California’s Nursing Homes: This Has to Stop!

Although California spends nearly $5 billion in Medi-Cal funds per year on nursing home care, discrimination against Medi-Cal-eligible residents is systemic, and the care provided to nursing home residents is getting worse every year. Poor regulatory oversight, minimal monetary penalties, repeat violations without consequences, and the never-ending quest by the nursing home industry for more money—these are only a few of the reasons that care is so bad and that the demand for nursing home care has decreased every year.

Too many California nursing homes don’t want to keep residents once they’ve sucked all of the Medicare rehab funds from them—dumping (mainly Medi-Cal) residents into acute care hospitals as a matter of course and refusing to take them back regardless of administrative law decisions to the contrary.

Meanwhile, California’s Department of Public Health— the agency charged with providing regulatory oversight of nursing homes—has put on blindfolds, refusing to acknowledge the grievous violations that harm and, often kill, nursing home residents.

From San Diego to Los Angeles to Madera to Santa Clara—it doesn’t seem to matter what part of the state the facility is in—residents are put at risk the minute they enter a California nursing home. A constant litany of sexual, verbal and physical abuse, neglect, refusal to provide pain medication, refusal to answer call buttons, allowing residents to lay in their own feces and urine, bedsores, falls resulting in broken bones and deaths and hundreds of preventable acute care hospital admissions at a cost of millions of dollars—this is the status of nursing homes in California in 2017.

- A resident in a Chowchilla nursing home was the victim of sexual abuse by a visitor who was known by the facility staff to be a registered sex offender. (Fine = $2,000)
- A resident in a Santa Clara nursing home was sexually violated by a CNA who continued to work at the facility despite the report of sexual abuse. (Fine=$1,000)
- A staff member in a Los Angeles facility recorded videos and photos of residents without their consent and sent them to someone outside the facility. (Fine=$2,000)
- A facility in Corona failed to report an outbreak of Legionnaire’s Disease to the Department of Health for three weeks after a resident was diagnosed with the disease putting all of the residents at risk of catching this often fatal disease. (Fine=$2,000)

California’s Nursing Homes: ... (continued on page 11)
CANHR’s statewide media campaign hopes to highlight the problems with nursing home quality of care and the enforcement system and the many problems in Residential Care Facilities for the Elderly in California. CANHR will be reaching out to tell real stories of abuse and neglect in long term care facilities. In the case of the media, it is always helpful if they can contact real consumers in their geographical area and use their stories.

A form on CANHR’s website authorizes CANHR to release your name and contact information to interested media regarding the issues you indicate. No information will be provided to anyone unless a reporter is interested in doing a story on a specific subject. If you would like to share your story, fill out the form or send to the CANHR office.

Donate to CANHR When You Shop on Amazon

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.

In Memory - Peter Summers

CANHR is sorry to report the death of Peter Summers, a former HCFA analyst and a friend and colleague of CANHR. Through his work with the Health Care Financing Administration (HCFA) – now CMS - “Pete” Summers was devoted to working to improve the quality of life and quality of care in our country’s nursing homes. He continued to consult after he retired from HCFA, volunteering at CANHR and contributing to numerous reports on the inadequacies of nursing home staffing and care issues. Pete Summers gave true meaning to the words “public servant.” And those he served, particularly nursing home residents and advocates, will always be grateful for his work.
Department of Social Services Launches Mobile Search site for RCFEs

The California Department of Social Services maintains a website that allows the public to search for licensed facilities and view information on their past inspections, reports, citations, and complaints. It provides individuals and their families with an important resource to assist in the evaluation of facilities. https://secure.dss.ca.gov/CareFacilitySearch/Search/ElderlyAssistedLiving

The Department has recently launched a mobile version of this website. CDSS Facility Search is a free application, and can be acquired in both the Apple and Google Play app stores. It maintains the same functionality of the transparency website, while providing a platform that is better suited to mobile devices. If you have any questions, please contact the cclwebmaster@dss.ca.gov.

Assisted Living Waiver Institutes Waitlist

In March 2017, California’s Assisted Living Waiver Program (ALWP) reached its capacity of 3,700 participants. The Department of Healthcare Services (DHCS) has instituted a waitlist, and on May 22, 2017 began accepting “Waitlist Request Forms.” Individuals interested in holding a spot on the waitlist should contact a Care Coordination Agency in their county to complete a one-page Waitlist Request Form. Please be advised that there are currently very significant wait times, due to the existing backlog of applications held by DHCS.

Individuals are nevertheless encouraged to submit a Waitlist Request Form to hold a spot on the list, and to demonstrate to the State that there is strong demand for this program, and a need for expansion. For more information, please contact CANHR at 1(800) 474-1116.

Free Online Advance Health Care Directive for Consumers

Every adult should have an advance health care directive (AHCD) to state their health care preferences and to name a substitute health care decision-maker in case there is ever an accident or condition that renders the adult unable to make their own decisions. This is true now more than ever in light of a recent U.S. Supreme Court decision that makes it easier for an agent under a power of attorney to sign an arbitration agreement and waive an individual’s right to have their case decided in a court of law.

To help consumers express their health care preferences and preserve their right to go to Court, CANHR has created its own AHCD form, free for download. The form protects consumers from situations like those in the above case by including explicit language limiting an agent’s authority to enter into pre-dispute arbitration agreements. The form also has innovative features specific to long-term care concerns as well as simple expressions of end-of-life wishes. Consumers can also download a detailed set of instructions for guidance in completing the form. Click here for more information.

New Income Limits for Aged & Disabled Program

Effective April 1, 2017, income limits for the Aged and Disabled Federal Poverty Level (A&D FPL) are as follows:

Single Individual: The income limit for an A&D FPL individual is $1,235. This income limit is equal to $1005 (100 percent of the FPL for an individual) plus the $230 standard disregard for an individual.

Couple: The income limit for an A&D FPL couple is $1,664. This income limit is equal to $1,354 (100 percent of the FPL for 2 Adults) plus the $310 standard disregard for couples.

Federal CMS Pulls Rule Banning Pre-Dispute Arbitration

The federal agency, Centers for Medicare & Medicaid Services (CMS), issued proposed revisions to arbitration agreement requirements for long-term care facilities. The Reform of Requirements for Long-Term Care Facilities Final Rule published on October 4, 2016 prohibited pre-dispute agreements for binding arbitration. The American Health Care Association and a group of nursing homes sued for preliminary and permanent injunction to stop CMS from enforcing that requirement. The court granted a preliminary injunction on November 7, 2016. After that decision, CMS reviewed and reconsidered the arbitration requirements in the 2016 Final Rule.

Unfortunately, current and prospective nursing home residents will again be forced to surrender their constitutional rights just to receive (mediocre – at best)
CANHR is supporting, opposing and/or closely following a number of pieces of legislation this session. This list is subject to change. Please check www.canhr.org for updated details on legislation, and www.leginfo.ca.gov for information on specific bills.

**Support**

**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 facility closure. The bill responds to a 2016 crisis in Eureka when Shlomo Rechnitz – who owns all five freestanding facilities in Eureka – threatened to close three of them in an effort to obtain higher Medi-Cal payments. **Status:** Hearing in Senate Health June 7.

**AB 286 (Gipson): To Allow Medi-Cal Beneficiaries to Return Home**
Under current law, Medi-Cal beneficiaries in nursing homes may retain a “home upkeep allowance” of $209 per month if a doctor certifies they are likely to return home within 6 months. The rest of their income is applied to Share of Cost, causing many to lose their housing and remain institutionalized at the expense of Medi-Cal. AB 286 would base the allowance on the actual cost of maintaining the home. **Status:** DEAD.

**AB 550 (Reyes): Restoring Funding for Long Term Care Ombudsman Programs**
In 2008, the 35 local Long Term Care Ombudsman programs had all state funding cut, leading to enormous reductions in staff and services for residents of long term care facilities. AB 550 partially remedies this problem, by boosting the base funding allocation and adding $2.25M in total funding. **Status:** DEAD.

**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 proof is reduced from clear and convincing to preponderance of the evidence. **Status:** Passed Assembly; ordered to Senate.

**AB 937 (Eggman): Requests regarding resuscitative measures**
Since the adoption of the Physician Order for Life-Sustaining Treatment (POLST) law in 2008, third party “representatives” may override a patient’s prior expressions of treatment preferences by executing a POLST. AB 937 would re-establish patients’ control over their own health decisions by ensuring that in any conflict among instructions, the patient’s most recent expression is given primacy. **Status:** Senate Judiciary.

**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. **Status:** Senate Judiciary.

**SB 202 (Dodd): Medi-Cal Personal Needs Allowance**
This bill would increase the personal needs allowance for residents of long term care facilities on Medi-Cal from $35 per month to $80 per month. **Status:** DEAD.

**SB 218 (Dodd): The Qualified ABLE Program**
This bill will prohibit the state from filing a claim against a beneficiary’s CalABLE account for recovery of medical assistance paid under Medi-Cal. **Status:** Passed Senate; ordered to Assembly.

**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. **Status:** Passed Senate; Ordered to Assembly.

**SB 416 (Anderson): Elder abuse: isolation**
This bill would make it a crime for a caretaker of an elder or dependent adult to willfully isolate that adult. **Status:** DEAD.

*Legislation Update Summer 2017 (continued on page 5)*
Oppose

AB 150 (Mathis): Disabled Persons: rights: liability

This bill would prevent a person from filing a complaint under the Disabled Persons Act (DPA) against businesses with fewer than 50 full-time employees, unless the person notifies the business and waits six months to see if the violations continue. If passed, AB 150 would create special barriers to enforcement of civil rights for residents living in non-ADA compliant facilities. Status: DEAD.

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 enable the expansion of for-profit nursing home chains that are providing poor care to their residents. Status: DEAD.

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

The Department of Health Care Services’ trailer bill 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. Status: DEAD.

Federal Proposed Laws

H.R. 1215 – OPPOSE

Congress is 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. 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. Status: House floor.

nursing home care.

This proposed rule includes the following proposals:

- The prohibition on pre-dispute binding arbitration agreements is removed.
- All agreements for binding arbitration must be in plain language.
- If signing the agreement for binding arbitration is a condition of admission into the facility, the language of the agreement must be in plain writing and in the admissions contract.
- The agreement must be explained to the resident and his or her representative in a form and manner they understand, including that it must be in a language they understand.
- The resident must acknowledge that he or she understands the agreement.
- The agreement must not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including federal and state surveyors, other federal or state health department employees, or representatives of the State Long-Term Care Ombudsman.
- The facility must post a notice regarding its use of binding arbitration in an area that is visible to both residents and visitors.

The proposed regulation can be found here.

This proposed rule is scheduled to be published in the Federal Register on June 8, 2017 and comments are due by August 7, 2017.
Financial exploitation is becoming increasingly prevalent and organized. Indeed, fraud has become one of most prevalent crimes around the globe. The Baker Fraud Report of March 30, 2017 states that over 10% (that is 1 out of 10) of US adult population lost money to a scam in the previous year! Currently, scams cost individuals, organizations and governments hundreds of billions of dollars each year, and many scam victims also endure depression and ill health. There is no other crime that affects so many people from almost all ages, backgrounds, and place of living. The increase in fraud and scams is especially toxic to seniors. Older adults have long been favorite targets for telemarketing scammers. As a group, seniors have more assets and, because of cohort traits such as civility and trust, the risk of victimization can increase.

With technology and increased organization, scammers have found a new approach to prolong and increase senior victimization. As in the past, once “on the hook”, scammers will groom senior victims, calling them multiple times a day to facilitate trust and a relationship. Using common tactics known to psychologists who study persuasion, the scammers will get their foot in the door, starting with small requests and gradually draining their victim’s resources with promises of “winnings” or “investment returns” just around the corner. Scammers will learn about every possible asset (reverse mortgage) and walk seniors through the steps necessary to tap the assets to complete the victimization. In the past, once the seniors’ assets are gone, the scammers would abandon them.

What is now new is the “recruitment” of these defrauded seniors as “mules” into the organized crime institutions who can carry out tasks on the ground for the scammers and provide another level of insulation from law enforcement for the scammers. These senior “mules” will receive checks from other seniors, deposit it into their bank accounts and then send most on to the scammers. They may be asked to deliver packages or messages on behalf of the scammers.

