the bottom of the hill, they turned left and the gurney turned over and she fell and hit her shoulder and head on a wall. The fall caused her to fracture her clavicle. The investigators noted that the facility could not produce a written agreement with the transport service. The facility was cited for failure to ensure the residents’ safety. Citation # 910008549.

Rose Villa Healthcare Center
9028 Rose Street, Bellflower

B $2000 Mandated Reporting 01/19/2012
A 55 year old resident with paraplegia was denied appropriate incontinence care, supervision, and supplies, leading to multiple urinary tract infections and painful urinary buildup. These failures occurred over the course of a year but were not properly assessed as abusive nor reported to the Department of Public Health. Citation # 940008814.

B $2000 Infection Patient Care 01/19/2012
A 55 year old male resident with paraplegia was not supervised when providing his own incontinence care despite a physician’s directive to do so. The resident was not given sterilization supplies for his urinary catheters which led to five urinary tract infections in a one year period. In addition, the facility sometimes did not have catheters for the resident, resulting in painful urinary buildup. Citation # 940008814.

Infinity Care of East Los Angeles
101 S. Fickett Street, Norwalk

B $500 Dignity Patient Rights Physical Abuse 09/27/2011
The facility was cited for failing to protect the resident from abuse from a CNA. On 2/17/11, A CNA caused the resident to fall back in bed on three separate occasions when the resident requested assistance to go to the bathroom. The CNA repeatedly pulled the resident’s hands forward to bring the resident to a seated position and would then release her hands causing her to fall backwards. The CNA was terminated on 2/22/11, when the allegation was substantiated. Citation # 940008596.

Verdugo Valley Skilled Nursing & Wellness Centre
2635 Honolulu Avenue, Montrose

B $1000 Evictions 10/20/2011
A resident was hospitalized on 4/22/11 for psychiatric care. On 4/28/11, the resident was determined to be stable and sent back to the facility via ambulance. The facility refused to readmit him, causing unnecessary physical and mental stress. An administrative hearing was held and the facility was ordered to readmit the resident which it did on 5/12/11. The facility was cited for failing to provide the resident with notice of his bed-hold rights and for failing to readmit him within the seven day bed-hold period. Citation # 920008647.

Villa Maria Care Center
723 E 9th Street, Long Beach

B $1000 01/25/2012
CitationWatch description will be published once citation is received. Citation # 940008723.

B $1000 01/25/2012
CitationWatch description will be published once citation is received. Citation # 940008722.

Keiro Nursing Home
2221 Lincoln Park Avenue, Artesia

B $500 Mandated Reporting Patient Care Physical Abuse Supervision Verbal Abuse 09/26/2011
The facility was cited for failing to report resident to resident abuse immediately or within 24 hours when a resident stated that her former roommate would scold her using profane language when she watched television and allegedly hit her. Citation # 940008592.

Woods Health Services
2600 A Street, La Verne

B $1000 Careplan Fall Injury Patient Care Supervision 09/23/2011
On 3/29/10, a resident who was a risk for falling, was left unsupervised while sitting on a shower chair in the bathroom, fell and fractured her hip. According to one of the resident’s relatives, the resident was left alone in the bathroom “many times”. The facility was cited for failing
to implement the resident’s care plan since it was noted that she was a risk for falling, and for failing to implement its own Patient Safety policy. Citation # 950008473.

Orange County

Emeritus At Yorba Linda
17803 Imperial Highway, Yorba Linda
AA $90000 08/09/2011
CitationWatch description will be published once citation is received. Citation # 060008760.

Newport Nursing and Rehabilitation Center
1555 Superior Avenue, Newport Beach
AA $100000 11/08/2011
CitationWatch description will be published once citation is received. Citation # 060008776.

St. Elizabeth Healthcare Center
2800 N. Harbor Blvd, Fullerton
B $0 8/11/2011
CitationWatch description will be published once citation is received. Citation # 060008649.

Riverside County

Life Care Center of Menifee
27600 Encanto Drive, Sun City
B $1000 Careplan 11/10/2011
A resident was found to have had towels instead of a bag used around her colostomy opening to collect stool during her stay in August 2006. The facility staff stated the resident’s skin was red and sore and they could not apply the normal colostomy bag. The physician was not notified. The resident’s skin worsened as a result of using towels to collect stool and she required hospitalization. The facility was cited for failing to properly care plan and for failing to provide colostomy care. Citation # 250008716.

Miller’s Progressive Care
8951 Granite Hill Dr, P.O. Box 3156, Riverside
B $1000 01/18/2012
CitationWatch description will be published once citation is received. Citation # 250008778.

Monterey Palms Health Care Center
44-610 Monterey Avenue, Palm Desert
B $1000 Fiduciary Patient Rights Theft & Loss 01/04/2012
The facility was cited for failing to ensure that a resident’s credit card was not taken out of her wallet without her knowledge, by a CNA who worked at the facility. An investigation revealed that the CNA had used the credit card without the resident’s permission. As a result the CNA was terminated. Citation # 250008864.

