Let’s Be Clear -
America’s New “Health Care” Act

House Republicans recently unveiled their version of “health care for all” in the form of the American Health Care Act – the repeal and replacement of the Affordable Care Act which enabled over 20 million Americans to access health care coverage. Budget reconciliation bills were introduced in the Ways and Means and Energy and Commerce committees and are collectively titled the American Health Care Act. With no hearings and no budget estimate from the nonpartisan Congressional Budget Office, the House Republicans hope to move the bill to the full house by early April without addressing how much the bill will cost and how Americans who are currently covered will be impacted.

While this replacement bill retains a number of the ACA provisions, e.g., prohibiting denial of coverage due to a pre-existing condition, and no lifetime or annual limits on coverage, many of the proposed provisions will make health coverage more expensive or deny coverage completely for those covered under Medicaid. The new proposal allows insurance companies to charge as much as five times more for premiums to older adults, and eliminates tax penalties for companies and those who refuse to purchase health insurance (the individual mandate under ACA) but allows insurance companies to charge a 30% surcharge on premiums for those who let their insurance lapse if and when they decide to purchase coverage. The 30% “premium penalty” – while not a “tax” per se – only enriches the insurance companies. And with no incentive for younger, healthier people to buy health insurance, the ability of insurance companies to spread the risk is limited and that will lead to higher premiums and denial of coverage particularly for older adults.
Planned giving leaves a legacy to honor your memory and helps to ensure the future of CANHR. With careful planning, it is possible to reduce or eliminate income and estate taxes while turning appreciated assets into income for yourself or others. Planned giving can include gifts by will, gifts of life insurance or, by a revocable living trust or charitable remainder trust. Call the CANHR office or email patm@canhr.org to get more information and a free booklet on planned giving.

CANHR has produced a new Medi-Cal Recovery consumer booklet. The booklet, “The New Medi-Cal Recovery Laws – effective January 1, 2017” - is now available for free download on www.canhr.org - under the Medi-Cal Recovery page. The booklet is available in English, Spanish, Vietnamese and Chinese and is available for free in bulk orders to qualified legal services programs. QLSPs simply need to contact CANHR. Also available for free download is CANHR’s popular booklet on Medi-Cal: A Consumer’s Guide to Financial Considerations & Medi-Cal Eligibility. Please visit www.canhr.org for more information.

It’s not just for the holidays! Any time of the year 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 CANHR by shopping at smile.amazon.com. On your first visit to AmazonSmile you will need to select, “California Advocates for Nursing Home Reform” as the charitable organization to receive donations from eligible purchases before you begin shopping. Amazon will remember your selection, and then every eligible purchase you make at smile.amazon.com will result in a donation.

Keep an eye out for this year’s United Way Work Place Giving Campaign for 2017, coming soon to your work place. As a Certified Community Campaign Agency, California Advocates for Nursing Home Reform (CANHR) is participating in:

- The Bay Area Community Campaign (#151)
- The California State Employees Charitable Giving Campaign (#151)
- The Combined Federal Campaign (#6010)

Consider CANHR when making a charitable contribution through payroll deductions and support CANHR services. A full description of CANHR services is available at www.canhr.org.
Don’t Let Congress End Our Elder Abuse Protections!

Congress is set to vote on H.R. 1215 - a pro-corporate, anti-justice bill to federalize health care malpractice lawsuits and limit victims’ access to justice. Aside from imposing price caps on justice and discouraging lawsuits when people are harmed, the bill would eliminate state protections like California’s elder abuse statutes that apply to medical malpractice, pharmaceutical products, nursing homes and health insurance claims. H.R. 1215 represents a craven effort to immunize health care providers from accountability for malpractice and terrible care. Call your Congressperson today and tell them to vote no on H.R. 1215. See the front page of CANHR’s website @ www.canhr.org for more information on H.R. 1215 and how you can oppose this terrible bill.

Federal Protections for Nursing Home Residents Under Attack

Longstanding federal safeguards, rights and benefits for nursing home residents are in jeopardy due to various proposals by the new Congress, Trump Administration and the nursing home industry. Proposals under consideration would gut or scale back regulations governing nursing homes, end government oversight by turning over nursing home inspections to private accreditation agencies, slash Medicaid funding and coverage by capping funding to the states, and diminish critical protections in the Affordable Care Act and other federal laws.

The nursing home industry wasted no time in trying to cash in on the new Administration. A December 15, 2016 letter from the American Health Care Association (AHCA) to then President-Elect Trump describes its shameless proposals to repeal the new federal nursing home regulations and give even more federal money to nursing home operators. AHCA incredulously claims that poverty and overregulation have brought the nursing home industry to the brink of failure.

Immense Wealth of Nursing Home Operators on Display

The National Union of Healthcare Workers (NUHW) issued a report on February 16, 2017 that California’s largest nursing home operator, Shlomo Rechnitz, has been globetrotting in a luxurious multimillion dollar jet he acquired in 2013. The report – Misplaced Priorities at 40,000 Feet – describes connections between the Rechnitz corporations that own and lease the jet and his nursing home business, Brius Healthcare. Sal Rosselli, the President of NUHW, has called for state authorities “to audit Brius and its subsidiaries to determine whether Rechnitz is siphoning off public funds intended for nursing home residents.”

America’s New “Health Care” Act.... (cont. from page 1)

Medicaid expansion enrollments will end in 2019, with those who left the expansion program in the interim for any reason unable to return. The proposal replaces federal financial participation (California, for example, is a 50-50 state, whereby 50% of funding for certain categories of Medi-Cal beneficiaries is from the federal government) with a per capita allotment, severely reducing federal funding which leads to a reduction in the states’ Medicaid budgets which leads to a reduction in the number of eligible Medi-Cal beneficiaries and a reduction in payments to providers. As Justice in Aging recently noted: “Over 6 million older adults rely on Medicaid, and 2/3 of all Medicaid spending for older adults goes to essential long term care services in nursing homes and at home and in the community. AHCA threatens the care of all of these seniors and the peace of mind of their families.”

Let’s be clear: this proposed “health care” bill is not about patient access or protections at all. It’s about denying coverage to millions of Americans to pay for tax cuts to the wealthy and lining the pockets of the insurance companies – crafted by congressional representatives who are guaranteed comprehensive health care for life at taxpayers’ expense.
CANHR is supporting, opposing and/or closely following the following pieces of legislation this session. Since it is still early in the new session, this list is subject to change. Please check www.canhr.org for updated details on legislation, and www.leginfo.ca.gov for information of specific bills. Also stay tuned for a number of federal bills that will impact health care, elder abuse issues and the aged and disabled, and register your opposition to those bills that would diminish consumer rights and remedies.

Support

**AB 286 (Gipson): To Allow Medi-Cal Beneficiaries to Return Home**

Under current law, a Medi-Cal beneficiary in a nursing home is allowed to retain $209 per month for a “home upkeep allowance” if a physician has certified that the resident is likely to return home within 6 months - while the rest of the resident’s income must go to pay the share of cost. The allowance of $209 has not changed in decades and is insufficient to maintain a home of any value in California. As a result, Medi-Cal beneficiaries who could otherwise go home within 6 months, end up losing their homes or apartments and having to stay long term in the nursing home at the expense of Medi-Cal. AB 286 would change this poor public and economic policy, by basing the upkeep allowance on the actual minimum cost of maintaining the resident’s home. This common sense proposal would not only enable residents to avoid losing their homes, but save needed Medi-Cal resources by reducing the costs of long-term care.

**AB 550 (Reyes): Restoring Funding for Long-Term Care Ombudsman Programs**

In 2008, the 35 local Long-Term Care Ombudsman (LTCO) programs had all of their state funding cut, leading to enormous reductions in staff and services for residents of long-term care facilities. Since then, the programs have had only sporadic and insufficient funding from the state despite larger numbers of residents to serve. AB 550 partially remedies this problem, by boosting the base funding allocation to the LTCO programs and adding $2.25M in total funding.

**AB 275 (Wood): Strengthening Closure Protections for Nursing Home Residents**

AB 275 would take modest steps to enhance protections for nursing home residents during a closure by requiring greater advance notice of a closure, clarifying the Department of Public Health’s authority to reject closure plans, and requiring facilities to prepare a community impact report if two or more facilities are planning to close on the same date. The bill responds to a months-long crisis in Eureka in 2016 when Shlomo Rechnitz – who owns all five freestanding skilled nursing facilities in Eureka – threatened to close three of them in an effort to obtain higher Medi-Cal payments for the facilities.

**AB 859 (Eggman): Protecting Seniors Abused by Nursing Homes**

This bill will protect seniors and dependent adults abused in nursing homes and discourage facilities from intentionally destroying evidence in violation of the law. AB 859 provides that when a judge or arbitrator finds the nursing home has illegally destroyed evidence, the standard of care is reduced from clear and convincing to preponderance of the evidence. Currently the only remedy for the intentional and willful destruction of evidence in such cases is a discretionary sanction or a jury instruction by the judge. AB 859 ensures that such illegal and willful destruction of evidence will not be tolerated.

**AB 937 (Eggman): Patients Should Control End of Life Care**

This bill will fix a longstanding terrible problem whereby anyone could overrule the written end of life care wishes of a patient through the use of a Physician Order for Life Sustaining Treatment (POLST) form. Current law states that when a request regarding end of life care in a POLST conflicts with a previously signed health care directive, the POLST prevails. The problem is that POLSTs do not need to be signed by the patient, in fact, they can be signed by anyone. Thus, third parties have the effective power to overrule a patient’s expressed wishes. AB 937 fixes this problem by stating that the most recent wishes expressed by the patient herself prevail in any conflict of instructions.

**AB 940 (Weber): Transfer and Discharge Notices to Long-Term Care Ombudsman**

This bill codifies a federal regulation that requires nursing homes to send copies of resident transfer
or discharge notices to the local long-term care Ombudsman. The bill adds a requirement the copy be sent within 24 hours of issuing the notice and specifies enforcement action for non-compliance.

**SB 202 (Dodd): Medi-Cal Personal Needs Allowance**

This bill would increase the personal needs allowance for residents of long term care facilities from $35 per month to $80 per month.

**SB 219 (Weiner): LGBT Senior Bill of Rights**

SB 219 prohibits long-term care facilities from taking discriminatory actions based on a resident’s actual or perceived sexual orientation, gender identity, gender expression, or HIV status. It also imposes penalties for violation of these rights and requires facilities to post a notice regarding these practices alongside its current nondiscrimination policies.

**Oppose**

**AB 1026 (Dababneh): Public Financing of For-Profit Nursing Homes Chains**

This bill would make low-cost financing and loan guarantees available to for-profit nursing homes through the California Health Facilities Financing Authority Fund and the Health Facility Construction Loan Insurance Fund. These actions would betray the mission of these programs to help nonprofit and public health facilities reduce their cost of capital and would enable the expansion of for-profit nursing home chains that are providing poor quality of care to their residents.

**Status:** Assembly Health

**DHCS Trailer Bill Legislation: 610: Fifty Percent Rule and Personal Injury Lien Recovery**

The Department of Health Care Services’ trailer bill proposal to amend the laws regarding recovery from personal injury cases should be rejected and the issue should be moved to the policy arena where it belongs. The Department’s proposal to eliminate the 50% recovery rule for personal injury liens should be rejected entirely. This proposal is inequitable to victims of abuse and neglect and will ensure that, rather than increase recoveries, few, if any, aged and disabled abuse victims will even want to pursue justice.

