New Laws Effective January 1, 2017

Hundreds of new California laws will become effective January 1, 2017, including many that will impact various long-term care and elder abuse issues. CANHR sponsored, supported or opposed a number of pieces of legislation this session, and highlights of some of the successful bills follow. Please check [www.canhr.org/legislation](http://www.canhr.org/legislation) for updated details on legislation, and [www.leginfo.ca.gov](http://www.leginfo.ca.gov) for information of specific bills.

SB 833 - Medi-Cal Recovery Reform:
Perhaps the most important bill of 2016 to Medi-Cal recipients who are age 55 years or older, SB 833 incorporated the Medi-Cal recovery reforms of SB 33 (Hernandez) which was co-sponsored by CANHR and Western Center on Law and Poverty. Effective January 1, 2017, - among other provisions - the state can no longer recover from the estates of surviving spouses or registered domestic partners; limits Medi-Cal recovery for those who are 55+ years of age to only what is required by federal law; allows a hardship exemption for homesteads of modest value; and most importantly, limits recovery to those estates that are subject to probate administration. In other words, if the estate is held in a living trust, joint tenancy, or in any other way that avoids probate – there is no recovery. If the estate is held in a will that will be subject to probate, then recovery is likely.

Take a look at CANHR’s Medi-Cal Recovery page to download information on this new law and how to avoid recovery: [www.canhr.org/medcal/medcal_recoveryinfo.htm](http://www.canhr.org/medcal/medcal_recoveryinfo.htm)

Insurance: Annuity Transactions - SB 924 (Roth):
Sponsored by CANHR, this new law seeks to deter those financial abuse predators who convince seniors to invest in risky annuities and other financial transactions under the guise of “helping them get benefits” such as VA Aid and Attendance or Medi-Cal. SB 924 provides that an insurance company must ascertain whether the purchase of an annuity by a senior consumer is suitable if it is connected to an attempt to qualify for a government benefit.

Dismissal/Denial of Petitions to Compel Arbitration: Appeals - SB 1065 (Monning):
Co-sponsored with the Consumer Attorneys of California, this bill shortens the appeal process for those who are aged or disabled and have received a trial preference in an elder abuse case, rather than being delayed by an appellate process that can take three years or more.

Other bills that CANHR supported that were signed into law:
Welcome New Staff and Goodbye Daniel

CANHR would like to welcome Yvonne Ramirez Hernandez as a new CANHR Long Term Care Advocate. Yvonne comes to CANHR from Greater Bakersfield Legal Assistance where she worked as a Consumer Health Advocate and with the volunteer Attorney Program. Yvonne’s valuable experience in assisting consumers to navigate health care options is a welcome addition to CANHR’s Advocacy Unit.

We also welcome Marcus Nelson as our new CANHR receptionist and AA. Marcus replaces Daniel Guerrero, CANHR’s receptionist for the past two years. Daniel has moved to Southern California to be closer to his family. He will be missed. Welcome Yvonne and Marcus, and we wish Daniel the very best in his new home.

Stay Informed Between Newsletters

Get updates on long-term care issues affecting you and your loved ones by subscribing to CANHR’s electronic newsletter, “CANHR News and Notes.” Visit www.canhr.org and click on “Sign up for our monthly E-Newsletter” right on the front page. Fill in your name and email and begin receiving monthly updates in your email box.

Donate to CANHR When You Shop on Amazon.com

Amazon will donate 0.5% of the price of your eligible Amazon purchases to California Advocates For Nursing Home Reform whenever you shop on AmazonSmile. AmazonSmile is the same Amazon you know - same products, prices, and service. Support us by starting your shopping at smile.amazon.com.

Thank you

We want to thank everyone who generously contributed money, time and/or resources to CANHR throughout the year. A very special thank-you goes to those of you who contributed to our trainings and newsletters; those of you who wrote letters to legislators in support of our bills; and particularly those of you who advocated on behalf of your family members and friends in long term care to make their lives better. We could not do our work without your support!

Warmest wishes for a happy holiday season and a great new year! - the staff at CANHR!
National Analysis Finds Nursing Home Compare Staffing Data Often Wildly Inaccurate

A consumer recently wrote to CANHR asking this about a nursing home where her mother had suffered terrible abuse and neglect: “How can this be a 5-star facility?” Of course we responded that the CMS Nursing Home Compare site consists primarily of provider-reported garbage and is certainly not data that consumers can rely on to pick a facility. So not surprisingly, on October 26, 2016, PennLive reported that its national analysis of 11,000 nursing homes found that nearly half had registered nursing (RN) levels on Nursing Home Compare that were 50 percent higher than shown in their federal reimbursement reports. The PennLive report, Think your nursing home is understaffed? It’s probably worse than it looks, is part of its continuing series, Failing the Frail.

The national analysis compared RN hours in two sets of data self-reported by nursing homes. The first set includes unaudited staffing reports completed by nursing homes during their annual inspections. The staffing levels compiled from these reports is reported on Nursing Home Compare and CMS uses it to calculate the staffing component of each nursing home’s Five-Star Rating. The second data set contains the Medicare/Medicaid cost reports filed with the federal government. The analysis found that nearly half of nursing homes across the nation appear to be significantly inflating their RN staffing levels on Nursing Home Compare.

PennLive created a national searchable database, Is your nursing home inflating its staffing level?, that allows the public to compare, by facility, the RN staffing levels reported on Nursing Home Compare with the levels reported in the Medicare/Medicaid cost reports. Most California nursing homes are included. In some cases, the RN staffing levels on Nursing Home Compare exceed the levels shown in the Medicare/Medicaid cost reports by over 1,000 percent.

NPR Reports on Death of San Francisco Nursing Home Resident

On November 27, 2016, NPR Weekend Edition Sunday reported that hospitalized patients unknowingly end up in substandard nursing homes where they suffer bed sores, infections and other types of neglect because hospitals usually fail to warn them about dangerous nursing homes or guide them to better ones. The report, Rule Change Could Push Hospitals to Tell Patients About Nursing Home Quality, told the story of Elizabeth Fee, an 88-year-old woman who died in January 2012 about two weeks after the California Pacific Medical Center (CPMC) in San Francisco discharged her to its own skilled nursing facility unit, which reportedly had a one star rating by CMS at the time. Mrs. Fee’s death due to an undiagnosed bowel obstruction was the subject of a CANHR Nursing Home Violation of the Month in September 2013 because of the nightmarish conditions surrounding her death. NPR reports that a proposed Obama administration rule that would require hospitals to tell patients about the quality of nursing homes they are considering is in jeopardy.

Nursing Home Closure Plans Reversed in Eureka

The nursing home crisis in Humboldt County triggered by Shlomo Rechnitz’s decision to close three of the five freestanding skilled nursing facilities in the County took a dramatic turn for the better with his November 7th announcement that he had rescinded plans to close two of the three nursing homes. Reportedly, Seaview and Eureka Rehabilitation and Wellness Centers will remain open and only Pacific Rehabilitation and Wellness Center will close. This reversal is very good news for current residents of these facilities, who were facing possible transfers to nursing homes hundreds of miles away. Mr. Rechnitz had seemingly used their lives as bargaining chips while seeking higher Medi-Cal rates for the nursing homes. Senator Mike McGuire described the situation as “a completely avoidable crisis brought on by a billion dollar corporation that has consistently put profits over people.”
Working to Protect Seniors’ Home Equity

CANHR is embarking on an innovative project to educate senior consumers on how to protect the equity in their homes. CANHR’s Home Equity Protection Program (HEPP) is a project funded by the State Bar of California to prevent financial mortgage scams and safeguard the homes of California’s low-income seniors. HEPP’s mission is to stem the tide of predatory reverse mortgage lending and improper estate planning practices that commonly lead to loss of the home in low-income communities.

If you are a senior homeowner considering extracting equity in order to access extra cash, you need to be aware of the significant risks associated with a reverse mortgage. For instance, did you know that if you take out a reverse mortgage and fail to keep up with your insurance, property taxes, and home maintenance, the loan will go into default, and the home will be foreclosed? Have you considered what will become of the loved ones living with you after you pass away or move out of the home, and the loan becomes due? A reverse mortgage may also affect your ability to qualify for long term care government benefits.

There may be alternatives to reverse mortgages that are better suited for accessing the cash you need. CANHR’s Home Equity Protection Program is designed to help low-income seniors understand their estate planning options. We suggest that you start with CANHR’s Guide on Inter-Family Lending - a lower-cost, more flexible alternative to commercial reverse mortgage loans www.canhr.org/factsheets/abuse_fs/familylendingguide.pdf.

A HEPP Toolkit is available free of charge to seniors and legal services programs, and contains information on Reverse Mortgages, Medi-Cal Recovery, Transfer on Death Deeds (TODs), and Advance Directives. For more information, visit www.canhr.org or call us at 1(800) 474-1116.