The scammers tell the initial victim that they are being “sponsored” by other investors or sweepstakes players. Certainly, there are some senior mules who figure out that they themselves are victimizing other seniors, at which point scammers will switch tactics from affection to intimidation. Reports have included having scammers sending a pizza to the individual with a note of intimidation. Or using social media to indicate they are aware of the seniors movements and other phone calls. Seniors believe that they are under surveillance, and become fearful and hesitant to cooperate with law enforcement. These seniors potentially face criminal prosecution for money laundering, becoming “unbanked” by their banking institutions, and a future of poverty secondary to these scammers. Currently, many of these scams are being initiated in Canada and Jamaica. Early intervention with senior scam victims and consumer protection is more critical than ever, including law enforcement involvement.

Unfortunately, policy is moving in the opposite direction. Rather than increasing protections for older consumers, the current administration is proposing rolling back the fiduciary rule which would require financial advisors to put their client’s interest first. With the fiduciary rule now in doubt, we are truly entering into the golden age of fraud.

(Dr. Stacy Wood is a Professor of Psychology at Scripps College in Claremont, CA)
Dear Anxious in Arcadia,

The facility is required to provide the resident with an itemized bill. According to California law Welfare and Institution Code §14134.6 and Health and Safety Code §1599.67 the facility shall inform residents of any changes in those charges, and shall indicate on a resident’s bill every good, product, service, and medication for which the resident is being charged, including whether or not a senior discount was obtained on the medication.

Always pay the facility the agreed upon rate for monthly charges, and tell them you will not pay additional charges without an itemized billing. Include a copy of the law that requires an itemized billing.

Dear Anxious in Arcadia,

My mom is private pay resident in a skilled nursing facility. Her monthly payments are $7,400.00/month. Last month she received a bill for $7,600.00. I asked the facility about the additional charges and they were not able to give me a detailed explanation, but informed me it was for miscellaneous services. How do I find out what these charges are for?

Sincerely,

Anxious in Arcadia
Are the questions that are raised in my headline possible? Yes. I am a legally blind and disabled resident of a CCRC for the past 17 years. My apartment currently costs me $67,000 per year and will go up every year. Despite my disabilities, I prepare my meals, write my columns and keep my apartment squeaky clean with only 45 minutes of housekeeping help per week.

Because my apartment costs absorb nearly all of my income, I applied for our CCRC executive director for some relief. His suggestion was that I move to a smaller apartment to reduce my financial obligation to the CRCC. Such a move would endanger my health and safety, which did not seem to disturb the management at all.

How can I possibly pay $67,000 per year and meet my other necessary obligations, such as supplemental care and an insurance policy that covers very high hospital costs that are not covered by Medicare? For example, I was hospitalized in 2013 year and received a bill for $60,000, which my insurance covered completely. My premium per month is $400, and my prescription medication costs $300 per month. I also have dental bills, fees to my accountant for doing my income tax, and fees to my attorney who oversees my health care and protects me from exploitation by the CCRC management. I also have personal care needs and must purchase items for daily living that are not supplied by the CCRC.

Peace of Mind

How can a resident have peace of mind or a sense of security under such circumstances?

The entrance fees I paid when I came here 17 years ago disappeared after my first 90 days of residency. I was assured not to worry about running out of money because I would be cared for even if that happened. Unfortunately, the marketing director never told me that under my financial structure, the CCRC would never be responsible if I ran out of funds. The suggestion was given that I should move into a studio and give up an apartment in which I had invested $54,000 in improvements in order to make the rest of my life productive and comfortable.

I rejected this suggestion since I am blind, and any such move would seriously jeopardize my health. I also require room to house equipment for the blind. The facility would benefit greatly by selling my apartment to a couple, as they would then receive two entrance fees, plus two monthly care fees, instead of my one monthly care fee – even though it is very high.

I consider that the pressures put upon me constitute as mental abuse. Some of the facts I reveal in this column about my own personal experience as a CCRC resident may prove useful to anyone thinking about moving into a CCRC. When I entered my CCRC 17 years ago, a candidate for residency had to be reasonably healthy and under the age of 84. Today, anyone can enter the facility if they have the money to satisfy the management, and they can be admitted even if they are seriously ill. There are no age limits. This leaves an older and sicker population in the facility leaving people, who came in earlier, to subsidize this population.

Access to Services

I had to fight to stay in my own apartment in order to get my services to puree my food, receive it in my apartment, and resist being moved to the skilled nursing facility only because I needed pureed food. My self-determination was also put at risk because the management was determined to silence me and prevent me from writing columns critical of the CCRC industry.

Professor Hyatt is an AARP California policy advisor. Professor Hyatt can be seen on YouTube on the USC School of Social Work website at https://www.youtube.com/watch?v=CMrC6o6Rm04.
A year ago the California Department of Public Health (DPH) took one of the boldest actions in its history to protect nursing homes residents from neglect and abuse. On July 8, 2016, the Department wrote Shlomo Rechnitz that it had denied his licensure applications for five nursing homes due to an appalling history of neglect and mistreatment in California nursing homes that Rechnitz owned or operated. The Department’s 21-page letters catalog a litany of serious violations in his nursing homes including 39 “immediate jeopardy” level deficiencies, 108 California citations and 13 penalties for understaffing from June 2013 to June 2016. Rechnitz is California’s largest nursing home operator with interests in about 80 facilities.

What happened next speaks volumes about the Department’s apparent lack of concern for the fate of the residents of these (and other) facilities. Instead of requiring a qualified operator to take over control of the five former-Windsor nursing homes in question, the Department has allowed Rechnitz and companies he is associated with to continue running them while he appeals the denials of the licensing applications.

How can the Department trust Rechnitz with the residents’ care throughout what may be years of appeals if he is not qualified for a license in the first place? Why is the Department putting the interests of an operator with such a disturbing record of poor care above the rights of the residents to receive high quality care?

Residents of other nursing homes are also in jeopardy. Since late 2014, Rechnitz’s companies have operated 18 nursing homes that he acquired from the Country Villa nursing home chain via bankruptcy. According to the Department, none of these nursing homes are licensed to Rechnitz. The Department has not acted on licensure applications he submitted in March 2016 despite the fact the same abysmal track record it cited for denying the Windsor-related applications in July 2016 applies equally to them.

Where is the Department’s sense of urgency and responsibility for the many hundreds of residents who live in these facilities?

In allowing Rechnitz and his companies to continue running these nursing homes, the Department is turning California laws designed to protect nursing home residents on their head. California licensure laws rightly require the Department to carefully screen nursing home operators in order to keep out those who would exploit or neglect residents. No California law permits anyone or any entity to operate a nursing home without a license or to manage one without the Department’s approval. If the Department believes there is some flaw in these laws, why has it not taken action to fix it?

That the July 2016 license denials are one of the finest moments in the Department’s nursing home regulatory history speaks very poorly of its past. Denying applications from unfit nursing home operators should be a routine part of its job, not considered an act of courage. Yet, for decades, the Department’s oversight of nursing homes has been so weak and ineffective that it has often appeared to be a captive of the nursing home industry.

Life-threatening conditions have been thoroughly documented in Mr. Rechnitz’s nursing homes, so it leaves us to seriously question the Department’s fitness to oversee the quality of care in California nursing homes and why they find him and his companies suitable to own or operate nursing homes in California.

The Department must act swiftly and strongly when the lives and well-being of California’s nursing home residents are threatened by unfit operators. If its current leaders are unable to carry out this core mission, the Department should bring in new leaders, regulators and attorneys who have the knowledge, experience and will to make California’s nursing home licensure laws work as they were intended and to hold nursing home chains accountable.

It is a privilege, not a right, to own or manage a nursing home in California. The Department’s mission and managers must recognize that this honor is only available to those who demonstrate that they can and will provide first-class care. Those who can’t should be immediately shown the exit, or better yet, never let in at all.
Residential Care Facility for the Elderly (RCFE) evictions seem to be on the rise, with more and more facilities issuing eviction notices and prepared to go to court to remove residents they don’t want to care for anymore. But residents have important protective rights! There are procedural requirements a facility must complete before evicting residents, namely an advance written notice telling the resident, in great detail, why he or she is being evicted. In addition, state regulations limit evictions to one of only five reasons. Here are some tips for disputing an RCFE’s reason for evicting a resident.

1. **Failure of resident to pay agreed upon rate for basic services within ten (10) days of due date.**

   Of the possible justifications for eviction, failure to pay is probably the least ambiguous – either you’ve paid your fee or not. However, if the resident has a disability that contributes to an inability to timely pay his or her fee, the resident can make a reasonable accommodation request to the licensee. A sample request can be found from the Department of Housing and Urban Development. The request should specify that the resident needs assistance in managing funds and may even need case management to apply for available public benefits to pay for care (SSI, Assisted Living Waiver). If the facility fails to provide the requested accommodation, it may be barred from pursuing eviction.

2. **Failure of resident to comply with state or local law after receiving notice of the alleged violation (e.g., drug use, assault, violation of probation, etc.).**

   In our experience, this is rarely cited as a reason for eviction but note the resident must receive a notice of the alleged violation before and in addition to a written discharge notice. Additionally, according to the RCFE Evaluator Manual, “the agency that has authority and jurisdiction over the applicable law,” not the RCFE, “determines if a violation has occurred.” The Manual also states the alleged violation “must be directly related to a living situation” in the RCFE. A vehicle code violation, for example, would likely not be relevant. The resident must also be given a reasonable opportunity to stop the violation before being evicted.

3. **Failure of resident to follow facility policies that are in writing, are stated or referenced in the admission agreement and are for the purpose of making it possible for residents to live together.**

   This is commonly cited as a reason for eviction but facilities rarely address the latter requirement: that the violated rules must be necessary for residents to live together. Instead, eviction notices will often discuss a resident’s interactions with staff or noncompliance with rules that govern solely personal conduct.

   If an eviction notice does allege a resident’s conduct has negatively impacted other residents’ quiet enjoyment of the facility, then the facility staff members were likely required by Welfare & Institutions Code Section 15630 to report any incidents to Community Care Licensing. If there are no reports, then there was no “resident-on-resident” abuse. A facility cannot claim that a resident abused, threatened, or harassed another resident on one hand but not report such alleged incidents on the other.

   Additionally, RCFEs should not be able to hide behind poor care. If a resident’s “behavior” is a predictable result of a facility’s failure to alleviate a resident’s natural distress, discomfort, or pain, it should not be able to blame and evict the resident. Residents should be ready to defend an eviction by demonstrating the facility’s failures, not the resident’s, are at issue.

   One last tip: make sure the policy that is allegedly violated actually is in writing, part of the resident’s admission agreement, and signed or agreed to by the resident.

4. **After formal assessment, the facility determines that it can no longer meet the resident’s changing care needs.**

   Facilities often can, but don’t want to, accommodate a resident’s changing care needs. In these cases, the
facility must be able to prove that it truly cannot meet the resident’s needs and that to do so, the facility would have to fundamentally alter the way it does business. The facility must base its determination on a resident reappraisal (22 Cal. Code Regs. Sec. 87463).

5. The facility changed its purpose (e.g., it is surrendering its license and will not operate as a Residential Care Facility for the Elderly (RCFE)).

When a facility is being sold, seek proof that the buyers are not going to operate a RCFE. It is possible the building will be sold and the residents moved out to clear the way for higher paying RCFE residents. 
For more information about challenging an RCFE eviction, see CANHR’s fact sheet.

California’s Nursing Homes: ...... (continued from page 1)

Read the citations included in this Advocate carefully. Many of the incidents are also criminal violations, and it’s safe to say that most are never prosecuted. In fact, most of the staff that sexually abused residents are likely still working in a California nursing home. The small fines are a good indication of how the Department values the health, safety, security and privacy of residents.

Most recently, an Office of the Inspector General study that found 1/3 of Medicare beneficiaries suffered harm from neglect or poor care with an average length of stay approximately 6 weeks! https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf

Our response is clear: where’s the outrage? Why do our legislators and the Governor keep giving nursing homes more money every year? Why is the Attorney General’s office out to lunch on nursing home abuse? The horrors that California’s nursing home residents are subjected to on a daily basis have to stop. CANHR is fighting hard to improve care, but there is no political will to change policies in any meaningful way. Join us. Let’s combine our voices, and tell our policymakers that poor, neglectful, and criminal care is not acceptable.”