While the Department contends that their proposal will result in increased General Funds, the proposed 100% rule will clearly have the opposite effect and result in additional General Fund losses. If the abused victim will recover nothing — and nothing is what they would recover under the Department’s proposal — there is no incentive to bring a lawsuit. Thus the parties who injured them will pay nothing to the victim or to the state.

Much of the abuse and neglect that occurs in our nursing homes can be directly attributed to the ongoing and systematic failures of the Department of Health’s oversight and enforcement system. It is reprehensible for the Department to seek the lion’s share of a recovery of a pain and suffering award from a deceased elder or dependent adult.

**Federal Proposed Laws**

**HR 1215 - OPPOSE**

Congress is fast tracking considering a bill that will effectively end California’s 20-plus year civil protection system for victims of elder abuse or neglect perpetrated by health care providers.

H.R. 1215 is a corporate wish list of anti-justice measures to immunize health care providers from accountability for terrible care by limiting justice for victims of health care malpractice. The bill is misleadingly named the “Protecting Access to Care Act of 2017.” A more apt name for H.R. 2115 would be “Obstruction of Justice for the Injured.”

While California already has a $250,000 cap on non-economic damages – the centerpiece of H.R. 1215 - elder and dependent adult abuse cases are rightfully exempt. H.R. 1215 would end this critical exemption. H.R. 1215 inoculates an entire class of professionals and the health care industry from being held liable when their actions fall below, even far below, the acceptable standards or when they intentionally hurt a patient.

**Affordable Care Act Repeal – OPPOSE**

The American Health Care Act is the repeal and replacement of the Affordable Care Act, which enabled approximately 22 million Americans to access health care coverage. With no hearings and no budget estimate from the nonpartisan Congressional Budget Office, the House Republicans hope to move the bill to the full house by early April without addressing how much the bill will cost and how Americans who are currently covered will be impacted. This bill will slash funding for the federal Medicaid program, unfairly target older adults for cuts in services and make it much harder for Americans to access long term care.
Dear Desperate in Downey:

Based on California’s new Medi-Cal recovery law, which applies to individuals who pass away on or after January 1, 2017, mobile homes and manufactured homes will now be excluded from estate recovery claims, because they are not subject to probate in California (Probate Code Section 13050(b)(3)). So your mother doesn’t have to do anything to avoid recovery on the mobile home – it’s exempt under the law.

Also, based on the new law, the state can only recover if your mother received nursing home care or “home and community based services” such as the Assisted living Waiver, Multipurpose Senior Services Program, Nursing Facility Waiver or In Home Operations Waiver. To learn more about how the new Medi-Cal recovery law will affect you, review CANHR’s consumer guide: www.canhr.org/publications/PDFs/Medi-Cal_Recovery.pdf

Did You Know?

Medi–Cal Beneficiaries Can request the amount of the Estate Recovery Claim

One of the most frequent complaints from Medi-Cal beneficiaries has been the inability to find out how much in benefits has been paid on their behalf. As of January 1, 2017, a Medi-Cal beneficiary who may be subject to recovery or their authorized representative can submit a request to find out the amount of the Medi-Cal claim, for a fee of $5. This information can be requested once a year via Internet, by phone or mail, and the Department must provide information within 90 days of receipt of the request.

The form can be downloaded from www.dhcs.ca.gov/services/Pages/DHCS_4017.aspx.

Please contact CANHR for more information or click on the link below, on how to deal with an estate recovery claim if you receive one and, for others, how to avoid a claim in the first place. www.canhr.org/publications/PDFs/Medi-Cal_Recovery.pdf
Focus On

HOW THE CALIFORNIA ATTORNEY GENERAL’S OFFICE HAS FORSAKEN NURSING HOME RESIDENTS

#1 Reducing Punishment For Nursing Homes That Break The Rules Or Harm Residents

When a nursing home is fined for breaking rules and harming residents, that is often not the end of the story. Facilities can appeal both the amount of the fine and the severity of the citation. After reviewing 98 recent appeals cases supplied to CANHR from a Public Records Act request, we found what nursing homes have long known:

- 90% of appeals were settled out of court, with the AG agreeing to reduce the fine or citation class;
- $1 Million Settlement agreements showed a $1.1 million reduction in fines;
- Of the settled cases, 98% of the citations or fines were reduced;
- 48% of AA citations were dropped to A citations.

Taxpayers pay nursing homes to litigate these citations! Facilities report litigation costs as an "administrative expense" through Medicare and Medi-Cal.

#2 Gutted Operation Guardians – The Best State Program We Had For Protecting Residents

Under former AG Bill Lockyer, the AG’s office formed Operation Guardians (OG), which sent a team of experts to review the care given in troubled nursing homes throughout the state. The OG investigations were frequent and robust and typically uncovered serious abuse and neglect of residents which was documented in reports shared with the nursing home and the Department of Public Health. In recent years, the program has withered, reports are no longer shared with anyone, and no known criminal prosecutions have been filed. OG’s once spirited efforts to improve quality of care have diminished significantly.

#3 Abandons Residents Who Have Been Illegally Evicted

Illegal evictions of nursing home residents who have been hospitalized has been a longstanding problem in California, largely due to the State’s refusal to enforce resident protections. Residents often appeal their evictions and receive a readmission order from the State but these orders are not enforced. In some of those cases, the nursing home sues the State to overturn the readmission order. The AG is tasked with representing the State in those lawsuits. Rather than defend the State’s order (or even consider helping the residents return to their home), the AG gives up, refusing to participate in the case. Residents who have been dumped illegally by their nursing homes suffer a second abandonment – this time by the AG’s office.

“The State will not take an active part in this present litigation, which is an appeal from [its] decision.”
The decision to move into a Continuing Care Retirement Community or not represents one of the most important decisions a person can make in their lifetime. The relationship between a CCRC and a resident is expensive, lengthy, highly personal, and complex. In the following exchange, we explore some of the more important considerations. For more detailed information about CCRC’s check out CANHR’s special web page: www.canhr.org/CCRC/

**Peace of Mind**

**Pro:** Availability of access to a continuum of care creates peace of mind, a sense of security, and relieves the burden on children and family to make decisions about meeting the health needs of their loved ones as they age.

**Con:** For continuing care “peace of mind,” residents have to pay an enormous 6-figure entrance fee that often represents virtually all the savings for a middle class person. Additionally, the long-term commitment severely impedes consumers’ primary power: taking their business elsewhere.

**Entrance Fees**

**Pro:** Entrance fees are sometimes fully refundable within the first 90 days of entry and partially refundable within the first 50 months. Some contracts allow for up to a 90% refund once the unit is vacated and the unit is reoccupied. Entrance fees also provide the main source for maintaining the campus and paying for capital improvements.

**Con:** The entrance fee may be refundable but there are often restrictions (refund predicated on re-sale) and limited “reserves” requirements, meaning the CCRC might not have your money when you need it. Residents can feel trapped if they’re unhappy in their community.

**Monthly Fees**

**Pro:** CCRCs provide a wide array of options for dining, activities, and wellness programs. Higher levels of care are provided at a discount compared to persons coming in from the outside.

**Con:** Despite the expensive buy-in, residents must pay a pricey monthly fee or else they will be evicted. The monthly rates can be and are increased from year to year, at the sole discretion of management.

**Access to Services**

**Pro:** Over 70% of all CCRCs provide a continuum of care on campus. Access to levels of care usually on the same campus (i.e. independent living, assisted living, possibly memory care, skilled nursing) is spelled out in the contract providing a guarantee. This makes it convenient for spouses with different care needs to stay close and for friends to visit.

**Con:** Residents requiring assisted living or nursing home services are sometimes required to go off-site to receive them. This can be quite disruptive, separating couples and making visiting very difficult.

**Self Determination**

**Pro:** Applicants can choose from a range of options for independent living with the entrance fee and monthly rental fees depending on size
and location of the unit. Increasingly, CCRCs are offering services in the independent units that support aging in place. Such services might be covered by long-term care insurance.

**Con:** Residents have virtually no control over where they are going to live within the CCRC once they’ve moved in. Residents have almost no rights to contest being moved to a different (more expensive) level of care or to a different room within a level care.

**Rights**

**Pro:** There are very few complaints by residents regarding the accessibility and quality of care in CCRCs. Residents’ rights are spelled out in the contract, and all contracts are reviewed by the state regulatory agency.

**Con:** Residents’ rights are underwhelming and enforcement of regulatory standards by the Department of Social Services is almost non-existent. This imbalance is exacerbated by contracts giving CCRCs almost total control over costs and life within the community.

**Other Considerations**

**Pro:** Living in a community offers many opportunities for engagement and socialization - a powerful antidote to isolation and loneliness.

**Con:** Institutional life can create dependency and a sense of being over-scheduled. Living in a peer-aged community can feel unnatural and can sometimes support cliques, further isolating residents.

**Pro:** Witnessing people aging with grace and dignity as they cope with physical and mental diminishments provide peer role models.

**Con:** Surrounded by decline and death can be depressing. Some CCRCs frown on walkers and wheelchairs in the dining areas or other displays of infirmity as it detracts from marketing appeal.

**Conclusion**

CCRCs have a lot to offer the people who can afford them. But the availability of guaranteed services cost a lot more than dollars. Residents give up control over most critical decisions in the CCRC contracts and have few legal protections. Be careful!

**AB 713 (Chu) – CCRC Level of Care Transfer Disputes**

Under current California law, Continuing Care Retirement Community (CCRC) providers follow a list of statutory requirements and standards to initiate a resident’s level of care transfer. This includes an analysis of the necessity and appropriateness of the transfer, taking into consideration the resident’s physical and mental condition. Residents who dispute a CCRC’s transfer decision may prompt a review by the Continuing Care Contracts Branch of the Department. However, when analyzing the appropriateness and necessity of the transfer, the Department only reviews whether or not the provider accurately followed the transfer procedure, dotted the “i’s” and crossed the “t’s”; they do not consider whether or not the resident’s physical or cognitive condition warrants a transfer.

AB 713 would require the Department, when reviewing a resident disputed transfer, to consider the appropriateness and necessity of the transfer, including the physical, cognitive, mental and emotional functional abilities of the resident, and an explanation of the assessment as conducted by the provider. This bill would also require the provider to use an assessment tool in determining the appropriateness of the transfer and share the assessment with the resident.

AB 713 is sponsored by the California Continuing Care Residents Association (CALCRA) and the Consumer Federation of California. To support this important bill, email your letter of support to the Office of Assemblymember Kansen Chu at annie.pham@asm.ca.gov.
Wage Protections for RCFE Staff Improve Quality of Care

In 2014, CANHR published an article in the Advocate about wage protections for RCFE staff. The article included summaries of actions taken by the U.S. Department of Labor’s Wage and Hour Division (WHD) against RCFE operators for wage violations. Unfortunately, RCFEs continue to deny employees rightfully earned wages, as described in the recent cases below.

The Fair Labor Standards Act (FLSA) guarantees RCFE employees minimum wage and overtime pay. The WHD is responsible for enforcing the FLSA, and ensuring that RCFE staff are paid properly for all the hours they work. The FLSA applies to residential care facilities, whether the institution is public or private or is operated for profit or not-for-profit.

Although the RCFE industry is a multi-million dollar industry with enormous profit margins, its success is not being shared with direct care staff. The WHD continues to find violations in the residential care field, especially in the Bay Area. In the 2015 fiscal year, the WHD’s San Francisco Office concluded more than 100 investigations of residential care facilities and nursing homes, resulting in $3 million in back wages and damages for more than 475 employees. Within the past two years, the WHD has taken action against the following RCFE operators for failing to pay proper wages:

San Miguel Homes for the Elderly (Union City)

- Consent judgment requiring payment of $425,000 in back wages and damages to 26 caregivers.