Taking Care of Business: Planning with Advance Directives

Don’t postpone important healthcare planning until it’s too late! Take some time now to create an Advance Health Care Directive (AHCD), a document that allows you to name a healthcare agent who will make medical decisions on your behalf when you are no longer able to make them yourself. In addition to naming an agent, an AHCD allows you to indicate what type of end-of-life treatment you prefer, and specify healthcare instructions. What kind of treatments would you want or not want to be given in the future? Who do you trust to make decisions for you, and who would be a back up for that person?

The best way to deal with potential incapacity in the future is to plan for it while you are still of sound mind. Download CANHR’s Advance Health Care Directive (www.canhr.org/publications/ahcd.html) along with a set of written instructions designed to guide you through the form. If you have questions about an Advance Health Care Directive, you should consult an attorney. Here’s a list of legal services programs by county: http://canhr.org/LRS/legal_services_by_county.htm and CANHR’s lawyer referral service contact form: http://canhr.org/LRS/GetALawyerReferral/ContactCANHRLRS.htm.

New Laws Effective January 1, 2017 (cont. from page 1)

Medi-Cal: Nonmedical transportation - AB 2394 (García):

Clarifies that nonmedical transportation is a benefit for all beneficiaries under the Medi-Cal program. Currently, the benefit is only offered to children on Medi-Cal and to Cal MediConnect beneficiaries.

CCRC Refunds - SB 939 (Monning):

Provides incentives for timely repayment of Continuing Care Retirement Community (CCRC) entrance fees, for CCRC contracts that condition repayment on the resale of the unit.

In-Home Supportive Services: Application - AB 1797 (Lackey):

Improves the In-Home Supportive Services (IHSS) application process by requiring that individuals applying electronically receive a confirmation number.

Care facilities: civil penalties - AB 2231 (Calderon):

Improves the penalty system in Residential Care Facilities for the Elderly (RCFEs); increases the amount of civil penalties imposed for a licensing violation under those provisions; and imposes civil penalties for repeat violations.
A common arrangement for CCRC residents is to pay a large entrance fee ranging from tens of thousands of dollars to over a million. In many of these arrangements, the entrance fee is refunded, at least partially, when the resident moves out or passes away. Sometimes the refund is determined by the length of the resident’s stay and other times the refund is made contingent on the re-sale of the resident’s unit once they are no longer living there. Regardless of the amount or the conditions of a CCRC entrance fee refund, the refund will likely be of substantial value and should be part of the resident’s estate planning considerations. In California, $150,000 in countable assets is enough to compel an estate into the probate process, which can take years and thousands of dollars to complete. People with over $150,000 of estate value are encouraged to structure and designate their assets so they do not get counted in a potential probate estate.

One common way of avoiding probate is to designate a “payable on death” beneficiary for a particular asset. In this format, the asset is transferred directly to an heir or group of heirs immediately upon the death of the asset’s owner. Another popular approach to avoid probate is to assign an asset to a living trust (a trust is a device that lets people retain control over their major assets but to keep them out of their name). Under either option, the asset is never technically part of the deceased owner’s estate and is not counted as a probate asset.

CCRC residents who will have at least part of their entrance fee refunded may want to work with the CCRC to designate any refund paid upon their death as payable directly to their heirs or living trusts. Residents who have already moved into a CCRC should review their refund designation and, if a post-death refund is not directed to a third party beneficiary or to an existing living trust, contact the CCRC management to make such a designation.

Estate planning matters, like designating a post-death CCRC refund should be handled under the guidance of an estate planning attorney. CANHR has a State Bar-certified estate planning Lawyer Referral Service that covers the entire state of California.

For a referral, please call 800-474-1116 or go to http://canhr.org/LRS/index.html

Find an Elder Law Attorney

Even as the crisis subsided, there were new revelations that the Department of Public Health had given Rockport Healthcare Services permission to close the nursing homes despite the fact the Department never gave Rockport approval to manage the facilities. A Rockport application to manage the nursing homes has been pending since 2014. The Department of Public Health’s failure to protect the residents during this crisis once again raises serious questions about its leadership, mission and priorities. California nursing home residents deserve far better from the agency charged with protecting their rights.

New Federal Regulations Take Effect

The first phase of revised federal nursing home regulations took effect on November 28, 2016, implementing numerous changes to the federal standards that have been in place since 1991. The new regulations are a mixed bag for nursing home residents that affect almost every aspect of life in a nursing home. Unfortunately, the most important new requirement – a ban on pre-dispute arbitration agreements – has been stayed by a federal court order in Mississippi ruling on behalf of the American Health Care Association.

The National Consumer Voice for Quality Long-Term Care published a summary of key changes to some of the requirements, including regulatory sections on Residents Rights; Freedom from Abuse, Neglect, and Exploitation; and Admission, Transfer and Discharge Rights.
**RCFE Corner**

**RCFE Admission Agreements Provisions: Legal v. Illegal**

RCFE admission agreements are contracts that specify the rights and responsibilities of both residents and the facility, and must comply with California laws and regulations. The RCFE admission agreement is the most important document for addressing concerns and resolving disputes. However, many admission agreements contain illegal and unenforceable provisions. Before signing an admission agreement, read it carefully and make sure that you understand its provisions. If you have questions, address them with the facility and make sure that the questions are answered to your satisfaction.

**Below are examples of several common illegal provisions in RCFE admission agreements:**

### Reasons For Eviction

**Legal:** There are only five legal reasons for eviction from an RCFE:

1. Non-payment
2. Failure to comply with state or local laws
3. Failure to follow facility policies that are for the purpose of helping residents to live together
4. Facility cannot meet a resident’s changing needs
5. Facility is no longer operating as an RCFE

[HSC 1569.269(a)(22); 22 CCR 87224(a)]

**Illegal:** Although an RCFE is prohibited from modifying the reasons for eviction in its admission agreement, [22 CCR 87507(c)(8)], facilities often list numerous impermissible reasons, such as:

- “You have a communicable disease.”
- “You are not elderly and have needs in conflict with other residents or the programs of services offered, or require more care and supervision than other residents.”
- “You would require a greater amount of care and supervision than other residents at FACILITY, or if you cannot generally benefit from the program of services available at FACILITY.”
- “You refuse to accept services required in order for FACILITY to meet your needs.”
- “You have health care needs that cannot be met at FACILITY, for reasons such as licensure, design or staffing.”
- “Your personal physician has determined that you require services not available at FACILITY.”
- “Any misrepresentation or omission made by you or on your behalf, whether written or verbal, should be grounds for termination of this agreement.”
- Since these reasons are not any of the five authorized reasons for eviction, it is illegal for an RCFE to include them in its admission agreement.

### Descriptions Of Services And Charges

**Legal:** Admission agreements must clearly specify the basic services required to be provided to each RCFE resident, any optional services that are available, and the corresponding charges. No fee may be charged that is not clearly stated in the admission agreement. [HSC 1569.884; 22 CCR 87507]

**Illegal:** Although admission agreements are required to clearly describe all services and charges, most agreements include inadequate or ambiguous descriptions of services and/or charges, such as:

RCFE Admission Agreements Provisions (cont on page 7)
“Resident is responsible for telephone installation and service.”

Since RCFEs are required to have telephone service on premises, and residents have the right to reasonable access to telephones, [22 CCR 87311, 87468(a)(14)], the provision is deficient because it fails to clearly specify the nature of the telephone installation and services the resident is responsible for, and the cost for those items. Additionally, since RCFEs are required to provide residents with access to telephones, the RCFE cannot refuse to provide telephone service even if the resident fails to pay for it.

“Personal supplies – Cost +”

This provision is deficient because it does not define the terms “personal supplies” or “cost +” to ensure that residents know what items they are agreeing to pay for and the cost of those items.

Security Deposits

- **Legal:** An RCFE may not require or accept any funds that constitute a deposit against any possible damages by the resident. [HSC 1569.651(c)]

- **Illegal:** Although security deposits are illegal, many RCFE admission agreements require residents to pay them by describing them in connection with refunds, such as:

  “After Apartment has been vacated and property removed, FACILITY will refund any unused portion of the final monthly fee minus any expense incurred in repairing damage caused by you to the Apartment.”

Waiver Of Rights: Theft Or Loss Of Personal Property

- **Legal:** Admission agreements cannot require residents to waive benefits or rights to which they are entitled by federal or state law. [HSC 1569.269(c)]

- **Illegal:** Although an RCFE is prohibited from requiring residents to give up benefits or rights, many admission agreements include hold harmless provisions, such as:

  “You agree to hold us, our associates and agents harmless for any damages, injury or other loss of personal property.”