San Jacinto Healthcare
275 North San Jacinto St., Hemet
B $1000 Fiduciary Mandated Reporting Theft & Loss 12/06/2011
On 11/18/10, a resident reported to the activity director that her debit card was stolen from her and used by a facility volunteer. However, the alleged theft was not reported to the Department of Public Health until 12/22/10, over a month after the resident reported her debit card was stolen. During an investigation, it was found that the volunteer did indeed steal and use the debit card. The facility was cited for failing to report the theft to the Department within 24 hours. Citation # 250008772.

San Bernardino County

Apple Valley Care Center
11959 Apple Valley Road, Apple Valley
B $1000 Hydration 10/14/2011
On 4/13/08, a resident was found lethargic and only able to respond minimally with an elevated pulse rate of 127. He was transferred to the acute care hospital where he was found to have stage III and IV infected pressure sores and was suffering from dehydration. The facility was cited for failure to provide an assessment of the resident’s needs when his pressure sores continued to advance and failure to ensure the resident received fluids necessary to ensure adequate hydration. Citation # 240008631.

Bear Valley Community Hospital D/P SNF
41870 Garstin Drive, Big Bear Lake
B $1000 Mandated Reporting Physical Abuse Staff (Inservice) Training 12/09/2011
Following an investigation of self reported incidents of an RN handling two residents in a rough manner, several staff members made statements regarding the RN’s inappropriate and abusive behavior to residents. The staff members stated the abuse was not reported for fear of retaliation. During the investigation, the facility was unable to provide documentation of staff abuse training. The facility was cited for failing to train staff on abuse reporting and failing to report abuse to the Department within 24 hours in accordance with the health and safety code. Citation # 240008796.

Country Villa Hacienda Healthcare Center
1311 East Date Street, San Bernardino
B $1000 Injury Notification 10/05/2011
On 5/28/11, during an unrelated examination by her physician a resident’s leg was observed to be swollen and painful. The resident was transferred to the Emergency Department where an x-ray revealed fractures of both bones in her lower leg. Two CNAs reported noticing the swelling but it was never reported. The facility was cited for failure to promptly notify the physician that the resident was having leg pain and swelling. Citation # 240008608.
The facility failed to obtain an x-ray of the abdomen with a contrast material that enhances the ability to locate objects, as ordered by the physician’s assistant. The facility failed to notify the physician of abnormal test and laboratory results. The feeding tube placement was not verified before use, consequently the feeding tube was placed in the colon (versus the stomach), perforating the resident’s colon and requiring surgical repair.

Rimrock Villa Convalescent Hospital
27555 Rimrock Road, Barstow

B $1000 Medication 05/09/2011
On 3/15/11, the resident was found on the floor. She sustained a broken thigh bone. The fall required surgery and was placed in the colon (versus the stomach), requiring surgical repair.

Western Healthcare Center
1700 E. Washington St., Colton

B $1000 Mandated Reporting Physical Abuse 09/29/2011
Sometime between 7/18/10 and 7/24/10, a CNA witnessed another CNA strike a resident. The incident of alleged abuse was not reported to the Department until 8/14/10. The facility was cited for failure to protect the resident from physical abuse and failure to follow their abuse reporting and policy procedures.

San Diego County

Care With Dignity Convalescent Hospital
8060 Frost Street, San Diego

B $1000 Fiduciary 11/10/2011
The facility was cited for failing to maintain accurate trust accounts for four residents. The facility failed to give the residents or their responsible parties, quarterly statements. The facility failed to provide receipts for expenditures from trust accounts. As a result neither the residents or their responsible parties knew if they had money in their trust account and were unable to track, access, or spend their money on their personal needs.

Carmel Mountain Rehabilitation & Healthcare Center
11895 Avenue of Industry, San Diego

B $1000 Mandated Reporting Physical Abuse Verbal Abuse 10/26/2011
The facility was cited for failing to report alleged abuse within 24 hours to the Department. The wife of a resident reported to one staff person that her husband was not treated well by the staff. That staff person told two others, but not the abuse coordinator. The resident reported “A man, skinny tall, white grab me in my wrist tight.” The resident also complained about a staff member poking him and calling him names. His wife reported the abuse on 8/9/11 and it was not reported for two days.

Casa De Las Campanas
18685 West Bernardo Drive, San Diego

B $1000 Injury Neglect 11/22/2011
The facility was cited for failing to fully assess a resident for injury after it was discovered she had multiple purple bruises on the right upper arm on 6/5/11. It is noted that the staff called the doctor and the family, but no new orders were documented. A family member came to visit the facility on 6/7/11 and “immediately saw how swollen and bruised the right arm was.” The doctor ordered an x-ray after the family member told the nurse about her observations. The resident’s x-rays showed a comminuted fracture of the humeral neck (the joint between the shoulder and the upper arm) with severe displacement of the right shoulder.