- Investigation found egregious minimum wage and overtime violations as the company made caregivers work around the clock without paying them for all of their hours.

- Company’s owners had employees falsify timesheets, and threatened to sue workers suspected of cooperating with the investigation.

Walnut Creek Willows (Walnut Creek), Elizabeth’s Care Home 1 and 2 (South San Francisco), Samantha’s Care Home (San Bruno),

New Haven Care Home (Union City), Rayzel’s Vila and Villa San Lorenzo (San Lorenzo)

- Consent judgment requiring payment of $643,992 in unpaid wages and damages.

- Employers misclassified caregivers as independent contractors, paid them a flat monthly salary well below minimum wage, provided no premium for overtime even though employees often worked more than 60 hours per week, and failed to keep any records of the employees’ hours worked.

LQC Care Home, Richlee Care Home, White Oaks Manor, Cerezo Residential Care Home, Ross Senior Care Home (Silicon Valley)

- Employers will pay $359,000 in back wages and an equal, additional amount in liquidated damages to 32 workers.

- WHD found that owners paid most workers a flat rate per day for working at least 12 hours per day that failed to cover at least $7.25 per hour, failed to pay overtime when they worked more than 40 hours per week, and failed to record the hours actually worked by employees.

St. Elizabeth Home for the Elderly I and II (Covina), St. Therese Home for the Elderly and St. John’s Home for the Elderly (San Dimas), St. Anthony’s Home for the Elderly, St. James Home for the Elderly, St. Michael’s Home for the Elderly (Glendora)

- Employer will pay $103,724 for overtime violations to 40 employees.
- WHD found that employer paid employees only for their scheduled hours, and failed to pay for any time spent caring for patients or performing other work-related duties before or after their scheduled shifts.

Tricia’s Care Home, Kelly’s Home, Cortez Home, Shoreview Home (San Mateo), Albright Home and Olympic Home (South San Francisco), Flora’s Home (Burlingame)

- Employer will pay $101,791 in back wages and an additional $101,791 in liquidated damages to 53 workers.

- WHD found that employees received monthly salaries that, in many instances, did not cover the federal minimum wage of $7.25 per hour, and didn’t receive legally required overtime pay for hours worked beyond 40 in a workweek.

- WHD also found that employer failed to maintain accurate records of work hours and pay, and misclassified some workers as independent contractors instead of employees.

Many elderly people and people with illnesses, injuries and disabilities rely on the vital services provided by RCFE staff. Because of their hard work, over 170,000 Californians are able to live more independently in community settings. The FLSA guarantees that these professionals receive the wage protections they deserve while protecting the rights of individuals to live in the community. Fair wages are critical in protecting one of California’s fastest-growing workforces, and one made up predominantly of women, women of color and immigrants. Lack of adequate pay increases turnover, destabilizes personnel, and puts RCFE residents at risk.

If you suspect that RCFE staff are not being paid proper wages, contact the WHD at 866-487-9243 or visit www.wagehour.dol.gov. For more information, see U.S. Department of Labor Fact Sheet #33: Residential Care Facilities (Group Homes) Under the Fair Labor Standards Act - http://www.dol.gov/whd/regs/compliance/whdfs33.pdf. See also Department of Labor newsletters at http://www.dol.gov/_sec/newsletter/.

- WHD found that employer paid employees only for their scheduled hours, and failed to pay for any time spent caring for patients or performing other work-related duties before or after their scheduled shifts.

**RCFE News and Notes**

**Applicability of RCFE Regulations to Residential Living/Independent Living Units in CCRCs**

CANHR was pleased to note that the Department of Social Services has finally recognized that the resident rights in the RCFE regulations apply fully to CCRC residents - both independent living and RCFE residents. This includes the Family Council and Resident Council laws. In a response to a question from the January 24, 2017 advocacy coalition meeting, DSS responded as follows:

**Question:** Since a CCRC must have an RCFE license, to operate, are RCFE laws and regulations applicable to both the residential living/independent living AND assisted living units in the CCRC? For example, are the physical premises requirements regarding water temperature set forth in 22 CCR 87303(e)(2) applicable to the residential living/independent living units in a CCRC?

**Response:** The Adult and Senior Care Program monitors continuing care providers for compliance with the Community Care licensing laws and regulations regarding buildings and grounds, accommodations, care and supervision of residents, and quality of service in both the residential living/independent living units and the assisted living units in the CCRC.

**Liability Insurance Required for all RCFEs**

AB 1523 (Chapter 205, Statutes of 2014) which became effective on July 1, 2015, requires all RCFEs, except those facilities that are an integral part of a continuing care retirement community, to maintain liability insurance. Liability insurance is required to cover injury to residents and guests caused by the negligent acts or omissions, or neglect by the RCFE licensee or its employees. Liability insurance is required to be maintained in an amount of at least $1 million per occurrence and $3 million in the annual aggregate. Licensing Program Analysts will verify that licensees comply with this requirement during inspections and complaint investigations.

**Important Phone Numbers for RCFE Consumers**

Centralized Complaint Information Bureau (CCIB): 1-844-538-8766
Caregiver Background Check Bureau (CBCB): 1-888-422-5669
Community Care Licensing Division - Public Inquiry and Response: 1-916-651-8848
Long Term Care Ombudsman: 1-800-231-4024
CANHR: 1-800-474-1116
Past Speaking Engagements, Panel Discussions and Training Sessions

- December 9: Staff Attorney Prescott Cole attended the Veteran’s Aid and Attendance Benefit Taskforce Meeting Institute on Aging Department of Insurance Offices San Francisco.

- December 13: Julie Pollock presented a workshop to social workers, nurses, and discharge planners at Palo Alto Medical Foundation on “Hot Topics in Medi-Cal and Long Term Care.”

- December 13: Staff attorney Tony Chicotel talked about law and ethics related to clients with impaired decision-making capacity at SAGE Eldercare Solutions.

- December 15: Prescott Cole participated in the Alameda County Elder and Dependent Adult Abuse Multi-disciplinary Team (CCE-MDT).

- December 16: Prescott Cole gave a presentation to the San Francisco Ombudsmen on how they can protect long-term care residents from the Veteran’s Aid and Attendance scam.

- December 19: Prescott Cole attended San Francisco’s Multidisciplinary Team Meeting to hear a presentation from the California Department of Business Oversight.

- January 10: Executive Director Patricia McGinnis presented on treatment of annuities under Medi-Cal to the Santa Clara County Social Services Agency, with attorney Peter Stern, who presented on Treatment of Trusts.

- January 24: Jody Spiegel participated in the RCFE Advocates Quarterly Meeting with Community Care Licensing.

- January 24: Pat McGinnis and Program Manager, Pauline Mosher, held a consumer forum on CCRC rights and remedies at St. Mark’s church in San Francisco.

- February 2: Prescott Cole taught an all day training session on the Home Equity Protection Project and elder law issues to the Riverside and San Bernardino Adult Protective Services.

- February 8: Efrain Gutierrez hosted a CANHR information table at Alice Manor in Los Angeles.

- February 8: Executive Director Pat McGinnis appeared on KAWL’s “Your Legal Rights” with host Chuck Finney and LRS Advisory Board member, Peter Stern, to speak about the new Medi-Cal Recovery laws.

- February 21: Jody Spiegel gave a presentation to the Orange County Ombudsman Program on CANHR Services and Hot Topics in Long Term Care.

Gwendolyn Smith, Julie Pollock, Heidi Stein, and Melissa Anne Ghiselli at PAMF Social Worker Training

Efrain Gutierrez and Assemblymember Adrin Nazarian in Sacramento on CANHR’S Legislation Day.

CANHR On The Move .................. (continued on page 13)
Efrain Gutierrez and Senator Ricardo Lara in Sacramento on CANHR’S Legislation Day.

- **February 21**: Prescott Cole gave a long-term care presentation to the California State Retirees Health Benefits Committee Meeting in Sacramento.

- **February 22**: CANHR’s staff travelled to Sacramento for its annual Legislative Action Day visiting old and new members and discussion CANHR priorities for 2017.

- **February 26**: Prescott Cole was a guest lecturer at Hasting’s Law School Medical-Legal Partnership for seniors class.

- **March 1**: Executive Director Patricia McGinnis presented a Webinar to legal services staff on California’s new Medi-Cal Recovery laws.

- **March 8**: Tony Chicotel presented a webinar to legal services programs on CANHR’s new Advance Health Care Directive form.

- **March 16**: Prescott Cole participated in the Alameda County Elder and Dependent Adult Abuse Multi-disciplinary Team (CCE-MDT)

- **March 17**: Prescott Cole was interviewed as a guest on Lake County Radio KPFC about elder issues and CANHR’s mission

---

**Upcoming Events**

**Save the Date!**

**SF State Genontology Program’s 30th Anniversary Dinner and Reception**

*Honoring State Senator Mark Leno - Distinguished Long-Term Care Advocate Award*

**View the Flyer**

**Wednesday, April 5, 2017**

5:00pm-7:00pm

Seven Hills Conference Center at SF State

For more information or to RSVP, please visit:

[www.sfstategerontology.eventbrite.com](http://www.sfstategerontology.eventbrite.com)
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:

**IN HONOR OF**

Jean S. Beck  
Linda Beck

Bill Benson  
Steve Crane

Celia Christian  
Lydia Gugich

Mike Connors, Tony Chicotel, and  
Janet Wells  
Toby Edelman

The Precious Elderly  
Ms. Virginia Barker

Sabita Goswami  
Subrata Goswami

Bessie Harris  
Bobbie Williams

Dr. Jerome  
Matthew O’Donnell

Pat McGinnis  
Gerry Murphy

Julie Pollock, CANHR  
Martin Young

Larry Roth & Donna Ambrogi  
Penny Deleray Taylor

Therese Serezlis  
Nola Serezlis-Slattery

Shoshanah  
Anne Brodzinsky

Peter Stern  
Richard Gorini

Thanks for the help.  
Roy Garrett

---

**CANHR Presents**

**What You Should Know about Long Term Care in California**  
**Medi-Cal Eligibility & the New Medi-Cal Recovery Laws**

*Presented by: Pat McGinnis, Executive Director CANHR*

**May 5, 2017**  
10am - 1pm  
Magnolia Place Family Center  
1910 Magnolia Ave Los Angeles, CA 90007

$30 regular price, $25 for SWAP members

To register:  
[https://goo.gl/g1dTNp](https://goo.gl/g1dTNp)

*For social workers, geriatric care managers, admission and discharge planners and other long term care professionals.*
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**