  This provision is illegal, because an RCFE is required to make reasonable efforts to safeguard residents’ property. If it fails to do so, it must replace or pay for the stolen or lost property at its market value. [HSC 1569.152(a); 22 CCR 87218(a)]

Do not let RCFEs get away with trying to enforce illegal provisions in admission agreements! If you have concerns about the legality of specific provisions, either before or after you sign the agreement, please contact CANHR. If the admission agreement contains an illegal provision, file a complaint with CCL and send a copy of the complaint to CANHR.

For more information, please see CANHR’s fact sheets


Dear Concerned in Colusa:

As in nursing homes, residents of assisted living facilities have the right to visit privately with anyone of their choosing, without prior notice, during reasonable hours. (H&S 1569.269(a)(24); 22 CCR 87468(a)(11)) Residents also have the right to make choices concerning their daily life in the facility, and to reasonable accommodation of their individual needs and preferences in all aspects of life in the facility. (H&S 1569.269(a)(8),(24))

The facility’s visitation and bedtime policies are in violation of your mother’s rights and California law. A visitation policy restricting visitation to 8am-5pm each day is unreasonable, and creates an unnecessary and undue hardship for any potential visitors with full-time jobs. Additionally, a facility cannot require residents to go to bed at any particular time; your mother is entitled to sleep or stay awake whenever she pleases.

Dear Concerned in Colusa:

I just returned to work full-time, and went to visit my mother at her assisted living facility on my way home. I got to the facility at 6:00pm, and the administrator told me that I could not visit my mother because visiting hours ended at 5:00pm. My mother told me that the administrator forced residents to go to bed early so that she and her son could have “family time” in the house during the evenings. Can the facility require that I visit my mom before 5pm and force her to go to bed at a certain time?

Sincerely,
Concerned in Colusa

Did You Know?

Nursing Home Residents Can Go Home for the Holidays

As the holidays approach, nursing facility residents and their family members often worry about losing their rooms, or their Medicare or Medi-Cal status, if they leave a nursing facility for brief periods of time. While the rules for Medicare and Medi-Cal differ, both programs will permit, and reimburse the facility for, short leaves – depending on how long the leave is.

The Medicare Policy Manual, Chapter 8 §30.7.3, states that residents who leave the facility for an “outside pass or short leave of absence for the purpose of attending a special religious service, holiday meal, family occasion, going on a car ride, or trial visit home” can do so without losing their coverage. If they return by midnight, the facility can bill Medicare for the day. If the resident is gone overnight (past midnight) and returns the next day, this is considered a leave of absence and the facility can bill the beneficiary to hold the bed during the absence. The facility must inform the resident of the option to make bed-hold payments, and the amount of the bedhold payments, prior to the leave of absence. Make sure you discuss this with the facility and are clear about cost, since the daily rate at a nursing home can be high.

Under Medi-Cal rules, a leave of absence (LOA) of up to 18 days per calendar year can be granted to a Medi-Cal resident of a nursing home in accordance with the resident’s plan of care, and the facility will continue to be reimbursed for care. Up to 12 additional days of leave per year can also be granted under certain conditions. (See 22 CCR §51335) This is a much more liberal leave policy than Medicare, but it is also subject to certain restrictions. The resident, family members and/or friends should ensure that provisions for leaves of absences are included in the resident’s care plan.
Suggested Gifts for Long Term Care Residents

It’s the holiday season again and, as you make out your shopping list, we have some suggestions for possible gifts for a special long term care resident:

- A new pair of comfortable slippers or robe in a favorite color.
- Crossword or word search books – in large print if need be.
- A gift certificate for a haircut, massage or manicure and pedicure. Treat yourself and go with the resident.
- A television for the resident’s room, or wireless headphones to hear the television.
- Pictures taken in the last year of friends and family, arranged in an album, frame or on a bulletin board to hang up.
- A favorite book, books on CD/tape or a wireless reading device.
- A calendar with important dates, such as birthdays and anniversaries. Select some cards and provide stamps for the resident to send.
- Brighten up the resident’s room with a quilt or lap blanket. Bring in a plant or have flowers delivered on a regular basis.
- A videotape/DVD to enjoy together at the facility. Record a family event, such as a baptism or a graduation for the resident to share in the celebration.
- If the resident is in a wheelchair or uses a walker, find a tote bag that can attach to it.
- Subscribe to a hometown newspaper or a favorite magazine
- Check with the nursing home staff about other appropriate items, such as powder, lotion, toothpaste, soap, aftershave, etc.
- One of the best gifts for a nursing home resident, of course, is the gift of your visits.

Happy Holidays!
• **September 6**: Executive Director Pat McGinnis and attorney Peter Stern presented a webinar on the new Medi-Cal Recovery rules to over 280 participants.

• **September 15**: Staff Attorney Tony Chicotel made a presentation about decision-making for unrepresented patients in the health care system at the Contra Costa County Transitional Care Summit.

• **September 29**: Efrain Gutierrez hosted a CANHR information table at the Los Angeles Convention Center 16th Annual Senior Appreciation Luncheon, courtesy of Councilman Curren D. Price, Jr.

• **September 30**: Executive Director Pat McGinnis lectured on admission and retention issues at the San Francisco State University RCFE Administrator Certification Program.

• **September 30**: Efrain Gutierrez hosted an information table at the Los Angeles Convention Center 16th Annual Senior Appreciation Luncheon, courtesy of Councilman Curren D. Price, Jr.

• **October 7**: CANHR Volunteer hosted an information table at the Alice Manor Senior Fair in Los Angeles.

• **October 7**: CANHR Volunteer hosted an information table at the Cerritos Senior Center 2016 Senior Health & Wellness Fair.

• **October 13**: Prescott Cole was a guest lecturer at Hastings’s Law School Medical-Legal Partnership for Seniors class.

• **October 19**: Prescott Cole participated in a Veteran’s Aid and Attendance Benefit Taskforce.

• **November 2**: Prescott Cole was a guest on KALW’s Your Legal Rights Radio Show speaking about the Veteran’s Aid and Attendance Benefit scam.

• **October 25**: Tony Chicotel was part of a Long-Term Care Ombudsman Coordinators’ Conference panel presentation on the problem of nursing home residents being illegally dumped into hospitals.

• **November 2**: Julie Pollock spoke to the Piedmont Gardens Family Council about CCRC resident rights and organizing family councils.

• **November 9**: Executive Director Pat McGinnis spoke at the Southern California Council of Elder Law Attorneys’ monthly meeting in Encino.

• **November 9**: Imperial County’s Area Agency on Aging hosted an elder abuse prevention training with Tony Chicotel presenting on abuse and neglect issues in long-term care.

• **November 10**: Jody Spiegel participated in the RCFE Advocates Quarterly Meeting with Community Care Licensing.

• **November 10**: Prescott Cole joined the key stakeholders of the Veteran’s Aid and Attendance Benefit Protection Project Coalition at the SF City Hall Press Conference.

*CANHR On The Move ............ (continued on page 11)*
• **November 10:** Prescott Cole participated in the launch of San Francisco Veterans Benefits Protection Project (VBPP), a coalition consisting of the Institute on Aging, California Department of Insurance (CDI), California Attorney General’s Office (AG), California Advocates for Nursing Home Reform (CANHR), SF Long Term Care Ombudsman, and the Department of Aging and Adult Services (DAAS), organized to protect senior veterans from financial abuse.

• **November 15:** Prescott Cole attended the Elder Issue Legislative Recap and 2016 Strategy Meeting in Sacramento sponsored by the Consumer Federation of California.

• **November 18 & 19:** CANHR staff presented its 20th annual Elder Law Conference in Monterey, California with over 300 attendees.

• **November 18:** CANHR Volunteer hosted an information table at the Los Angeles Midnight Mission Veterans’ Stand Down Event.

• **December 6:** 2016 Prescott Cole was a guest speaker on KALW Your Legal Rights Radio Show speaking about elder abuse and neglect lawsuits against nursing homes and assisted living facilities.

**In Memory**

CANHR mourns the loss of Tim Millar – our colleague, our friend and our brother, who died on October 28, 2016. A certified financial planner and owner of Millar Financial, Tim was a part of the CANHR family for over 25 years. He served on CANHR’s Lawyer Referral Service Advisory Committee almost from its inception. He was a member of CANHR’s Board of Directors. He was a part of CANHR’s “traveling training troupe”, providing training on annuities and Medi-Cal to private bar attorneys across California and at our annual Monterey trainings. Tim was also a key organizer and trainer for CANHR’s annual Elder Law Conferences.

Tim did so much for so many in his professional and personal life that his footprint will be lasting. Most of all, Tim was a kind, thoughtful and loving friend and devoted to his wife, Linda, and daughter, Sarah. We will miss Tim’s great intelligence, his sense of humor and his smile. Those of us who had the honor to work with Tim and to be his friend know that the world is a better place because he was here – even if it was too brief a visit. To say Tim will be missed is an understatement. His loss leaves a hole in our hearts.

