Department of Public Health Seeks to Gut Nursing Home Oversight

In a brazen attempt to deregulate nursing homes, the Department of Public Health (DPH) presented a legislative proposal in May that would gut California’s oversight of nursing home care and destroy countless reforms established by the Legislature over the last 30 years.

Fortunately, the Senate and Assembly quickly rejected the proposal. Despite these defeats, it is possible that the Department of Public Health will continue to try to pass this measure. It is a dangerous sign that DPH is trying to abandon its duty to protect nursing home residents.

The plan would have cut oversight of hospitals and other health care facilities, but its most far-reaching changes were aimed at deregulating nursing homes. If passed, it would have eliminated all State timelines for investigating nursing home complaints and repealed a California law that required DPH to conduct licensing inspections of nursing homes.

Its most shocking provision would have repealed a longstanding requirement that DPH start investigating nursing home complaints that pose an imminent danger of death or serious bodily harm to a resident within 24 hours. Delaying investigations while residents are dying from neglect and abuse would be a terrible injustice to victims and would send the wrong message to nursing home operators.

Of equal concern, the Department proposed to repeal the requirement that it begin investigating other complaints against nursing homes within 10 working days. This requirement is the subject of a September 2006 San Francisco Superior Court order obtained by CANHR that requires DPH to comply with the 10-day timeline. Prior to the lawsuit, DPH often ignored serious nursing home complaints for months or years and had a huge backlog of complaints. By repealing the investigation timelines, DPH was seeking a return to the days when it wasn’t accountable to anyone.

The Department’s proposal to eliminate state licensing inspections of nursing homes would repeal most of SB 1312, legislation authored by Senator Alquist in 2006 to restore those inspections. The law requires the Department to evaluate compliance with the dozens of California laws and regulations that exceed federal standards. Without this process, the California requirements would be unmonitored, unenforced and meaningless to residents.

The California requirements that DPH seeks to ignore include the right to informed consent, abuse reporting, minimum staffing requirements, family council rights, family visitation rights, bed hold rights during hospitalization, admission agreement standards, protections against theft and loss and many others.

Senator Alquist, who sits on the Senate Budget Subcommittee, expressed anger that DPH sought to undo her legislation and sell-out nursing home residents in the process. In lengthy comments at the hearing, she said that California laws designed to protect residents have little value if they are not enforced. She mocked DPH’s use of the term “deficiency” to describe nursing home violations, saying it did not do justice to the harm suffered by residents who are being mistreated.

Claiming the proposed changes are “efficiency” measures, DPH used the budget process to bypass the

DPH Cutback Proposal .............. (continued on page 3)
Giving to CANHR!

As a subscriber to The Advocate, you have most likely given a donation to CANHR within the last year. These gifts are crucial to CANHR and our mission. Without them we could not continue to advocate for long-term care residents, their families and loved ones. So in addition to your annual contribution, CANHR would like you to consider some other giving options that could possibly provide you some great benefits as well.

Contributions can be made in many ways and one of the easiest ways to make a meaningful gift is to include CANHR in your will or revocable living trust. If you already have a will, it is not necessary to rewrite your entire will to make a donation to CANHR. You can simply prepare (or instruct your attorney to prepare) a simple revision (called a “codicil”) to your current will or an amendment to your living trust. An example of the language to be included in the will, living trust, or codicil could be:

I hereby give, devise and bequeath to California Advocates for Nursing Home Reform, a nonprofit corporation organized and operating under the laws of the State of California, located at 650 Harrison Street, 2nd Floor, San Francisco, CA 94107, the sum of $______ (or _____percent of the rest, residue and remainder of my estate) to be used for the general purposes of the organization. Federal Exemption Number: 94-2939542.

In addition to benefiting CANHR, your bequests can reduce the size of your taxable estate, qualify for a full estate tax charitable deduction, and help to implement your family financial plans.

Are you a Social Worker who needs info? Just SWAP!

CANHR would like to invite you to join our Social Worker Advocacy Program (SWAP). Designed specifically for long term care social workers, geriatric case managers, admission and discharge planners and other community based service providers, this program can connect you with the answers you need.

By joining the SWAP team today, CANHR can help you to stay up to date on changes to Medi-Cal, gain access to a statewide network of social workers and stay up to date on current legislation affecting your clients. In addition to consulting with CANHR’s experienced advocates and receiving our quarterly newsletter, you will receive a discount on any upcoming Social Worker on-line trainings as well as access to our SWAP list serve where you can easily and quickly get your questions answered. Call Deborah Espinola at (415) 974-5171 for information on how to join today.

In Memorium

CANHR mourns the loss of John Fecondo, our friend and colleague, who passed away on April 14, 2012. John, who received his MA in Gerontology from San Francisco State University, spent over a year interning with CANHR assisting in the development of our CCRC project. He was a passionate advocate for the elderly, which clearly showed in his work as Executive Director of University Mound Ladies Home. John’s death is a great loss to all of us who work in aging.
What Nursing Homes Must Post for the Public

Both Federal and California laws and regulations require nursing homes to post various notices in a manner that is prominently displayed and clearly visible to all residents, staff, and visitors. The notices are primarily required to provide residents, prospective residents, and their families information about the nursing home and its policies so they can assess their care and make better choices about their placement.

Staffing Information

Perhaps most notably, nursing homes must provide notice of: the number of patients receiving treatment at the facility; the total number of hours worked by all direct care staff (RN’s, LVN’s, and CNA’s); and the patients assigned to a given caregiver during his or her assigned shift. Because California nursing homes are required to provide a minimum of 3.2 hours of care per patient per day, inspectors, residents, and staff can determine whether the facility is adequately staffed by reviewing the posted notice although sometimes the posted notice is not adjusted to reflect staffing adjustments when an employee quits or calls out sick.

Quality of Care Information

Nursing homes must prominently display their Five-Star Quality Rating as determined by the Center for Medicare & Medicaid Services. The Five-Star Quality Rating System was designed to provide a “snapshot” of the facility’s quality of care. Nursing homes must also visibly display a notice that residents may inspect a facility’s most recent government survey, including any plans of correction to address any regulatory noncompliance.

California nursing homes must post a notice that the staff, residents, and visitors of the facility may request that the facility be inspected, the procedure for requesting an inspection, the right to request an inspection anonymously, and the prohibition against retaliation for the decision to request an inspection.

Other Information

Additional materials that must be displayed include:

- The facility’s license to operate.
- The phone numbers of physicians who will provide care in the event that the attending physician is unavailable.
- The work schedules of the resident dietician and any dietician service staff.
- Menus for regular and therapeutic diets a week prior to being served.
- A daily schedule of all social, religious, creative, educational, and exercise activities provided by the facility.
- Policies designed to reduce theft and loss of its residents’ personal property.
- Information provided by the facility’s Family Council, if one exists.

Nursing homes must inform residents of their rights as well as protect and facilitate the exercise of those rights. Accordingly, they must prominently display information pertaining to various services available to their residents, including:

- The names, addresses, and telephone numbers of State-funded advocacy groups, including the State Ombudsman Program and the Medi-Cal Fraud Unit.
- Information regarding the application for and use of Medicare and Medi-Cal benefits.

DPH Cutback Proposal ......................(cont. from page 1)

Legislature’s normal process to review legislation. Due to this suspect maneuver and DPH’s total failure to give notice of its plan, the measure was heard with very little advance notice and even less public awareness about its goal to deregulate nursing homes.

Helpful reviews by the Assembly and Senate Budget Subcommittee staff showed that DPH’s proposal would not save the State any money.

The DPH proposal represents a deep betrayal of its duty to protect California nursing home residents from neglect, abuse and mistreatment. It leaves residents and their families to wonder who they can turn to when they suffer mistreatment in a nursing home. And it leaves us to wonder what it will try next.

The only good news with this development is the outstanding overnight response by CANHR members, consumers, Ombudsmen, Disability Rights California and other advocates who rose up against it, and the excellent work of the Assembly and Senate members and staffers who stopped it in its tracks.

Links to the DPH proposal, the Senate’s analysis of it, and CANHR’s opposition letter are posted at canhr.org.
Governor’s May Revise Budget – More Nasty Cuts To Come

(Source: California Budget Project)

Governor Jerry Brown released the May Revision to his proposed 2012-13 budget on May 14. The May Revision updates policy proposals, revenue projections, and estimated expenditures for the current year as well as the upcoming budget year, which begins on July 1. The May Revision estimates a two-year budget gap of $15.7 billion, up from a $9.2 billion gap as estimated in January. The May Revision identifies lower-than-anticipated tax collections as the primary cause of the widening gap. The Governor outlines $16.7 billion in “solutions” to close the budget gap and provide a $1.0 billion reserve. Spending reductions make up nearly half ($8.3 billion) of the “solutions.”

In addition, the May Revision assumes that voters pass a tax measure that the Governor is attempting to place on the November 2012 ballot. The measure would temporarily increase personal income tax rates on very-high-income Californians and boost the sales tax rate by one-quarter cent, raising an estimated $8.5 billion in 2011-12 and 2012-13 combined. The May Revision specifies $6.1 billion in spending cuts – primarily to schools, colleges, and universities – that would automatically take effect in January 2013 if voters do not approve the proposed tax measure in November.

Regardless of whether voters pass the tax measure, the May Revision proposes deeper cuts to the Medi-Cal and In-Home Supportive Services (IHSS) programs than those proposed in January.

The Governor’s $16.7 billion in budget “solutions” include $8.3 billion in spending reductions, including a $1.2 billion cut to Medi-Cal, an $879.9 million reduction to the California Work Opportunity and Responsibility to Kids (CalWORKs) Program, and deep cuts to IHSS, child care, the courts, and the Cal Grant college financial aid program; $5.9 billion in additional revenues, nearly all of which is attributable to the proposed tax measure; $2.5 billion in fund shifts, loan payment deferrals, borrowing from special funds, and other one-time measures; and a $1.0 billion reserve.

IHSS: The Governor’s May Revision includes spending reductions of $224.5 million to the In Home Supportive Services Program (IHSS) in 2012-13, a deeper cut than the $163.8 million reduction proposed in January. Specifically, the May Revision makes a 7 percent across-the-board cut in authorized IHSS worker hours, effective August 1, 2012, for a spending reduction of $99.2 million in 2012-13; retains the Governor’s proposal from January to eliminate domestic and related services – including housework, food shopping and other errands, meal preparation, and laundry – for most IHSS participants living with others. This change would result in reduced state spending of $125.3 million in 2012-13.

Medi-Cal Cuts: The May Revision maintains the Governor’s January proposal to shift more than 1 million seniors and people with disabilities who currently qualify for both Medi-Cal and Medicare – so-called “dual eligibles” – from fee-for-service Medi-Cal into managed care. However, the May Revision modifies or clarifies the original proposal in a number of ways, including phasing in the integration of long-term care services as each county transitions into managed care, delaying the implementation date from January 1 to March 1, 2013, and specifying that IHSS participants would continue to “select and direct” their home care provider.

The May Revision also includes several proposals affecting hospitals and nursing homes. Among other provisions, the May Revision rescinds the 2012-13 rate increase for nursing homes, but continues to collect the fee used to fund the rate increase and shifts the fee revenues – $47.6 million – to the General Fund, and suspends for now, payments under the “Quality/Accountability Payment Program” – a poorly conceived “pay for performance” program under which nursing homes would receive supplemental payments based on specified performance standards such as staffing ratios and patient satisfaction.