Linda Bradford  
Donald C. Freeman  
Herman Chetlen  
Martin Chetlen  
Ethel Christensen  
Ron Christensen  
Celia Christian  
Lydia Gugich  
Victoria Delas  
Anthony Delas  
Professor Milorad M. Drachkovitch  
Helen Drachkovitch  
Beryl DuBois  
Candie Brady  
Margaret Mizner Glidden  
Nancie Glidden  
Douglas M. Grant  
Joan Grant  
Elvira H. Jones  
Jane D. Bennett  
Francis X. Kelly  
Colette A. Kelly  
Norma King  
David King  
Mrs. Lucille Labat  
Louis Labat  
Wayola B. Larson  
Mr. Paul Larson  
Josephine Luckjohn  
Georgia Riportella  
Ruth Martinez  
Jeni Pfeiffer  
Lily Mason  
Ron Wing  
Sherry O. McIlwain  
Gloria McIlwain  
Timothy Millar  
Laura Destro  
Tim Millar  
Mary Gerber  
Tim Millar  
Catherine Hofman  
Timothy P. Millar  
Kenneth Leung  
Timothy Millar  
Menah Sharif Magee  
Tim Millar  
Canice McLaughlin  
Timothy P. Millar  
Linda Millar  
Tim Millar  
Robert Nakatani  
Timothy Millar  
Daniel Rossi  
Lupe Mora  
Rose M. Morosa  
The Parents of Linda DiGangi  
Arlene & Ted Morrissey  
Jeanette D. Santage  
Franklin & Rosita Pennill  
Lee Pennill  
Denis J. Powell  
Argene Powell  
Julius Schnall  
Jean Schnall  
LaVerne Schwacher  
Debra Vogler  
Merle Sprock  
Dale W. Sprock  
Marylin Carmelita Young  
Margrethe Jorgensen  
Joan Young  
Martin Young

**In Memory - Nona Tolentino**

Nona Tolentino, the former Director of the Kern County Long-Term Care Ombudsman program and a fierce advocate for long term care, recently passed away. Nona and her staff were instrumental in the State Attorney General’s 2009 case against employees at Kern Valley Healthcare District, where two dozen residents were illegally drugged and three residents died from chemical restraints. Nona brought the case to the attention of state officials and the subsequent criminal prosecutions helped generate the momentum for a national effort to curb misuse of antipsychotic drugs in nursing homes. Though Nona retired in 2015 to spend more time as a grandma, her impact continued to be felt in the Ombudsman program, Greater Bakersfield Legal Assistance, and throughout Kern County. Despite the challenges of her job, Nona was always a total joy to work with. We will miss Nona and her considerable moxie.
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: ____________________________
NEED AN ATTORNEY?

CANHR’S LAWYER REFERRAL SERVICE (LRS)

THE ONLY STATEWIDE BAR CERTIFIED LAWYER REFERRAL SERVICE SPECIALIZING IN ELDER LAW

- Elder Adult And Dependent Abuse And Neglect In Care Homes
- Elder Financial Abuse From Financial Institutions
- Estate Planning For Long Term Care

Give us a call or request a referral online

(415) 974-5171

www.canhr.org/LRS/GetALawyerReferral/ContactCANHRLRS.htm

CANHR prohibits the use of its name for the purpose of advertisement by attorneys, financial planners or any other organization or entity.
Butte County
Riverside Convalescent Hospital
375 Cohasset Road, Chico
B $2000 Bedhold Eviction 12/09/2016
On 11/4/16, the facility transferred a 78 year old resident to the hospital for an involuntary confinement based on an alleged mental disorder. On 11/8/16, the Department was contacted by the hospital to report that it has received, treated and medically cleared the resident, but that the facility refused to allow him to return. The facility was cited for failing to provide the resident with a written bedhold notice when he was taken to the hospital, and then failing to allow the resident to return to the facility after he was medically cleared at the hospital. Citation # 230012752.

Sacramento County
Arden Post Acute Rehab
3400 Alta Arden Expressway, Sacramento
B $2000 Bed Hold 12/2/2016
On 4/9/16, a stroke victim resident who was partially paralyzed and in chronic pain phoned for an ambulance to take him to the hospital. The resident had called after the facility refused his request for an ambulance. After he was at the hospital and ready to return the facility refused to allow him back. The facility's records indicated that the Administrator ordered the resident not be readmitted because he had self-transferred to the hospital against the facility's medical advice, and if he returned to the facility, he was to be sent back to the hospital. During an interview with the Administrator the investigator was told, "It is facility practice not to accept back residents who leave against medical advice." The Administrator admitted that neither a notice of discharge nor a bed hold notice was given to the resident. The facility was cited for failing to properly readmit a resident. Citation # 030012787.

Monterey County
Westland House
100 Barnet Segal Lane, Monterey
B $2000 Patient Care 12/13/2016
On 11/11/16, a male resident fell while walking with an occupational therapist. The day before he had a session with a physical therapist and complained of being dizzy due to low blood pressure. He indicated he had severe back pain from the fall. A physician's order dated 11/7/16 indicated he was to receive an occupational therapy treatment for three weeks. A review of this evaluation also indicated he was a fall risk due to weakness. The DPT stated ninety-five percent of the time staff were required to use gait belts to walk residents. The resident fell twice because there was no gait belt used and a wheelchair was too far away. The facility failed to maintain his highest level of functioning and psychosocial well-being when OT staff failed to use a gait belt and a wheelchair to safely ambulate the resident. This failure resulted in a fall for the resident with injuries and ongoing pain. Citation # 070012805.
sion. On 6/17/15, the resident was determined both medically and behaviorally stable for readmission to the facility. The Director of Nursing, with the support of the Administrator, refused to readmit the resident to the facility. As of 10/29/16, the resident remained in the hospital. The facility was cited for failing to provide resident’s legal representative/responsible party with a legally sufficient written notice as soon as practicable upon his transfer to a hospital, and for failing to establish and follow a written policy requiring the resident's readmission to the first available bed when his hospital stay exceeded the 7 day bedhold period. Citation # 030011816.

B $2000 Evictions 9/30/2016

On 7/4/16, a SNF resident was sent to the hospital for a mental evaluation. On 7/7/16, a hospital Case Manager stated that the resident was evaluated, medically cleared and ready to return to the facility. However, when the SNF was notified, it refused to take him back, even though it had three available unoccupied male beds. As of 9/16/16, the facility continues not to follow its Bed Hold policy, and the resident remains a patient at the hospital. The facility was cited for failing to establish or follow a written policy requiring the resident’s readmission to the first available bed when medically stable. Citation # 030012599.

San Francisco County

Kindred Nursing and Rehabilitation-Golden Gate
2707 Pine Street, San Francisco

B $2000 Injury Patient Care 12/06/2016

On 1/29/16, a Physical Therapist wheeled a resident on a wheelchair without using foot rests, failing to ensure her feet were off the floor. The resident’s right foot caught on the floor and she suffered from severe pain. She was transported to the hospital and was diagnosed with a fracture of her right leg bone. The facility was cited for failing to ensure the residents’ environment was free of accident hazards as is possible and adequate supervision and assistance devices were received to prevent accidents. Citation # 220012792.

Laguna Honda Hospital & Rehabilitation Ctr D/P Snf
375 Laguna Honda Blvd., San Francisco

AA $100000 Fall 12/23/2016

A resident with dementia suffered fatal injuries when he was left unattended with his wheelchair unlocked and rolled down an incline, over a curb, and fell face first into the street. The resident suffered the fall during an offsite activity on 11/26/14. A CNA was assisting residents into the facility van and left them unattended to start the van and warmup the engine. The CNA was assisting residents into the facility van and left unattended with his wheelchair unlocked and rolled down the floor. The resident’s right foot caught on the floor and she suffered from severe pain. She was transported to the hospital and was diagnosed with a fracture of her right leg bone. The facility was cited for failing to ensure the residents’ environment was free of accident hazards as is possible and adequate supervision and assistance devices were received to prevent accidents. Citation # 220012792.

San Joaquin County

Creekside Center
9107 N. Davis Road, Stockton

B $2000 Verbal Abuse 10/05/2017

On 6/6/2016 a resident placed a complaint that a nurse at the facility said “You stink” to the resident. The resident's family also complained that the nurse had allegedly yelled at the resident. The comment hurt the resident's feelings and she did not feel safe getting care from the nurse anymore. In an interview the nurse stated that the resident didn't take a shower for a month and the resident's bed was covered in crumbs. The nurse was not removed from the resident's care and the facility failed to report or initiate an investigation on the abuse allegations within 24 hours. Citation # 030012583.

Golden Living Center - Portside
2740 N. California Street, Stockton

B $2000 Mandated Reporting Physical Abuse 9/20/2016

On 7/25/16, a resident hit, kicked, screamed and yelled at another resident. Both of the residents had dementia. According to facility records, neither resident was injured. The facility was cited because it failed to report the alleged resident to resident abuse to the Department of Public Health within 24 hours of the incident. Citation # 030012577.

Kindred Transitional Care & Rehab-Valley Gardens
1517 Knickerbocker, Stockton

B $2000 Verbal Abuse 11/10/2016

On 4/2/16, a certified nursing assistant (CNA) overheard another CNA tell a resident to "shut up, bitch." The CNA who overheard the abuse told a licensed nurse at the facility about it but the facility failed to report the verbal abuse to the Department of Public Health until 4/5/16, three days later. The alleged abuser was not removed from the work schedule during this period. The facility was cited for failing to immediately report the alleged abuse to the Department of Public Health. Citation # 030012717.

New Hope Post Acute Care
2586 Buthmann Road, Tracy

A $20000, Res Care/Ressafety 10/07/2016

On 4/23/2016 a resident was found unsupervised on the floor bleeding from lacerations over her eye and hip. A nurse at the facility reported that the resident was found on the floor in pain and the nurse called 911. The resident was transferred to a hospital and had urgent surgery on her left leg. The facility failed to provide the resident supervision as ordered by her physician. The Department determined the facility failed to provide the resident adequate supervision when a fall occurred. Citation # 030012611.

B $2000 Mandated Reporting 9/30/2016

A resident told two CNAs that he witnessed a staff person hit another resident on 7/10/16. The alleged incident was not reported to the Department until at least a month later. One of the CNAs explained that she thought the resident-witness would make the report because she "didn't know residents weren't mandated reporters." The facility was cited for failing to immediately report an allegation of abuse within 24 hours as required. Citation # 030012604.

Wagner Heights Nursing And Rehabilitation Center
9289 Branstetter Place, Stockton

B $2000 Mandated Reporting Physical Abuse 9/20/2016

On 8/8/2016, a resident threw a cup of hot mocha in the face of another resident and cursed at her. The facility was cited because it failed to report an allegation of abuse to the Department of Public Health within 24 hours. Citation # 030012583.
Nonetheless, the facility discharged the resident to her son and withdrew money from her account without permission. She was unable to pay because her son had taken her checkbook.

On 6/18/16, a resident with cognition and functional mobility problems was discharged from the facility for reasons including failure to pay and health improvement. The resident stated that she was unable to pay because her son had taken her checkbook and withdrew money from her account without permission. Nonetheless, the facility discharged the resident to the son and alleged abuser with no known address. The facility was cited for failing to ensure a safe discharge. Citation # 070012420.

Canyon Springs Post-Acute

180 North Jackson Avenue, San Jose

B $10000 Mandated Reporting Notification Physical Abuse 11/22/2016

After a resident alleged that she had been hit on the face and buttock, the facility staff failed to report the allegation to facility management, law enforcement, or ombudsman within the 24 hour period required by law. Citation # 070012773.

Santa Cruz County

Driftwood Healthcare Center - Santa Cruz

675 24th Avenue, Santa Cruz

A $20000 Hydration Nutrition Patient Care 12/29/2016

The facility failed to notify a physician after a resident had decreased food and fluid intake, extreme weight loss of 21 pounds over 8 days, and low blood oxygen levels. As a result, the resident failed to receive appropriate interventions for nutrition, hydration or acute respiratory failure. The resident died within 2 weeks of admission to the facility. Citation # 070012789.

Hearts & Hands, Post Acute Care & Rehab Center

2990 Soquel Avenue, Santa Cruz

B $2000 Medication 10/10/2016

The facility failed to follow policy on administration of medication when 15 residents were not provided with prescribed medication in a timely manner, which can have a negative impact on resident health outcomes. Citation # 070012626.