**From left to right:** Neil Granger, Elder Financial Abuse Consultant; Dave Jones, California’s Insurance Commissioner; Kimberly Swierenga, Esq.; Prescott Cole, Esq.; Shawna Reeves, Director of Elder Abuse Prevention, Institute on Aging.

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**In Memory - Tim Millar**

Tim will always have a special place in my heart. - Kenneth Leung

With deep respect. - Sanjiv Shukla

Thank you for wanting to donate on Tim’s behalf. - Becky and Linda
CANHR welcomes memorial and honorary gifts. This is a great way to honor a special person or a loved one, while helping those who are long term care residents. Recent gifts have been made in the names of the following persons:

MEMORIALS

Miriam Cross Boorman & Francis Gloria Frankfield
Elizabeth Boileau
Betty Camfield
Lee Camfield
Shirley Cornejo
Patricia Czoberek
Mrs. Mary Covey
Liz and Gerry
Frances Daugherty
Deborah Power
Professor Milorad M. Drachkovitch
Helen Drachkovitch
Richard and Mary Fleischer
Jane Reid
Maxine & Ernie Gallo
La Vonne Gallo
Nellie R. Hansen
Larry Hansen
Marion S. John
George & Carolyn John
Taeko Kawaguchi
Mamiko Kawaguchi
Norma King
David King
Sheila Lillian Krieger
Robyn Krieger
Ursula & Edmund Kroll
Christopher Kroll
Phyllis Manders
Julie Bernard
Phyllis Manders
Nora Clarke
Phyllis Manders
Jim Kahn
Phyllis Manders
Michelle Smith
Sherry McIlwain
Joyce McGriff
Tim Millar
Sanjiv Shukla
Timothy P. Millar
Linda Millar
Margaret Parker
Anne Brooks
Isabel Perez
Omir Perez

Denis J. Powell
Argene Powell
Margaret T. Ragsac
Roy Ragsac
Alice and Tom Riley
Barbara Riley
Maria & José Ruiz
Verona Ruiz
Alice M. Scobey
Mary Webster
Beatrice Smythe
Susan Nissen
Eunice & Don Stuart
Ms. Kathleen Stuart
Gilda Tometich
Tom Tometich
Rita Twomey–My Beloved Mother
Denise Twomey
Paul & Gladys Weber, and,
Shelby & Selma Allen
Mary & Friel Allen
Patricia Jo Wilkinson, Esq. A beloved colleague and friend
From the CANHR staff

IN HONOR OF

Mary W. Ballantyne
Robert Peterson
Bessie W. Harris
Bobbie J. Williams
Dr. Jerome
Matt O’Donnell
Timothy P Millar
Kenneth Leung

David Olmsted
Dave Olmsted
Give To CANHR

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

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

What You Get
- Donations over $50 receive a CANHR tote bag (while supplies last)
- Join a statewide network of informed and concerned consumers, caregivers, and advocates
- Receive our quarterly newsletter, The Advocate, which includes important long term care information and a detailed report of citations issued against individual nursing homes.
- Receive periodic updates on important legislation.

Donate Online  https://www.gifttool.com/donations/Donate?ID=1325

Mail-in Donation Form
To mail in your donation, please fill out the form and return it with your donation to:
CANHR, 650 Harrison Street, 2nd Floor, San Francisco, CA 94107.

Enclosed is my check for: □ $500 □ $100 □ $75 □ $50 □ Other _______________________

This gift is in memory of: __________________________________________________________

(or) in honor of: ________________________________________________________________

☐ Contact me about legislation and other advocacy opportunities.

☐ Save paper, send me The Advocate via e-mail. E-mail: _____________________________
Name: _______________________________________________________________________
Address: _____________________________________________________________________
City/State: ___________________ Zip: ___________________________
Telephone: _____________________ E-mail: _______________________
Facility Name: _________________________________________________________________
Happy Holidays and Best Wishes From the CANHR Staff


South Pasadena: Left to Right: Efrain Gutierrez, Jody Spiegel and Michael Conners

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

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

**Butte County**

**Riverside Convalescent Hospital**
375 Cohasset Road, Chico

B $2000  Patient Rights  Physical Abuse  Verbal Abuse  
09/23/2016

The facility was fined for failure to protect a resident from verbal and physical abuse after a resident requesting assistance to the toilet was pushed down onto her bed by a staff member, and told that she should “do it herself.” The resident reported that she was pushed so hard by the CNA that her neck made a popping sound. Citation # 230012578.

**Mariposa County**

**Avalon Care Center - Sonora**
19929 Greenley Road, Sonora

AA $80000  Dietary Services  Feeding Injury Neglect  
04/20/2016

On 8/23/14, a 90 year old resident was hospitalized and died after choking on a large piece of chicken served to him at lunch. The resident had a history of dysphagia (difficulty swallowing) and had experienced previous choking incidents at the nursing home that caused him to become cyanotic. He was on a mechanically soft diet that called for all meat to be ground or chopped and he was supposed to receive assistance with eating during meals to protect him from choking. On the date of his death, there was a single CNA passing trays and no one directly assisting the resident with his meal. When he started choking, 911 was called, paramedics responded and removed a large piece of chicken that was completely blocking his airway. He was pronounced dead at the Emergency Room shortly afterward. The coroner confirmed that choking on the large piece of chicken (not chopped or ground) was the cause of death. The facility was cited because its failure to ensure adequate supervision and direct assistance with his meal and failure to ensure the meal was provided in a texture the resident could safely swallow led to his death. Citation # 030012183.

**Monterey County**

**Carmel Hills Care Center**
23795 W. R. Holman Highway, Monterey

B $1000  Mandated Reporting  Patient Care  Physical Abuse  
07/14/2016

A quadriplegic resident with diagnosis of encephalopathy (disease of the brain) and dementia with behavioral disorder was subject to abuse from a staff member while the resident was being bathed. The nurse on duty increased the hot water temperature and sprayed the resident in his face. More investigation to the incident found the resident to sustain second degree burns. Citation # 030012428.

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**Sacramento County**

**Arden Post Acute Rehab**
3400 Alta Arden Expressway, Sacramento

B $2000  Bed Hold  Evictions  Transfer  11/06/2015

A male resident with dementia was admitted to the facility on 9/16/15 for rehabilitation services following a hospitalization for a fractured hip. He was involuntarily transferred to the hospital on 9/18/15, due to aggressive dementia-related behaviors. That same day, 9/18/15, the hospital determined him to be stable, but the facility refused to readmit him. The facility was cited for failure to provide a Notice of Discharge, failure to provide a written bed-hold policy, and for refusal to readmit the resident to the facility. Citation # 030011834.

**Eagle Crest**
8336 Fair Oaks Blvd., Carmichael

A $4000  Decubiti (Bedsores)  06/08/2016

In July of 2012 a 85 year-old resident with paralysis from a stroke, inability to swallow, a feeding tube, diabetes and dementia was admitted into the facility. On 8/9/12 the resident was sent to the hospital with open bedsores on her back and buttocks that were "unstageable" (a pressure ulcer that is covered by adhering tissue making it difficult to determine the depth of the wound). A review of the facility's admission 7/20/12, "Nursing Assessment," noted that it lacked a comprehensive skin assessment or pain assessment and did not contain a nursing care plan for skin breakdown. In an interview with the facility Director of Nursing indicated that because there wasn't a complete skin assessment on admission there were no treatment orders, nursing care plan or follow-up and that they, "dropped the ball." The facility was cited for failing to ensure the resident received care to prevent formation of bedsores. Citation # 030012313.
Sherwood Healthcare Center
4700 Elvas Avenue, Sacramento
B $2000 Mandated Reporting Notification Patient Care Physical Abuse Sexual Abuse 05/18/2016
The facility failed to report an incident of alleged abuse within the required 24 hour time period required by law after a staff member witnessed one resident touch the genitals of another resident. The staff member reported that he was unaware of the facility's policies on reporting abuse, and therefore did not report to any of the required agencies including the administrator, local police or ombudsman. Citation # 030012238.

Windsor Care Center of Sacramento
501 Jessie Avenue, Sacramento
B $2000 Mandated Reporting Patient Care Physical Abuse Verbal Abuse 04/20/2016
During the night shift on 2/10/16, a nursing assistant gave the middle finger to a 91 year old male resident, cleaned a 63 year old resident's genitals "very roughly," and slapped, yelled at, and hit a 69 year old resident who had a dementia diagnosis. All of these incidents were witnessed by another nursing assistant, and the abuse allegations were substantiated after an investigation by the Department. The facility was cited for failure to report an allegation of abuse within 24 hours. Citation # 030012176.