PLANNED GIVING LEAVES A LEGACY TO HONOR YOUR MEMORY AND HELPS TO ENSURE THE FUTURE OF CANHR.

CANHR has been a not for profit 501(c)(3) corporation since 1983. 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

gifts 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.
Past Speaking Engagements, Panel Discussions and Training Sessions

- **March 16**: Senior Staff Attorney, Prescott Cole participated in the Alameda County Elder and Dependent Adult Abuse Multi-disciplinary Team.

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

- **March 17**: Tony Chicotel spoke at the Alameda County Area Agency on Aging Round Table about long-term care issues.

- **March 22**: Tony Chicotel visited the Santa Clara County Ombudsman Program at Catholic Charities and presented on nursing home therapy problems as well as decision-making for unrepresented nursing home residents.

- **March 22**: Efrain Gutierrez conducted a scam prevention session for seniors at Alice Manor and Ramona Estates in Los Angeles.

- **April 1**: Prescott Cole was Key Note Speaker at Lake County Senior Summit, “Elder Financial Abuse”.

- **April 5**: CANHR staff attended San Francisco State University Gerontology Program’s 30th anniversary celebration where Senator Mark Leno was presented with the **Distinguished Long-Term Care Advocate Award**. Pat McGinnis, Executive Director of CANHR and an adjunct professor in the Gerontology Program presented the award to Senator Leno.

- **April 5**: Staff Attorney Jody Spiegel, gave a presentation to the Pasadena Ombudsman Program on CANHR Services and Hot Topics in Long Term Care.

- **April 20**: Efrain Gutierrez provided CANHR resource and information at the Hofmann Community Center Senior Health Fair in Lawndale.

- **April 25**: Prescott Cole attended the LAAC Support center Meeting in Oakland.

- **April 25**: Julie Pollock gave a webinar on Medi-Cal Recovery Basics to attorneys and staff members at California Rural Legal Assistance.

*Senator Leno with Pat McGinnis, Julie Pollock, Pauline Mosher and Armando Rafailan at the SF State Gerontology Program’s 30th anniversary celebration*

*Prescott Cole with Mary Heare Amodio at Lake County Senior Summit, “Elder Financial Abuse***

**CANHR On The Move ……………… (continued on page 13)**
• **April 26:** Jody Spiegel participated in a stakeholder meeting regarding Medication Aides in Residential Care Facilities for the Elderly.

• **April 26:** Executive Director Patricia McGinnis spoke to the Probate Bar of the San Bernardino County Bar Association on the changes in Medi-Cal Recovery due to SB 833.

• **May 1:** Prescott Cole was a guest lecturer at the San Francisco State University speaking on the topic of financial elder abuse.

• **May 4:** Pauline Mosher, Program Manager presented to the San Francisco Health Insurance Counseling and Advocacy Program about Medi-Cal topics including share of cost and Medi-Cal recovery.

• **May 4:** Tony Chicotel made a presentation at the annual California Association of Superior Court Investigators meeting about poor decisions made by conservators.

• **May 5:** Pat McGinnis and Southern California Outreach Coordinator, Efrain Gutierrez, presented a training on Medi-Cal & Recovery to Social Workers and Discharge Planners at the Magnolia Place Family Center in Los Angeles.

• **May 5:** Tony Chicotel spoke at Long-Term Care Services of Ventura County’s wonderful event “Long-Term Care Explained in a Short-Period of Time.”

• **May 9:** Prescott Cole participated on the State Bar Legal Services Coordinator Meeting along with representatives from Qualified Legal Service Programs and Training Centers.

• **May 11:** Prescott Cole taught an all day training session on the Home Equity Protection Project and elder law issues to the San Jose Adult Protective Services.

• **May 12:** Prescott Cole taught an all day training session on the Home Equity Protection Project and elder law issues in Davis.

• **May 15:** Prescott Cole was a presenter at the 30th Annual Adult Protective Services Multidisciplinary Team Conference “Back to Basics” Rancho Cucamonga.

• **May 17:** Administrative Assistant, Marcus Nelson held an information desk at the 35th Annual Senior Health & Information Fair at the Richmond Memorial Auditorium.

• **May 18:** Efrain Gutierrez provided CANHR resources and information at the South Pasadena Senior Center.

• **May 23:** Prescott Cole taught an all day training session on the Home Equity Protection Project and elder law issues to the Sonoma County Adult Protective Services.

• **May 23:** Julie Pollock and Tony Chicotel hosted a “Policy Updates” session at Legal Assistance for Seniors’ annual Elder Abuse Conference in San Francisco.

• **May 26:** Prescott Cole and Tony Chicotel represented CANHR at the U.S. Attorney General’s Elder Justice Task Force for the Northern District of California.

• **June 15:** Prescott Cole was a presenter at the 20th Annual Elder Abuse Conference in Bakersfield.

• **June 26:** Prescott Cole taught an all day training session on the Home Equity Protection Project and elder law issues in Fresno County.
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**

Sharon Brennan
Jackie Johnson

Donna Smith and Luther B. Denson
Ruth Holland

Rosamond Edeline
Gail & Vern Bean

Greg S Ohanneson
Elizabeth Boileau

Margaret Parker
Anne Brooks

Corinne Presky
Joyce Kawahata

Corinne Presky
Randee Paller

Corinne Presky
Marsha Saltman

Corinne Gordon Presky
Liana Spalla

Corinne Presky
Sandra Stockey

Ronald Randolph
Brenda Williams

Peter Summers
The CANHR staff

**In Honor Of**

Tony Chicotel
Flora Calem

Corinne Presky
Barbara Hansom

Jody Spiegel
Robert Sandberg

**Upcoming Events**

**CANHR Social Worker Training**

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Friday, August 11

10 am - 1pm
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- **July 14:** CANHR will be hosting a resource and information table at the Torrance Memorial Senior Fair, 3330 Lomita Blvd., Torrance, CA 90505.

- **August 11:** CANHR will be hosting a resource and information table at the Congresswoman Linda Sanchez 15th Annual Senior Fair at Cerritos College, 11110 Alondra Blvd., Norwalk, CA 90650.

- **August 19:** CANHR will be hosting a resource and information table at the Buena Park Senior Center, 8150 Knott Ave., Buena Park, CA 90620.

- **November 3:** CANHR will be hosting a resource and information table at the Nakaoka Community Center Senior Fair, 1670 W. 162nd St., Gardena, CA 90247
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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.

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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 issue. Appeals of citations and collection of fines can take up to three years. For up-to-date information on any citation or facility, visit CANHR's Nursing Home Guide at www.nursinghomeguide.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 a resident or the substantial probability of death or serious harm, and carry a fine of up to $20,000. Class “B” citations are fined up to $2,000 and are issued for violations which have a direct or immediate relationship to health, safety, or security, but do not qualify as “A” or “AA” citations. “Willful material falsification” (WMF) violations also result in a fine. Fines are not always required to be paid. Citations can be appealed, requiring the Department of Health Services to substantiate the violation. Violations repeated within twelve months may be issued “trebled fines”— triple the normal amount.

### Alameda County

#### Alameda Healthcare & Wellness Center

430 Willow Street, Alameda  
**B $2000 Careplan Patient Care 8/24/2016**  
On 3/18/2016, a resident was diagnosed with diabetes complained to a nurse about pain to the right and left feet. When assessed, the nurse noticed overgrown toenails extending to the rear of foot. A doctor was notified and the resident was sent to the acute hospital emergency room. During an interview with the charge nurse she said, "I didn't see her toes. No one reported to me about her toenails." The facility failed to follow patient care policy and insure the resident was provided the necessary foot care and services to maintain the highest physical well-being. Citation # 020012394.

#### Baywood Court Health Center

21966 Dolores Street, Castro Valley  
**B $1500 Injury Physical Environment 1/19/2017**  
On 4/28/16, a female resident sustained second degree burns when she spilled hot tea onto her left thigh. The facility failed to serve hot beverages at a safe temperature, resulting in the resident sustaining a second degree burn. Additionally, the facility failed to implement safety precautions after the accidental burn incident, potentially placing her and other residents at risk for another accidental burn from hot water. Citation # 020012887.

#### Chaparral House

1309 Allston Way, Berkeley  
**B $1200 Mandated Reporting 2/2/2017**  
The facility failed to follow its abuse prevention and reporting policy when two nursing students reported that two CNAs had abused a resident. The two students told the LVN who ran their CNA training program about the alleged abuse, but the LVN did not report the allegation to anyone. Citation # 020012920.

### B $1200 Physical Abuse Verbal Abuse 2/2/2017

Two nursing students reported seeing two CNAs physically restrain a resident with cognitive impairments while providing hygiene care on 11/28/16. When the resident became increasingly self-protective, the CNAs put a towel over the resident's nose and mouth, and one CNA called the resident a "nasty bitch." While the incident was being investigated, the CNAs were not removed from resident care. The facility was cited for failing to protect the resident from physical and verbal abuse. Citation # 020012919.

#### Gateway Care & Rehabilitation Center

26660 Patrick Ave., Hayward  
**B $1000 Elopement Patient Care 10/26/2016**  
On 11/30/15, a female resident was found outside the facility at 9pm, being attended to by paramedics and then sent to the ER. The resident had been wearing a wander guard when she left the facility, but it was found to inconsistently alarm when checked by a technologist from the wander guard company. The facility failed to ensure a safe environment when it failed to follow the manufacturer's instructions for use of the facility's wander management system. This failure resulted in the resident leaving the facility unsupervised and falling and sustaining an injury. Citation # 020012678.

#### Morton Bakar Center

494 Blossom Way, Hayward  
**B $2000 Physical Abuse 3/27/2017**  
On 5/30/16, a CNA was captured on camera making a "swinging motion" with her arm towards a resident's face, and a second swing which touched the resident's cheek. The CNA also grabbed the resident by the shirt. The CNA defended her actions by saying that the resident had shouted a racial slur and spit in her face. The resident had diagnoses that included a disorder that affects thoughts and behavior. The resident denied spitting and
told the investigator that she didn't want to talk about it anymore. The facility was cited for failing to protect the resident from physical abuse that had the potential for physical and psychological harm. Citation # 020013083.

Oakland Healthcare & Wellness Center
3030 Webster St., Oakland
B $1500 Fall Injury Physical Environment Security Supervision 5/12/2016
On 12/22/2015, a resident known to have had falls and was diagnosed with dementia was left unattended and rolled his wheelchair down a ramp leading to the facility's garage. The gate blocking the ramp was left open by a facility housekeeper and the resident rolled down to the bottom and hit a concrete wall. The resident sustained multiple injuries that included broken bones in his face and abrasions on his left knee and forehead. The facility housekeeper failed to close the gate before leaving it unattended. The violation had a direct relationship to the health and safety or security of the resident. Citation # 020012249.

The Rehabilitation Center of Oakland
210 40th Street Way, Oakland
B $1500 Evictions 5/19/2016
On the morning of 9/28/15, a 31 year-old resident who had been admitted for treatment of an arm wound after being discharged from a hospital was given an Amtrak ticket, a $50 voucher and a taxicab voucher by the facility's business developer and encouraged to go out to find an alternative place to live. When the resident returned at 8 pm found that she was being locked out and that her possessions had been thrown into a trash can. The resident had no place to go, became scared and hid in the bushes. The police arrived but were not able to get anyone in the facility to let the resident back in until after 11:00 pm when the night nurse came on duty. As a result of this, the resident suffered emotional distress. The facility was cited for failing to implement their policy and procedure to protect the resident from mistreatment and neglect. Citation # 020011916.

Washington Center
14766 Washington Ave., San Leandro
B $1500 Medication 2/8/2017
Upon admission of a female resident with atrial fibrillation on 8/25/16, a facility nurse erroneously left out a vital blood thinner medication on her transcription of a pharmacy order. Despite a physician's prescription and the delivery of the medication, the resident did not receive it any time during her six-day stay, which was abruptly ended when the resident suffered a stroke. The resident died 19 days later due to the stroke. Citation # 020012945.

Contra Costa County
Antioch Convalescent Hospital
1210 A Street, Antioch
B $1500 Careplan Fall Injury Patient Care Physical Environment 11/16/2015
A 85 year old resident, diagnosed with Alzheimer's disease, arthritis and known for falls was left on the toilet unattended while the CNA left to get the resident's clothing. The CNA heard the resident fall off the toilet and found the resident on the floor, face down with blood coming out of her nose. The resident's X-ray report showed multiple nasal bone fractures with depression. In an interview with the Director of Nursing stated that the CNAs should have never left the resident alone in the bathroom and should have collected the resident's supplies before attending to the resident in the restroom. This resident's fall was preventable. Citation # 020011841.