B $2000 Mandated Reporting Theft & Loss 10/10/2016

The facility failed to follow policies for reporting alleged abuse after a resident's wallet and $520 in cash went missing. Per policy, facility staff should have reported the incident to the local law enforcement agency in order to ensure the incident was not a result of elder abuse. Citation # 070012625.

B $2000 Physical Environment 10/10/2016

The facility failed to provide adequate space for resident care when 6 resident rooms were found to only provide 71.5 square feet per resident instead of the required minimum of 80. Facility staff reported that the lack of space made it difficult to properly use medical equipment required for care, such as mechanical lifts. Citation # 070012627.

Stanislaus County

Valley Subacute & Rehabilitation Center

515 E. Orangeburg Avenue, Modesto

B $2000 Physical Environment 10/20/2016

During the facility's remodeling in September 2016, the resident call light system was inoperable and residents were exposed to unsafe building conditions such as exposed wiring and pipes. The facility failed to obtain proper building permits for the work and was cited for failing to have a safe and functional environment for residents. Citation # 040012663.
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 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.

### Fresno County

**Alice Manor Convalescent Hospital**

8448 E. Adams Avenue, Fowler

B $2000 Neglect Patient Care Supervision 2/08/2017

On 7/15/15, a female resident with a diagnosis of schizophrenia was admitted to the facility. She was hospitalized for suicide attempts on 5/11/16, 6/10/16, 7/10/16, 8/1/16, and 8/10/16. On these occasions she wrapped her call light cord around her neck or ingested entire bottles of over-the-counter medications she had access to, such as Vitamin C. After each hospitalization, no updates or revisions were made to her care plan, in regards to offering psychotherapy or a psychiatric evaluation or even monitoring her mood or behavior. The facility was cited for failure to provide the necessary care and services for its residents. Citation # 040012956.

### Kern County

**The Terraces at San Joaquin Gardens Village**

5555 North Fresno Street, Fresno

B $2000 Patient Care Supervision 10/19/2016

On 6/9/16 an 86 year old female resident wandered out of the facility and fell, suffering lacerations to her forehead which required 5 stitches and injuries to her right arm. The Director of Nursing stated she had a wander guard chair alarm for her wheelchair at the time of the fall. Her care plan indicated staff must ensure the device is functional and in place at all times. However, on the day of the fall, she was using a different wheelchair while hers was being cleaned. Her wander guard was not transferred to the different chair. The facility failed to implement the resident's care plan for a wander guard. This failure allowed the resident to go outside unnoticed and unsupervised. Citation # 04002662.

**Delano PostAcute Care**

729 Browning Rd., Delano

B $2000 Physical Abuse 08/15/2016

On 5/11/16 the daughter of a female resident stated her mother made an allegation about sexual abuse that occurred in early 2016 or late 2015. The resident told her daughter that a CNA came up behind her and hugged her. The CNA's hands cupped her breasts, then moved down to her mother's privates. The Administrator stated, "It was not a sexual abuse allegation after I spoke with her. I met with the daughter. It was care planned. We didn't report the incident to the Department because we didn't think it happened." The facility failed to report incidents of alleged or suspected abuse of a resident to the Department within 24 hours. Citation # 120012463.

B $2000 Fiduciary 12/01/2017

On 10/13/16 a resident reported $773 being stolen from her safe box which she had in her night stand. The box had a key which she put in a top drawer. The resident stated, through a Spanish interpreter, that the money went missing sometime between 10/11 and 10/13/16. The Administrator told the interviewer that she did not reported the incident to the Department because she did not report "losses". The facility was cited for failure to report an allegation of theft to the department within 24 hours as required by law. Citation # 120012757.

### Valley Healthcare Center

4840 East Tulare Street, Fresno

A $20000 Neglect Notification Patient Care Supervision 2/2/2017

On 8/24/16 a resident was admitted to a facility for rehabilitation following a below knee amputation. He suffered from End Stage Renal Disease and was dependent on hemodialysis treatment three times per week. The resident missed two consecutive dialysis treatments during his stay at the facility. The missed dialysis treatments led to a decline of the residents' health condition. Registered Nurses at the facility failed to notify the physician of the residents missed two consecutive dialysis treatment sessions and failed to perform physical assessments of the resident and recognize his condition was declining. The resident died in the facility on 8/28/16 less than four days after his admission to the facility. The facility failed to protect the resident from neglect and did not provide adequate patient care. Citation # 040012932.
Delano Regional Medical Center D/P SNF
1401 Garces Hwy, Delano
B $2000 Patient Care 11/01/2016
On 9/29/16, the Wound Consultant Notes indicated that a 53 year old nonverbal male had a very deep and infected Stage 4 tailbone wound that reached down to the muscle and bone. On 10/12/16, while the wound dressing was being changed and the wound assessed, the resident flailed in pain and his facial expression became very tense. The facility failed to ensure the resident was free from pain during care of his wound. This failure resulted in the resident have pain during the procedure. Citation # 120012699.

Evergreen Bakersfield Post Acute Care
6212 Tudor Way, Bakersfield
A $20000 Sexual Abuse 11/21/2016
The facility was cited for failing to ensure that a 57 year old female resident with altered mental status was not subjected to sexual abuse. The resident was sexually assaulted on 09/26/16 by a 72 year old male resident with a history of inappropriate sexual behavior. She suffered abrasions to her genital area and a new fear of being touched by caregivers. Citation # 120012740.

Kern Valley Healthcare District D/P SNF
6412 Laurel Ave, Lake Isabella
B $2000 Patient Rights 10/11/2017
On 6/15/16 and 7/2/16, a 75 year old male resident inappropriately touched another resident and he had a history of sexually abusing others. The interventions for this behavior on both care plans included to keep him on a one to one monitoring by staff. On 8/31/16 a female resident reported to the night nurse that he had entered her room and was touching her buttocks. She later avoided going to her usual social activities and was afraid to fall asleep. The Charge Registered Nurse was unable to provide information that indicated the assigned one to one staff for him on that night. The facility failed to ensure the resident who had a history of committing sexual abuse of other residents was on one to one monitoring as indicated in his plan of care. This failure resulted in the harming of another resident, when the male resident entered her room and inappropriately touched her while she was asleep. Citation # 120012608.

The Rehabilitation Center Of Bakersfield
2211 Mount Vernon Avenue, Bakersfield
B $2000 Transfer 11/22/2016
The facility was cited for inappropriately discharging a resident when a 78 year old resident who was unable to stand, and needed full assistance with dressing and toileting was discharged home by a transport van because facility staff believed she no longer had insurance coverage, when in fact, she did. Upon discharge to her home, the resident was unable to enter due to her extreme physical limitations, and was transported to the emergency room for lower extremity pain. Citation # 120012754.

Los Angeles County
Alameda Care Center
925 W. Alameda Ave, Burbank
A $10000 Injury Patient Care Patient Rights Physical Abuse Supervision 1/09/2017
On 5/6/16, a resident with a history of aggression, physical and sexual abuse towards other residents, pushed a female resident twice, causing her to fall on the floor face down. The injured resident was transferred to the hospital for stitches and became non-ambulatory as a result of the incident. The resident who attacked her had four documented physical altercations with four different residents in the previous six months. The facility was cited for failure to adequately monitor the resident and failure to protect residents from physical abuse. Citation # 920012812

Alexandria Care Center
1515 N Alexandria, Los Angeles
A $20000 Careplan Medication Patient Care 12/23/2016
The facility was cited for failing to effectively provide the necessary care and services a resident needed by not managing her pain as instructed. The resident suffered from right foot and leg pain that was not controlled by her medication or evaluated and treated promptly. As a result, she experienced unnecessary, prolonged, pain and suffering. She cried, screamed, and plead for mercy, due to the unbearable and constant pain. Citation # 920012817.

All Saints Healthcare
11810 Saticoy Street, North Hollywood
A $15000 Fall Injury 12/14/2016
The facility was cited for failing to ensure a resident received adequate supervision and assistance devices to prevent accidents. The resident had a history of falls and was assessed at risk for falls. The facility failed to develop and implement a plan of care and monitor and supervise the resident. As a result, the resident fell from her wheelchair sustaining a laceration to the forehead and a nasal bone fracture. The resident was transferred to the general acute care hospital and received suture repair to the laceration of the forehead. Citation # 920012749.

Arbor Glen Care Center
1033 E. Arrow Hwy., Glendora
B $2000 Patient Care 11/16/2016

All Saints Healthcare
11810 Saticoy Street, North Hollywood
A $15000 Feeding Patient Care 1/09/2017
On 9/13/2016, a resident's g-tube was dislodged while being repositioned by a staff person, causing severe bleeding that necessitated an emergency hospitalization and sutures. The resident's careplan and policies required two staff persons for all resident movement but only one was moving the resident when the g-tube was dislodged. The facility was cited for failing to follow the careplan requiring two-person assistance and failure to ensure safe handling of the g-tube. Citation # 920012874.
On 7/7/2016 at 1:00 p.m., during an unannounced visit to the facility to investigate a complaint regarding resident neglect and an injury of unknown origin, Resident 1 stated that he did not know how he fractured his right hand, and added that he noticed it was painful when he was getting showered by certified nurse assistant (CNA) on 6/30/2016. A review of a document titled "Imaging Report" dated 7/1/2016 indicated non displaced acute fracture metacarpal (broken little finger), osteopenia (loss of bone tissue), and degenerative change. The facility failed to investigate an injury of unknown source, and send a written notification of Resident's injury of unknown source to the State survey and certification agency within 24 hours. Citation # 950012756.

**Avalon Villa Care Center**
12029 S Avalon Blvd, Los Angeles

**B $2000 Physical Abuse**  
8/19/2016

The resident stated that on 4/18/15, a CNA threw his roommate's urinal at him, getting some urine on him. Following this incident, a supervisor came in and took the CNA out of the room. Soon after a second CNA came in sat on his bed and started laughing and said that it was the resident's fault that it happened. The resident stated he kicked the CNA off his bed and then the CNA threw water from a pitcher on him. The resident stated he felt so anxious that he needed medication after the incident. The facility was cited for failing to ensure that the resident was free from physical abuse from the staff. The investigation conducted by the facility resulted in the termination of both CNAs. Citation # 940012519.

**Bell Convalescent Hospital**
4900 E. Florence Ave, Bell

**B $2000 Bed Hold**  
Patient Rights  
06/24/2016

A 43 year-old male was admitted to the facility on 3/28/14. On 5/19/14, the resident was transferred to the acute care hospital for displacement of the GT tube with gastrointestinal bleeding. The physician ordered a seven day bed hold. On 5/22/14, a review of the case manager's notes indicated the resident was not being accepted back to the nursing facility. The DON stated she was not refusing to re-admit him, but stated the facility was unable to care for him because he needed a sub-acute care. The social worker designee stated that the resident never signed an admission agreement. At the time of transfer of a resident for hospitalization, a nursing facility must provide a written notice which specifies the duration of the bed-hold policy. The facility refused to honor the resident's 7-day bed hold and would not readmit him. Citation # 940012354.

**Brookfield Healthcare Center**
9300 Telegraph Rd., Downey

**A $20000 Patient Care**  
09/30/2016

The facility was cited for not ensuring that the resident environment remains as free of accident hazards as possible and each resident receives adequate supervision and assistance devices to prevent accidents. In addition, the facility failed to provide Resident 1 adequate supervision and assistance devices and revise the care plan to prevent Resident 1's fall from a wheelchair. As a result, Resident 1 who is 95 years old, sustained a hip fracture from a fifth fall and was transferred to the general acute care hospital (GACH) for surgical repair of the fracture, and administration of pain management. Citation # 940012602.