Windsor El Camino Care Center
2540 Carmichael Way, Carmichael
B $2000 Mental Abuse Patient Care Physical Abuse Verbal Abuse 11/18/2015
Facility was cited for failing to keep residents safe from physical and psychological abuse after a nurse slapped a resident's cheek, placed a sheet over her head, and slapped her again across the cheek. A second resident who witnessed the incident was crying and shaking while reporting the abuse after the same nurse threatened her, saying "see, that's what happens when you don't listen." Citation # 03001854.

Santa Clara County
Milpitas Care Center
120 Corning Ave., Milpitas
B $2000 Infection Patient Care 08/31/2016
The facility failed to provide the necessary medical care when a resident, diagnosed with diabetes, was prescribed an urgent podiatry referral for his foot. The referral was not made, resulting in the resident developing an infection on his big toe. Citation # 070012531.

San Tomas Convalescent Hospital
3580 Payne Avenue, San Jose
B $500 Administration Mandated Reporting Physical Abuse 04/22/2016
The facility failed to appropriately report to the CA Department of Public Health an incident of alleged abuse after a resident reported that an unidentified man hit her on the bottom and the hand. Citation # 070012205.

Skyline Healthcare Center - San Jose
2065 Forest Avenue, San Jose
B $2000 Injury Patient Care 09/15/2016
Facility staff failed to properly assess a resident for fall risk, did not properly implement bowel and bladder training therapy, and did not provide the resident with timely assistance to the bathroom. As a result, when the resident became frustrated after not receiving a response to her requests for assistance to the toilet, she stood and attempted to use a bedside commode and fell. The fall caused a hip fracture which required surgery. Citation # 070012574.

Stonebrook Health And Rehabilitation
350 De Soto Drive, Los Gatos
B $2000 Fall Injury Patient Care Supervision 07/26/2016
The facility failed to provide adequate supervision and assistive devices to prevent a resident from falling. The resident required extensive care when she moved from a seated to a standing position. The resident fell when she attempted to transfer herself from a wheelchair to her bed. There was no supervision while she was attempting to transfer. Citation # 070012422.

Terraces of Los Gatos, The
800 Blossom Hill Road, Los Gatos
B $1000 Verbal Abuse 08/12/2016
On 6/24/16, a resident had been admitted for rehabilitation services after an acute hospital stay for pneumonia. She complained to the occupational therapy assistant (OTA) that her roommate had called her a "cow" and said, "I hope you choke to death and die" after she had a coughing attack. This was reported to the facility's director of rehabilitation on the 24th, then to the facility's interdisciplinary team on 6/27, but never to the Department as required. The facility was cited for failing to report to the Department an allegation of verbal abuse between residents within 24 hours. Citation # 070012469.

Willow Glen Center
1267 Meridian Avenue, San Jose
B $2000 Careplan Medication 02/02/2016
Facility staff failed to properly manage and monitor a resident's use of a Fentanyl patch when a nurse did not remove an old patch before applying a new patch. Staff failed to monitor the resident's breathing, and when she became lethargic and presented with slurred speech, she was taken to the hospital, where the double doses of pain medication patches were discovered. Citation # 070012005.

Santa Cruz County
Pacific Coast Manor
1935 Wharf Road, Capitola
B $2000 Bed Hold Patient Rights 05/16/2016
The facility failed to readmit a resident after a hospital visit during a seven day bed hold period, and failed to comply with the Department of Health Care Services' Administrative Appeal order to readmit the resident Citation # 070012253.

Shasta County
Mayers Memorial Hospital D/P SNF
43563 Hwy 299 E, P.O. Bx 459, Fall River Mills
B $2000 Physical Abuse 05/31/2016
On three separate occasions in February and March 2015, a resident was abused by another resident. On 2/16/15, the resident grabbed the victim's wheelchair, shook him back and forth and hit him in the head. On 3/18/15, the resident again grabbed the victim's wheelchair and pushed it against the wall. On 3/25/15, the resident yelled at and hit the victim resulting in a large goose egg and bruising to his left eye. The facility was cited for failing to implement its abuse prevention policy to protect the resident from verbal and physical abuse. Citation # 230012276.

Yolo County
Alderson Convalescent Hospital
124 Walnut Street, Woodland
B $2000 Patient Rights Sexual Abuse 08/09/2016
On 03/26/2016, a male resident diagnosed with schizoaffective disorder walked into a female resident's room while she was sleeping and touched her vagina. She was found frantic, upset, and developed psychosocial distress. Several notes and interviews indicated the male resident had many indecent exposure incidents in the past and had stated himself the behaviors were beyond his control. Citation # 030012495.
**Fresno County**

**Sunny Side Convalescent Hospital**

2939 S. Peach Ave., Fresno

B $2000 Fiduciary Theft & Loss 07/27/2016

On 6/24/15, the facility's owner and administrator transferred $20,000 from the resident's pooled trust account to his own business account to "meet [the facility's] payables and payroll." The subsequent monthly trust account statements issued to residents did not represent the real balance in their accounts, but instead, "what money should be in the account." The facility was cited for each of the approximately 53 residents whose property was misappropriated.

Citation # 040012397, Citation # 040012400-10, # 040012412-14, # 040012425-27, # 040012430-31, # 040012433, # 040012436-45, # 040012449-60, # 040012462, # 040012464, # 040012466, # 040012468, # 040012471, # 040012473, # 040012475, # 040012477, # 040012478.

**Kern County**

**Delano PostAcute Care**

729 Browning Rd., Delano

B $2000 Mandated Reporting Sexual Abuse 08/15/2016

The facility failed to report two separate incidents of sexual abuse alleged by two residents involving CNAs touching them inappropriately. The facility performed internal investigations of both alleged incidents but did not report to DPH as required by law.

Citation # 120012461.

**Kern Valley Healthcare District D/P SNF**

6412 Laurel Ave, Lake Isabella

A $20000 Injury Medication Supervision 09/22/2016

An 84 year old resident who had dementia was hospitalized for four days to recover from a Norco overdose he suffered after taking a bubble pack of this narcotic pain medication from a nurse's station, where a nurse had left it unattended on 8/1/16. The bubble pack was found on the resident's dresser with 14 of the 30 tablets missing. Some of the missing tablets were later found. The facility was cited because the resident experienced a serious change of condition due to ingesting some of the Norco, it failed to provide him adequate supervision and failed to follow its own policy, which said that narcotic medications were to be kept under two locks at all times.

Citation # 120012551.

**Ridgeway Regional Transitional Care and Rehabilitation Unit**

1081 N China Lake Blvd, Ridgecrest

B $2000 Mandated Reporting Patient Care 08/31/2016

On 7/1/16, a 77 year old female resident with dementia was sitting in her wheelchair, transferred herself to the toilet and fell. She sustained a cut to her right eyebrow and was transferred to the local acute hospital. She was then transferred to another hospital as she was diagnosed with having a subdural hematoma, which is a collection of blood outside the brain and wrist fracture. There were complaints of pain in following days but no indication that pain medicine was given to her. She stated she told the staff regarding her pain and "Yes, it's like talking to a wall, they could care less." The facility failed to follow its pain policy and procedure to control the pain. The facility failed to provide treatment and caused the resident to suffer pain, thus negatively impacting her quality of life.

Citation # 120012527.

**Los Angeles County**

**Belagio in the Desert**

2639 W. Ave K4, Lancaster

B $1000 Bed Hold Patient Care 10/13/2016
The facility failed to follow policies and procedures for transfer and discharge of a patient when they transferred a resident to an emergency room without the need for emergency care. When the resident attempted to return to the facility they refused to readmit her, citing issues with her insurance. The resident was forced to spend two days in the emergency room before finding an appropriate bed at another hospital. The facility failed to provide the resident or her family member with a discharge notice, a reason for discharge, or a post-discharge plan. Citation # 980012643.

Bell Convalescent Hospital
4900 E. Florence Ave, Bell
A $20000 Patient Care 4/21/2016
On three separate occasions, 6/4/15, 11/19/15 and 12/12/15 a 58 y/o resident was transferred to the ER with fecal impaction and hydration issues. On the third transfer, the resident was diagnosed with acute renal failure and urosepsis. During an initial facility tour on 3/17/16 it was noted that the resident's water pitcher was positioned on a night stand out of his reach, and on a subsequent visit on 3/18 the pitcher was filled with a thickened liquid (with a consistency that coats and drips off a spoon), also positioned out of the resident's reach. The facility was cited for, among other things, failure to assess and document the actual amount of fluid intake and output, and failing to provide fluids and to ensure that fluids were accessible to a resident who was at risk for dehydration and required extensive assistance in eating and drinking. Citation # 940012186.

Centinela Skilled Nursing & Wellness Centre East
1001 South Osage Ave, Inglewood
B $ Physical Environment 04/17/2014
On 4/10/13, during a rectification survey it was discovered that the facility had removed a stove and exhaust hood and converted the kitchen to a rehabilitation room without permits or approval from California's Office of Statewide Health Planning and Development. The facility was cited for violations that had a direct relationship to the health, safety and security of all residents of the facility. Citation # 910010591.