Kindred Transitional Care and Rehabilitation - Village Square
1586 W. San Marcos Blvd., San Marcos

B $1000 Decubiti (Bedsores) Deterioration Hydration Neglect Patient Care 10/17/2011
The facility was cited for failing to conduct and document assessments related to a resident’s altered mental status, dehydration and development of Stage III and Stage IV sores. The resident was admitted on 12/16/10, and during her three week stay, her sodium and blood urea nitrogen (BUN) were abnormal. There was no plan in place to monitor her syndrome of inappropriate anti diuretic hormone secretion. The facility was ordered to give her an IV for dehydration, but were unable to access a vein. The resident was transferred to the hospital on 12/30/10 for a 12 day stay, that required IV fluids, two blood transfusions, MRSA treatment, wound treatments and the placement of a feeding tube.

The Springs At Pacific Regent
3884 Nobel Drive, San Diego

B $1000 Fall Physical Environment 12/12/2011
The facility was cited for failing to fully assess a resident for injury after it was discovered she had multiple purple bruises on the right upper arm on 6/5/11. It is noted that the staff called the doctor and the family, but no new orders were documented. A family member came to visit the facility on 6/7/11 and “immediately saw how swollen and bruised the right arm was.” The doctor ordered an x-ray after the family member told the nurse about her observations. The resident’s x-rays showed a comminuted fracture of the humeral neck (the joint between the shoulder and the upper arm) with severe displacement of the right shoulder.

Valle Vista Convalescent Hospital
1025 W. Second Street, Escondido

B $1000 Patient Care Sexual Abuse Supervision 12/12/2011
The facility was cited for failing to ensure that a resident was provided with adequate supervision after the resident attempted to solicit sex for money with a female resident. As a result, 11 days later, the resident approached a vulnerable and cognitively impaired resident and fondled her her breasts.
Vista Healthcare Center  
247 E. Bobier Drive, Vista  
A $20000 Fall Injury Transfer 11/04/2011  
On 8/4/11, a 75 year old resident suffered a fractured hip and severe pain when she fell from a mechanical lift while being transferred to bed by two hospice nursing assistants. The nursing assistants had not been trained on the lift’s use and were using the lift without the safety latches recommended by the manufacturer. The resident was hospitalized for 7 days and had surgery to repair her hip. Her pain was so intense that she required 19 doses of IV pain medication in her first day of hospitalization. The facility was cited because the resident sustained serious injury due to its unsafe use of the lift. Citation # 080008689.

San Luis Obispo County

Bayside Care Center  
1405 Teresa Drive, Morro Bay  
A $10000 Careplan Neglect 02/01/2012  
On 9/7/11, a resident who used oxygen for shortness of breath via a nasal cannula, attempted to light a cigarette and the oxygen ignited. The resident sustained burns to her face and transferred to the hospital. She expired later than day. The facility was cited for failing to prevent the accident; there was no careplan in place. Citation # 050008833.

Santa Barbara County

Buena Vista Care Center  
160 South Patterson Avenue, Santa Barbara  
B $1000 Dignity Mental Abuse Patient Care 11/14/2011  
A resident with a history of anxiety and depression was admitted to the facility for rehabilitation due to a fractured neck sustained at home. The resident lived with her grandson, and planned to return home with him once rehabilitation was done. He passed away suddenly while she was in the facility. She lost 32 pounds in one month from September to October 2011. The facility was cited for failing to provide medically-related social services to help her adjust to changes in her physical function and living situation in order to maintain her highest practicable well being. Citation # 050008659.  
B $800 Theft & Loss 11/14/2011  
The facility was cited for failure to document missing property and money. One incident noted that a laptop had been stolen in February of 2011 but it wasn’t until late September of 2011 that it entered into the facility’s Theft and Loss Log and an investigation was begun. The citation also noted that the facility failed to reimburse residents for their losses. Investigators discovered that personal property of some residents was being stored in the social service office for safekeeping but there were no receipts for the valuables. Investigators noted that some of the residents no longer resided in the facility and no attempts had been made to return their money or valuables. Citation # 050008660.

Samarkand Skilled Nursing Facility  
2566 Treasure Drive, Santa Barbara  
A $10000 01/19/2012  
CitationWatch description will be published once citation is received. Citation # 050008727.

Ventura County

Westlake Health Care Center  
250 Fairview Road, Westlake Village  
A $9500 Careplan Fall Injury 01/10/2012  
On 9/5/11, a resident known to be at high risk for falling, fell out of his head first, when a CNA tried to change his briefs. His care plan called for two people to assist in his care. He suffered a laceration to his eyebrow and a subdural hematoma, requiring a nine day hospital stay. The facility was cited for failing to comply with his careplan and for failing to have adequate supervision. Citation # 050008821.