Tampico Terrace Care Center
130 Tampico Street, Walnut Creek
B $1500 Medication 8/12/2015
On 5/18/15, a relative of a resident reported to the Department that the resident was given the wrong medication which caused his blood pressure to drop, 911 to be called, and the resident being rushed to the ER. The resident, who suffered from hypertension, coronary artery disease, chronic kidney disease and bleeding in the brain with resulting blindness, had been given another resident's multiple medications. The facility was cited for failing to ensure that the staff properly identified residents before administering medications. Citation # 020011660.
Eureka Rehab & Wellness Center, LP
2353 Twenty-Third St, Eureka

A $20000 Careplan Fall Injury Patient Care Staffing 2/28/2017

Eureka Rehab & Wellness Center was cited for failure to provide sufficient nursing staff to meet the needs of its residents. Seven different residents surveyed suffered at least 26 documented falls between May and December 2016, resulting in multiple hospitalizations, bone fractures, skin tears, stitches, and other injuries. Additionally, two additional residents interviewed reported they had to wait over 30 minutes before their call lights were answered, often having to urinate on themselves and stay wet for long periods of time. Multiple nursing assistants were interviewed regarding the number of residents they were responsible for, and the time it took to complete their caregiving tasks. The interviews revealed that each nursing assistant had grossly inadequate time to meet the care needs of the residents they were assigned to. Citation # 110012902.

A $20000 Careplan Fall Injury Patient Care Supervision 2/28/2017

A resident know to be a high risk for falls had 6 falls during a 6 month period at the facility from 5/24/16 to 12/6/16. On one occasion the physician was not notified until 5 days after the fall. The resident fell and sat on the floor wet with urine. The resident sustained skin tears to her nose due to the falls. The resident's care plan required supervision with one person to assist with transfers and walking and indicated fall risk prevention and management. The facility failed to maintain an accident hazard free environment and provide adequate supervision and assistance. Citation # 110012999.

A $20000 Careplan Fall Injury Patient Care Staffing 2/28/2017

A resident diagnosed with schizophrenia and muscle weakness had 3 falls during a one-month period at the facility from 8/16/16 to 9/17/16. On one occasion the resident tripped over a hoyer lift left in his room by a CNA. The resident sustained skin tears, reopened skin tears and nasal bone fracture due to the falls. The resident's care plan required supervision with one person to assist with transfers and walking and indicated fall risk prevention and management, with low position bed, padded type pants and cover the hips to cushion a fall. A staff member stated that there is not enough staff to watch everyone at night. The facility failed to maintain an accident hazard free environment and provide adequate supervision and assistance. Citation # 110012998.

A $20000 Fall Patient Care Supervision 2/28/2017

The facility failed to provide adequate supervision and assistance, and failed to update the care plan for a resident who fell 5 times within one month. The last of the falls resulted in a head injury which required staples. The resident fell 3 additional times after that fall due to a lack of implementation of fall prevention measures. Citation # 110012997.

A $20000 Fall 2/28/2017

On 8/28/16, a resident who was blind in both eyes was walking unassisted down the hallway to the bathroom. The resident grabbed a spring rod which the housekeeper had placed across the bathroom door entrance while cleaning, and fell to the floor. The resident sustained an upper arm bone fracture, and was sent to the Emergency Room and admitted to the hospital. The facility was cited for failing to maintain an accident free environment, and provide adequate supervision and assistance. Citation # 110012991.

B $2000 Mandated Reporting Verbal Abuse 3/14/2017

The facility failed to report an incident of witnessed abuse within the required time period, and to the relevant authorities, after a staff member saw a resident block the doorway to her room, preventing her roommates from exiting, threw hairbrushes at staff, and verbally threatened other residents and staff. Citation # 110012936.

A $20000 Administration Fall Patient Care Staffing 2/28/2017

Eureka Rehab & Wellness Center was cited for failure of its Quality Assessment and Assurance Committee (QAA) to develop corrective action plans to prevent falls, to identify staffing issues and ensure sufficient staffing, and failure to communicate QAA minutes to staff. Seven different residents surveyed suffered at least 26 documented falls between May and December 2016, resulting in multiple hospitalizations, bone fractures, skin tears, stitches, and other injuries. Additionally, two additional residents interviewed reported they had to wait over 30 minutes before their call lights were answered, often having to urinate on themselves and stay wet for long periods of time. Citation # 110012905.

A $20000 Careplan Chemical Restraints Fall Patient Care 2/28/2017

The facility was cited for failure to provide adequate supervision and maintain an environment free of accident hazards when a female resident with dementia fell multiple times in a five month period between May and November 2016. The falls resulted in multiple injuries, multiple hospitalizations, and eight stitches to the head.
During this time period, the resident was prescribed psychotropic medications, including Depakote, which increase the risks of falls in elderly patients. Psychotropic drugs are often misused as "chemical restraints" to sedate patients with dementia in nursing homes. Citation # 110012904.

**A $20000 Careplan Fall Medication Patient Care 2/28/2017**

On 10/21/16, a resident fell from her bed to the floor. Staff did not respond promptly to the resident’s complaints of pain, and an x-ray was not taken until six days later. The x-ray indicated that the resident had a bone condition, which included symptoms of severe pain. The facility was cited for failing to adequately assess and treat the resident’s pain, and failing to care plan to taper her pain medication, which resulted in the resident crying and having difficulty moving around due to severe pain in her left leg, secondary to the bone condition and fall. The facility was also cited for failing to follow through with a 11/30/16 treatment order for medication for ear wax removal, which caused a second resident’s ear to be plugged up and loss of hearing. Citation # 070012641.

**Modoc County**

**Surprise Valley Community Hospital D/P SNF**

Main & Washing..P.O.Bx 246, Cedarville

**B $2000 Neglect 2/13/2017**

A 69 year old female resident was not given CPR when she stopped breathing and her heart stopped on 10/27/2016. A nurse reported that the resident suddenly stopped breathing a slumped in her bed in her presence. Yet, he did not give CPR because the resident was on a soft mattress and his back problems prevented him from moving the resident to the floor. The facility’s "crash cart" used for emergency interventions was not used, nor could it have been, as its wheels were frozen and would not move. Citation # 230013152.

**Monterey County**

**Cypress Ridge Care Center**

1501 Skyline Drive, Monterey

**B $2000 Neglect Notification 12/12/2016**

On 9/20/16, a resident was hospitalized due to acute gastrointestinal bleeding, an apparent side effect of Warfarin, a blood thinning medication the resident was taking. Blood tests a day prior to hospitalization indicated that the dose of warfarin was too high. The resident stated she "vomited blood" for six hours before she was transferred to the hospital. She kept telling nursing staff she was feeling sick but "they would not listen" to her. The facility was cited because its charge nurse failed to respond when the resident began vomiting and to timely notify her physician of the change of condition. These failures led to a delay in her hospitalization. Citation # 070012806.

**Windsor Gardens Rehabilitation Center of Salinas**

637 East Romie Lane, Salinas

**B $2000 Careplan Fall Patient Care Supervision 10/14/2016**

The facility was cited for failing to ensure a female resident was provided with the adequate supervision she needed to prevent her from falling. Her assessed needs and careplan indicated she had a history of falling and was at high risk for falls. One of the falls resulted in a fractured right hand, minor head injury, and laceration of the scalp. Citation # 070012641.

**Placer County**

**Lincoln Meadows Care Center**

1550 Third Street, Lincoln

**B $2000 Neglect Notification 4/13/2017**

A resident reported her roommate was raped by an employee on 5/30/16. No effort was made to report the allegations to the Department of Public Health (DPH). The resident later reported the incident to another staff member on 8/24/16 but the facility administrator disregarded the report. The facility was cited for failing to report alleged abuse to DPH as required by law and by its own policies. Citation # 030013118.

**Roseville Point Health & Wellness Center**

600 Sunrise Avenue, Roseville

**B $600 Chemical Restraints 4/25/2017**

When a resident awoke in the middle of the night on 12/7/12 screaming "help," the facility staff sought and received an order to drug the resident with Haldol, a powerful chemical restraint. The prescribing physician failed to discuss the order with the resident's representative within 48 hours as required by law. The facility was cited for failing to ensure this requirement was satisfied. Citation # 030013152.

**Sacramento County**

**Manorcare Health Services (Citrus Heights)**

7807 Uplands Way, Citrus Heights

**B $2000 Bed Hold Evictions 2/3/2017**

On 3/11/16, the facility transferred an 83-year-old resident with dementia to the hospital to "stabilize behaviors" and then failed to provide a 7-day bed hold as required by law. The administrator stated, "I did not issue a bed
hold for the resident because we were not going to take him back." Citation # 030012933.

**Mid-Town Oaks Post-Acute**

2600 L Street, SACRAMENTO

B $2000 Bed Hold Evictions 4/14/2017

A resident was hospitalized with pain and weakness in his arm on 7/25/16. When the resident was cleared for readmission, the facility refused to readmit him, claiming there were no available beds despite having available beds. The facility was cited for failing to honor the resident’s right to be readmitted following his hospitalization. Citation # 030013121.

**San Mateo County**

Brookside Skilled Nursing Hospital

2620 Flores Street, San Mateo

B $2000 Bed Hold 3/9/2017

On 2/5/16, a resident who suffered from bipolar disorder was hospitalized for an infection. When the resident was ready for readmission the facility refused to readmit. A review of the resident's record indicated behavioral problems such as delusions, and exhibition verbal behaviors such as screaming, threatening and cursing towards others, and rejecting or refusing care and treatment. There were also reports of the resident rummaging through linen carts, throwing dirty linen, cloths and food a staff. The facility was cited for failing to allow the resident to return. Citation # 220013025.

**Santa Clara County**

Camden PostAcute Care, Inc.

1331 Camden Avenue, Campbell

B $1000 Mandated Reporting Physical Abuse 4/12/2017

On 3/24/17, a resident reported to facility staff than a CNA stuck his fingers in her rectum during a shower. The facility did not send an incident report to the CDPH until 3/27/17, and had not completed its investigation report as of 4/3/17. Additionally, the alleged abuser continued to work at the facility. The facility was cited for not reporting the incident to the CDPH within 24 hours, not reporting the completed investigation to the CDPH within five working days of the incident, and not immediately removing the alleged abuser from duty. Citation # 070013106.

Children's Recovery Ctr Of Northern Cal. D/P SNF

3777 South Bascom Avenue, Campbell

B $2000 Medication 12/09/2016

On 9/7/16, a resident's physician issued new medication orders, discontinuing one medication and increasing the dosage of two other medications. The facility did not implement the new orders until 9/22/16 – 15 days later – when it discovered that the new orders had not been transcribed in the medication administration record. The facility was cited for failing to administer the correct medications. Citation # 070012807.

**Cupertino Healthcare & Wellness Center**

22590 Voss Avenue, CUPERTINO

B $2000 Decubiti (Bedsores) Patient Care 2/3/2017

The facility failed to ensure a male resident received appropriate care to prevent a pressure sore from developing on his left heel, which was observed on 1/18/17. The resident was immobile and a high risk for pressure sores, but staff failed to reposition him or implement other interventions to prevent pressure sores from developing. Citation # 070012939.

Hillview Convalescent Hospital

530 W. Dunne & La Selva, Morgan Hill

B $1000 Careplan Patient Care Physical Restraints 12/20/2016

On 3/24/17, a resident was found with skin discoloration on his right eye. There was no documented evidence of the cause of the skin discoloration. The facility was cited for failing to report the resident’s injury to the Ombudsman. Citation # 070013101.
On 11/28/16 a female resident with Alzheimer's disease was observed in her room sitting on her wheelchair with a seat belt. There was no care plan or physician's order for a seatbelt. Multiple times the resident fell, including on 12/1/16, where she was found with the wheelchair on top of her, still strapped in. The facility failed to ensure the resident was free from physical restraints and failed to determine the appropriateness of the restraint, when there was no physician's order for the use of a seat belt. Citation # 070012823.