**Camellia Gardens Care Center**
1920 N. Fair Oaks, Pasadena

**B $2000 Mandated Reporting**  
Patient Care  
1/26/2017

The facility was cited after staff failed to notify state licensing and certification agency about a resident's injury of unknown origin. The resident, with very limited cognitive and movement abilities, was found by staff to have a large bruise on his hip and groin area, of which there was no known cause. Citation # 950012911.

**Centinela Skilled Nursing & Wellness Centre West**
950 Flower Street, Inglewood

**B $2000 Patient Care**  
Physical Restraints  
5/31/2016

A resident was found tied to her wheelchair with a bed sheet around her waist inside of her gown. After interviews and video review, a CNA admitted to restraining the resident in the wheelchair, and stated he thought it was okay because he was trying to ensure patient safety. The facility was cited for failing to ensure the resident was free of physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Citation # 910012281.

**Chatsworth Park Care Center**
10610 Owensmouth Ave., Chatsworth

**B $2000 Bed Hold Evictions**  
Patient Rights  
12/23/2016

An 84-year-old female resident on Medi-Cal was admitted to a hospital on 10/30/16. Three days later, on 11/2/16, she was ready to return to the nursing facility, but the facility refused readmission, causing her to be displaced and transferred to another skilled nursing facility with no preparation. The facility was cited for failure to provide the resident with a written bed hold notice, failure to readmit the resident during the bedhold period, and failure to readmit the resident to the first available bed following the bed hold period. Citation # 920012834.

**Courtyard Care Center**
1880 Dawson Avenue, Signal Hill

**A $20000 Fall Injury**  
Staff (Inservice) Training  
12/03/2015

The facility was cited for failing to prevent an accident,
when they failed to ensure a newly hired LVN was able to competently put together and operate portable oxygen equipment. The LVN attempted to replace an oxygen tank behind a resident's wheelchair. When she opened the full tank it made a loud noise scaring the resident, causing the resident to immediately get up to walk away and fall to the floor. The fall resulted in the resident sustaining a dark purple discoloration on the right side of the face and neck and right eye, a fracture of the area under the eye and a fracture of the right arm. The resident was transferred to the acute care hospital. Citation # 940011853.

**Del Amo Gardens Convalescent**

22419 Kent Avenue, Torrance

A $20000 Elopement 10/03/2016

On 2/14/16, at 4:45 p.m., the facility's surveillance cameras recorded a resident leaving the side doors adjacent to his room. The resident was found three days later by the police department in another city 20 miles away. He was taken to the hospital and was diagnosed with dehydration. On the day of the elopement, the facility had notified the family that they needed to visit with him because he was getting in and out of the bed and wheelchair verbalizing that that he wanted to go home. The facility was cited for failing to to ensure that a resident with dementia and poor safety awareness, and who exhibited elopement risks did not elope from the facility. Citation # 910012603.

**AA $100000 Fall 5/17/2016**

A 97 year old female resident died on 7/31/2015 after sustaining major injuries from a fall while being transferred from her wheelchair to her bed in an Invacare lift sling. One of the sling straps broke and the resident hit the floor and suffered blunt force trauma with ten broken ribs that caused her lungs to fill with blood. She died two hours later. The facility was cited for failing to follow manufacturer's guidelines to inspect the sling for wear and tear and failing to implement the resident's careplan calling for at least two staff people to assist with using the lift sling. The broken strap was heavily worn and dangerous and should never have been used. Citation # 910011975.

**Flower Villa, Inc.**

1480 S. La Cienega, Los Angeles

A $20000 Patient Care 1/7/2017

A resident with seizure disorder did not receive proper monitoring by facility staff after lab tests revealed that her levels of seizure-control medication were very low. Lab tests were not shared with nurses on staff so that the resident could be monitored on a regular basis in order to prevent injuries related to seizures. During a seizure, the resident fell and hit her head, cutting her forehead, requiring transfer to a hospital. Upon her return to the facility, the staff failed to conduct an interdisciplinary team meeting to create a new care plan to address the resident's high risk for falls due to seizures. Citation # 940012872.

**Fountain View Subacute And Nursing Center**

5310 Fountain Ave., Los Angeles

A $20000 Careplan Decubiti (Bedsores) Infection 12/1/2016

The facility was cited after admitting a resident who had no pressure sores and although the resident was identified as a risk for pressure sores, the facility failed to provide the necessary services for prevention and treatment once the sores developed. This resulted in the resident being transferred to the acute care hospital where he was found with an infected pressure sore Stage IV, a superficial pressure sore to the right posterior leg and severe sepsis. The resident was transferred back to the facility on 5/6/16 and on 6/22/16 the resident was transferred back to the hospital where he was found to have an abscess, two days after admission the resident expired. The immediate cause of death was cardio-pulmonary arrest. Citation # 920012729.

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

5335 Laurel Canyon Blvd., North Hollywood

B $2000 Bed Hold 11/01/2016

The facility failed to allow a resident to return to the facility after hospitalization and failed to offer the resident the next available bed when resident was ready to be discharged. As a result the resident was unable to return to the facility which he considered his home. The resident expressed sadness, fear and anxiety regarding moving to another facility. This violation had direct or immediate relationship to the health, safety, or security of the resident. Citation # 920012714.

B $2000 Patient Care Patient Rights Physical Abuse Verbal Abuse 12/21/2016

On 12/21/15, an investigation was started after reports of a caregiver had been rough with residents while providing care. One resident diagnosed with muscle weakness, asked the CNA for a pillow and reported that the CNA said "Shut Up" and held the resident down by the neck for three seconds. The resident while crying stated that he thought the CNA was going to kill him and he was afraid of him. The Assisted Director of Staff Development reassigned the CNA to the resident care after a the facility was short on staff members. The facility failed to ensure the resident was free from verbal, mental, and physical abuse, and failed to investigate rough treatment from the CNA when the resident reported it. Citation # 920012826.

**Genesis Healthcare Center**

1201 Walnut Avenue, Long Beach

B $500 Theft & Loss 10/11/2016

On 12/29/15 a male resident reported to a CNA that $80 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.

**Gladstone Care And Rehabilitation Center**
435 E. Gladstone, Glendora

A $160000 Fall 10/28/2016

On 4/23/13, a 72 year-old resident broke her left hip after she unclipped her bed alarm pull cord, got out of bed unassisted, and fell from her bed for the third time in four months. She required surgery to repair her broken hip. The resident’s initial care plan indicated that she was at risk for falls, and her physician ordered the use of a bed alarm and to monitor its placement every shift. The DON stated that she knew that the resident was removing her bed alarm, but was not able to show alternatives or additions to the bed alarm until after the resident’s third fall. The facility was cited for failing to provide adequate supervision and assistance device to prevent falls for the resident. Citation # 950012695.

**Glendora Grand, Inc.**
805 West Arrow Highway, Glendora

B $20000 Physical Environment Supervision 11/23/2016

On July 7, 2016, the facility arranged for an all-day outing to the park with 55 residents. 31 of the residents were from the locked unit of the facility, and required close supervision. The facility staff failed to adequately supervise and monitor the residents during the outing. Citation # 950012772.

A $200000 Patient Care 12/22/2016

The facility was cited after taking a large group of residents on an outing to a park without sufficient supervision to ensure the safety of the residents, 31 of whom were from the secured ward and had psychiatric conditions such as schizophrenia. Staff did not ensure that residents who attended the trip had physician’s orders which allowed them to attend, and did not provide sunscreen or block, resulting in many residents who reported pain from sunburns. Citation # 950012831.

**Glenoaks Convalescent Hospital**
409 W. Glenoaks Blvd, Glendale

A $15,000 Careplan Decubiti (Bedsores) Infection 11/21/2016

The facility was cited for not providing the necessary treatment and services to prevent pressure sores, and promote the healing of a pressure sore after the resident developed one. The facility failed to conduct an assessment or implement a plan of care for the resident's newly developed pressure sore in the tailbone area, the skin around the genitals and a skin tear to the scrotum. As a result, the resident was transferred to the acute care hospital due to sepsis and was found with a blood-filled blister called an SDTI in the sacral area measuring 7 centimeters in length by 10 centimeters in width, a large red skin scrape, and a skin tear to the scrotum. The resident remained at the hospital for 16 days until he expired from symptoms, which could have resulted from sepsis. Citation # 920012727.

**Greenfield Care Center Of Gardena**
16530 S Broadway, Gardena

A $10000 Physical Abuse 8/24/2016

On July 7, 2016, a family member went into a resident’s room and started arguing with him and threw salsa into his eyes, which caused burning and pain. The resident screamed for help, and an employee came into the room to assist him. At least eight employees were aware of the incident, but DPH, law enforcement and the Ombudsman were not notified, and there was no documented evidence of the physical and mental abuse. The facility was cited for failing to ensure that the family member did not physically abuse the resident, and did not have access to enter the facility and place all residents at risk of being abused. Citation # 910012533.

B $1500 Patient Rights 8/24/2016

Resident 1 was in bed on July 7, 2016 at 12:45 p.m. and at that time a Family Member 1 was visiting Resident 1. At that time Employee 1 witnessed the Family Member enter Resident 1’s room, leave the room, return to the room, come back again, and then leave quickly. Employee 1 stated she heard Resident 1 calling for help and entered the room, at which time, Resident 1 told Employee 1 that Family Member 1 threw salsa in his face. The facility failed to immediately notify and consult with the attending physician when Family Member 1 physically abused Resident 1, by throwing a red liquid substance (Salsa) into Resident 1’s eyes and onto his upper body. Citation #910012535.

**Griffith Park Healthcare Center**
201 Allen Ave., Glendale

A $20000 Feeding 10/04/2016

A male resident with Parkinson's Disease, swallowing problems, and an order for a puréed diet was given a whole banana for a snack and choked and died on 11/17/2014. The resident required assistance with eating, but was left alone eating the banana. The Heimlich maneuver and CPR were attempted, but were unsuccessful in saving the resident's life. The facility was cited for failing to provide necessary supervision and a puréed diet as ordered. Citation # 920011836.

**Hawthorne Healthcare & Wellness Centre, Lp**
11630 S. Grevillea Ave., Hawthorne

A $20000 Patient Care 6/21/2016

The facility was cited for failure to properly monitor and manage a resident's diabetes. As a result, the resident became sluggish, tested with a critically high glucose level, was transferred to an acute care hospital where they were diagnosed with kidney failure requiring insulin therapy. Citation # 910012317.

A $20000 Physical Abuse 6/10/2016

On 8/17/11 a resident was admitted to the facility for rehab
for a left femoral fracture and left hip replacement. On 8/18/11, her roommate, who was known to be combative and disruptive, went over to her bed and grabbed her by her left knee and ankle and yanked it, causing it to become dislocated. When staff responded to her screams they noted that the roommate was saying she needed to get her out of "her room". The facility was cited for failure to monitor a resident who had been prescribed Haldol, and for failure to follow a physician's order to obtain a psychiatric evaluation on a resident with known anger and agitation problems and desires to hit and strike people. Citation # 910012297.

**Huntington Drive Health and Rehabilitation Center**

400 W. Huntington Dr, Arcadia

A $16000 Fall Patient Care 12/14/2016

The facility failed to ensure a resident received the adequate supervision and physical assistance she needed when walking and standing. As a result, the resident fell when a CNA left her unattended and unsupervised. She suffered a fractured left hip and required pain medication, surgery, and hospitalization for four days. Citation # 950012815.