The above is only a brief preview of the impact of the proposed cuts on health and human services. Almost every aspect of life for Californians will be impacted by the Governor’s proposals, from birth to death. For a more complete analysis of the Governor’s May Revise proposals, see the California Budget Project: http://www.cbp.org/pdfs/2012/120514_May_Revise.pdf

Should You Purchase Long Term Care Insurance?

That was the question posed in a May 14, 2012 point-counterpoint article in the Wall Street Journal. Prescott Cole, CANHR’s senior staff attorney, argued that the high and unpredictable costs of such insurance outweighed the limited benefits, while Mark Meiners, a professor of health economics and policy at George Mason University, argued that the risks of being finan-
Both of these laws were violated. CANHR cannot prevent this RCFE from closing its doors or from transferring the residents, but we will continue to advocate for better enforcement so that California has fewer to none of these occurrences. CANHR is working with other agencies to make sure that the residents are transferred to other facilities with the least amount of transfer trauma.

This is just ONE case where the licensee blatantly broke the law, and the licensing agency – the supposed “consumer protection agency” – stood by and let it happen. Why does this keep happening?

For almost 30 years, CANHR has sponsored and supported legislation to protect long term care residents. In recent years CANHR has sponsored several bills to protect RCFE (Residential Care Facilities for the Elderly) consumers from being displaced from their homes. Often these laws go into effect and little is done to enforce them. The lack of enforcement is due to several reasons, including lack of staffing at governing agencies, lack of knowledge about the new laws, as well as a lack of repercussion if the law is broken. Although, our economy seems to be improving, foreclosure is inevitable in certain circumstances and becomes more tragic when vulnerable residents are given no notice that they will soon be evicted from their home.

SB 897 (Leno), The RCFE Residents Foreclosure Protection Act of 2011 was signed by the Governor on September 30, 2011. This bill requires RCFE licensees to notify the Department of Social Services, the residents and their representatives when the facility is in financial distress such as foreclosure or bankruptcy. It provides for civil penalties and loss of licensure when a facility fails to notify residents and a resident is subsequently relocated and suffers transfer trauma.

On April 30, 2012, our office received a call from a distressed ombudsman stating that a facility, due to a foreclosure of the property, was evicting the residents of a six-bed facility with no notice. The facility’s owner had known about the foreclosure process for a while, and the bank had even initiated an unlawful detainer action (the action needed to get the tenants out). When the Sheriff went to get the “tenants” out and discovered it was an RCFE, the Sheriff backed off. The ombudsman reported that Department of Social Services, Community Care Licensing (CCL), the licensing agency, had already revoked the facility’s license and had known about the foreclosure for at least a month—and did NOTHING.

SB 781 (Leno), The RCFE Eviction Protection Act was signed by the Governor on October 11, 2009. This Act strengthened eviction protections by requiring RCFEs to notify residents in writing, of their rights when faced with an eviction and requires facilities to provide a list of resources available to identify alternative housing and care options. Neither the residents nor their representatives knew that the residents needed to move. They did not know that the building was being foreclosed. Neither CCL nor the licensee gave them notice. Although the Sheriff backed off, there was no date given as to when he would be back.

Long Term Care News ........................(cont. from page 4)
Scams are successful because scam artists are clever and very good at what they do. They talk a good game, they have an answer for everything and by the time most people realize they have been scammed, the money they lost is long gone. So what can people do to protect themselves? A healthy dose of skepticism along with knowledge of some of the common techniques scammers use is a good place to start.

Common Traits of Scams

1) IT’S TOO GOOD TO BE TRUE – If it seems too good to be true, it probably is – we have all heard this a million times, but scammers count on people to ignore this old maxim. Many scammers draw people in with “get rich quick” schemes.

*Example:* A phone call, email or chance encounter with someone who says that they have come into a large sum of money, like an inheritance or lottery win, but for some reason they need your help to collect the money. A common phony excuse is that they are not a citizen of the country where the money is located. Scammers promise you a share of the money, if you help them. In order to prove that you are not a cheat, the scammer asks for collateral or help paying “fees,” which the scammer pockets and never returns.

Things you can do to protect yourself:

• Remember, if it sounds too good to be true, it probably is!

• Be skeptical of stories or promises from strangers and acquaintances about money, especially when it involves you handing over your money.

• If someone asks you to participate in a crime or scam, refuse immediately.

2) SCAMMERS ASK YOU TO KEEP SECRETS – Scammers are able to continue scamming as long as they are not caught. In order to accomplish this, they often ask victims to keep dealings a secret. Scammers can come up with pretty compelling lies about why secrecy is a good idea.

*Example:* Someone asks you to sign a document, but not tell anyone about it – a mortgage, a power of attorney, a deed, a new will. Scammers do not want other people to know what they are up to. To prevent this, scammers will often threaten that if family members knew about the changes they would be mad and would try to have you conserved or “put in a nursing home” – scammers know that many people are scared of this, so they use it to their advantage.

Things you can do to protect yourself:

• If someone asks you to keep important things a secret, be suspicious that it is a scam.

• Do not sign documents without fully understanding them.

• Ask yourself whether you would advise a friend to keep the information secret if they were in your position.

• Have a trusted friend or family member that you can run things by so you do not feel isolated.

• Beware of people who try to drive a wedge between you and previously trusted friends or family.

• When contemplating changes to important documents, ask yourself who really benefits. If it is the person asking you to make the changes, that is a red flag.

3) CASH TRANSACTIONS – Many scammers like to prevent a paper trail, so they prefer to deal in cash. This is because when the victim realizes he or she has been scammed, it will be hard to prove because it will be the victim’s word against the scammer’s word. Sorting out the truth in these situations can be very difficult.

*Example:* A person comes to your door and says they are a contractor and can give you a good deal on a house repair because they have left over materials from a previous job. They say they will only accept cash up front.

Things you can do to protect yourself:

• Always be suspicious when a stranger approaches you and asks for money.

• Insist on getting a receipt for all cash transactions.

• Before hiring someone, ask for references and check them.

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Focus On Scams.............................. (continued on page 7)
In 2001 Senator Martha Escutia authored a bill, SB 333 that established Elder Death Review Teams in California. The Elder Death Review Teams (EDRT) includes law enforcement, prosecutors, the coroner, adult protective services, hospitals, state licensing officials, experts in the field of forensic pathology, and the state’s Long-Term Care Ombudsman, among others. SB 333 authorized counties to establish an interagency elder death team to assist local agencies in identifying and reviewing suspicious elder deaths and facilitating communications among persons who perform autopsies and persons involved in the investigation or reporting of elder abuse or neglect.

Most importantly, SB 333 allowed each organization represented on an elder death review team to share with other members of the team information in its possession concerning the decedent who is the subject of the review or any person who was in contact with the decedent and any other information deemed by the organization to be pertinent to the review. Information gathered by the elder death review teams can be used to make recommendations, which in turn can be used by their counties to develop education, prevention and prosecution strategies that will lead to improved coordination of services for families and the elder population.

While EDRTs do not have the authority to independently investigate deaths in facilities, the EDRT team can review the death of anyone 65 and older that involved a prior call for suspected abuse to county officials; review open cases of alleged abuse; and review referrals by health-care providers or protective services agencies where there is disagreement among investigators over the cause of death.

Several bills over the past few years would have expanded the role of EDRTs and required EDRTs to look specifically at deaths in California nursing homes. These include SB 1644 (Romero), in 2004, SB 397 (Escutia) in 2005, and AB 535 (Ammiano) in 2010. These were important bills that would have provided a closer look at the whys of nursing home deaths and which were caused by abuse and/or neglect. Unfortunately, after much industry opposition – all of these bills failed.

The recent suspicious death of a close friend who was cared for in a northern California nursing facility brought home the importance of expanding the authority and presence of the Elder Death Review Teams.

Why CCRC Residents Need to Know About Elder Death Review Teams
by Lillian L. Hyatt, M.S.W

In 2001 Senator Martha Escutia authored a bill, SB 333 that established Elder Death Review Teams in California. The Elder Death Review Teams (EDRT) includes law enforcement, prosecutors, the coroner, adult protective services, hospitals, state licensing officials, experts in the field of forensic pathology, and the state’s Long-Term Care Ombudsman, among others. SB 333 authorized counties to establish an interagency elder death team to assist local agencies in identifying and reviewing suspicious elder deaths and facilitating communications among persons who perform autopsies and persons involved in the investigation or reporting of elder abuse or neglect.

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The recent suspicious death of a close friend who was cared for in a northern California nursing facility brought home the importance of expanding the authority and presence of the Elder Death Review Teams.
The Family Council Corner, which will be a regular feature of the CANHR Advocate, is part of a larger, statewide initiative to encourage the development of Family Councils throughout California. The purpose of the Family Council Corner is to:

- Share stories of Family Council’s successes in promoting quality of care and life for residents;
- Present practical tips on forming and sustaining Family Councils; and
- Respond to common problems and concerns faced by Family Councils.

Family Councils offer a supportive environment where you can share your concerns, get support, and act collectively to produce changes that can positively affect the quality of life and care for all residents. True consumer empowerment comes with adequate knowledge of resident’s rights and of the laws governing facilities and adequate advocacy support to enable family councils to organize without fear of retaliation from facilities. California has some of the most powerful Family Council laws in the country, and it is time to use them.

Other aspects of CANHR’s Family Council initiative will include:

- Revising and disseminating the Family Council Organizing Guide;
- Producing short, practical videos on various substantive and skills areas to support Family Council formation and sustainability;
- Conducting regional workshops to connect Family Council members to share and learn from one another’s experiences, and to receive training on important nursing home topics; and
- Providing technical support to existing and forming Family Councils through staff contacts with Family Council leaders and establishment of a listserv where experiences can be easily shared and questions answered.

If you have already organized a Family Council, let us know! To share your stories, offer tips, ask questions or receive more information on the Family Council Initiative and ways you can become involved, contact Deborah Espinola (Deborah@canhr.org) for Northern California or Terry Donnelly (Terry.Donnelly@canhr.org) for Southern California.

Start organizing a Family Council today!

Request a free DVD – Organizing Family Councils - and download a guide to Organizing Family Councils in Long Term Care Facilities by going to:

http://www.canhr.org/familycouncils/
Legislation Update 2012

Please check the CANHR Web site for updated details on legislation.

CANHR Sponsored

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. Status: on hold in Assembly.

AB 2149 (Butler): Prohibition of Gag Orders in Elder Abuse Settlement Agreements
This bill would provide that an agreement to settle a civil action for physical abuse, neglect, or financial abuse of an elder or dependent adult shall not include any provision that, among other things, prohibits contact or cooperation with the county adult protective services agency, the long-term care ombudsman or any governmental entity. The bill would provide that any such provision is void as against public policy. Status: Assembly Floor.

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. Status: Passed Senate, now on Assembly side.

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. Status: expected to pass the Senate and go to the Assembly.

CANHR Support

AB 1553 (Monning): Medi-Cal Managed Care Exemption
This bill would establish a process that would permit an eligible Medi-Cal beneficiary to receive fee-for-service Medi-Cal, if available, as an alternative to managed care plan enrollment if the beneficiary meets specified criteria. Status: Assembly Appropriations.