Idylwood Care Center

1002 W. Fremont Avenue, Sunnyvale
B $1000 Fall 11/23/2016
A female resident with mental health issues and a history of falls was placed on a toileting schedule of every two hours but there was some evidence that it was not followed. She was also supposed to have transfer poles near her bed and toilet but they were not installed. Although the resident's falls were due to dizziness, orthostatic blood pressure measurements were not regularly made. On 6/25/2016, the resident fell and hit her head and suffered a concussion. The facility was cited for failing to provide adequate supervision and toileting to prevent falling by the resident. Citation # 220012750.

Lincoln Glen Skilled Nursing

2671 Plummer Avenue, San Jose
B $2000 Fall Supervision 11/10/2016
The facility failed to provide adequate supervision, assistance, and implement interventions to prevent falls for two residents. As a result, one of the residents fell unattended and sustained a fractured hip, was hospitalized, and had to have surgery. Citation # 070012724.

B $2000 Patient Care 3/29/2017
The facility failed to provide care in line with standards of clinical practice for a resident by not providing training to staff on procedures related to use of a rectal tube, used to relieve gas. A staff member inserted the tube without removing the protective cap first, resulting in the cap staying inside of the resident's body. The resident was taken to a hospital for removal of the cap. Citation # 070013089.

Los Altos Sub-Acute And Rehabilitation Center

809 Fremont Avenue, Los Altos
B $2000 Patient Care 4/3/2017
A resident developed a fungal infection and macerations to her feet in March of 2017 after refusing foot care and wearing the same pair of socks for many days. The refusal of foot care was not addressed in her plan of care. Upon hospitalization on 3/7/17, she was described as having grossly elongated and thickened nails. The facility was cited for failing to provide necessary care and services to the resident. Citation # 070013069.

Los Gatos Meadows Geriatric Hospital

110 Wood Road, Los Gatos
B $2000 Mandated Reporting Verbal Abuse 9/20/2016
The facility was cited after staff failed to report alleged verbal abuse from one resident to another within the 24 hour period required by law. After one resident yelled at her roommate repeatedly to move out, staff redirected the upset resident, but did not report to local authorities. Citation # 070012573.

Los Gatos Oaks Convalescent Hospital

16605 Lark Avenue, Los Gatos
B $2000 Patient Rights Physical Abuse 12/19/2016
On 11/28/16, a female resident attempted to sit up in bed. A male CNA then used his palm on her forehead to forcibly shove her down to her pillow. The administrator in training stated she terminated the CNA for staff abuse. The facility failed to ensure the resident was free from abuse. Citation # 070012824.

Mission De La Casa Nursing & Rehabilitation Center

2501 Alvin Avenue, San Jose
B $2000 Mental Abuse Physical Abuse 2/07/2017
On 12/19/2016 a resident stated that CNA (Certified Nurse Assistant) A who was caring for the resident was being rough with him, scratched him on his abdomen, touched him inappropriately, and invited the resident to watch a pornographic video with CNA A on his cell phone. In an interview with the RN (Registered Nurse) E on 1/30/2017, she scheduled CNA F to assist CNA A when it was time to care for the resident, so another person would be able to witness comments or concerns. The facility failed to implement the facility's abuse policy when an alleged
resident abuse was not reported within 24 hours to the appropriate agencies. Citation # 070012940.

Skyline Healthcare Center - San Jose
2065 Forest Avenue, San Jose
B $2000 Fall 4/26/2017
On 2/24/17, a resident who was a high risk for falls and wandering fell and broke his hip while walking unsupervised to the dining/patio area. The resident's records indicated that he had fallen seven times between 9/8/16 and 2/24/17, with three of the falls occurring in the dining room. The resident's records also indicated that the resident had problem behaviors including refusing care and was difficult to redirect by nursing staff, as he could become verbally and physically aggressive. The facility was cited for failing to ensure that the resident received adequate supervision to prevent falls and injury. Citation # 070013097.

Stonebrook Health And Rehabilitation
350 De Soto Drive, Los Gatos
B $1000 Medication 11/23/2016
During an observation, the nursing staff had a 28.5% medication error rate for three residents on 11/8/2016. Of 28 medications, 8 errors were made. Dosages were wrong, medications were given in the wrong form, and other prescribed medications were not given at all. The facility was cited for having a medication error rate of five percent or greater, jeopardizing the residents' health. Citation # 070012751.

Vasona Creek Healthcare Center
16412 Los Gatos Boulevard, Los Gatos
B $2000 Mandated Reporting Physical Abuse 4/19/2017
On 4/2/17, a resident reported to facility staff that another resident grabbed her hand, and would not let it go. The resident stated that her hand was hurt, and that she felt “irritated and a little scared.” The facility was cited for failing to report the incident to the CDPH, the Ombudsman or the police. Citation # 070013135.

Willow Glen Center
1267 Meridian Avenue, San Jose
B $1000 Patient Care 1/06/2017
On 11/17/2017 a resident used a walker left in his room to go to the bathroom The resident used the walker without assistance and the resident fell and sustained a lower back fracture. The resident's clinical record indicated that the he was admitted to the facility with joint pain, difficulty walking, generalized muscle weakness, and back pain. The record also indicated that the resident requires moderate assistance with toilet transfer. The facility failed to monitor the resident's environment to ensure he did not use a walker in his room and receive adequate supervision and assistance for devices to prevent a fall. Citation # 070012866.

B $500 Patient Rights Verbal Abuse 10/31/2016
The facility failed to ensure a resident was free from verbal abuse. On the morning of 10/7/16 the resident and CNA caring for him got into a verbal argument. The CNA admitted he became angry because of the way the resident was treating him and might have said a bad word in the situation because the resident kept on swearing at him and talking very derogatorily to him. Citation # 070012668.

A $10000 Fall 9/22/2016
On 7/4/16, a 69 y/o stroke victim resident who had a history of falls and a limited range of mobility was heard yelling for help and was found face down on the bathroom floor after falling while attempting to transfer herself from the toilet to her wheelchair. The resident had been identified as a fall risk and was to be assisted while toileting. The CNA who was supposed to have been assisting her had left her alone to attend to another resident. The fall resulted in a head injury with internal bleeding and the resident died the next day. The facility was cited for inadequate supervision. Citation #070012470.

Woodlands Healthcare Center
14966 Terreno De Flores Lane, Los Gatos
B $2000 Elopement Patient Care 3/09/2017
A resident diagnosed with dementia and determined at high risk for wandering was not provided with an appropriate care plan or interventions to prevent wandering. As a result, the resident was left unattended, left the facility, and was found at a local emergency room after falling in the middle of a crosswalk and injuring her head. Citation # 070013026.

Santa Cruz County
Driftwood Healthcare Center - Santa Cruz
675 24th Avenue, Santa Cruz
B $2000 Mandated Reporting Physical Abuse 2/16/2017
On 12/6/16, a resident claimed that a CNA hit the resident on the left arm and shoulder. The facility was cited for failing to report the resident’s claim of abuse to the DPH. Citation # 070012966.

Golden Age Convalescent Hospital
523 Burlingame Avenue, Capitola
B $2000 Fall 8/11/2016
On 4/4/16, a resident with severe dementia and a history...
of elopements, falls and minor injuries was found sitting on the floor with skin discoloration on her chin and a laceration on her right eyebrow. The facility was cited for failing to adequately supervise the resident from elopements and fall incidents. Citation # 070012497.

**Hearts & Hands, Post Acute Care & Rehab Center**
2990 Soquel Avenue, Santa Cruz

**B $1500 Patient Care 12/09/2016**

On 11/8/2016 Resident 1 was taking a shower with help from a CNA (Certified Nurse Assistant) A and the resident told the CNA to turn off the running water and the CNA A stated, "I cannot handled you because you're too bossy." In result, CNA A left the resident unattended without any clothes on. During an interview on 11/16/2016, CNA A confirmed he told the resident she was too bossy and knew resident was offended by his action. Citation # 070012804.

**B $2000 Fall Injury Patient Care Supervision 4/05/2017**

A resident experienced a fall and suffered a laceration to the forehead on 2/4/17 after exiting the facility in his wheelchair to sit outside. The door monitor alarm went off, the receptionist followed the resident in an attempt to bring him back in however the resident refused. The receptionist went back to the facility and left the resident outside unsupervised. Meanwhile, the resident stated he wheeled himself to the sidewalk and his wheelchair hit the gutter and it flipped over, causing him to fall and hit his head on the ground next to a parked car. The paramedics were called and the resident was transferred to the hospital for evaluation. Citation # 070013053.

**Kindred Nursing and Transitional Care-Santa Cruz**
1115 Capitola Road, Santa Cruz

**B $1000 Elopement Neglect 12/05/2016**

Two residents with dementia left the facility unobserved on 10/11/2016. They were found by a neighbor and returned to the facility. Both residents had Wanderguard alert bracelets and both were functioning. The alarm allegedly sounded but an investigating nurse did not see any residents leaving the building. The facility was cited for failing to provide adequate supervision. Citation # 070012788.

**Watsonville Post Acute Center**
525 Auto Center Drive, Watsonville

**B $500 Patient Care 12/22/2016**

On 11/27/2016 a resident with a history of elopement attempts and diagnosed with Alzheimer's left the facility unsupervised. The resident fell outside the building in the parking lot and sustaining a discoloration on her left cheek and a skin tear on the left hand. The resident's health plan indicated that she needed to be monitored by staff. In a interview with the social service director and the director of nursing confirmed there were no new interventions implemented to prevent or protect the resident from falls or wandering. The facility was cited for failing to prevent unsafe wandering and implement a different intervention in response to repeat attempts of elopement. Citation # 070012840.

**A $10000 Elopement Fall 11/28/2016**

A resident with dementia and many noted issues with trying to leave the facility was found outside of the facility, lying on the sidewalk, by bystanders on 10/15/2016. She had a broken jaw "with significant displacement" and had to be hospitalized. She had attempted to leave the facility at least five times on 10/15 but the staff made no attempt to alter its careplan. The facility was cited for failing to provide adequate supervision to prevent an accident or injury. Citation # 070012741.

**Tulare County**

**Linwood Meadows Care Center**
4444 W. Meadow Lane, Visalia

**B $2000 Mandated Reporting 4/11/2017**

A resident's son contacted the District Attorney (DA) regarding financial abuse by a caregiver. On 6/30/16, the DA spoke with the facility Social Services Director about the incident. The facility did not report the incident to the DPH, and was cited for failing to report an allegation of financial abuse within 24 hours. Citation # 120013095.

**Yuba County**

**Marysville Post-Acute**
1617 Ramirez Street, Marysville

**B $2000 Evictions 1/04/2017**

A male resident with dementia, COPD, lower leg cellulitis and an open wound was sent to a small residential facility despite receiving defective notice, no discharge summary, and no preparation or orientation. He was sent with medications but no instructions. Less than 24 hours later, the resident had been arrested by the police and sent to a hospital. The facility was cited for inappropriately discharging the resident to a facility that was grossly unable to meet his needs. Citation # 230012786.
On 7/2/16, a resident died at the facility after he aspirated food into the airway. Citation # 940013003.

In May of 2016, a female resident died due to injuries sustained from multiple consecutive falls at the facility. The resident had dementia, and despite her high risk for falls, she was left unsupervised and allowed to fall while walking alone into her room on 5/16/16, resulting in multiple facial fractures, bleeding to the brain, and stitches on her scalp. She was hospitalized and readmitted to the nursing facility the following day. Upon readmission, the resident demonstrated discomfort due to the stitches on her face. Rather than address her underlying pain, the staff administered Ativan, a powerful psychoactive medication used to treat anxiety, and commonly used as a "chemical restraint" to sedate residents in nursing facilities. Then, the very next day, 5/17/16, she fell again while unsupervised. The facility was unable to produce evidence that they monitored her every 30 minutes as directed by her care plan after the first fall. The doctor made the decision not to transfer her to the hospital again, based on a POLST form. The resident died seven days later from injuries sustained from the first fall. The facility was cited for failing to implement the resident's care plan related to falls and failure to provide necessary care and services to meet the resident's needs. Citation # 040013080.