**Lakewood Healthcare Center**

12023 S. Lakewood Blvd, Downey

B $2000 Injury Mandated Reporting Patient Care Physical Abuse 07/18/2016

On 9/22/15, a male resident was observed to have an "injury of unknown source" on the left side of his face. A visiting family member, and a caregiver, noticed bruises, discoloration and swelling on the resident's left cheek. The caregiver reported it to the team leader, but the facility did not address or report the incident to the Department until 10/14/15, 12 days after the allegation was made. The facility was cited for failure to report an injury to the Department. Citation # 940012411.

A $20000 Injury Medication Patient Care Physical Abuse Supervision 8/19/2016

On 7/27/16 a CNA made an allegation of abuse regarding a resident who had been prescribed Haldol, and for failure to follow a physician's order to obtain a psychiatric evaluation on a resident with known anger and agitation problems and desires to hit and strike people. Citation # 920012545.

**Lighthouse Healthcare Center**

2222 Santa Ana Blvd, Los Angeles

A $16000 Elopement Patient Care Supervision 5/26/2016

A 64 year old resident left the facility unsupervised and went missing on 1/9/15. It took the facility over 5 hours to notice the resident had gone missing. The resident had multiple health conditions and required medications. As of 1/17/15 the resident had not been located. The facility failed to follow its policy and procedure regarding resident wandering and elopement. Failed to perform resident head counts every shift, ensure the doors were locked and the alarm was armed, and security guards failed to do their rounds as stipulated in their job description. Citation # 940012287.

**Maclay Healthcare Center**

12831 Maclay Street, Sylmar

A $20000 Careplan 10/21/2016

On 2/7/2014 a resident that was known to be at high risk for falls, and was receiving psychoactive medications, fell from her wheelchair and sustained a fractured hip. A CNA heard the resident scream from inside the room and found the resident on the floor. The resident was transferred to a general acute hospital and a physician was called and ordered immediate X-Ray of both hips. The resident required surgery and required several days of hospitalization. The facility failed to provide the necessary care and services to ensure that the resident's environment was free of accidents and hazards. As a result the resident experienced unnecessary pain, and required several days of hospitalization. Citation # 920011517.

**Maywood Skilled Nursing & Wellness Centre**

6025 Pine Avenue, Maywood

A $20000 Dietary Services Feeding Patient Care Supervision 06/28/2016

A 90 year old female resident with a high risk for choking was hospitalized twice in a five day period, on 4/4/14 and again on 4/9/14, for choking on food. The facility was cited for failure to ensure she received her prescribed pureed diet, and failure to supervise her while eating. Citation # 940012353.

**Mount San Antonio Gardens**

900 E. Harrison Avenue, Pomona

B $2000 Mandated Reporting Mental Abuse Physical Abuse 10/04/2016

On 7/27/16 a CNA made an allegation of abuse regarding another CNA. The CNA claimed she witnessed another CNA place a washcloth inside a female resident's mouth and put a pillow over her face. She also said that since February 2016, when residents tried to get up from their seats, the
Riviera Healthcare Center
8203 Telegraph Road, Pico Rivera
A $20000 Injury Physical Abuse Supervision 1/21/2016
On 7/6/2014, a resident was hospitalized and required brain surgery after he was punched in the face by another resident. The injured resident, who had advanced dementia, had entered the other resident's room and upset him, leading to the punch. The injured resident sustained a sub-acute subdural hematoma and skull fracture. He had a history of going into other residents' rooms and upsetting them, yet the facility did not have a care plan addressing his wandering behavior and safety risk. The facility also had failed to obtain psychiatric evaluation and treatment for the injured resident as ordered by his physician on 5/19/2014. The facility was cited due to these failures. Citation #940011911.

B $2000 Mandated Reporting 1/21/2016
On 7/6/14, a resident punched another resident in the face after that resident wandered into his room and tried to swing at him. The resident who was hit was transferred to a hospital emergency room, where a brain scan showed that he sustained a subdural hematoma with a midline shift of the brain to the left, and a fracture of the right temporal bone requiring brain surgery at another hospital. The Department received the complaint on 7/14/14, and the administrator stated that he forgot to report the incident. The facility was cited for failing to report a physical abuse incident to the Department within 24 hours. Citation #940011982.

Royal Oaks Care Center
3565 E Imperial Hwy, Lynwood
B $2000 Patient Care 11/08/2016
On July 25, 2016, a male resident's assessment and care screening indicated cognitive skills were severely impaired but did not indicate the resident had no function limitation in range of motion. Additional summaries until September 16 also did not mention contractures or joint mobility limitations. On that day, he said he could not move his legs because it was painful. A PT assessed the resident had minimal joint mobility to his right shoulder, ankles, and limitation on his hips and knees. The facility failed to assess the resident's joint mobility status upon admission as indicated in the facility's policy and procedures. This resulted in the resident not receiving necessary exercises to prevent development of contractures and limitation of mobility. Citation #940012738.

B $2000 Patient Care 11/08/2016
In September 2016, a physical therapist came to assess the joint mobility status of a resident who had been admitted to the facility in August 2014, and reported that the resident had moderate joint mobility limitations on the left shoulder, hand, and ankle. The therapist stated that he had not received report of any changes in the resident's joint mobility status from the nursing staff. The facility was cited for failing to assess a resident's joint mobility accurately, monitor resident response to treatment exercises and report to the rehabilitation department for reassessment and further intervention. Citation #940012733.
On March 11, 2016, a physician's order for a resident stated the RNAs was to perform passive range of motion (PROM) on the resident's right lower extremity/right upper extremity as tolerated every day; five times a week. In June he was assessed by a PT and found to have no contractures. From July 2016 through September 18, 2016, PROM exercises were provided and the resident tolerated the exercises. There was no indication of contractures. On September 19, 2016, the RNA was unable to perform the range of motion exercises due to contractures. No one seemed to know when the contractures developed and she stated there was an order to sometimes not exercise the resident's fingers. However, there was never a change in the physician's order. The facility failed to assess the resident's joint mobility accurately, monitor his response to treatment exercises and provide range of motion exercises as ordered by the physician. This resulted in unidentified development of contracture to his right wrist, fingers, right knee and toes. Citation #940012734.

Royal Palms Post Acute
630 W. Broadway, Glendale
A $10000 Elopement 1/25/2017
On the night of 11/17/16, a resident with dementia walked out of the facility undetected. The police found her the next day lying on a sidewalk with hypothermia and shortness of breath requiring hospitalization. The resident's careplan failed to account for her likelihood of leaving despite her well-known desire to leave the facility. The facility was cited for failing to provide necessary care, including care conferences to address the resident's behavior, supervision based on the resident's needs, monitoring effectiveness of interventions, and reviewing and revising the care plan. Citation #940012783.

Serrano North Convalescent Hospital
5401 Fountain Avenue, Los Angeles
A $15000 Patient Care 10/14/2016
On 1/27/16, Resident 1 was who deemed high risk for falling was permitted to transfer from her bed to her shower to use the restroom without assistance from the staff or fall prevention equipment (i.e. cane, walker). The facility's administrator stated the facility had been refusing several readmissions because of the inability to provide care to residents. This failure to readmit the resident back had a direct and immediate relationship to the health, safety, and security of the resident. Citation #940012877.

Royal Terrace Health Care
1340 Highland Ave., Duarte
B $2000 Infection 11/01/2016
On 11/17/15, a resident was transferred to an acute hospital with scabies and pressure ulcer. The resident was readmitted to the facility on 11/18 and a notation in his records indicated that he had a generalized body rash. On 1/4/16, a state investigator observed the resident vigorously scratching himself and that his entire body was covered with raised papules (solid rounded growths elevated from the skin, when scratched become crusted and infected.) A further investigation was conducted and it was found that other residents were infected with scabies and that they had been itching an scratching for several weeks. The facility was cited for failing to detect and implement transmission-based precautions in order to prevent a scabies contamination. Citation #950012710.

Santa Fe Heights Healthcare Center LLC
2309 N Santa Fe Ave, Compton
A $20000 Sexual Abuse 11/16/2016
On 11/23/14, a male resident with Alzheimer's dementia and an extensive history of inappropriate sexual behavior was found with his hand on the groin area of a hospice female resident whose diaper was pulled down. Prior to this incident, that resident had been found in the woman's room either touching her or in bed next to her. The day after the 11/23 incident, the woman had episodes of screaming and was sent to the acute care hospital for evaluation. It was noted that the male resident also had a history of inappropriately touching staff. The facility was cited for failing to properly monitor the resident's activities and preventing him from crossing into other resident's rooms. Citation #940012755.

B $2000 Bed Hold 1/10/2017
On 4/23/2016 a resident with kidney failure and type 2 diabetes was subjected to stress and anxiety when a facility failed to readmit the resident back to the facility after being released from the hospital. Instead the resident was transferred to another facility without proper preparation and notice. The facility's administrator stated the facility had been refusing several readmissions because of the inability to provide care to residents. This failure to readmit the resident back had a direct and immediate relationship to the health, safety, and security of the resident. Citation #940012877.

Sharon Care Center
8167 W 3rd Street, Los Angeles
B $1400 Verbal Abuse 07/07/2015
The facility was cited for failing to ensure the resident was treated with dignity and respect and was not subjected to verbal abuse of any kind. When the resident lost control of her bladder and urinated on the floor a certified nursing assistant called the resident a "vieja cocina," which translated means...
"dirty old lady." As a result, the resident felt embarrassed, cried and felt bad about herself. Citation #910011600.

**Skyline Healthcare Center-Los Angeles**

3032 Rowena Avenue, Los Angeles

<table>
<thead>
<tr>
<th>B</th>
<th>$10000</th>
<th>Patient Rights</th>
<th>Physical Abuse</th>
<th>12/28/2016</th>
</tr>
</thead>
</table>

On 8/18/16, a resident called for help to change her incontinent brief. Upon her arrival, a CNA slapped the resident on both forearms three times and removed the call light away from the residents’ reach. In an interview, the CNA admitted to striking the residents’ arms. The facility was cited for failing to ensure a resident was not subjected to physical abuse. Citation #920012844.

**Solheim Lutheran Home**

2236 Merton Avenue, Los Angeles

<table>
<thead>
<tr>
<th>A</th>
<th>$10000</th>
<th>Patient Care</th>
<th>1/09/2017</th>
</tr>
</thead>
</table>

On 3/21/16, a female resident who had a history of falls, had a physician’s order to have a personal alarm while in bed or wheelchair for safety and fall prevention. On 5/18/16, she had an unwitnessed fall, and was lying on the floor on her left side along the hallway without her wheelchair. She was in severe pain and suffered a hip fracture. The RNA stated she did not see or hear any personal alarm. The facility failed to ensure proper functioning of the resident's wheelchair alarm. As a result, she fell sustaining a left hip fracture and pain to the left leg requiring transfer to a general acute care hospital for evaluation and treatment. Citation #920012856.