AB 1710 (Yamada): Nursing Home Administrator Act of 2012
This bill makes the Nursing Home Administrator Program (NHAP) self-sustaining by revising accounting procedures, eliminating the cap on fee increases, and requiring the Department to report projected costs annually to the Legislature. Status: passed to Senate.

AB 1747 (Feuer): Life Insurance Consumer Protections
This bill includes a number of consumer protections against cancellation of life insurance policies due to lapses in payment of premiums, including a requirement that every life insurance policy issued or delivered in this state contain a provision for a grace period of not less than 60 days from the premium due date that provides that where the premium owed is paid fully within the grace period the policy remains in force and a provision that gives the applicant the right to designate at least one individual, in addition to the applicant, to receive notice of lapse or termination of a policy for nonpayment of premium. Status: on Assembly Floor.

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. Status: Assembly Appropriations.

CANHR Oppose

AB 1698 (Portantino): CCRC Home Services
A repeat of AB 1022 (2008), which was vetoed by the Governor, this bill establishes a category of continuing care home programs in which services are provided to elderly persons in their own residences by continuing care retirement communities (CCRC), and exempts the residences from licensing provisions applicable to residential care facilities. (This bill was pulled by the author. Thanks to all who registered their opposition to this onerous proposal.)
My father has been on the Aged and Disabled Federal Poverty Level Program (Community Based Medi-Cal) with no share of cost. Recently his countable income has gone up from $1,161 to $1,374, and now his share of cost has gone from $0 to $734.00 a month! He really can’t afford this, as he needs these funds for his rent and food. Is there anything he can do to eliminate the share of cost?

Sincerely,

Bummed in Bakersfield

Dear Bummed,

Your father’s net monthly income needs to be below $1161, to qualify for the Aged and Disabled Program with no share of cost. You must get his monthly countable income down by $193.

The one major deduction that can reduce the share of cost is medical premiums. If your father can purchase $193 a month in supplemental healthcare, these premiums will bring down his countable income.

Does he have a vision plan, dental plan, or a Medicare Advantage/supplemental plan? Each additional monthly premium will be deducted from his net income to get him at or below the $1,161, limit to qualify with no share of cost.

$1,374 (income) - $20 (any income deduction) -$20 (vision)-$40 (dental) -$150 (Medicare advantage) = $1,144.

Medi-Cal applicants can seek reimbursement for unpaid medical bills.

Many Medi-Cal applicants have unpaid medical bills prior to their application submission. Some applicants paid for medical services and, in other cases, family member’s have paid these bills hoping to be reimbursed once the applicant is approved for Medi-Cal. If you would have been eligible for Medi-Cal during those 90 days prior to application submission you may be reimbursed for those expenses.

To cover these expenses, make sure to check “yes” on Question #53, found in Section 7 on the Medi-Cal application. According to Welfare and Institutions Code §14019.3, the claim must also meet the following criteria:

1. The service was a covered benefit under the Medi-Cal program.
2. The provider was an enrolled Medi-Cal provider at the time the service was rendered.
3. The service was ordered by a health care provider, within the scope of his or her practice.
4. The beneficiary is eligible for reimbursement, as specified in subdivision (a).
5. The reimbursement shall be the amount paid by the beneficiary, not to exceed the rate established for that service under the Medi-Cal program.

Dear Advocate,

My father has been on the Aged and Disabled Federal Poverty Level Program (Community Based Medi-Cal) with no share of cost. Recently his countable income has gone up from $1,161 to $1,374, and now his share of cost has gone from $0 to $734.00 a month! He really can’t afford this, as he needs these funds for his rent and food. Is there anything he can do to eliminate the share of cost?

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**Past Speaking Engagements, Panel Discussions and Training Sessions**

- **February 29:** Tony Chicotel, CANHR staff attorney, presented a free CANHR-sponsored webinar on Incapacity and Surrogate Decision Making to legal services program staff.
- **March 6:** CANHR staff visited Sacramento for its annual “Leg Day” to meet new legislators and discuss policy priorities for 2012.
- **March 7:** Pat McGinnis, CANHR’s Executive Director, presented a free CANHR-sponsored webinar on Frequently Asked Questions About Medi-Cal Eligibility and Recovery for legal services program staff.
- **March 9:** Prescott Cole attended a senior financial about task force meeting at the Department of Insurance.
- **March 14:** Brad Erdosi, Esq., a private bar attorney in Irvine and CANHR LRS member, presented a free CANHR-sponsored webinar on VA Aid & Attendance Benefits for legal services program staff.
- **March 20:** Prescott Cole presented a class on elder abuse for gerontology students at San Jose State University.
- **March 21:** Prescott Cole, CANHR’s senior staff attorney, presented a free CANHR-sponsored webinar on Financial Elder Abuse for legal services program staff.
- **April 4:** Mike Connors presented to the Los Angeles Ombudsman program on misuse of antipsychotic drugs and other issues.
- **April 21:** Tony Chicotel met with the Family Council of Waters Edge Nursing Home in Alameda and discussed various resident rights issues.
- **April 24:** Tony Chicotel traveled to San Jose to present “Hot Nursing Home Topics” to staff members at Santa Clara Valley Medical Center.
- **May 9:** Tony Chicotel presented at the Ombudsman Coordinators’ Conference in Sacramento. The topic was California’s standard nursing home admission agreement, version 2.0.
- **May 9:** Claire Lomax, a volunteer, represented CANHR at the 30th Annual Senior Information and Health Fair in Richmond.
- **May 14:** Prescott Cole, CANHR’s Senior Staff attorney, was featured in the Wall Street Journal article, “Should You Purchase Long Term Care Insurance,” warning consumers about the pitfalls of investing in long term care insurance.
- **May 14:** Deborah Espinola, LTC Advocate, represented CANHR at Kaiser’s Dementia Resource Fair in San Francisco.
- **May 21:** Prescott Cole presented as a panelist on “Reverse Mortgage Madness” at Legal Assistance for Seniors 7th Annual Conference on Elder Abuse in San Francisco.
- **May 24:** Prescott Cole was the moderator and presenter for the Financial Exploitation and Elder Abuse panel at Elder Financial Protection Networks Call to Action 2012 in San Francisco.
- **June 1:** Patricia McGinnis presented at a training for long term care professionals (non-attorneys) on Long Term Care Medi-Cal and Medi-Cal Recovery at the Western Justice Center Foundation in Pasadena.
- **June 4 & 5:** Tony Chicotel presented at “Dementia Care Without Drugs” symposia in San Diego and Los Angeles. CANHR co-sponsored the symposia with the San Diego County Long Term Care Ombudsman and Elder Law & Advocacy in San Diego and with WISE & Healthy Aging, Bet Tzedek Legal Services and Senior Care Training in Los Angeles.
- **June 6:** Prescott Cole attended the Legal Assistance Association of California’s Pathway to Justice summer session in San Francisco.

*June 15 is World Elder Abuse Awareness Day*
http://www.inpea.net/weaad/worldday2012.html
CANHR staff taking part by wearing purple
CANHR Upcoming Events

**June 15, 2012: World Elder Abuse Awareness Day:**

- The 7th annual World Elder Abuse Awareness Day (WEAAD) will be held on June 15, 2012 and is a reminder to all advocates for elders to do your part in stopping elder abuse in our time. A number of international, national and local events will be held in honor of WEAAD, including a free community event sponsored by the Center of Excellence on Elder Abuse and Neglect at the University of California, Irvine. The Friday, June 15th program will be held from 10am to 11:30am and includes free parking and refreshments. For details, call (949) 370-3262 or email burnight@uci.edu.

**October 24, 2012: Marin Senior Information Fair:**

- CANHR will be hosting an information both at the Marin Senior Information Fair from 9:00 AM to 3:00 PM, located at Marin Exhibit Hall, 10 Avenue of the Flags, San Rafael, CA 94903. For more information go to www.marinseniorinformationfair.org

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**MEMORIALS**

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<tr>
<th>Blanche Oween Smith</th>
<th>F. X. Kelly</th>
<th>Milton Schmidt</th>
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<tr>
<td>David Smith</td>
<td>Colette Kelly</td>
<td>Barbara Laurito</td>
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<tr>
<td>Denis John Powell</td>
<td>Helen Hansen</td>
<td>My Mother</td>
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<td>Argene R. Powell</td>
<td>Zena Corcoran</td>
<td>Bobby Groves</td>
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<tr>
<td>Donna R. Smith</td>
<td>Isabel Martin</td>
<td>Our Parents</td>
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<tr>
<td>Ruth Holland</td>
<td>Laura Brooks</td>
<td>Mr. &amp; Mrs. Kenneth Burchill</td>
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<td>Dorothy Kamberg</td>
<td>Kate Trogdlen</td>
<td>Robert A. Maclnnes</td>
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<td>Nancy Biederman</td>
<td>Margaret Wager</td>
<td>Gail MacInnes</td>
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<td>Eleanor D. Bell</td>
<td>Lottie Shulman</td>
<td>Ross &amp; Olive Kerr</td>
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<td>Lyn Delaney</td>
<td>Judith Betts</td>
<td>Bill &amp; Janette Kassis</td>
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<tr>
<td>Elizabeth G. Derr</td>
<td>Mary Chao &amp; Hua Lung Chang</td>
<td>Pearl Caldwell &amp; Mary Ballantyne</td>
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<td>Sue Derr</td>
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<td>Dr. &amp; Mrs. R. T. Muller</td>
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<td>Helen Drachkovitch</td>
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**IN HONOR OF**

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<tr>
<th>All of the people and families suffering from dementia</th>
<th>Lou Dell White</th>
<th>Sheryl Yeager</th>
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<tbody>
<tr>
<td>Anonymous Donor</td>
<td>Christine Bobbitt</td>
<td>Brooke Yeager</td>
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<tr>
<td>CANHR’s past service to me</td>
<td>My Mom, Angela Martin</td>
<td>Tony Chicotel and Prescott Cole</td>
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<tr>
<td>Richard Will</td>
<td>Jo Ann Jensen</td>
<td>Andrew de Vries</td>
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<tr>
<td>Pat McGinnis - for all of your help!</td>
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<tr>
<td>Mary Kulvinskas</td>
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**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:**

- Blanche Oween Smith
- F. X. Kelly
- Milton Schmidt

- Denis John Powell
- Helen Hansen
- My Mother

- Donna R. Smith
- Isabel Martin
- Our Parents

- Dorothy Kamberg
- Kate Trogdlen
- Robert A. Maclnnes

- Eleanor D. Bell
- Lottie Shulman
- Ross & Olive Kerr

- Elizabeth G. Derr
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- Helen Drachkovitch

- All of the people and families suffering from dementia
- Anonymous Donor

- CANHR’s past service to me
- Richard Will

- Pat McGinnis - for all of your help!
- Mary Kulvinskas

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Support CANHR...
If you appreciate our services and the information we bring to you, please help us by making a donation. Make a secure donation online at www.canhr.org or fill out this section and return it with your donation to:

CANHR, 650 Harrison Street, 2nd Floor, San Francisco, CA 94107.