Raintree Convalescent Hospital
5265 E Huntington Ave, Fresno

B $2000 Bed Hold 4/28/2017

On 9/27/16, a resident who was legally blind and suffered from diabetes and end stage renal failure was transferred to the hospital for therapeutic treatment. When he was cleared for return the facility refused to readmit him. The refusal caused the resident to experience considerable distress. Due to the fact that he could only see shadows and speak Spanish, he found it difficult to adapt to new environments. The resident, who had been in the facility for six years, expressed missing his friends in the facility, going out to the patio area and walking around in the fresh air. The facility was cited for failing to readmit the resident to the first available bed following hospitalization. Citation # 040013169.

Fresno County

Bethel Lutheran Home, Inc.
2280 Dockery Avenue, Selma

AA $100000 Chemical Restraints Fall Injury Patient Care Supervision 3/24/2017

In May of 2016, a female resident died due to injuries sustained from multiple consecutive falls at the facility. The resident had dementia, and despite her high risk for falls, she was left unsupervised and allowed to fall while walking alone into her room on 5/16/16, resulting in multiple facial fractures, bleeding to the brain, and stitches on her scalp. She was hospitalized and readmitted to the nursing facility the following day. Upon readmission, the resident demonstrated discomfort due to the stitches on her face. Rather than address her underlying pain, the staff administered Ativan, a powerful psychoactive medication used to treat anxiety, and commonly used as a "chemical restraint" to sedate residents in nursing facilities. Then, the very next day, 5/17/16, she fell again while unsupervised. The facility was unable to produce evidence that they monitored her every 30 minutes as directed by her care plan after the first fall. The doctor made the decision not to transfer her to the hospital again, based on a POLST form. The resident died seven days later from injuries sustained from the first fall. The facility was cited for failing to implement the resident's care plan related to falls and failure to provide necessary care and services to meet the resident's needs. Citation # 040013080.

Los Angeles County

All Saints Healthcare
11810 Saticoy Street, North Hollywood

B $2000 Mandated Reporting Physical Abuse 4/10/2017

On 1/22/17, a resident's family member reported bruising on the resident's upper arm as a result of abuse from a CNA. Despite the report, the facility did not report to the Department of Public Health (DPH) and did no investigation. The facility was cited for failing to investigate alleged abuse and make a report to DPH. Citation # 920013111.

Antelope Valley Care Center
44567 15th Street West, Lancaster

A $20000 Careplan Infection Patient Care 2/13/2017

The facility failed to ensure a resident who wore an arm sling after shoulder surgery, was provided the necessary care and services to prevent her skin from breaking down and infecting. This resulted in a hospitalization on 9/23/15, where the resident was diagnosed with a skin rash, infection and ringworm to the right armpit. Citation # 920012883.

Avalon Villa Care Center
12029 S Avalon Blvd, Los Angeles

A $20000 Injury Patient Care 2/24/2017

On 7/14/16, a CNA turned a resident in her bed quickly while providing care, and caused the resident to hit the side rail of the bed. The resident sustained a broken shoulder bone, and eye swelling and discoloration, and was transferred to the hospital. The facility was cited for failing to handle the resident gently and carefully during care. Citation # 940013002.

A $20000 Fall 2/24/2017

A resident admitted to the facility in April 2016 and identified at high risk for falls, fell three times in two months (5/17/16, 6/3/16, and 6/28/16), sustained fractures in both hips, and was admitted to the hospital twice within one month. The facility was cited for failing to care plan the cause of falls, ensure effectiveness of interventions, and identify the necessary type and frequency of supervision. Citation # 940013003.

A $20000 Injury Neglect Notification Respiration 3/1/2017

On 7/2/16, a resident died at the facility after he aspirated and staff took three to four hours to provide emergency care.
The resident’s roommate stated that the resident was making choking sounds, and that he used the call light, but nobody came so he yelled for staff. A CNA heard the resident making “unusual” breath sounds, but did not check on him, nor report the incident. An LVN observed the resident with rapid breathing and administered oxygen, but did not do a comprehensive assessment, nor immediately notify the RN of the resident’s significant change in condition. The RN observed the resident as pale and unresponsive, called 911, and performed CPR. The paramedics arrived, and the resident was pronounced dead. The facility was cited for failing to provide the resident with necessary care and services, ensure that the resident received proper treatment and care for respiratory problems, immediately inform and consult with the resident’s physician when there was a change in the resident’s health status, and develop and implement policies that prohibited resident mistreatment, neglect, and abuse. Citation # 940012986.

Bel Tooren Villa Convalescent Hospital
I6910 Woodruff Ave., Bellflower
A $14000 Careplan Neglect Patient Care 2/17/2017
On 10/15/13, a female resident fell on the floor and fractured her left wrist. A physician ordered an x-ray as well as a splint and to be sent to the ER. There was long delay in medical attention for the resident. The facility failed to follow the fall management policy and procedures and to discuss the care after a fall with a fracture. The delay in surgery put the resident at risk of malunion of the bones and infection. It also caused prolonged pain for the resident. Citation # 940012943.

Brier Oak On Sunset
5154 Sunset Blvd., Los Angeles
A $15000 Careplan Infection Notification Nutrition Patient Care 4/12/2017
A resident’s wound to the frontal scalp deteriorated, increased in size, and developed infection. The facility was cited for failing to continuously assess the resident’s skin condition, notify staff of changes in a timely manner, and revise her care plan and nutritional status. Citation # 920013109.

A $10000 Careplan Dietary Services Feeding Nutrition Patient Care 4/12/2017
A resident suffering from anemia, diabetes, and difficulty swallowing lost a total of 19 pounds in six months. The facility was cited for failing to continuously assess the resident’s nutritional condition, revise the resident’s care plan, assist the resident with eating, and following the physician’s order to monitor weekly weights. Citation # 920013110.

Brookdale San Dimas
1740 San Dimas Avenue, San Dimas
A $20000 Patient Care 3/16/2017
On 9/19/2014 a resident was found to have mild redness on the coccyx. The same day a physician ordered to apply medicated topical ointment for 14 days. On 9/25/2014 the resident was found to have an actual open pressure sore. Even though the resident's pressure sore had worsened there was no documented evidence that the physician was notified immediately to obtain treatment orders. The resident then needed to be transferred to a hospital emergency for immediate admission. These failures resulted in the resident developing an avoidable stage 4 pressure sore that caused foul smelling discharge and resulted in a delay in care and services. Citation # 950012058.

California Post-Acute Care
3615 Imperial Hiwy, Lynwood
B $2000 Administration Mandated Reporting Notification 3/14/2017
On 12/26/2016, a resident hit another resident in the dinning room. The incident was not reported to the department until 12/28/2017. According to the facility's procedures under "Abuse Policy," the incident must be reported by telephone within 24 hours to local law enforcement and the department. The facility failed to report the incident and had a direct relationship to the health, safety, and security of the resident. Citation # 940013048.

B $2000 Decubiti (Bedsores) 9/30/2016
A resident was noted to have redness around her tail bone on 6/17/15, indicative of a possible skin breakdown from pressure. The resident's physician was not told about this change of condition until 23 days later. By that time, the resident has five small open wounds. A nurse claimed to have called the physician but received no answer and was unable to leave a message. No follow up calls were made. The facility was cited for failing to notify the physician of a significant change of condition, which delayed treatment and exacerbated the condition. Citation # 940012610.

Chandler Convalescent Hospital
525 S.Central Ave., Glendale
B $2000 Injury Patient Care Patient Rights Physical Abuse Supervision 2/14/2017
On 5/1/16, a male resident with dementia who had a history of getting into other resident's beds, went into another male resident's bed and was punched in the face by that resident, resulting in bleeding and abrasions to the forehead, nose, and upper lip. The facility was cited for failing to appropriately supervise the residents, failure to develop behavioral management interventions, and failure to provide a safe environment for all residents. Citation # 920012970.

Chatsworth Park Care Center
10610 Owensmouth Ave., Chatsworth
B $2000 Patient Care 4/10/2017
On 12/9/16, a male resident was receiving oxygen for labored breathing and low oxygen levels in the blood. Paramedics transferred him to the hospital emergency department. He was to be monitored per physician's order every shift. The facility failed to follow the physician's order to monitor the resident's oxygen saturation every shift, failed to implement the resident's care plan to administer oxygen as needed, and failed to implement the facility's policy and procedures regarding oxygen therapy. As a result, the resident was diagnosed with acute respiratory failure and septic shock. Citation # 920013112.

B $2000 Physical Abuse 4/10/2017
On 10/11/16, the Public Guardian's office contacted the facility's social worker regarding a family member's complaint about a staff person physically abusing a resident. The family had reported that the resident had a discoloration on his eye and scratches on his arms. On 12/14/16, that family member was interviewed by the Department and said that the resident had complained about being poked and hit by a staff member a few times. The Department's investigation determined that there was no documentation in the resident's clinical record about the alleged abuse and there was no documentation that the local Ombudsman, law enforcement, or the Department were notified, as required by law. The facility was cited for failure to investigate and report allegations of abuse. Citation # 920013113.
Country Villa Belmont Heights Healthcare Center
1730 Grand Ave, Long Beach
A $20000 Security 3/1/2017
On 1/7/17, an unannounced visit was conducted at the facility to investigate complaints regarding a resident with Alzheimer's wandering in and out of other residents' rooms and rummaging through their personal property. Residents expressed annoyance and anger about him coming into their rooms and his behavior created an atmosphere of fear amongst female residents. The records indicated that the staff was well aware of the situation, but failed to provide adequate supervision. The facility was cited for failing to establish appropriate and effective interventions to address, and manage the resident's wandering behavior. Citation # 940013010.

A $16000 Decubiti (Bedsores) 11/01/2016
On 11/14/16, a resident was transferred from the facility to a general acute care hospital (GACH). The facility did not provide the resident or the resident's representative with a written notice regarding its bed hold policy. On 11/28/16, a social worker from the GACH called the facility regarding the resident's return, but the facility refused to re-admit the resident. As a result, the resident was not able to return to the facility of preference and had a longer stay in the GACH until a placement in another facility was found. The facility was cited for failing to provide the resident with a written bed hold notice, and failing to allow the resident to return to the facility after the hospitalization exceeded the seven day bed hold. Citation # 940012660.

Country Villa Los Feliz Nursing Center
3002 Rowena Ave, Los Angeles
B $20000 Evictions 1/31/2017
On 1/7/17, an unannounced visit was conducted at the facility to investigate complaints regarding a resident with Alzheimer's wandering in and out of other residents' rooms and rummaging through their personal property. Residents expressed annoyance and anger about him coming into their rooms and his behavior created an atmosphere of fear amongst female residents. The records indicated that the staff was well aware of the situation, but failed to provide adequate supervision. The facility was cited for failing to establish appropriate and effective interventions to address, and manage the resident's wandering behavior. Citation # 940013010.

Del Rio Gardens Care Center
7004 E Gage Avenue, Bell Gardens
B $2000 Mental Abuse 2/22/2017
On 9/20/2016 an evaluator went to visit a facility to investigate an incident of an R.N. verbally abusing a Resident 2. A review of Resident 2's Minimum Data Set dated 9/8/2016 indicated that the resident required extensive assistance from the staff with eating, toileting, and personal hygiene. During an interview with Resident 2, the evaluator made note that he/she was confused about the questions being asked regarding the verbal abuse from R.N. 2. Citation # 940012981.

Downey Community Health Center
8425 Iowa Street, Downey
A $16000 Feeding Neglect 2/06/2017
A resident receiving hospice services, and who needed assistance eating was not provided such assistance. He was not given snacks or supplements per physician's orders, and the facility staff were not documenting the resident's meal consumption. The resident had lost 11 pounds and weighed only 105 pounds. The facility was cited for failing to implement the resident's care plan, and assisting the resident with eating. Citation # 940012950.

Edgewater Skilled Nursing Center
2625 E. Fourth St., Long Beach
A $20000 Infection Neglect 1/09/2017
On 2/17/16, a resident developed hematuria (blood in his urine) from a bacterial infection, resulting in severe fluid and blood loss but he was not sent to a hospital for 53 hours. By that time, the resident had sepsis and a number of significant infections, anemia, and a bladder hematoma. The resident used a urinary catheter and blood thinners and was at high risk for urinary tract infections and excess bleeding. His physician was not updated until the resident experienced weakness and an elevated heart rate. The physician declined to order lab tests. The facility was cited for failing to offer the resident's physician, notify the physician, notify the medical director and director of nurses when the physician declined to order labs, and transfer the resident to the hospital upon experiencing a change in condition. Citation # 940012873.