Chandler Convalescent Hospital
525 S.Central Ave, Glendale
A $10000 Physical Abuse 10/27/2016
On 7/7/16, during an investigation regarding the abuse of a resident by a female nurses assistant, a CNA told investigators that sometime in April 2015 he had witnessed an aide repeatedly slap a resident across the face and made fun of for being "bald" while being transferred from a shower chair to a wheelchair. The CNA said that the aide had used both hands to strike the resident on the face. He also said that he told her to stop hitting the resident and that the resident tried to cover her face while being slapped. The CNA said he didn't report the incident because he was busy, but it later told another CNA about it (on 6/20/15) then made a report on 6/21/15. The facility was cited for failing to ensure that a resident was not physically or verbally abused by its staff and for the CNA failing to immediate report the abuse when it was witnessed. Citation # 920012672.

Country Villa Claremont Healthcare Center
590 S. Indian Hill Blvd, Claremont
B $2000 Neglect Verbal Abuse 09/02/2016
On 7/14/16, a female resident had an episode of urinary incontinence and waited 55 minutes before the nursing assistant answered her call light to change her. The nursing assistant then yelled at her "at the top of his lungs" that she was not the only resident he had to take care of, and then he cleaned her with cold water. The resident's roommate stated she also heard the nursing assistant yell at her roommate. The facility was cited for failing to ensure the resident was free from verbal and mental abuse. Citation # 950012558.

Del Rio Convalescent Center
7002 E Gage Avenue, Bell Gardens
B $1000 Other 08/04/2016
The facility was cited for failing to post its CMS star rating in an area used for communal activities such as a dining area or activities room. Incidentally, the star rating posted in the facility lobby, indicating 3 stars out of 5, was outdated. The facility's current posting was only 1 star. Citation # 940012488.

El Rancho Vista Health Care Center
8925 Mines Avenue, Pico Rivera
B $1000 Administration 03/08/2016
At 7:45 am on 6/14/16, during an unannounced visit made to the facility it was observed that they had not properly posted the 2016 Centers for Medicare and Medicaid Services 5 Star Rating Information in three locations as required. The postings were to be in areas used for employee breaks and areas used for communal activities. The only posting done by the facility was a 2015 "3 Star" rating in the lobby. The Department noted that the facility's 2016 rating was "2" and cited them for failure to post the most recent overall star rating. Citation # 940012484.

Genesis Healthcare Center
1201 Walnut Avenue, Long Beach
B $500 10/11/2016
On 12/29/15 a male resident reported to a CNA that $80 was missing from his wallet from the night before. The CNA noticed that 3 of his bedside drawers were locked, which was unusual. Maintenance opened the drawers and found that $60.00 was missing. The report indicated that on 12/30/15, after the facility's conclusion of the investigation the administrator refunded $60.00 to the resident. There was no documented evidence that the alleged theft and loss was reported to the Department of Public Health. The facility failed to notify the Department of Public Health of alleged financial abuse immediately, or within 24 hours. Citation # 940012624.

Granada Hills Convalescent Hospital
16123 Chatsworth Avenue, Granada Hills
B $2000 Physical Environment 06/24/2014
On 1/18/13, the Department found that the facility had undergone construction projects without obtaining the proper permits and approval. The projects included a new laundry room without a sprinkler system; alteration of the fire alarm system without testing or approval; and installation of a new HVAC system without fire dampers. During a subsequent survey on 5/4/14, the facility was still unable to provide documentation that the above issues had been corrected. Citation # 920010778.

Greenfield Care Center Of Gardena
16530 S Broadway, Gardena
B $1500 Administration Mandated Reporting Physical Abuse 08/24/2016
The facility failed to properly report and investigate an incident of abuse of a resident after a family member entered their room and threw salsa in the resident's face, causing burning and pain in his eye. Although the incident was reported by staff, the administrator failed to report the abuse to law enforcement, the Department of Public Health, and Ombudsman. The administrator also failed to conduct an investigation of the incident, document the incident, or initiate a plan for prevention of further abuse. Citation # 910012536.

Greenfield Care Center Of South Gate
8455 State Street, South Gate
A $20000 Patient Care 08/02/2016
On 7/28/15, an unannounced visit was made to the facility to investigate an allegation that the facility failed to act on a resident's complaints of abdominal pain, vomiting, and loss of appetite for approximately two weeks. The resident had a history of gastric bypass surgery, a procedure where the stomach is rerouted so a person does not absorb as much food. On 7/14 the resident called 911 without the staff's knowledge and got herself transferred to the hospital where she underwent a six hour emergency surgery for bowel obstruction. The facility was cited for failing to ensure that the resident, who had a history of gastric bypass was provided with necessary care and services, including but not limited to failing to assess and monitor the resident's progressive complaints of lack of appetite, abdominal pain, nausea and vomiting or to notify the physician. Citation # 940012435.

Harbor View Behavioral Health Center

490 W 14th Street, Long Beach

B $2000 Administration Mandated Reporting Physical Abuse 04/27/2016

On 1/17/16 a resident attempted to choke a female resident while she slept. The facility did not report the incident until 1/19/16, two days later. The facility failed to report all incidents of alleged abuse or suspected abuse of a resident of the facility to the department within 24 hours. Citation # 940012498.

Hyde Park Convalescent Hospital

6520 West Blvd, Los Angeles

A $20000 Fall Injury Patient Care 06/28/2016

On March 25, 2012, a male resident fractured his right arm when he was improperly transferred from his wheelchair to bed. During the transfer, the resident's arm got stuck under the armrest of the wheelchair. The nursing assistant who transferred the resident did not report the incident to his supervisors until the next day. On March 26, 2012, the resident was sent to the hospital where he was diagnosed with a right arm fracture. The facility was cited for providing inadequate supervision and assistance to prevent accidents. Citation # 910012351.

Imperial Healthcare Center

11926 La Mirada Blvd, La Mirada

A $16000 Fall Staffing 5/26/2016

On 10/29/2014, a 68-year-old female resident with cerebral palsy who required two staff people to assist with transferring to and from her bed fell from a Hoyer lift sling when only one staff person was moving her into her bed. The sling used during the transfer was the wrong size. The resident sustained a fractured femur that required surgery as well as head and back injuries. Nursing aides stated that many staff take the chance to transfer residents with the Hoyer lift by themselves due to the facility's shortness of staff. The facility was cited for failing to prevent accidents and failure to follow the resident's care plan. The citation did not include the reported facility understaffing. Citation # 940012278.

Intercommunity Healthcare & Rehabilitation Center

12627 Studebaker Rd., Norwalk

A $16000 Careplan Chemical Restraints Patient Care 9/12/2016

On 6/30/16, a 94-year-old male resident with dementia was prescribed Seroquel (an antipsychotic medication) off-label to treat "scratching and itching behavior and a skin rash." The resident was also prescribed Trazadone (an antidepressant) on 7/13/16. The resident's family members stated they had been seeking a dermatologist to consult with the resident regarding his rashes, but facility staff told them that the Seroquel would treat his scratching behavior. The resident had abnormal lab results related to kidney impairment that could have been the cause of chronic itching. The facility was cited for failure to ensure the resident was not prescribed an antipsychotic without indication for its use, failure to ensure that the side effects of the antipsychotic medication were monitored, and failure to ensure the resident received adequate care to treat his ongoing rash and itching. Citation # 940012507.

B $2000 Physical Abuse Mandated Reporting 08/03/2016

On 8/3/15, a CNA transferred a resident from the wheelchair to the bed, and the resident's head hit the bed's side rail and made a loud noise. On 8/4/15, the family member of the resident spoke with the Administrator and DON regarding her concern that the CNA had mistreated the resident during the transfer through rough handling. The Administrator did not report the allegation of physical abuse to the Department until 8/11/15, seven days after the allegation was made. The facility was cited for failing to report within 24 hours the allegation of abuse. Citation # 940012487.

La Paz Geropsychiatric Center

8835 Vans Avenue, Paramount

A $10000 Patient Care Physical Abuse Supervision 06/10/2016

On 7/11/2015, A resident went to his room, and while opening his locker, his roommate came close to him and stated, "Don't bug me." The resident flicked the encroaching resident off and the resident retaliated by hitting him in the back of the head. This led to a fight. The facility failed to ensure that these resident's were free from abuse. Citation # 940012314.

B $2000 Physical Abuse 08/26/2016

On 9/9/16, at 7:30 am a resident with schizoaffective disorder and senile dementia was observed holding down and attempting to hit one of his roommates. At 2:30 pm that same afternoon he went after another of his roommates and started punching him. One week after that there was another altercation outside the bathroom. One of the attacked residents told investigators that he reported being attacked to the doctor, medication nurse, and the social services designee but nobody did anything about it. The investigators noted that the facility's Interdisciplinary Team had discussed changing the combative resident's room, but decided a room change would not decrease his assaultive behavior since there were no distinguishing factors indicating which resident he was likely assault. The facility was cited for failing to remove and monitor the resident after the physical altercations. Citation # 940012543.