Enclosed is my check for: ☐ $500 ☐ $100 ☐ $50 ☐ $30 ☐ Other ____________

This gift is in memory of: __________________________________________________________
(or) in honor of: __________________________________________________________________

☐ Contact me about legislation and other advocacy opportunities.
☐ Save paper, send me The Advocate via e-mail. E-mail: _______________________________

Name: __________________________________________________________________________
Address: _________________________________________________________________________
City/State: ______________________ Zip: ______________________
Telephone: ______________________ E-mail: ______________________

CANHR prohibits the use of its name for the purpose of advertisement by attorneys, financial planners or any other organization or entity.
Citation Watch - Consumer Report

The following citation summaries are compiled from the citations issued by the California Department of Public Health to Northern California skilled nursing facilities and received by CANHR as of the publication of this Advocate. CANHR makes every effort to ensure that consumers are provided with accurate information. CANHR welcomes comments and suggestions or notice of errors. Please direct such comments to mis@canhr.org or by calling the CANHR office at (800) 474-1116.

Citations without summaries will be reprinted with summaries once received by the CANHR office. Citations from earlier months are included if a description was not printed in a previous Advocate. Appeals of citations and collection of fines can take up to three years. For up-to-date information on any citation or facility, visit the Nursing Home Guide through CANHR’s web site: www.canhr.org or call the CANHR office.

Explanation of citation classifications: “AA” citations are issued when a resident death has occurred due to nursing home regulation violations, and carry fines of up to $100,000. A class “A” citation is issued when violations present imminent danger to resident or the substantial probability of death or serious harm, and carry a fine of up to $20,000. Class “B” citations are fined up to $2,000 and are issued for violations which have a direct or immediate relationship to health, safety, or security, but do not qualify as “A” or “AA” citations. “Willful material falsification” (WMF) violations also result in a fine. Fines are not always required to be paid. Citations can be appealed, requiring the Department of Health Services to substantiate the violation. Violations repeated within twelve months may be issued “trebled fines”— triple the normal amount.

Alameda County

Willow Tree Nursing Center
2124 57th Ave., Oakland

B $700 Medication 11/10/2011
On 8/20/10, a resident was hospitalized and required blood transfusions due to blood in her urine that resulted from the facility’s failure to monitor the resident while she was receiving Coumadin, an anti-coagulation medication. The facility was cited for this failure. Citation # 020008733.

Butte County

Country Crest
50 Concordia Lane, Oroville

B $500 Mandated Reporting 02/14/2012
On 1/8/12, a resident slapped another resident while they were seated at a table. The facility reported the abuse to the Department 40 hours after the incident. The facility was cited for failure to report to the Department within 24 hours of the abuse incident. Citation # 230008979.

Cypress Healthcare Center
1633 Cypress Lane, Paradise

B $1000 Dignity 02/24/2012
On 11/30/11, a resident asked for assistance with toileting and was told to wait. The resident stated she waited for two hours and was finally forced to wet herself. She said she felt upset about the incident. The facility was cited for failure to ensure the resident was treated with dignity, consideration and respect. Citation # 230009006.

B $1000 Patient Rights 03/02/2012
On 10/26/11, a female resident with a history of going into other residents’ rooms, wandered into a male resident’s room and dumped a pitcher of water on him. The male resident became upset, then repeatedly punched the female resident in the chest and face. The facility was cited for failure to protect the residents from mentally and physically abusing each other. Citation # 230009063.

B $500 Physical Abuse 03/15/2012
On 8/14/11, a nursing assistant slapped an 84 year old resident’s arm after he punched her in the stomach. The resident suffered from dementia. The incidents occurred in the resident’s bathroom while three nursing assistants were giving personal care after an episode of bowel incontinence. The facility was cited because the resident was subjected to abuse. Citation # 230009116.

Olive Ridge Post Acute Care
1000 Exec. Parkway, Oroville

B $1500 Patient Care Supervision 03/27/2012
The facility was cited for failing to implement the resident’s care plan resulting in the resident eloping from the facility. The resident walked through the main lobby, past the front desk and out the front door. He crossed a heavily traveled two lane, two-way street, without an intersection or stoplights and went into a market where he was later found by a staff member. This failure had the potential to result in the resident becoming lost, injured or killed. Citation # 230008810.

B $1000 Dignity Fall Patient Rights Verbal Abuse 03/27/2012
The facility was cited for failing to protect a resident from physical and verbal abuse, when a Certified Occupation Therapy Assistant (COTA) continued therapy exercises after the resident requested to stop. This resulted in the resident falling, and when the resident began to call out “Help Me.” The COTA responded by telling the resident to “Shut up.” Citation # 230009174.

B $1000 Patient Care 04/10/2012
On 2/11/12, only one CNA had come to work for the “West Hall” which had 40 residents, some with mandated instructions that two staff assist with bed mobility, transferring and toileting. In the back of West Hall, all but three of the 18 residents were incontinent and/or in need of assistance. In the front of West Hall, 22 residents were recovering from acute illnesses and/or surgeries, with half of them needing assistance with mobility and toileting. One resident who had urinated on herself after the call light had not been answered said
she felt sorry for the CNA who was “so tired working all by herself.” When interviewed, the Director of Nurses had no comment when shown that, on the night shift 2/11/12 schedule there was only one CNA scheduled and assigned for West Hall. The facility was cited for failure to ensure sufficient nursing staff to provide adequate nursing and relative services for their residents. Citation # 230009206.

Windsor Chico Creek Care and Rehabilitation Center
587 Rio Linda Ave., Chico

B $1000 Careplan Fall 04/19/2012
A 79 year old female resident with paralysis was dropped while transferring from a wheelchair to a shower chair on 8/20/11. The resident required 2 staff members to assist with transfers but only one staff member was assisting in the shower. The resident’s transfers were supposed to be done via Hoyer lift, but no lift was used. After the fall, the resident was moved before she was assessed by a licensed nurse. Two days later, it was discovered the resident had broken her femur. The facility was cited for failing to implement the resident’s care plan. Citation # 230008886.

El Dorado County

Gold Country Health Center
4301 Golden Center Drive, Placerville

B $1000 Patient Care Supervision 12/28/2011
On 10/16/09 at approximately 5:05 pm, a resident who had a history of wandering was reported missing from the facility. She was later found at approximately 5:30 pm outside of a restaurant that was located one block away from the facility. The facility was cited for failing to provide adequate supervision and interventions to keep the resident safe. Citation # 030008829.

Humboldt County

Seaview Rehabilitation & Wellness Center, LP
6400 Purdue Dr., Eureka

B $1000 Physical Abuse 09/20/2011
On 8/14/10, a resident who suffered from cognitive impairment grabbed another resident’s cane, then hit him on the left side of his head with his fist. The incident occurred in front of the nurses’ station. The incident wasn’t reported to the Department of Public Health until 8/18/10. The facility was cited for failure to notify the Department of the incident within 24 hours as required by law which results in an automatic B violation. Citation # 110008562.

B $1000 Physical Abuse 09/20/2011
During an interview on 8/18/10, A resident stated that a second resident entered his room, exposed himself and grabbed the first resident’s crotch. The resident stated he felt embarrassed and violated by the incident. The facility was cited for failure to protect the resident from sexual abuse. Citation # 110008445.

Marin County

Country Villa Novato Healthcare Center
1565 Hill Road, Novato

B $1000 Decubiti (Bedsores) 12/19/2011
A resident who was admitted on 3/1/11 developed two pressure sores at the facility within a month, including sores on her right heel and buttock. The facility failed to have a skin breakdown prevention plan in place until 18 days after her admission, and then failed to document daily skin checks as called for in the care plan. The sores were first discovered by a family member on 3/23/11, before staff saw or reported them. The resident’s nurse practitioner stated that the center of the pressure sore on the heel was black, meaning that the tissue had “died,” and that staff should have noticed it. The facility was cited because its failure to take measures to prevent the pressure sores directly affected the health of the resident. Citation # 110008661.

Marin Convalescent & Rehabilitation Hospital
30 Hacienda Dr., Tiburon

B $1000 03/08/2012
CitationWatch description will be published once citation is received. Citation # 110008952.

B $1000 03/08/2012
CitationWatch description will be published once citation is received. Citation # 110008874.

B $1000 03/08/2012
CitationWatch description will be published once citation is received. Citation # 110008866.

B $1000 03/08/2012
CitationWatch description will be published once citation is received. Citation # 110008872.

B $1000 03/08/2012
CitationWatch description will be published once citation is received. Citation # 110008873.

B $1000 03/08/2012
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B $1000 03/08/2012
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B $1000 03/08/2012
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CitationWatch description will be published once citation is received. Citation # 110008872.

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CitationWatch description will be published once citation is received. Citation # 110008873.

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CitationWatch description will be published once citation is received. Citation # 110008872.

B $1000 03/08/2012
CitationWatch description will be published once citation is received. Citation # 110008870.

B $1000 03/08/2012
CitationWatch description will be published once citation is received. Citation # 110008869.

B $1000 03/08/2012
CitationWatch description will be published once citation is received. Citation # 110008870.
B $1000 03/08/2012
CitationWatch description will be published once citation is received. Citation # 110008871.

B $1000 03/08/2012
CitationWatch description will be published once citation is received. Citation # 110008868.

Merced County
Franciscan Convalescent Hospital
3169 ‘M’ Street, Merced
B $1000 Careplan Fall Patient Care Physical Restraints 03/27/2012
The physician’s orders stated the resident was to have a mobility alarm when she was in a chair or out of bed. On 10/2/11, the resident was left unattended in the dining room without her alarm and fell on her right side. She suffered a fractured right femur which required surgery, and a skin tear on her right forearm. The facility was cited for failing to follow the physician’s orders when they did not use the mobility alarm. Citation # 040009139.

Modoc County
Modoc Medical Center D/P SNF
228 W. McDowell Avenue, Alturas
B $1000 Verbal Abuse 12/06/2011
On 8/7/11, a CNA came into a resident’s room, verbally abused her, then slammed the door shut, which subjected the resident to involuntary seclusion. The resident stated that the incident caused her to be frustrated and alone. The facility was cited for failure to ensure that the resident was treated with dignity and respect and not subjected to abuse. Citation # 230008785.

B $1000 Verbal Abuse 02/08/2012
On 10/7/11, a CNA observed a resident’s daughter verbally abuse another resident, telling her to “Get the f*** out of here you smelly gross old woman; go to your own room.” The abused resident said she was a little afraid of the daughter. The facility was cited because it did not keep the resident free from mental and verbal abuse. Citation # 230008970.

B $1000 Mandated Reporting 02/08/2012
On 10/7/11, a CNA observed a resident’s daughter verbally abuse another resident, telling her to “Get the f*** out of here you smelly gross old woman; go to your own room.” The facility was separately cited because the resident was subjected to verbal abuse. This citation was issued because it failed to report the abuse to the Department of Public Health until one week later, well beyond the 24-hour requirement. Citation # 230008965.

B $1000 04/04/2012
CitationWatch description will be published once citation is received. Citation # 230009021.

Monteery County
Kindred Nursing and Transitional Care - Pacific Coast
720 East Romie Lane, Salinas
B $700 Mandated Reporting Physical Abuse 02/15/2012
On 12/18/11, a family member reported that a resident said two staff members put a towel in his mouth and spanked him. The facility initiated an investigation, noted that the resident had significant memory/cognition problems, and concluded that no evidence could be found to substantiate the allegation. On 1/23/12, investigators interviewed the administrator and Director of Nurses who both stated that they did not think they had to report allegations of abuse if they concluded that the allegation was not valid. The facility was cited for failing to make a report of abuse to the Department of Health within 24 hours, as required by law. Citation # 070009012.