Glendale Healthcare Center
1208 S. Central Ave., Glendale
A $18000 Hydration Infection Notification Patient Care 3/24/2017
The facility failed to provide a resident with the sufficient fluids necessary to maintain proper hydration and health, and to prevent dehydration. The facility failed to monitor indicators associated with dehydration and notify the resident's physician in order for a timely medical intervention to take place. As a result, the resident was hospitalized for five days at a general acute care hospital for treatment of dehydration, UTI, acute kidney injury, and sepsis. Citation # 920012969.

Greenfield Care Center Of South Gate
8455 State Street, South Gate
B $1000 Other Physical Environment 11/10/2016
The facility failed to fix a leaking roof in a room three residents shared. The issue was reported to the facility and it took approximately 8 months for the roof to be repaired. Upon observing the room, four patches on the ceiling were visible with brown circles indicating water had seeped from the ceiling above two of the residents' beds. As a result the facility was cited for subjecting the residents in the room to undue hazards, stress and
anxiety. In addition, they failed to maintain a sanitary, orderly, and comfortable interior. Citation # 940012718.

Infinity Care Of East Los Angeles
101 So. Fickett St, Los Angeles
A $15000 Fall 2/28/2017
On 9/16/16, a resident who had experienced prior falls fell and broke her hip. The resident's fall risk assessment indicated she was a risk for falls due to multiple medications and muscle weakness. The fall occurred while the resident was using a walker to get to the bathroom. The facility was cited for failing to provide adequate supervision and assistance for the resident. Citation # 940012995.

Kindred Transitional Care and Rehabilitation-Foothill
401 W. Ada Ave., Glendora
A $16000 Patient Care 2/15/2017
The facility failed to adequately supervise or provide assistive devices to a resident who was determined to be at risk for falls after three previous falls. The facility failed to provide the bed or wheelchair alarm or get a sitter as ordered by the physician. As a result, the resident fell and sustained hip and shoulder fractures, one of which required surgery. Citation # 950012924.

Lakewood Healthcare Center
12023 S. Lakewood Blvd, Downey
A $20000 Careplan Elopement Supervision 1/6/2017
On 5/15/14, a resident diagnosed with schizoaffective disorder who resided on a locked unit at the facility jumped two fences and left the facility undetected. He was missing for four days before a detective found him and temporarily returned him to the facility. Prior to the elopement, the resident had been expressing fear that someone was coming to hurt him and that he wanted to leave the facility. The facility was cited because it failed to provide a safe and secure environment, to closely monitor the resident, to institute one-on-one staffing when needed and to take other actions needed to help the resident feel safe. Citation # 940012743.

B $2000 Medication Physical Abuse Sexual Abuse 1/26/2017
A female resident reported that a male nurse held her head down on the bed and forced her to take medications. The resident reported that juice and water spilled all over her after the nurse forced her mouth open and made her take the medications. The resident reported the same male nurse ignored her request for a female nurse when he applied Elimite, a treatment for scabies, all over her naked body on 8/24/15. The resident stated that she felt like she was raped. The facility was cited for failing to protect the resident from abuse. Citation # 940012910.

B $2000 Physical Abuse 1/26/2017
In October 2015, a resident reported that a male nurse was very rough and aggressive with her roommate, pushing and upsetting her. The resident stated the nurse shoved her roommate on the bed at least two times, using excessive force. On one occasion, the nurse and another nurse grabbed her roommate and tossed her on the bed. The facility was cited for failing to protect the resident from abuse. Citation # 940012909.

B $2000 Mandated Reporting Physical Abuse 3/10/2017
In September 2016, the facility failed to report two altercations involving a resident to the Department of Public Health as required. In the first incident, the resident fell after being pushed by another resident. The second incident involved the resident pushing another resident and striking out at the staff member(s). Citation # 940013043.

B $2000 Fall Injury Mandated Reporting 3/10/2017
A resident suffered at least five falls between August and November 2016, some of which resulted in injuries and hospitalization. One of the falls occurred when the resident was pushed by another resident. The facility was cited for failing to investigate and report incidents of unwitnessed falls with injury and a fall that originated from a resident-to-resident altercation. Citation # 940013041.

B $2000 Physical Abuse 3/10/2017
On 8/14/2016, during the routine Situation Background Assessment and Request (SBAR-nursing assessment) Resident 1 had an abrasion on her left arm from an unknown source. When the director of nurses (DON) was interviewed on 12/1/2016 at 4 p.m. the DON was unable to provide documentation of Resident 1’s left arm abrasion. The facility was cited for “Abuse-Reporting and Investigating” indicated to protect the health, safety, and welfare of facility residents by ensuring that all reports of resident abuse, mistreatment, neglect, or injuries of an unknown source are promptly and thoroughly investigated. Citation # 940013042.

A $20000 Careplan Fall Injury Neglect Patient Care Physical Abuse Physical Restraints Supervision 11/18/2016
A resident with a history of seizures, muscle weakness, and psychosis fell on 8/29/16 at 7:15 p.m. She was not transferred to the general acute care hospital until 11:23 p.m. and no neurological assessment was conducted. The resident suffered a collapsed lung that required surgery, blunt torso trauma, fractured ribs, and a laceration to the forehead. Also, the resident was observed to have purple bruises on her right eye socket and eyebrow. The resident stated facility staff kept jamming ice to her head over and over and had manhandled and tied her to a wheelchair. The resident cried and repeatedly stated she did not want to return to the facility. The facility was cited for failing to assure the resident was free from neglect, received necessary care and services, and was provided adequate supervision to prevent harm. Citation # 940012732.

Lighthouse Healthcare Center
2222 Santa Ana Blvd, Los Angeles
B $2000 Elopement Supervision 10/31/2016
On 3/6/16, a male resident with a diagnosis of schizophrenia eloped from the facility without being noticed. The facility was cited for failing to provide adequate supervision. Citation # 940012694.

Maclay Healthcare Center
12831 Maclay Street, Sylmar
A $20000 Careplan Fall Medication 3/10/2017
A resident with high risks of falls reported that he fell on 8/19/16. No incident report was completed and the resident's careplan was not updated for pain management or preventing additional falls. An investigation revealed the facility was not implementing the resident's careplan for preventing falls, including routine visual checks, assistance with transfers, and verbal reminders. The resident was eventually prescribed pain medications but it was not administered as ordered. The facility
was cited for failing to: implement the careplan, prevent falls, and administer pain medications in a timely manner. Citation # 920013029.

Maywood Skilled Nursing & Wellness Centre
6025 Pine Avenue, Maywood

WMF  $2000  Patient Records  2/12/2017
A 54 year old male resident had an oxygen tank near his bed to help him with breathing. He also had a physician's order to monitor the oxygen levels in his blood. When asked when was the last time staff monitored his oxygen levels, he said it was over a month ago. However, his records indicated his oxygen levels were documented as checked every day, on each shift, for the months of May, June, and July 2015. The facility failed to follow the resident's physician's order to monitor the oxygen saturation. They failed to ensure his record was accurately documented. Citation # 940012011.

Montecito Heights Healthcare & Wellness Centre, LP.
4585 North Figueroa Street, Los Angeles

B  $2000  Patient Rights  11/22/2016
The facility failed to follow policies and procedures to prevent a staff member from recording videos and photos of residents without their consent. The videos and photos were texted to a former resident of the facility without the consent or knowledge of those recorded. Citation # 940012768.

Mountain View Convalescent Hospital
13333 Fenton Avenue, Sylmar

A  $20000  Careplan Injury Patient Care  3/2/2017
The facility failed to identify patient care needs when turning a resident to his side to smooth his incontinence pad. This resulted in an injury on 08/15/11, where the residents' right arm was fractured. Citation # 920012224.

Pacific Care Nursing Center
3355 Pacific Place, Long Beach

A 95 year old resident was observed to have a new purple discoloration on his lower eye area on 7/10/16. The facility failed to report the injury of unknown source and the results of their investigation to the department. Citation # 940012011.

Paramount Meadows Nursing Center
7039 Alondra Blvd, Paramount

B  $1800  Administration Careplan Injury Patient Care Patient Records Patient Rights Physical Abuse 3/6/2017
On 1/19/17, a resident with dementia had an incident with a caregiver. It was reported that the caregiver was witnessed holding down the resident's wrist and then kicking the resident in the knee. The facility failed to ensure that the resident was free from physical abuse, and develop a plan of care plan. The violation had a direct relationship to the health, safety, and security of the resident. Citation # 94001781.

Pico Rivera Healthcare Center
9140 Verner Street, PICO RIVERA

A  $15000  Fall Patient Care  2/6/2017
A female resident with dementia preferred to sleep in her wheelchair and fell out of it when she tried to stand up. The care plan included providing visual checks, educating the resident to use the call light, and how to lock her wheelchair. She fell again on 8/2/16. The facility failed to provide supervision while she attempted to transfer herself from the wheelchair to the bed. They failed to ensure the wheelchair brake was locked, determine why her preference was to sleep in the wheelchair, and failed to follow their policy to place a star sticker by her door, indicating her risk for falling. Citation # 940012944.

Rio Hondo Subacute & Nursing Center
273 E Beverly Blvd, Montebello
A  $20000  Decubiti (Bedsores) Medication  2/04/2016
A 69 year old female resident received a laxative twice a day for over two months, as a result she suffered skin abrasions, a stage II pressure ulcer, 10-pound body weight loss, and had to receive wound care treatment. In addition, the same resident also received unnecessary drugs, as a result she was transferred to urgent care, received IV fluid and medications to decrease the high levels of potassium in her blood. The facility was cited for failing to ensure medications administered to the resident had adequate monitoring and were not given in the presence of adverse consequences. Citation # 940011998.

Riviera Healthcare Center
8203 Telegraph Road, Pico Rivera

A  $20000  Careplan Notification Patient Care  10/12/2016
The facility failed to provide necessary care and services to three residents in order to attain or maintain their highest practicable physical well being, in accordance with their care plans. The first resident experienced left jaw/tooth pain, severe left knee pain, and elevated blood sugar levels. On all occasions there was a delay in notifying the resident's physician of such conditions. The second and third residents did not have their blood sugar monitored as ordered by their physicians as well, putting them at risk for low and high blood sugar episodes that could result to coma or death. Citation # 940012637.

Royal Oaks Care Center
3565 E Imperial Hwy, Lynwood

A  $20000  Dietary Services  3/1/2017
A number of residents with swallowing problems who required thickened liquids were at risk for choking and aspiration pneumonia as a result of inadequately trained staff and poor care plan implementation. Upon review, many resident's liquids were inadequately thickened, or not thickened at all. The facility was cited for failing to ensure residents with swallowing problems were provided thickened liquids. Citation # 940013011.

San Fernando Post Acute Hospital
12260 Foothill Blvd, Sylmar

B  $2000  Mandated Reporting Neglect Patient Care Verbal Abuse  4/21/2017
On 1/9/17, a female resident who required extensive assistance from staff for dressing, bathing, personal hygiene, and incontinence, complained that when she pressed her call light for assistance, the nursing staff would come, turn the call light off, leave without caring for her and would not come back for at least 30 more minutes to help her. This happened frequently, especially during the night shift. When she had a bowel movement, the staff would respond rudely and say, "Again." Occasionally, the nursing staff would take her cell phone, which she used to call her family when she was not getting proper care, out of reach on her bedside table. The resident felt helpless because she
depended on the staff for care. The facility was cited for failure to investigate an allegation of neglect and failure to report the allegation to the Department. Citation # 920013122.

B $2000 Hydration 4/21/2017
On 2/28/17, a ventilator dependent resident who was on a feeding tube was observed in bed with dry skin and cracked peeling lips. The resident's care plan indicated that the resident was at risk for dehydration. The resident's file indicated that the resident had been transferred to the hospital a total of seven times over a five month period with problems related to abnormal laboratory test results, urinary tract infection, and/or dehydration, among other diagnosis. The facility was cited for failing to ensure that the resident was provided with the amount of water recommended by the dietitian. Citation # 920013151.