Landmark Medical Center

2030 N Garey Ave, Pomona

B $2000 Elopement Patient Care Security 09/08/2016

On 6/19/2015 during a shopping outing, a female resident with anemia, peptic ulcer, bipolar disorder, and schizoaffective disorder was accompanied to the restroom by staff and ran away. The resident had no medications, money or clothes other than what she was wearing. Staff searched for the resident and were unable to find her. A care plan indicated she had a history of AWOL from previous placements, but not from this facility. As of 07/21/2016 the resident had not returned to facility and they did not have any new information regarding her. Citation # 930012566.

Los Angeles Community Hospital D/P SNF

4081 E. Olympic Blvd., Los Angeles

B $2000 Physical Restraints 04/24/2015

On 4/24/15, an RN observed a resident lying in bed with swollen hands, and soft restraints applied to both wrists that had not been released for 3-4 hours. The facility was cited for failing to ensure that the resident had the right to be free from any physical restraints, because the resident’s clinical record did not indicate an assessment and care plan for restraint use, least restrictive measures prior to restraint use, nor a physician order for the use of restraints. Citation # 930011647.
Maple Healthcare Center
2625 Maple Avenue, Los Angeles
A $20000 Careplan Injury Patient Care 10/28/2016
The facility failed to provide and coordinate appropriate medical care and services to prevent a resident's gastrostomy tube from continuously being forced out of position. The resident's G-tube was inserted in his abdominal area and was used to feed the resident. The resident also developed a pressure injury on his skin from the tube disc used to keep the G-tube in place. The resident's careplan initiated on 1/18/16 indicated he attempted to pull out his G-tube and was at risk for injuries. An intervention plan was developed, yet the resident was ultimately transferred six times to get his G-tube replaced in the general acute care hospital from 1/17/16 to 8/25/16. Citation # 940012671.

Maywood Skilled Nursing & Wellness Centre
6025 Pine Avenue, Maywood
A $20000 Medication Neglect Patient Records 2/12/2016
A resident with COPD (chronic obstructive pulmonary disease) and frequent shortness of breath was ordered to receive oxygen saturation checks at least three times a day. A nurse in the facility stated that she had falsely signed that she was checking the residents oxygen saturation levels when she actually had not. In addition, the resident was given morphine beyond the limits prescribed by his physician and his PRN medications were not properly recorded in his medication administration records. The facility was cited for inadequately monitoring the resident and keeping him free of unnecessary drugs. Citation # 940012009.

Mirada Hills Rehabilitation And Convalescent Hosp
12200 S. La Mirada Blvd, La Mirada
B $ Medication Patient Care Patient Records 01/10/2014
The Department investigated the facility on 12/6/13 and again on 12/9/13, and found that the nursing staff failed to administer medication at the prescribed time for 31 surveyed residents (medications are considered "on time" if administered within one hour of the prescribed time). The facility was cited for failure to administer medications as prescribed, failure to notify the physician of late administration of medication, and failure to accurately record the time the medications were administered in 31 patient records. Citation # 940010371.

Montebello Care Center
1035 W Beverly Blvd, Montebello
B $2000 Mandated Reporting Patient Care Physical Abuse 08/22/2016
After a 96 year old resident with dementia was found to have bruised and fractured ankle of unknown origin, the facility was cited for failure to appropriately report an injury to a resident within a 24 hour period as required by law. Citation # 940012523.

Mount San Antonio Gardens
900 E. Harrison Avenue, Pomona
A $18000 Physical Abuse 10/04/2016
On 7/17/16, a certified nursing assistant (CNA) put a wash cloth inside a resident's mouth and a pillow over her face while providing care. A CNA who was assisting removed the pillow from the resident's face, but the abusive CNA placed it back again and kept it there for 3-5 minutes until care was completed. Another CNA witnessed a similar abusive act on 7/14/16 involving the same resident and stated that residents would cry while receiving care from the abusive CNA due to rough treatment. The administrator believed that the abusive CNA's main purpose was to muffle the resident's screams during care. The facility was cited because it failed to protect the resident from physical abuse. Citation # 950012615.

Palos Verdes Health Care Center
26303 Western Ave, Lomita
B $2000 Physical Abuse Security 09/12/2016
The facility failed to ensure a 74 year-old female resident was free from physical abuse. The resident's roommate, who had a history of aggressive physical behavior, scratched her face and arms. The facility failed to respond to the incident in a timely manner and adequately supervise the resident for her safety during and after the attack. Citation # 910012564

 Paramount Meadows Nursing Center
7039 Alondra Blvd, Paramount
A $20000 Infection Neglect 06/28/2016
A resident with COPD (chronic obstructive pulmonary disease) and frequent shortness of breath was ordered to receive oxygen saturation checks at least three times a day. A nurse in the facility stated that she had falsely signed that she was checking the residents oxygen saturation levels when she actually had not. In addition, the resident was given morphine beyond the limits prescribed by his physician and his PRN medications were not properly recorded in his medication administration records. The facility was cited for inadequately monitoring the resident and keeping him free of unnecessary drugs. Citation # 940012009.

Mirada Hills Rehabilitation And Convalescent Hosp
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The Department investigated the facility on 12/6/13 and again on 12/9/13, and found that the nursing staff failed to administer medication at the prescribed time for 31 surveyed residents (medications are considered "on time" if administered within one hour of the prescribed time). The facility was cited for failure to administer medications as prescribed, failure to notify the physician of late administration of medication, and failure to accurately record the time the medications were administered in 31 patient records. Citation # 940010371.
Riviera Healthcare Center
8203 Telegraph Road, Pico Rivera
B $2000 Infection Mandated Reporting 08/05/2016
During July and August 2015, four residents had clinically suspected cases of scabies. The facility was cited for failing to report an outbreak of scabies to the Department within the requisite 24 hours. Citation # 940012494.

Rose Villa Healthcare Center
9028 Rose Street, Bellflower
B $2000 Verbal Abuse 08/04/2016
On 7/30/15, a family member reported to the administration that a LVN told a resident that she smelled and needed to be changed, then slammed the resident's private curtain shut. This left the resident feeling humiliated and the family member concerned about the resident receiving safe care and services from the facility's staff. This resulted in the family taking the resident home against medical advice. The facility was cited for failing to report to the Department about an incident of verbal abuse by it staff with 24 hours as required. Citation # 940012489.

Royal Oaks Manor - Bradbury Oaks
1763 Royal Oaks Drive-North, Bradbury
B $1500 Patient Care 06/03/2016
The facility failed to follow proper procedures for monitoring and treating pressure sores, which develop from staying in one position for too long. When a 94 year old resident with dementia developed a pressure sore, he went 10 days without prescribed treatment, leading to an increase in size and seriousness of the sore. Citation # 950012311.

A $15000 Careplan Staffing Transfer 07/18/2016
The facility was cited after it failed to provide a resident with two person assistance during transfer to the toilet, resulting in anxiety and distress during the transfer, as the resident was repeatedly yelling out for additional help during the transfer. As a result of not receiving the support with transfer as required in both the resident's care plan and the facility's transfer policy, the resident fell, resulting in injuries to his toes and feet. Citation # 950012334.

Shadow Hills Convalescent Hospital
10158 Sunland Blvd, Sunland
B $2000 Bed Hold Patient Care Transfer 08/23/2016
The facility failed to ensure its bed-hold and readmission policies were implemented by failing to hold a bed for seven days when a resident was transferred to a general acute care facility for evaluation and treatment of abdominal pain. The facility did not have a bed ready for the resident when she was to be transferred back to the facility. As a result, the resident remained at the acute care facility for four months until she was transferred to another facility. Citation # 920012530.

Tarzana Health And Rehabilitation Center
5650 Reseda Blvd, Tarzana
A $20000 Patient Care Supervision 10/27/2016
The facility failed to ensure a resident who had a history of falls, muscle weakness, difficulty walking, and was a smoker was provided with the necessary supervision, assistance, and an environment free of accident hazards as possible to prevent fall and injuries. As a result, on 2/29/16, five days after being admitted to the facility, the resident fell when returning from the smoking area unaccompanied and sustained an injury to the head and right knee. The resident required an immediate transfer to a general acute care hospital where she had to undergo head surgery due to a hemorrhage she suffered. Citation # 920012654.