Napa County
Meadows of Napa Valley Care Center, The
1900 Atrium Parkway, Napa
B $1000 Administration 12/01/2011
The facility was cited for failing to post the overall facility Five Star Medicare Rating in the specified fonts and in the specified required locations, which resulted in the information being unavailable and unreadable by residents, staff and the public. Citation # 110008626.

Nevada County
Wolf Creek Care Center
107 Catherine Lane, Grass Valley
B $500 Dignity Verbal Abuse 03/14/2012
The facility was cited for failing to ensure that the resident was treated with dignity and respect and not subjected to verbal abuse by a CNA, when the resident grabbed the CNA’s bottom and the CNA told the resident “If you touch me again, I’m going to hit you.” Citation # 230009112.

Placer County
Auburn Oaks Care Center
3400 Bell Road, Auburn
B $1000 Medication 12/29/2011
On 7/5/10, a resident was given the wrong medication. Against regulations, one RN poured the medications and another RN administered them. Only after the medication had been administered did the first RN realize the resi-
A resident who had been given the wrong medication. The resident was given the narcotic, methadone, which can cause serious side effects in someone not used to taking narcotics. The resident received five times the initial recommended dose and was in the ICU at the acute care hospital for two days. The facility was cited for failure to ensure the medications were administered by the same nurse who pored them, and failure to ensure medications meant for one resident were not administered to another. Citation # 030008835.

Sacramento County

Briarwood Health Care

5901 Lemon Hill Avenue, Sacramento

B $1000 Medication Patient Care 11/16/2011
The facility was cited for failing to ensure three residents were free from the administration of unnecessary anti-psychotic medications which contained black box warnings. The facility also failed to ensure that the consultant pharmacist identified drug therapy irregulars during the monthly medication regimen review process and ensured that they were appropriately reported and acted upon. Citation # 030008725.

Carmichael Care & Rehabilitation Center

8336 Fair Oaks Blvd., Carmichael

B $1000 Fall 01/06/2012
A 61 year old male resident with left-side paralysis fell on 6/25/10. The resident stated he was fine and placed back into bed. The resident complained of pain the next day and was hospitalized on 6/27/10, and found to have a fractured hip. The facility was cited for failing to promptly assess the resident and notify his physician after he fell. Citation # 030008848.

Norwood Pines Alzheimers Center

500 Jessie Avenue, Sacramento

B $1000 Patient Care Staffing 11/01/2011
The facility was cited for failing to provide quality patient care and ensure all relevant state and federal staffing requirements were met on six different dates. On one of those dates, a resident suffered an injury when she was left unsupervised. These violations had a direct impact on health, safety, and security on the facility’s residents. Citation # 030008665.

B $1000 Injury Mandated Reporting 11/01/2011
On 5/29/09 and 6/14/09, the resident suffered head injuries as the result of falls that were un witnessed. The facility was cited for failing to investigate injuries of unknown origin, and for failing to report the injuries to the Department. Citation # 030008666.

B $1000 Careplan Injury 11/01/2011
On 5/29/09, a resident at high risk for falls was found with an injury of unknown origin on her right forehead. The resident’s care plan was not updated to include any interventions to be implemented to reduce the risk of further injury. On 6/14/09, the resident sustained another injury of unknown origin to her head resulting in a trip to the acute care facility for a CT scan. The facility was cited for failure to provide adequate supervision to prevent injury and failure to revise the care plan based on assessed needs after the first injury. Citation # 030008667.

B $800 Nutrition 11/01/2011
A resident was transferred to the acute care hospital for an unrelated issue on 6/15/09. Physician’s notes dated 6/17/09, indicated that the resident was “cachectic” (physically wasting related to poor nutrition) and anemic. The resident lost nine pounds in three months, seven of it in the second month at the facility. The facility was cited for failure to ensure the resident maintained an acceptable body weight and failure to ensure the plan of care was revised based on the resident’s needs. Citation # 030008668.

Saint Claire’s Nursing Center

6248 66th Avenue, Sacramento

B $1000 Evictions 01/30/2012
A 91 year old female resident was given notice of discharge on 6/12/09, effective on 7/1/09. There was no physician order for discharge, no evidence of preparation or orientation for the resident, and the proposed location of discharge was to a family member’s address that was no longer valid. The facility was cited for attempting a discharge without proper orders, notice, or preparation. Citation # 030008942.

B $800 Supervision 01/30/2012
On 5/24/09, a 91 year old female resident with dementia was found by a family member in the facility parking lot “trying to catch a bus to Richmond.” No staff member knew where the resident was. The resident had made many prior attempts to leave the facility. The resident was wearing an alert bracelet but the batteries were dead. The facility was cited for failing to provide adequate supervision or an effective alarm system. Citation # 030008941.

San Francisco County

San Francisco General Hospital D/P SNF

1001 Potrero Avenue, SAN FRANCISCO

A $10000 Careplan Neglect 09/29/2011
The facility was cited for failing to ensure that a resident received appropriate treatment and services to prevent loss of range-of-motion to his left hand. The resident was admitted to the facility on 8/14/07 and during his assessment it was not noted that he had weakness in his upper left side. On 8/9/10, he had an occupational therapy evaluation and on 3/15/11, he had an orthopedic evaluation, both evaluations noted decrease left hand mobility. From the day of admittance to the day of observation 4/1/11, there was no plan of care for his left hand and resulted in four of the resident’s five fingers on his left hand being contracted and continuously pressed against the palm. Citation # 220008599.

San Joaquin County

Lincoln Square Post Acute Care

1032 N. Lincoln Street, Stockton
of her death. Because the facility’s failure was a direct proximate cause the resident died due to asphyxiation on 6/24/11 as a result of obstruction to her tracheostomy tube. The resident’s report stated that the resident died from asphyxia- tion due to obstruction of the tracheostomy tube related to the failure to remove the cap. The facility was cited because the facility’s failure was a direct proximate cause of her death.

San Mateo County

San Mateo Medical Center D/P SNF
222 West 39th Avenue, San Mateo

A $20000 Supervision 11/01/2011
A male stroke victim caught on fire when he was smoking unsupervised on 12/31/10. The resident was on a cocktail of psychotropic medications including an antipsychotic, two antidepressants, an anti-anxiety, and a sleeping pill in addition to Methadone, which may have caused sedation and confusion. Another resident discovered the victim on fire and yelled for help but none was forthcoming for two to three minutes. The resident died three days later from his burns. The facility was cited for failing to ensure the resident was properly assessed for burn risk while smoking. Citation # 220008683.

Seton Medical Center
1900 Sullivan Ave., Daly City

AA $100000 Neglect 01/12/2012
An 81 year old resident who suffered from chronic respiratory failure, died due to asphyxiation on 6/24/11 as a result of obstruction to her tracheostomy tube. The obstruction was caused when a nurse failed to remove a cap while changing the tracheostomy tube. The cap prevented the resident from receiving oxygen. The manufacturer’s directions advised that the cap must be removed before use and warned that failure to do so may result in death. A representative for the manufacturer said that “it is like suffocating the patient” if the cap is not off in this situation because a patient cannot exhale. The Coroner’s report stated that the resident died from asphyxiation due to obstruction of the tracheostomy tube related to the failure to remove the cap. The facility was cited because the facility’s failure was a direct proximate cause of her death.

Citation # 220008934.

Santa Clara County

A Grace Sub Acute & Skilled Care
1250 S. Winchester Boulevard, San Jose

B $1000 Careplan Fall 11/21/2011
The facility was cited for failing to keep a resident safe from falls and failing to develop and revise a care plan for preventing falls. The resident fell on 3/7, 3/15, 3/22, 3/31, 4/27, 4/28 and 4/29/09. The resident fell four times before a low bed and mats were ordered as an intervention. On 4/30/09, the resident was found lying face down, with blood around his upper body. The resident was transferred to the emergency room, with lacerations on the bridge of his nose and face. Citation # 030008759.

B $100000 Neglect 01/12/2012
An 81 year old resident who suffered from chronic respiratory failure, died due to asphyxiation on 6/24/11 as a result of obstruction to her tracheostomy tube. The resident’s report stated that the resident died from asphyxia- tion due to obstruction of the tracheostomy tube related to the failure to remove the cap. The facility was cited because the facility’s failure was a direct proximate cause of her death.

Citation # 220008934.
forehead. The facility was cited for failure to provide adequate supervision and assistance devices to prevent accidents. Citation # 070008957.

Santa Cruz HealthCare Center
1115 Capitola Road, Santa Cruz

B $1000 Physical Abuse 01/18/2012
On 1/18/11, a volunteer staff member kissed a resident on the mouth. The resident reported she considered the volunteer to be her boyfriend and that he had been courting her for months. Notwithstanding its policy against engaging in inappropriate relationships with residents, the facility failed to notify the Ombudsman and the Department of Public Health of this incident. The facility was cited for this failure and for allowing the volunteer to continue to have contact with residents and lead evening activity programs unsupervised. Citation # 070008020.

Shasta County

Copper Ridge Care Center
201 Hartnell Ave., Redding

B $1000 Injury Patient Care Physical Environment 03/16/2012
The facility was cited for failing to ensure that the resident was free from a hazardous accident, that caused an injury, when four toes on his left foot and one toe on his right foot, sustained second degree burns on the hot surface of the baseboard heater in his room. Citation # 230008989.

Golden Living Center - Redding
1836 Gold Street, Redding

B $1000 Dignity Mental Abuse Patient Care Patient Rights Verbal Abuse 11/29/2011
The facility was cited for failing to ensure that a resident was treated with dignity and respect. While the resident was using a bedpan she had gotten some urine on the bed. The CNA told her it was a hassle to change her sheets, when the resident told the CNA that she did not want to get dressed at that time because she did not want her pants to smell like pee. The CNA threw her pants down on the bedside table, causing the resident to become upset and cry. Citation # 230008701.

Canyonwood Nursing And Rehab Center
2120 Benton Drive, Redding

B $500 Fiduciary Patient Care 01/20/2012
During an interview on 1/22/11, an employee stated that in July or August, she had accepted $300 cash from a resident but did not tell anyone. She also stated there were two other times she had accepted $20 cash. She stated she never brought it up to pay the resident back as she felt she had “adopted him as a grandfather” and “considered (the resident) family.” The employee acknowledged that she received the facility’s “Code of Conduct” and “Employee Handbook” and stated she “knew it was wrong.” The facility was cited for failure to carry out its “Employee Code of Conduct.” Citation # 230008912.

Windsor Redding Care Center
2490 Court Street, Redding

B $1000 Dignity Verbal Abuse 11/30/2011
During an interview on 11/10/11, a resident stated that after toileting, she wanted to put her pants back on so she could go to her room and wash her hands. The CNA assisting her wanted her to leave them off and told the resident to be quiet and let him do his job in a sarcastic manner. This caused the resident to become upset and cry. The facility was cited for failure to treat the resident with dignity and respect. Citation # 230008750.