B $2000 Patient Care 4/21/2017
On 9/20/16, a physician ordered that a partially paralyzed diabetic was to receive restorative nursing assistance three time a week for leg range of motion (ROM) therapy. The exercises were necessary to prevent decrease in the resident's joints range motion. On 3/1/17, during an interview the resident stated that no staff member helped him with joint mobility. The resident's range of motion was tested on 3/7/17 and it was determined that there was noticeable decline in the ROM of both hip joints and left knee. The facility was cited for failing to properly provide for the resident's ROM exercises. Citation # 920013149.

Sunrise Convalescent Hospital
1640 N. Fair Oaks, Pasadena
A $20000 Physical Abuse Physical Restraints Verbal Abuse 9/1/2015
On 7/9/2011 a 61 year old female resident diagnosed with dementia was tied to her wheelchair with a sheet and restraint belt for five hours at night by an employee of the facility. The belt came from the employee's bag she brought from home. The resident had allegedly walked into another resident's room that night so she was tied down and drugged with a tranquilizer. While the resident was restrained, two other employees verbally abused and laughed at her. When another resident found the restrained resident sobbing and questioned the employees, he was told "mind your own business." One employee stated no one would "believe a resident over a nurse." All three employees were terminated. The facility was cited for failing to ensure the resident was free from verbal and physical abuse. Citation # 950011688.

The Orchard - Post Acute Care
12385 E. Washington, Whittier
A $20000 Infection Neglect Patient Care 1/19/2017
Two residents suffered multiple urinary tract infections due to neglect. A 91 year-old resident developed four urinary tract infections between April and October 2016. The resident stated the staff does not answer her call light timely resulting in her holding her urine for long periods of time, having accidents and not getting changed on time. The waits were so long at times that it hurt her abdomen and caused her to wet herself. The resident reported that the certified nursing assistants would sometimes come in her room and turn off the call light without helping her and "no one ever comes back." A 67 year-old resident was observed with her unclamped catheter bag lying on her chest/abdomen area with straw-colored urine back-flowing toward the bladder, causing a risk of infection. The resident had suffered several urinary tract infections between December 2015 and June 2016. The facility was cited because it failed to ensure residents received necessary care to prevent urinary tract infections. Citation # 940012867.

B $2000 Administration Mandated Reporting Mental Abuse Supervision Verbal Abuse 1/19/2017
On 11/14/2016 a resident with Alzheimer's was scolded by their family member while participating in a group activity because she couldn't perform the activity very well. The resident has memory problems and impaired decision making. One resident witnessed the incident on more than one occasion and thought the resident's family member mean and indicated that the act was excessive. The activity assistant was in the room conducting the activity and failed to report the incident to the facility's administration. The facility failed to uphold it's policy on Abuse Prevention. Citation # 940012868.

A $20000 Infection Medication Neglect Patient Care 11/01/2016
A male resident was not given lactulose, a medication used to treat complications of liver disease, for six days out of two consecutive weeks between 8/3/15 and 8/14/15. On 8/15/16, he was lethargic, complained of pain, had a swollen abdomen, and requested to go to the hospital. The facility staff did nothing. On 8/18/15, at 4:46 am, the resident called the police and asked for paramedics to take him to the hospital. The on-call physician stated the resident's condition was not urgent, and the staff still refused to send him to the hospital. Later on 8/18/15, the resident's family member picked him up and took him to the hospital herself. She said the nurses asked her to sign a paper saying the hospital admission was "against medical advice." Upon admission to the ER, the resident was diagnosed with sepsis, a urinary tract infection, and other types of infection. He had to undergo a procedure to remove fluid from his abdomen. The facility was cited for failure to develop a plan of care for the resident's liver damage, failure to intervene when there was a change in condition, failure to administer medication, and failure to notify the physician when the medication was not given as ordered. Citation # 940012705.

The Rehabilitation Center on La Brea
505 N. La Brea Ave, Los Angeles
A $20000 Neglect 11/03/2016
In July and August 2016, the facility neglected a 53 year old male resident who was recovering from a neck fracture. To aid in his recovery, the resident's physician ordered a neck brace, extending to his chest and back area, be applied at all times except during hygiene care. The facility did not apply the brace for over a month after it broke, and did not take timely steps to replace it. Consequently, the resident was forced to stay in bed all day, suffered dizziness and pain, became more dependent, had diminished quality of life and required an increase in narcotic pain medications. The facility did not develop a care plan for the resident's use of the brace. It was cited for these failures. Citation # 940012658.

A $20000 Careplan Patient Care 11/03/2016
A resident without medical necessity was given a catheter based on his family member's request, even though the facility staff noted that the resident had a history of pulling out his catheter, causing trauma to his privates, and exposing himself to serious blood infections and UTIs. Although it was determined that the resident was sustaining penile ulcers and hurting himself, staff continued to follow the request of the resident's family rather than policies in place for treatment of urinary incontinence. Citation # 940012657.
A $20000 Careplan Patient Care 11/03/2016
The facility was cited for failing to follow their "pain monitoring during care and treatment" procedures and failing to implement the plan of care for a resident which included providing pain medication. During the wound care treatment of a 94-year-old male, the facility failed to offer pain medication. The resident was observed yelling, grimacing in pain, and thrashing around in bed when removing the dressing from his leg. The facility failed to translate questions into Russian to adequately assess his pain. Citation # 940012659.

Vernon Healthcare Center
1037 W Vernon, Los Angeles
B $2000 Mandated Reporting Physical Abuse 3/10/2017
On 1/22/17, a resident reported physical abuse by a CNA. The resident was bruised on the upper arm and reported it was caused by rough treatment from the CNA. The facility failed to report the incident to the Department of Public Health and failed to keep the CNA from interacting with the resident, who was frightened and tearful. The facility was cited for failing to investigate and report an alleged abuse incident. Citation # 940013034.

Wellsprings Post-Acute Center
44445 N.15th St. West, Lancaster
A $20000 Fall Injury Patient Care Supervision 3/14/2017
On 12/7/16, a female resident had a traumatic fall from her bed, resulting in a fracture to the left pelvis and left hip. She was hospitalized for five days following the fall. The facility was cited for failure to provide adequate supervision of the resident and ensure that fall prevention measures were implemented. Citation # 920012982.

Whittier Hills Health Care Center
10426 Bogardus, Whittier
A $16000 Careplan Neglect Patient Care 10/06/2016
A resident who received dialysis was to receive gauze dressing changes at the catheter site every 24 hours per facility's policy and procedures. The facility's records indicated no dressing had been changed from 2/1/16 to 2/29/16 and 3/1/16 to 3/31/16. The resident was no longer on dialysis as of 2/17/16, but the physician was not notified and the catheter was left in place. On 3/17/16, the resident had site pain and yellow pus and the staff said they could not touch it. She was admitted to the acute hospital and put on antibiotics. The facility failed to routinely assess and provide dressing changes in order to prevent an infection. Citation # 940012629.

Windsor Gardens Convalescent Center of Long Beach
3232 E Artesia Blvd, Long Beach
A $15000 Patient Care Physical Abuse 2/24/2017
On 9/10/14 a male resident with dementia and a history of entering female residents' rooms, entered the room of a female resident against her will. She started to yell for help and he started swinging at her, striking her left breast. She stated she was scared and she did not feel safe. She and other residents made these complaints more than once. The facility failed to identify the risk factors of the aggressive and wandering behaviors exhibited by the male resident and thoroughly investigate the allegation of abuse against the resident made by another resident. These failures resulted in psychological harm to the female residents. Citation # 940012984.

Windsor Palms Care Center of Artesia
11900 East Artesia Blvd, Artesia
A $20000 Fall 3/1/2017
On 9/25/16, a resident who suffered from Parkinson's disease fell, and broke his hip while trying to get himself to the toilet. The resident's fall risk assessment indicated that he was a high risk due to confusion, gait/balance problems, incontinence and unawareness of safety needs. An LVN, who was with the resident when he fell stated that she had seen the resident standing by his bed holding onto the night stand trying to push himself up, and seeing that he was losing his balance, came in and stood behind him to assisted with the fall. The LVN stated that she could not hold onto him like she wanted to because he was "too tall". The facility was cited for failing to develop a proper care plan that ensured the resident received adequate supervision to meet his toileting needs. Citation # 940012913.

Woodruff Convalescent Center
17836 S Woodruff Ave, Bellflower
A $15000 Medication Patient Care 1/18/2017
The facility failed to provide appropriate pain management after a resident with diagnosis including respiratory failure and a stage 4 bed sore (when tissue loss has reached both muscle and bone) exhibited signs and symptoms of severe pain including screaming in pain. Although she was receiving prescribed narcotic medication, her pain was not relieved, and staff failed to document pain levels, and failed to report resident's uncontrolled pain to a physician. Citation # 940012886.

Madera County
Golden Livingcenter - Chowchilla
1010 Ventura Avenue, Chowchilla
B $2000 Sexual Abuse 05/04/2017
The facility was cited for failing to ensure that a resident was not subjected to sexual abuse. A visitor groped the resident on her leg and private area at the facility. The facility staff knew the visitor had a criminal record and was listed on the national database for sex offenders. Citation # 040013178.

Orange County
Palm Terrace Healthcare & Rehabilitation Center
24962 Calle Aragon, Laguna Hills
A $15000 Patient Care 4/21/2017
On 12/8/16 a female resident was admitted for rehabilitation following an injury. There was no evidence to show a registered nurse assessment was completed upon her admission to the facility. During her 6-week stay at the facility, only physical and occupational therapy assessments were made. On 1/19/17, the resident complained of abdominal pain. The facility failed to identify a significant change of condition in a timely manner for the resident. Over the course of two and a half days, the resident became weak, could no longer participate in physical therapy, developed abdominal pain, became incontinent, and vomited blood. The staff's failure to identify the significant decline in
her condition resulted in her not receiving the necessary care and treatment resulting in her needing to be transported to the acute care hospital. Three minutes after arrival at the ER, she suffered a heart attack and died on 1/20/17. Citation # 060013120.

**Riverside County**

**Banning Healthcare**
3476 W. Wilson St., Banning
B $2000 Fall Injury Patient Care 2/23/2017
The facility was cited for failing to ensure a resident remained free from falls and injuries when a staff member failed to get assistance from another staff member to help assist the resident while he was in the bathroom. This failure resulted in the resident sliding out of his wheelchair, falling to the floor, and sustaining a fracture to his right thigh bone. Citation # 250012953.

**Cherry Valley Healthcare**
5800 W. Wilson St., Banning
B $2000 Patient Care 3/01/2017
On November 28, 2016, a resident was rushed to an acute hospital due to a fall and head injury. The resident was found by a CNA and she reported that the resident became unresponsive and was given breathing assistance through tube. It was discovered that the resident sustained a large subdural swelling of her brain. The Director of Nursing reported that the resident's bed alarm failed to alert the staff and the floor next to the resident's bed was not equipped with a perimeter cushion or pad. The facility was cited for failing to act on preventive measures and addressing the factors of the fall. Citation # 250012954.

**Corona Health Care Center**
1400 Circle City Drive, Corona
B $2000 Infection Mandated Reporting Patient Care 3/10/2017
The facility failed to properly report a potential outbreak of Legionnaire's Disease after a resident was diagnosed with the highly contagious condition. Facility staff did not notify the Department of Public Health until 21 days after discovering the resident's diagnosis, potentially putting other residents at risk for exposure. Citation # 250012976.

**Murrieta Health and Rehabilitation Center**
24100 Monroe Avenue, Murrieta
B $2000 Theft & Loss 2/15/2017
The facility failed to protect a resident from misappropriation of her property after a staff member stole a resident's wedding ring and sold it at a pawn shop. According to her family, the resident was so distraught after losing the ring that she was unconsolable, began to refuse food and water, and died 17 days after the incident. The staff was eventually charged with grand theft and placed on administrative leave several months later. Citation # 250012937.

**San Diego County**

**Vista Knoll Specialized Care Facility**
2000 Westwood Road, Vista
A $20000 Careplan Fall Notification Patient Care Patient Records 1/25/2017
A resident suffered black tarry stools and his feeding tube site dressing became saturated with blood. Facility staff failed to notify the physician and document assessments in his record. As a result, he was transferred to the hospital and required fluid resuscitation. On 9/3/16 a second resident at the same facility experienced a trip and fall and fractured and displaced her right shoulder. The only treatment she received was pain medication and a sling. Due to the pain she was unable to move her right arm normally. The facility delayed her treatment and scheduling of her recommended surgery. The facility was cited for failing to provide adequate supervision. Citation # 250012963.