The Orchard - Post Acute Care
12385 E. Washington, Whittier
B $2000 Injury Mandated Reporting Physical Abuse 08/19/2016
A female resident reported to her family that on 8/29/15, a nursing assistant grabbed, pulled, and bruised her left arm while assisting her to the restroom. The family reported the incident to a charge nurse on 8/30/15, but the nurse never further investigated the incident or reported the suspected abuse to a supervisor or the department of public health. On 8/31/15, a licensed nurse observed the resident's left arm to be bruised with purple, reddish raised skin. The facility was cited for failure to report an incident of suspected abuse of a resident. Citation # 940012525.

The Rowland
330 W. Rowland St, Covina
A $16000 Careplan Decubiti (Bedsores) Patient Care 09/14/2016
The facility failed to prevent the development and progression of an avoidable pressure sore for a resident who was at risk for developing a pressure sore. The resident's admission assessment conducted on 4/3/15 indicated he was admitted to the facility without a pressure sore. On 2/29/16 an evaluation regarding resident's risk of developing a pressure sore indicated he was at moderate risk of developing a pressure sore. During an interview on 3/16/16 a CNA stated he was unable to turn and reposition the resident as instructed every two hours because he was busy taking care of another resident. On 1/31/16 the physician assessed the resident's sacrum pressure sore had progressed to a stage III pressure sore. Citation # 950012569.

Verdugo Vista Healthcare Center
3050 Montrose Ave, La Crescenta
B $20000 Patient Care 09/01/2016
A resident with sensory impairment limiting her ability to feel pain or discomfort was admitted to the facility on 09/02/15 with no pressure sores and was identified as low risk for such. A review of the care plan dated 11/30/15 indicated the resident had developed wounds to her back and was at risk for wound infection. The care plan required staff assess the wound and provide wound treatment. On 2/9/16, the Director of Staff Development (DSD) stated the protocol for pressure sores was not implemented for the resident because the nurses did not identify her wounds as pressure sores. As a result, the facility failed to ensure the resident received the care necessary for the prevention, assessing, and treatment of pressure sores. Staff failed to promote healing, prevent infection, and prevent new sores from developing. Citation # 920012496.

Vermont Healthcare Center
22035 S Vermont Ave, Torrance
A $20000 Fall Patient Care 06/10/2016
On 12/16/10, a male resident had a seizure and slid out of the shower chair, which did not have a seat belt, and fell on his face on the floor. The resident sustained bilateral nasal bone fractures and nasal septal deviation with deformity of the cheek bones. The plan of care dated 6/21/10, indicated a potential for injury from tremors and involuntary movements and a high risk for falls/accidents due to Parkinson's disease. The facility failed to implement the facility's shower policy and procedures to ensure the resident had a seat belt while sitting in a shower chair, during shower. Citation # 910012300.

Windsor Palms Care Center of Artesia
11900 East Artesia Blvd, Artesia
A $20000 Patient Care 05/26/2016
A 79 year old resident experienced many falls, including two falls on one same day. His last fall on 1/18/16 resulted in a left hip fracture, requiring him to go to a general acute care hospital (GACH). The facility failed to identify a plan of care, investigate each fall and
follow its policy and procedure regarding supervision of the resident. Citation # 940012233.

A $20000 Fall Injury Neglect 07/13/2016
On 5/27/16, a resident fell and suffered fractures and bruising of both lower legs while a certified nursing assistant (CNA) was transferring her from bed to a shower chair using a mechanical lift. The CNA assisted the resident with this transfer by himself, disregarding the facility's policy requiring two people to assist residents with transfers involving a mechanical lift. Treatment was delayed for two days because the CNA did not report the fall to the charge nurse and the resident was not hospitalized until four days after she was injured. The CNA was fired after the incident. The facility was cited because the resident suffered serious injuries due to its failure to follow its policy on transfers with mechanical lifts, and failure to timely report the resident's fall. Citation # 940012367.

A $20000 Fall Injury 05/26/2016
On 8/10/15, a resident who had a high risk for falls suffered a fractured left arm when he fell from bed while a certified nursing assistant (CNA) was transferring him from bed to a shower chair using a mechanical lift. The resident required two-person assistance for this type of transfer, per the facility's policy, but only one CNA assisted him. This resulted in the resident falling, his left arm being caught in the lift's sling, and fracturing his arm. He was hospitalized and received strong narcotic pain medications. Surgery was recommended, but not performed due to the resident's other health conditions. The facility was cited because the resident suffered a serious injury due to its failure to follow its policies and the manufacturer's guidelines in using a mechanical lift. Citation # 940012231.

Woodruff Convalescent Center
17836 S Woodruff Ave, Bellflower
B $2000 Injury Mandated Reporting Sexual Abuse 10/21/2016
On 8/7/16, a 46 year old female resident with cancer in the brain and kidney was transferred to the hospital for pelvic pain. At the hospital, she complained that she sustained a bruise on her face and that a facility staff member touched her in her private area. The hospital informed the facility of the resident's allegation, but the facility failed to report the incident to the Department. Citation # 940012673.

York Healthcare & Wellness Centre
6071 York Blvd., Highland Park
A $20000 Careplan Dietary Services Feeding Hydration Patient Care 4/8/2016
A female resident was admitted to the facility on December 12, 2014 with a diagnosis of dementia, pelvic fracture, and a high risk for dehydration. On December 18, a family member noted the resident moaning and "not really conscious" and reported this to the facility. On December 22, 2014, the resident was transferred to the hospital for dehydration and fecal impaction. The facility was cited for failure to conduct a nutritional assessment for the resident; failure to reassess the resident for increased risk of dehydration in light of a urinary tract infection; failure to review or document the resident's fluid intake, especially after the resident refused seven (7) meals consecutively; and failure to implement the resident's plan of care to monitor for fecal impaction. Citation # 940011868.

Madera County
Oakhurst Healthcare & Wellness Centre
40131 Hwy 49, Oakhurst
B $2000 Careplan Patient Care 09/16/2016
The facility failed to ensure a male resident's podiatry services were provided as ordered by his physician resulting in hospitalization, antibiotics, and wound care. The resident's diagnosis included diabetes, chronic kidney disease, peripheral vascular disease, neuropathy, hypertension, and no toes on his left foot due to a previous amputation. Additional resident records indicated he suffered from fungus infected, overgrown, large nails and bleeding areas to his right foot. During an interview, the social service director (SSD) stated that the facility was required to provide podiatry services as ordered and was responsible for the payment of those services given to residents with non-eligible insurance. The director of nursing (DON) stated interventions should have included to keep the resident indoors as he liked to sit outside in the sun in his wheelchair barefoot, ensure the CNA's performed daily skin checks, ensure licensed nurses performed their skin assessments during the completion of the weekly progress notes and ensure the resident wore shoes to protect his feet. Citation # 040012581.

Riverside County
Palm Grove Healthcare
1665 East Eighth Street, Beaumont
B $2000 Administration Fiduciary Patient Records 6/30/2015
On 10/6/13, the facility Administrator told state investigators that the former Business Office Manager (BOM) had admitted "mismanaging" residents trust funds. A resident had no Medi-Cal Share of Cost but yet a total of three withdrawals were made from the resident's trust fund for a total amount of $3,498.00 allegedly for Share of Cost expenses on 5/6/13, 6/6/13, and 7/4/13. The facility failed to ensure the resident's trust funds were free from financial abuse. Citation # 250011514

A resident had $5,603.00 withdrawn from his account that was unaccounted for and with no receipts or description. The facility Business Office Manager, who was in charge of resident funds from 2008 to 2013, admitted to mismanaging trust accounts and fraudulently writing checks to herself. A state auditing agency found discrepancies in excess of $97,000 in the resident trust accounts in 2012. The facility was cited for failure to prevent financial abuse. Citation # 250011513.

The Grove Care and Wellness
3401 Lemon Street, Riverside
B $1500 Fiduciary 6/30/2015
On 10/6/13, the facility Administrator told state investigators that the former Business Office Manager (BOM) had been in charge of handling residents' funds from 2008 through August of 2013 and that the BOM had admitted "mismanaging" residents trust funds. A state auditing agency conducted an investigation beginning in 2013, and found a discrepancy in excess of $97,000 in resident trust funds from 1/1/12 through 12/31/12. During an interview with the former Business Office Manager, she admitted to "mismanaging" resident trust funds. A resident had an additional Share of Cost withdrawn from his trust fund totaling in $2,051.00. The facility failed to ensure a resident was free from financial abuse. They failed to implement a policy to prevent financial abuse of the resident's trust funds. Citation # 250011515.

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The Grove Care and Wellness
3401 Lemon Street, Riverside
B $2000 Neglect Patient Care 10/31/2016
On 1/17/16, an electrical fire occurred in the mechanical room of the facility, and staff assigned to care for residents in the skilled nursing section were instructed to leave their assigned work area and assist with evacuating residents from the assisted living floors. The facility was cited for evacuating clients from the assisted living floors who were ambulatory out of the building ahead of any attempted evacuation of the skilled nursing residents. Citation # 940012685.