Solano County

Orchard Post Acute Care
101 S. Orchard Street, Vacaville

A $16000 Medication 11/02/2011
On 2/24/11, a newly graduate nurse was receiving orientation at the facility and was being instructed on how to administer medications to the residents. During a moment where she was not being supervised, the new nurse took it upon herself to give a resident what she thought was the resident’s meds. The medication she gave was someone else’s which caused the resident to go into an altered level of consciousness and aspiration pneumonia. The facility was cited for failure to ensure that the nursing staff followed facility policy for identifying the resident prior to administering medications and for failure to adequately supervise a new graduate nurse during orientation. Citation # 110008200.

Sonoma County

Emeritus at Santa Rosa
300 Fountain Grove Parkway, Santa Rosa

A $18000 Fall Injury Physical Environment Supervision 10/27/2011
The facility was cited for failing to identify an unlocked gate that opened to a concrete stairwell of nine steps, as a hazard. This failure resulted in a wheel chair bound resident opening the unlocked gate, falling down the
stairs and consequently being sent to the emergency room where the resident died. Citation # 110008190.

**Fircrest Convalescent Hospital**
7025 Corline Court, Sebastopol

**B $1000 Mental Abuse Physical Abuse 11/14/2011**
On 9/10/10, a witnesses saw a CNA pinch a resident’s nipple causing him to scream, “It hurts; do not do that!” The offending CNA was seen walking away, laughing after the incident. The facility was cited for failure to protect the resident from physical and mental abuse. Citation # 110008625.

**Petaluma Post-Acute Rehabilitation**
1115 B Street, Petaluma

**B $1000 Administration 12/07/2011**
The facility was cited for failing to ensure that the Medicare 5 Star Rating signs were posted in accordance with the Federal Centers for Medicare and Medicaid Services Requirements. The 5 Star Ratings were not posted in the required areas, the postings were not in a 2 inch font, in addition the text below the Five Star rating was not in a 28 sized font. This could have resulted in preventing residents and visitors from adequately seeing the needed information. Citation # 110008712.

**Stanislaus County**

**Evergreen Nursing & Rehabilitation Care Center**
2030 Evergreen Avenue, Modesto

**B $1000 Fall Injury Patient Care Staff (Inservice) Training 03/15/2012**
The facility was cited for failing to provide a staff educational program for the safe use of shower gurneys which included the manufacturer’s precautions not to use the side rails as grab bars. This resulted in a resident sliding off the shower gurney and sustaining a hip fracture, thoracic spine fracture, a concussion, intracranial bleeding, syncope and a seizure. Citation # 040009117.

**Yolo County**

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

**B $1000 Mandated Reporting Physical Abuse 12/08/2011**
The facility was cited for failing to report alleged abuse to the Department within 24 hours or promptly to the Administration. The daughter of a resident reported to the Director of Staff Development her concerns about a CNA’s rough manner when caring for her mother. The resident’s roommate claimed that the resident was tossed around excessively in bed during a change of her brief and cried out in pain and pleaded for the CNA to “Stop it” and “Go away.” Citation # 030008791.

**B $1000 Careplan Dignity Physical Abuse 12/08/2011**
The facility was cited for failing to ensure that a resident was treated with dignity and respect and not subjected to any kind abuse, for failing to implement their policy for elder abuse and for failing to implement the resident’s care plan. The resident’s care plan called for “reassurance during transfers, turning, changing, cries, screams.” The staff was to “introduce self, explain procedure before performing.” The resident’s daughter reported that on 4/17/09, that her mother was tossed around excessively in bed during changing and cried. The resident cried out in pain and pleaded with the CNA to “Stop it” and “Go away” according to the resident’s roommate. Citation # 030008793.

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

**B $100 Administration 11/30/2011**
The facility was cited for failing to post their CMS Five-Star Rating information, as required, in the proper format, and required locations within the facility. This action prevented residents, consumers and families the ability to identify and compare this nursing facility to others, and to identify areas of care concerns. Citation # 230008704.
The following citation summaries are compiled from the citations issued by the California Department of Public Health to Southern California skilled nursing facilities and received by CANHR as of the publication of this Advocate. CANHR makes every effort to insure that consumers are provided with accurate information. CANHR welcomes comments and suggestions or notice of errors. Please direct such comments to mis@canhr.org or by calling the CANHR office at (800) 474-1116.

Citations without summaries will be reprinted with summaries once received by the CANHR office. Citations from earlier months are included if a description was not printed in a previous Advocate. Appeals of citations and collection of fines can take up to three years. For up-to-date information on any citation or facility, visit the Nursing Home Guide through CANHR’s web site: www.canhr.org or call the CANHR office.

Explanation of citation classifications: “AA” citations are issued when a resident death has occurred due to nursing home regulation violations, and carry fines of up to $100,000. A class “A” citation is issued when violations present imminent danger to resident or the substantial probability of death or serious harm, and carry a fine of up to $20,000. Class “B” citations are fined up to $2,000, and are issued for violations which have a direct or immediate relationship to health, safety, or security, but do not qualify as “A” or “AA” citations. “Willful material falsification” (WMF) violations also result in a fine. Fines are not always required to be paid. Citations can be appealed, requiring the Department of Health Services to substantiate the violation. Violations repeated within twelve months may be issued “trebled fines”— triple the normal amount.

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**Fresno County**

**Coalinga Regional Medical Center D/P SNF**
1191 Phelps Avenue, Coalinga

B $1000 Fall 04/03/2012
On 11/22/11, a CNA was attempting to make a solo transfer of a resident from her bed to a wheelchair. When the CNA started to move the resident, the sling became unhinged and the resident fell four feet to the ground and landed on her head. The resident was transported to the ER with a laceration to the back of her scalp. The facility was cited for failing to follow the procedure which required more than one CNA to operate a lift during the transfer of a resident. Citation # 040009205.

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**Kern County**

**Golden Living Center - Bakersfield**
3601 San Dimas St., Bakersfield

B $1000 Careplan Injury Patient Care Transfer 02/21/2012
On 12/13/11, a resident sustained a three inch long and one quarter inch wide laceration to her left leg while she was being transferred from her wheelchair to her bed, using a lift device. It was noted in the resident's care plan that two staff were to assist while transferring the resident, however only one was present at the time of the incident. The facility was cited for failing to follow the resident's care plan regarding transfers. Citation # 120008976.

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**Los Angeles County**

**California Convalescent Center 1**
909 S Lake Street, Los Angeles

B $1000 Physical Environment 07/27/2011
The facility failed to maintain an effective pest control program in order to keep the facility free of bed bugs and cockroaches. This resulted in an infestation of bed bugs and cockroaches in patient rooms, corridors and laundry room. Citation # 910008420.

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**Citrus Valley Medical Center - Ic Campus, D/P Snf**
210 W. San Bernardino Road, Covina

A $10000 Careplan Fall Injury Patient Care 02/24/2012
The facility was cited for failing to implement a care plan for a resident who recently had a left total hip replacement. The care plan indicated the resident required a minimum of two person assist in walking. On 10/20/10, the resident was being assisted by one person while walking to the bathroom and fell. The resident sustained a left hip fracture requiring surgery of the left femur. Citation # 930008929.

**Country Villa Maple Healthcare Center**
2526 S. Maple Avenue, Los Angeles

A $15000 02/10/2012
CitationWatch description will be published once citation is received. Citation # 940008692.

**Covina Rehabilitation Center**
261 W. Badillo St., Covina

A $10000 Fall Injury Patient Care Transfer 01/31/2012
The resident's minimum data set indicated that two-person physical assistance was required for bed mobility and transfers. On 11/24/09 at 11 am, the resident fell and fractured his right femur while a CNA was transferring the resident from the bed to the wheelchair. The facility was cited for failing to transfer the resident with two staff members as indicated in the assessment, and for failing to implement its policy and procedure for positioning and moving. Citation # 95000890.

**Downey Care Center**
13007 South Paramount, Downey

AA $80000 Neglect Notification 01/24/2012
A 79 year old resident with diabetes developed a diabetic coma, became brain dead and died on 3/15/10 due to the facility's failure to monitor her blood sugar levels. The resident's diabetic history was well known to the facility because she had been admitted to the facility 5 separate times during the year prior to her death. Following
Driftwood Healthcare Center
4109 Emerald Avenue, Torrance

B $500 Administration 12/23/2011
The facility was cited for failing to post the 5 Star Medicare rating information. This information was to be posted in areas accessible and visible to members of the public, areas used for employee breaks, and areas used by residents for communal functions, such as dining, resident council meetings or activities. Failure to post this information could have resulted in residents, prospective residents and staff not having needed information when comparing nursing homes, as well as being unable to identify areas about which they may have had questions. Citation # 910008847.

B $500 12/23/2011
CitationWatch description will be published once citation is received. Citation # 910008847.

Foothill Nursing And Rehabilitation Center
401 W. Ada Ave., Glendora

B $1000 Careplan Notification 11/10/2011
Nurses notes from 10/26/11-10/28/11, indicate a resident with chronic lower back pain was in constant pain for almost two days despite receiving the prescribed doses of her pain medication. The facility did not contact the resident’s physician as required by their pain management policy. The facility was cited for failure to address the resident’s pain in accordance with policy. Citation # 950008741.

Four Seasons Healthcare & Wellness
5335 Laurel Canyon Blvd., Valley Village

B $500 03/16/2012
CitationWatch description will be published once citation is received. Citation # 920009122.

Goldstar Rehabilitation and Nursing Center of Santa Monica
1340 15th Street, Santa Monica

B $2000 Medication 02/14/2012
The facility was cited for failing to administer prescribed medications to 14 out of 35 resident on a certain floor of the facility. On 10/1/10 and 10/2/10, 73 doses of medication were signed for as being given, however they were not. The staff member was removed from the schedule and received a warning. Citation # 910009008.

B $2000 Medication 02/15/2012
The facility was cited for failing to administer prescribed medications to 6 out of 35 resident on a certain floor of the facility. On 10/3/10 and 10/4/10, 24 doses of medication were signed for as being given, however they were not. On 10/1/10 and 10/2/2010, 14 out of 35 residents failed to receive their medications. The staff member was suspended. Citation # 910009007.

WMF $1000 Medication Neglect Patient Care
Patient Records 02/15/2012
On 10/3/10, the facility was notified by a staff member that some medications were not administered to 20 of 35 fourth floor residents for the previous two days. The LVN responsible for administering those medications was later identified. However, the facility failed to discipline the LVN, and allowed the LVN to continue to work the evenings of 10/3/10 and 10/4/10. The LVN was eventually suspended on 10/4/10. The facility was cited for failing to ensure the medications for 20 residents were administered as prescribed and not falsely documented. Citation # 910007783.

Imperial Care Center
11441 Ventura Blvd, Studio City

B $500 Physical Environment 01/12/2012
On 6/16/11, an evaluator witnessed that construction workers repairing damage from a previous sewer leak had removed approximately two feet of the lower level fire resistant corridor walls. In addition, the fire protection sprinkler system, smoke detectors and fire alarm pull stations were covered with plastic sheets leaving the area without a fire protection system. The facility was cited for failure to meet the standards for prevention of fire. Citation # 920008895.