**Studio City Rehabilitation Center**

11429 Ventura Blvd., Studio City

<table>
<thead>
<tr>
<th>AA</th>
<th>$100000</th>
<th>Infection</th>
<th>Neglect</th>
<th>2/8/2017</th>
</tr>
</thead>
</table>

On 10/22/09, a resident was hospitalized in severe pain with acute peritonitis from a severe bowel impaction. She was moaning in pain, had a distended abdomen, and altered level of consciousness. Her survival rate was deemed to be zero. She was diagnosed with a perforated viscus and sepsis. The resident died in the hospital two days after her emergency room admission. In the weeks prior to her death, the resident was at increased risk of constipation because she was often bed-bound, was taking several medications that could cause constipation, ate poorly and received insufficient fluids. The facility did not give her ordered medication, Milk of magnesia, to prevent constipation. Its plan of care did not adequately address the resident's past history of rectal bleeding, constipation and colon surgery. On the morning of her hospitalization, the resident was disoriented – yelling and screaming – yet there was no evidence that the facility assessed her abdomen or appropriately responded to her suffering. The nursing home was cited for neglecting to monitor, assess, and respond to changes in her bowel movement habits to prevent constipation before it progressed to fecal impaction and death. Citation #920012307.

**Sylmar Health And Rehabilitation Center**

12220 Foothill Blvd., Sylmar

<table>
<thead>
<tr>
<th>A</th>
<th>$20000</th>
<th>Injury</th>
<th>Patient Care</th>
<th>Physical Abuse</th>
<th>Supervision</th>
<th>1/18/2017</th>
</tr>
</thead>
</table>

On August 11, 2014, a resident with a diagnosis of schizoaffective disorder, substance dependence, and a history of aggressive behavior, punched another resident in the head, knocking him to the floor and causing him to have a seizure. The attacker was noted to have "high violence risk" and was to be directed to the "evaluation room" to engage in discussion with staff when he exhibited an increase in hallucination and behavior problems. The injured resident was hospitalized and received 10 staples in his scalp. The facility was cited for failure to provide a safe environment and adequate supervision to prevent physical abuse. Citation #920012679.

**The Orchard - Post Acute Care**

12385 E. Washington, Whittier

<table>
<thead>
<tr>
<th>B</th>
<th>$2000</th>
<th>Patient Care</th>
<th>1/19/2017</th>
</tr>
</thead>
</table>

On 11/15/2016 a quality of life interview was conducted with 11 alert residents, however, Resident 20, 21, and 22 expressed that their call lights had not been answered timely. Resident 21 stated that a CNA (certified nursing assistant) told her to urinate in her diaper when the resident used her call light to receive assistance. Resident 20 and 22 expressed similar concerns about staff members not adhering to their call lights in a timely manner. The facility failed by not ensuring that residents were treated with respect and dignity. Following its policy, which indicated residents should be treated with kindness, dignity, and respect. Following its policy, which indicated to answer call lights within a timely manner (3-5 minutes), listen to the resident's requests/need, and to respond to the request. Citation #940012869.

**Valley Manor Convalescent Hospital**

6120 N. Vineland Avenue, North Hollywood

<table>
<thead>
<tr>
<th>A</th>
<th>$20000</th>
<th>Fall</th>
<th>10/28/2016</th>
</tr>
</thead>
</table>

A resident with significant fall risks fell from her bed and broke her hip on 12/23/2015 and died on 1/10/2016 from blunt force trauma related to the fall. The resident had a bed alarm and two bed rails to prevent falls but both interventions were poorly monitored. Bed alarms were tested for three other residents but none of them were operational. The facility was cited for failing to prevent falls, failure to ensure bed alarms were functioning, and failure to evaluate fall prevention interventions. Citation #920012557.

<table>
<thead>
<tr>
<th>A</th>
<th>$20000</th>
<th>Fall</th>
<th>Injury</th>
<th>Patient Care</th>
<th>11/10/2016</th>
</tr>
</thead>
</table>

On July 28, 2015, a 78 year old male resident fell from his bed and broke his hip on 12/23/2015 and died on 1/10/2016 from blunt force trauma related to the fall. The resident had a bed alarm and two bed rails to prevent falls but both interventions were poorly monitored. Bed alarms were tested for three other residents but none of them were operational. The facility was cited for failing to prevent falls, failure to ensure bed alarms were functioning, and failure to evaluate fall prevention interventions. Citation #920012557.

<table>
<thead>
<tr>
<th>A</th>
<th>$20000</th>
<th>Fall</th>
<th>Injury</th>
<th>Patient Care</th>
<th>11/10/2016</th>
</tr>
</thead>
</table>

On July 28, 2015, a 78 year old male resident fell from his bed and broke his hip on 12/23/2015 and died on 1/10/2016 from blunt force trauma related to the fall. The resident had a bed alarm and two bed rails to prevent falls but both interventions were poorly monitored. Bed alarms were tested for three other residents but none of them were operational. The facility was cited for failing to prevent falls, failure to ensure bed alarms were functioning, and failure to evaluate fall prevention interventions. Citation #920012557.
Valley Palms Care Center  
13000 Victory Blvd, North Hollywood  
A $15000 Careplan Fall Injury Supervision 10/28/2016  
On 6/21/16, a resident sustained a fall resulting in a fracture to the right shoulder causing severe pain. The facility was cited for failure to prevent the development and promote the healing of pressure ulcers. A resident informed facility staff of pain to the right heel for a week, before they finally identified the resident had developed a pressure ulcer. Another resident developed a Stage III pressure ulcer to the tailbone area and was observed wearing a urine soaked incontinence brief. Another resident was admitted to the facility with a Stage IV pressure ulcer to the tailbone area, yet the ulcer was observed to be covered with loose stool and there was no documentation the staff ever turned, repositioned, or checked the resident and provided pericare to the resident by washing or bathing the site as instructed in the care plan. Citation #060012898.

Windsor Gardens Healthcare Center Of The Valley  
13000 Victory Blvd, North Hollywood  
A $2000 Fall 1/23/2017  
The facility was cited for a series of falls, injuries and mishaps to multiple residents in the year 2016. On 7/1/16, a resident's ribs were fractured after falling while being transferred in a Hoyer lift sling. That resident also suffered a skin tear on the forearm when scratched by another resident's dog. On 11/8/16, a resident who had four falls in two weeks fell in the bathroom and lacerated his face, and on 4/23, another resident, who had six prior falls, fell and suffered a hip fracture. The citation also included a finding that the facility had failed follow a physician's order to place a pad alarm on a resident's wheelchair that would alert staff if that resident attempted to get up. Citation #060012897.

Madera County  
Avalon Health Care-Madera  
1700 Howard Road, Madera  
AA $100000 Medication 12/09/2016  
A 63 year old resident with kidney and liver problems was killed from an overdose of the painkiller Dilaudid when he was accidentally given 20 times the ordered dose on eight occasions covering a three day span from 8/28/2016 - 8/30/2016. The resident had been getting 4 ml of diluted Dilaudid and when that ran out, she was erroneously given 4 ml of a much more concentrated solution. On 8/31/2016, the resident died a horrible death from neurotoxicity: screaming, dry heaving, twitching throughout his body, and drugged with psychotropics administered through a rectal tube. The facility was cited for failing to ensure the resident was free from significant medication errors. Citation #040012802.

Orange County  
Flagship Healthcare Center  
466 Flagship Road, Newport Beach  
B $2000 Careplan Decubiti (Bedsores) Neglect Patient Care 1/23/2017  
A total of three residents failed to receive the necessary care and services to prevent the development and promote the healing of pressure ulcers. A resident informed facility staff of pain to the right heel for a week, before they finally identified the resident had developed a pressure ulcer. Another resident developed a Stage III pressure ulcer to the tailbone area and was observed wearing a urine soaked incontinence brief. Another resident was admitted to the facility with a Stage IV pressure ulcer to the tailbone area, yet the ulcer was observed to be covered with loose stool and there was no documentation the staff ever turned, repositioned, or checked the resident and provided pericare to the resident by washing or bathing the site as instructed in the care plan. Citation #060012898.

Riverside County  
Community Care And Rehabilitation Center  
4070 Jurupa Avenue, Riverside  
B $2000 Fall 1/11/2016  
On 5/22/16, a 78 year-old female resident, who was a high risk for falls, was left unattended in the bathroom by a nursing assistant and fell, resulting in a hip fracture. The facility was cited for failure to ensure the resident had adequate supervision to prevent accidents. Citation #250012716.

Community Care On Palm  
4768 Palm Avenue, Riverside  
B $2000 Careplan Fall Injury Supervision 1/05/2017  
The facility was cited for failing to ensure the patient was provided with necessary care and services to maintain her highest physical well-being. The facility failed to evaluate
the patient's decline in physical mobility and failed to identify interventions after multiple falls occurred. The facility also failed to update/revise the care plan to provide adequate safety measures. This resulted in a fall after the resident attempted to ambulate to the bathroom without staff assistance. The resident was transferred to the hospital where she was confirmed to have a left hip fracture, left wrist fracture, and the laceration to the left eyebrow requiring the stitches. Citation #250012847.

**San Diego County**

**Eldorado Care Center, LP**

510 E. Washington Avenue, El Cajon

B  $800  Mandated Reporting  1/13/2017

On 6/17/16, a resident was found on the floor outside another resident's room, and was subsequently taken to the emergency room after an x-ray indicated "Acute left hip fracture." DPH became aware of the incident while conducting a review of medical records during the facility's recertification survey in October 2016. The facility had not reported the incident to DPH, nor the police department, and was cited for failing to report an abuse incident within the required time frame. Citation #09001288.1.

**Palm Terrace Care Center**

11162 Palm Terrace Ln, Riverside


The facility failed to implement an infection control program, failed to contact the health department after a patient tested positive for Legionnaire's Disease. The facility did not conduct an investigation as to the cause of the infection, or begin to implement measures that would prevent the spread of the disease. As a result, 10 additional patients became infected, and for one patient, the infection was a contributing factor in her death. Citation #250012713.

**Palm Terrace Care Center**

11162 Palm Terrace Ln, Riverside

A  $10000  Hydration  10/27/2016

A 64 year old resident with partial paralysis and kidney disease requiring dialysis was hospitalized for severe dehydration on 9/25/2015, 12 days after he was admitted to the facility. The resident received nutrition and hydration through a g-tube but his hydration levels were inadequately monitored. When hospitalized, the resident was found to have a water deficit of five liters. The facility was cited for failing to ensure the resident was provided sufficient fluid. Citation #250012258.

**Riverside Behavioral Healthcare Center**

4580 Palm Ave., Riverside

B  $2000  Neglect  Physical Environment Supervision  11/10/2016

Two residents committed suicide by hanging themselves from bed sheets they tied to fire suppression sprinklers in facility restrooms. The first suicide involved a 21 year old male resident who died on 9/10/2014. The second suicide involved a 19 year old female resident who died on 1/3/2015. The facility considered installing sprinkler heads that were flush with the ceiling after the first resident's suicide to prevent future suicide attempts, but it had not taken any action by the time of the subsequent suicide on 1/3/2015. No increased monitoring of residents took place following the initial suicide. The resident who died on 1/3/2015 had a history of suicide attempts, had made recent suicidal statements and knew the male resident who previously committed suicide in the same manner. The facility was cited because it failed to adequately monitor her to prevent suicide attempts and failed to ensure a safe physical environment. Citation #250012712.

**The Grove Care and Wellness**

3401 Lemon Street, Riverside


The facility neglected to ensure staff assigned to the skilled nursing facility remained in the facility to provide care and support for the skilled nursing residents during an electrical fire at the facility on 01/17/16. The facility failed to implement the policy and procedure for the priority of resident evacuations when residents from the assisted living floors who were ambulatory were assisted out of the building before any attempted evacuation of the skilled nursing residents. This violation of the regulations had a direct or immediate relationship to the health, safety, or security of the residents. Citation #250012685.