Imperial Convalescent Hospital
11926 La Mirada Blvd, La Mirada

A $5000 Careplan Decubiti (Bedsores) Deterioration
Patient Care 02/06/2012
The resident was admitted to the facility from an acute care hospital on 1/6/11. The resident’s care plan indicated she was at risk for break in skin and bladder incontinence. On 1/16/11, the resident had a Stage II pressure sore. On 1/17/11, the resident was diagnosed with a urinary tract infection and developed nausea and vomiting. On 1/18/11, the resident was transferred to an acute care hospital for further evaluation, and she was diagnosed with severe dehydration, sepsis, and a kidney infection. The facility was cited for failing to provide treatment and services to prevent formation and progression of a pressure sore to the tailbone. Citation # 940008612.

Las Flores Convalescent Hospital
14165 Parche Avenue, Gardena

A $20000 03/29/2012
CitationWatch description will be published once citation is received. Citation # 910009196.

B $1800 Chemical Restraints Physical Abuse
03/29/2012
A 79 year old male resident with dementia was prescribed Seroquel for “resistance to care and combativeness.” When the resident refused Seroquel, he was prescribed Ativan for “irritability” and then administered both drugs. Nine days later, the resident was observed with shaking and jerking movements, a side effect of psychotropic medications. Nei-
ther the resident nor his responsible party were informed of the medications’ use and consent was not obtained. The facility was cited for using psychotropic drugs as a chemical restraint, without consent, and without proper monitoring of side effects. Citation # 910009194.

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

**B $2000 Neglect Patient Care Security Supervision 01/27/2012**
The resident was admitted to the facility on 6/24/10 with a diagnosis that included decreased mental function and a loss of contact with reality. The resident had a history of wandering and fighting with residents, and required supervision. On 10/2/10, at around 7:20 pm, the resident was reported missing. On 2/8/11, the facility's Assistant Administrator stated the resident was still missing from the facility. The facility was cited for failing to supervise and monitor the resident. Citation # 910008955.

**Mid-Wilshire Health Care Center**
676 S Bonnie Brae, Los Angeles

**B $1800 Fall Injury Notification 02/08/2012**
On 11/15/09, a resident removed her bed alarm and attempted to get out of the bed over the side rails. The resident fell and suffered a laceration to her right eye and a fractured hip. On 10/2/09, a resident stated he went to the bathroom by himself, lost his balance and slid to the floor, hitting his shoulder in the fall. Neither fall was reported to the Department within the required 24 hour period. The facility was cited for failure to report the incidents to the Department. Citation # 910008985.

**Mirada Hills Rehabilitation And Convalescent Hosp**
12200 S. La Mirada Blvd, La Mirada

**A $20000 Fall 02/09/2012**
An 80 year old female resident with Parkinson’s Disease and high risk of falls, fell eight times in a ten week period from February to April 2010. The resident suffered myriad injuries from her falls. The resident was on various psychotropic drugs to “relax” the resident and restrain her from getting out of bed. The resident was placed on one-to-one supervision but fell on 4/18/10 when she was left unsupervised. The resident suffered massive facial fractures and head trauma. The facility was cited for failing to adequately supervise the resident and failing to implement her careplan. Citation # 940008589.

**North Valley Nursing Center**
7660 Wyngate Street, Tujunga

**B $900 Physical Abuse Verbal Abuse 02/01/2012**
On 5/14/11, an employee told a resident to shut up, covered the resident’s mouth and squeezed it with her hand, then slapped the resident on the back of his shoulder. The employee was subsequently discharged. The facility was cited for failure to protect the resident from verbal and physical abuse. Citation # 92008940s.

**Paramount Meadows Nursing Center, Llc**
7039 Alondra Blvd, Paramount

**B $1000 03/27/2012**
CitationWatch description will be published once citation is received. Citation # 940009192.

**Pineridge Care Center**
14122 Hubbard Street, Sylmar

**B $1800 Injury Neglect Physical Environment 03/15/2012**
The facility was cited for failing to ensure that a chronic smoker was not burnt when smoking. On 10/11/11, the resident was observed holding a lit cigarette close to his middle finger which had a discolored closed blister. When the resident was asked how it happened, he stated “I burned it with the cigarette.” Citation # 920009103.

**Providence Little Company of Mary Transitional Care Center**
4320 Maricopa, TORRANCE

**B $1000 Dignity Verbal Abuse 01/05/2012**
On 8/10/11, a resident stated that the Occupational Therapist told him if he cannot do the therapy his medical insurance would “kick him out of here (the facility).” The resident had declined therapy as he had radiation treatment later that day and wanted to rest. According to the resident, he felt threatened and was scared of the staff member. The facility was cited for failure to treat the resident with dignity and respect. Citation # 930008536.

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

**B $1000 Medication 01/11/2012**
On 11/21/11, a resident who was receiving Cipro (an antibiotic medication) intravenously indicated he preferred to take the medication orally. The physician was notified and the order changed but the resident mistakenly received the medication both orally and through an IV. The resident was at increase risk of toxicity from the overdose due to end stage renal failure. The facility was cited for failure to administer the medication as prescribed. Citation # 910008898.

**Santa Anita Convalescent Hospital**
5522 Gracewood Avenue, Temple City

**A $10000 Fall 12/22/2011**
A resident at risk for falls had physician’s orders for use of a waist belt restraint while in his wheelchair. On 10/24/08, the resident was found on the floor with blood on his forehead and nose. The resident was transferred to the Acute Hospital Emergency Room and treated for blunt head trauma, a skin tear and bruising. Investigation revealed an employee had forgotten to retie the waist restraint after the resident’s meal. The facility was cited for failure to implement the resident’s care plan and ensure the restraint was used properly. Citation # 950005996.

**Santa Clarita Convalescent Hospital**
23801 Newhall Avenue, Newhall

**A $15000 Patient Care 02/29/2012**
On 6/15/11, a resident with a history of drug use left the facility on a pass. The next day the charge nurse noted that the resident was lying in bed with his eyes fixed, pupils pin point, and non-responsive. A lab test indicated the resident had overdosed on narcotics. On 6/20/11, the resident was again found unresponsive and it was again determined that
the resident had overdosed. On 6/21/11 a CNA reported to the charge nurse that the resident had a syringe, a spoon and a plastic bag with a sticky substance in it. The Department determined that the staff did not utilize the information available to them when developing a plan of care. The facility was cited for failing to provide treatment to manage a resident’s behavior associated with the acquiring and self-administration of an illegal substance (heroin). Citation # 920008996.

**Sunnyside Nursing Center**
22617 S Vermont Ave, Torrance

**A $15000 12/28/2011**
On 7/22/11, a resident who was assessed as a high fall risk was left unattended. The resident walked a few steps, fell and sustained a hip fracture. This was her third fall in three days. The facility was cited for leaving the resident unattended, for failing to implement the care plan to prevent falls and failing to implement the facility’s written policies and procedures regarding falls. Citation # 910008825.

**Sycamore Park Care Center**
4585 North Figueroa Street, Los Angeles

**B $500 Medication 02/10/2012**
During a recertification inspection on 9/14/11, it was discovered the medication room was 91.8 degrees Fahrenheit. Medication must be stored at room temperature between 59 and 86 degrees F. The facility was cited for failing to store medications at a temperature necessary to maintain their integrity. Citation # 940008992.

**Victoria Care Center**
3541 Puente Avenue, Baldwin Park

**B $1000 Fall Injury Supervision 11/01/2011**
On 4/17/08, a resident at risk for falls was left unattended. The resident walked a few steps, fell and sustained a hip fracture. This was her third fall in three days. The facility was cited for leaving the resident unattended, for failing to implement the care plan to prevent falls and failing to implement the facility’s written policies and procedures regarding falls. Citation # 910008825.

**View Heights Convalescent Hospital**
12619 S. Avalon Blvd., Los Angeles

**B $2000 Physical Environment 03/02/2012**
On 2/2/12, between 7 pm and 8:30 pm, the hot water temperature was tested during a general environmental inspection tour of the facility. The facility’s policy and procedure on Water and Plumbing required that hot water temperature be maintained at no less than 105 degrees F and no more than 120 degrees F. The results of the inspection found that 12 bathrooms had hot water above 120 degrees F. The facility was cited for failing to ensure the residents’ environment remained as free from hazards as possible. The unsafe hot water temperature placed 62 residents at risk for burn, scalding, and tissue damage. Citation # 940009066.

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

**A $20000 04/03/2012**
CitationWatch description will be published once citation is received. Citation # 940009093.

**B $10000 Deterioration Feeding 01/25/2012**
Between 4/1/11 and 9/19/11, a resident's weight reduced 17 pounds from 125 lbs. to 108 lbs. The resident was dependent on a gastrostomy tube for sustenance. The facility was cited for failure to document signs of feeding intolerance, monitor the resident’s weight, and involve the resident’s physician in assessing underlying reasons for the weight loss. Citation # 940008723.

**B $1000 Fall Injury 01/25/2012**
On 1/25/11, 4/10/11, and 9/14/11 a resident fell while attempting to ambulate without assistance. One fall resulted in serious injury requiring stitches to the resident’s eyebrow. The incident had previously been identified as at risk for falls and having a decline in the ability to ambulate. Physician’s orders required a front wheel walker (FWW) but it was not observed by the resident’s bed during inspection. The facility was cited for failure to develop interventions to prevent falls, ensure the resident was instructed in the use of the FWW and encourage use of the device. Citation # 940008722.

**Virgil Rehabilitation And Skilled Nursing Center**
975 N. Virgil Ave, Los Angeles

**B $1000 Theft & Loss 12/27/2011**
The facility was cited for failing to enforce their policies regarding employees not accepting “any cash, gifts, special accommodations, favors or use of property or facilities to or from anyone with whom the facility does business or is negotiating business of behalf of the facility.” A staff member took two checks totaling the amount of $650 from a resident. The staff stated that they would repay the money. The staff member was terminated and the $650 was returned to the resident by the facility. Citation # 920008857.

**Westside Health Care**
1020 S Fairfax Ave, Los Angeles

**A $19500 Careplan Medication Notification 03/21/2012**
On 8/25/08, a resident was found on the floor due to elevated blood sugar. The diabetic resident was supposed to maintain a blood sugar of between 80-120 mg/dl. From 6/29/08 to 8/25/08, there were ten instances where her blood sugar was over 500 mg/dl. The facility was cited for failing to notify her physician about the change in blood sugar levels and for administering the incorrect amount of insulin. Citation # 910009168.

**Whittier Hills Health Care Center**
10426 Bogardus, Whittier

**B $1200 Evictions 02/27/2012**
The facility was cited for failing to give a resident and their representative proper notice of transfer to another skilled nursing facility. On 9/30/11, a resident was transferred to another facility without prior notice, preparation and approval from the resident and family member. Citation # 940009045.

**B $1000 Theft & Loss 02/27/2012**
The facility was cited for failing to investigate a report of lost/stolen property, update the resident’s inventory when the resident’s hand bag was brought to the facility and for failing to report the missing property with a value of
over $100 to local law enforcement. On 9/15/11, a family member brought the resident’s purse to her and asked that it be added to the inventory. The purse had several credit cards, her social security card and a check book. On 9/16/11, the purse went missing and the facility took no action. Between 9/15/11 and 9/22/11 (the date the accounts were closed), there were $3,000 in fraudulent charges made on the resident’s accounts. Citation # 940009046.

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.

Riverside County

Country Villa Riverside Healthcare Center
4580 Palm Ave., Riverside
A $10000 Neglect 03/14/2012
In March 2010, a resident injured his finger and asked for bandages and tape. The resident dressed his own wound and added rubber bands which stayed on his finger for at least several days. The finger eventually became gangrenous and had to be amputated on 4/2/10. The facility was cited for failing to assess the resident’s injury. Citation # 250009109.

Lifehouse of Riverside Healthcare Center
8781 Lakeview Avenue, Riverside
B $1000 Verbal Abuse 02/23/2012
The facility was cited for failing to ensure a resident was free from abuse. A CNA did not clean a resident’s bed pan when requested, and also asked the resident for her personal snacks (soda and nuts). When the resident reported this on 8/10/10, the CNA who worked the night shift went to the resident’s room and woke her up and confronted her. The resident felt threatened and frightened. Although the CNA was suspended for the incident, records show the CNA reported to work the next day. Citation # 250009024.

ManorCare Health Services-Hemet
1717 West Stetson Avenue, Hemet
B $2000 03/29/2012
CitationWatch description will be published once citation is received. Citation # 250009184.

Miller’s Progressive Care
8951 Granite Hill Dr, P.O. Box 3156, Riverside
B $1000 Physical Abuse 01/18/2012
On 8/21/08, a housekeeper and a dietary staff member witnessed a CNA hit a resident on the back of the head with a clipboard as the resident tried to take food from the food cart. The facility was cited for failing to protect the resident from physical abuse. Citation # 250008778.

San Bernardino County

Apple Valley Care Center
11959 Apple Valley Road, Apple Valley
B $1000 Mandated Reporting Physical Abuse 02/15/2012
On 5/30/11, staff noticed that an 87 year old resident had a black eye. The resident said that he did not remember how it happened. An entry was made in the Nurse’s Notes that mentioned the resident’s eye injury, but the facility didn’t investigate the matter or report the incident to the Department of Health. The facility was cited for failure to report an injury of unknown cause within 24 hours as required by law. Citation # 240009002.

Asistencia Villa Rehabilitation And Care Center
1875 Barton Road, Redlands
B $1000 Careplan Fall Injury Patient Care Transfer 01/18/2012
The resident’s care plan indicated that two persons and a Hoyer lift were to be used when transferring the patient. On 10/15/09 at approximately 10:30 am, one CNA was trying to transfer the resident out of her bed using a Hoyer lift. However, the resident fell and suffered a laceration to her head which required seven stitches. The facility was cited for failing to implement the resident’s care plan when only one person was used during a transfer. Citation # 240008918.

Braswell’s Colonial Care
1618 Laurel, Redlands
B $1000 Notification Patient Care 02/21/2012
An 84 year old male resident was found unresponsive with food in his mouth on 6/26/11. The resident had been found retaining food in his cheek (which increases risk of food aspiration) on 6/24/11 but his physician was not notified. On 6/26/11, the resident was found to have fever spikes but the physician was still not notified. The resident was hospitalized with aspiration pneumonia and sepsis and placed on a ventilator. The facility was cited for failing to promptly notify the resident’s physician when he had a change in condition. Citation # 240009030.

Braswell's Community Convalescent Center, LP
13542 Second Street, Yucaipa
B $1000 Careplan Fall Injury Patient Care Supervision 01/12/2012
The resident’s care plan indicated that a lap buddy was consistently implemented. However, on 8/17/10 at approximately 9:45 am, the resident was left unattended and eventually seen on the floor in front of her wheel chair. The lap buddy had not been applied as indicated in her care plan. The resident suffered lacerations to the right side of her face, left index finger, and fourth left knuckle, and also had a bump to her forehead. She was taken to the emergency room for her injuries. The facility was cited for failing to implement the resident’s care plan when the lap buddy was not applied. Citation # 240008903.
Braswell's Hampton Manor  
11970 Fourth Street, Yucaipa  
B $1000 Notification Patient Care 12/22/2011  
The facility was cited for failing to notify the physician after the resident had three incidents of coffee-ground emesis (an episode of vomiting that resembles coffee grounds). This failure resulted in a delay of treatment. The resident's condition deteriorated into full cardiac arrest and the resident died that same morning. Citation # 240008840.

Country Villa Hacienda Healthcare Center  
1311 East Date Street, San Bernardino  
B $1000 Verbal Abuse 02/23/2012  
The facility was cited for failing to keep a resident free from abuse. On 2/8/11, a CNA was overheard yelling at the resident, saying: “Why did you put your call light on? Why are you crying you’re not a baby, only babies cry.” The facility was also cited for failing to ensure that staff followed the abuse policy, by failing to remove the CNA immediately from providing care to the resident. Citation # 240009036.

Hi-Desert Medical Center D/P Ssn  
6601 Whitefeather Rd, Joshua Tree  
B $1000 Dignity Mental Abuse Neglect Patient Care Patient Rights Verbal Abuse 01/17/2012  
On 7/10/10, the resident turned on her call light because she needed assistance using the bedpan. However, nobody responded to her call for about 45 minutes and she went to the bathroom in her bed. When a CNA finally responded, the resident asked where she had been. The CNA stated she was assisting another resident. The two eventually got into a verbal argument, and the CNA left the room without assisting the resident. The resident turned on her call light again, and the same CNA responded. The two got into another verbal argument, and the resident stated that the CNA threw the wash cloth on the bed and walked out of the room, leaving the resident “extremely angry, uncomfortable, helpless, felt unwanted.” The CNA was eventually suspended for two days. The facility was cited for failing to protect the resident from verbal and mental abuse from staff, respond to the resident's call light in a timely manner, and ensure the resident’s linen and skin were consistently clean, dry and free of feces. Citation # 240008914.

B $1000 Injury Notification Patient Care 03/12/2012  
The facility was cited for failing to notify the physician when the resident began exhibiting early signs of a change in condition, low blood pressure on 3/22/2010. The resident fell out of her wheelchair and broke her hip on 3/24/2010. On 3/26/2010, the resident was no longer was able to recognize family members and appeared dehydrated. On 3/29/2010, the physician was notified and orders were obtained to send the resident to the acute care hospital, where the resident was diagnosed with acute renal failure. Citation # 240009101.

Plot Nursing Home  
800 East 5th St., Ontario  
B $1000 Infection Medication Patient Care 02/27/2012  
The facility was cited for failing to ensure the correct, prescribed intravenous antibiotic doses were administered to the resident to treat the resident’s endocarditis (infection affecting the heart and the heart valves). This resulted in re-admission to the acute care hospital to re-start the correct treatment. Citation # 240009037.

Upland Rehabilitation And Care Center  
1221 East Arrow Hwy., Upland  
A $20000 Patient Care 01/04/2012  
A 63 year old male resident with a history of swallowing problems and aspiration pneumonia, had his diet changed on 1/23/08 by a speech therapist. The diet went from “nothing by mouth” to soft foods and finely chopped meals with thin liquids. The diet change was not approved by the resident’s physician as required by the facility’s policies. The resident was hospitalized on 2/2/08 for severe respiratory distress and died from aspiration pneumonia on 2/7/08. The facility was cited for failing to ensure the resident’s care was properly ordered by a physician. Citation # 240008877.

B $1000 Careplan Fall 01/12/2012  
On 7/30/11, a visitor discovered a resident lying on the street in front of the facility with a broken hip. A review of the resident's records indicated that he suffered from dementia and hallucinations and was assessed as at risk for falls. The resident was known to wheel himself around the facility. It was not known how he managed to exit the building undetected. The facility was cited for failing to develop a resident care plan to address staff responsibility for the resident and for fall prevention. Citation # 240008902.

B $1000 Neglect 01/18/2012  
The facility was cited for failing to implement their sign in and out policy to track residents when they left the facility. A male resident who left the facility almost daily for several years only signed out a number of times. On 5/31/10, he left the facility and did not return. He was found dead 06 miles from the facility the next day. He died of hypothermia. Citation # 240008919.

B $1000 Fall Injury Patient Care Staff (Inservice) Training 03/09/2012  
The facility failed to ensure that staff followed the written policy and procedure pertaining to the use of a Hoyer Lift. As a result, on 6/1/07, a resident was dropped from a Hoyer lift and sustained injuries that included hematoma to the right side of her head. Citation # 240009054.

Valley Healthcare Center  
1680 North Waterman Avenue, San Bernardino  
B $1000 Fall 01/18/2012  
A resident fell on 9/23/10, while being assisted by a CNA. The facility cited for failing to report the fall to the Charge Nurse before moving the resident from the floor as facility policy stated. The resident was not assessed before being moved and later complained of pain to the ankle. It was documented on 9/24/10, that the x-ray revealed no fractures, and orders were received for ice packs four times daily and bed rest. On 9/26/10, there was no documentation that the physician was notified of continued swelling, bruising and severe pain. On 9/30/10, ordered x-rays showed a fracture ankle and distal tibia. Citation # 240008920.
The facility was cited for failing to keep a resident safe and prevent injury. The resident’s doctor ordered a non-self-release seat belt on 7/16/10 at 8:30 am. At 7:20 pm, the resident was found on the floor, with no seat belt. She sustained a fractured hip. Citation # 090009016.

San Diego Healthcare Center
2828 Meadow Lark Dr., San Diego
B $1000 Fall Injury Mandated Reporting Patient Care Patient Records 02/17/2012
On 6/30/11, while walking to the shower, the resident fell and broke her right hip. However, the licensed nurse who was taking care of the resident failed to assess her injuries and document the fall as indicated in the facility’s Fall Prevention and Management Program. This failure had a direct and immediate impact on the resident’s health. Citation # 080009027.

VISTA HEALTHCARE CENTER
247 E. Bobier Drive, Vista
B $1000 Medication Neglect Patient Care 02/17/2012
The resident was admitted to the facility on 1/14/12 with diagnoses that included chronic widespread pain of muscles and ligaments, and hospice care for end stage chronic obstructive lung disease. On 2/8/12 at 6:15 pm, the resident stated that she had severe pain all over her body since about 3 am. She usually received morphine every couple of hours for her pain, but had not received it for about 15 hours. The physician’s orders indicated she was to receive morphine every two hours as needed for pain. The facility failed to medicate the resident as prescribed, causing severe pain to the resident for 15 hours. Citation # 080009028.

Santa Barbara County
Samarkand Skilled Nursing Facility
2566 Treasure Drive, Santa Barbara
A $10000 Fall 01/19/2012
A resident died on 4/3/11, ten days after falling and sustaining multiple life threatening injuries including a subdural hematoma, a fractured spine and facial fractures. The facility reported that the resident was found on the floor outside the bathroom door and she was hospitalized on 3/24/11 for evaluation. She was readmitted on 3/28/11 with orders for comfort care and died on 4/3/11. The physician’s discharge summary stated “death secondary to fall with head injury.” During the year prior to her death, the resident fell an additional 7 times at Samarkand, but the facility did not reevaluate her high risk needs and did not implement additional safety measures and increase supervision. The facility was cited due to these failures. Citation # 050008727.

B $800 Patient Care Patient Rights Retaliation Against Resident Supervision 04/05/2012
On 9/27/09 at about 3:30 am, a CNA (CNA1) found the resident crying and moaning in the closed and dark dining room. When CNA1 asked the staff person responsible for the resident (CNA2) why the resident was placed there, CNA2 replied “she keeps yelling” and he “didn’t want her to wake up the other residents.” The facility was cited for failing to protect the resident from involuntary seclusion. Citation # 050008714.