It’s Time to Regulate Nursing Home Chains

It’s never been clearer that the for-profit chains that dominate nursing home care in California are engaging in massive profiteering at residents’ expense. The epidemic levels of elder abuse in many of the facilities they operate are unlikely to stop until these chains and their owners are strictly screened, monitored and held accountable.

A May 1, 2018 report by California’s State Auditor, Elaine Howle, is the latest proof that California needs to dramatically overhaul its nursing home oversight system. The report – *Absent Effective State Oversight, Substandard Quality of Care Has Continued* – paints a grim picture of nursing home care in California. It describes increasing instances of severe neglect, failing oversight by the Department of Public Health, and surging profits for nursing home chains that engage in self-dealing.

The Legislature ordered the audit last year due to reports that Brius Healthcare, California’s largest nursing home chain, was diverting large amounts of public funds to other companies (known as related-parties) it owned or controlled.

The State Auditor found enormous increases in related-party transactions. From fiscal years 2007 through 2015, nursing home payments to related parties grew by 66 percent, and now exceed $1 billion annually. Three of California’s largest nursing home chains – Brius, Longwood and Plum – reported paying a combined $150.8 million to related parties in fiscal year 2015.

During this same period, nursing home deficiencies that caused, or were likely to cause, serious injury, harm, impairment, or death to residents increased by 35 percent.

It is no coincidence that instances of severe neglect and related-party payments grew sharply together. By siphoning-off large amounts of public funds intended for care and staffing to complex webs of companies they control or own, nursing home chains are systematically neglecting residents most basic needs.

The silver lining in the findings is the growing awareness among California legislators that nursing home chains need to be held accountable. *Legislators who sought the audit* and others are beginning to recognize that residents are routinely being harmed and exploited by chains that receive billions of dollars in public funds each year.

The upcoming gubernatorial election also brings hope for meaningful reforms. The current administration has coddled and enriched rogue nursing home operators; and done next-to-nothing to regulate them. California’s new governor may see the results of these practices – the scathing audit findings, spiraling public complaints against nursing homes, and the Department of Public Health’s dreadful reputation – as a call to action to regulate nursing home chains.

How should chains be regulated? To start, California should identify chains operating in the state; assess the performance of each chain on a continuing basis; and

*It’s Time to Regulate ....................... (continued on page 9)*
**Staff News**

**Pauline Mosher**, CANHR’s Deputy Director, graduated in May from the Master’s Program in Gerontology at San Francisco State University. **Julie Pollock**, MSW, CANHR’s Program Manager, has received a full scholarship at USF to attend law school. Julie plans to continue working at CANHR while attending school. Congratulations, Pauline and Julie. We are proud of you. **Joaquin Macias**, who has worked for CANHR on and off for a number of years, is back from teaching in China and is helping with IT and layout for publications. Welcome back, Joaquin. **Yvonne Hernandez**, LTC Advocate and **Marcus Nelson**, Administrative Assistant/Receptionist will be moving to Las Vegas in mid-July. We will sorely miss their advocacy and dedication.

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**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.

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**United Way Campaign Gearing Up**

Keep an eye out for this year’s United Way Work Place Giving Campaign for 2018, coming soon to your work place. As a Certified Community Campaign Agency, California Advocates for Nursing Home Reform (CANHR) is participating in:

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

Consider CANHR when making a charitable contribution through payroll deductions and support CANHR services. A full description of CANHR services is available at www.canhr.org.
Dear Concerned in Concord,

Yes, you must pay out-of-pocket for prescriptions not covered by Medi-Cal. However, the charges can be deducted from the Share of Cost before you pay the nursing home. Under the Johnson v. Rank judgement effective October 1, 1989, all Medi-Cal recipients must have the opportunity to use their Share of Cost to purchase medically necessary or remedial care, supplies and/or equipment not paid for by the Medi-Cal program, as long as it is prescribed by a physician. Provide the receipt, and a copy of the prescription, to the facility and deduct the cost of the prescription from that month's Share of Cost. Although you will have to initially pay for the prescription at the pharmacy, you can deduct the amount paid from your father's Share of Cost for that month.

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Did You Know?

The New Medicare Cards are Prompting Phone Scams

CMS will be mailing new Medicare cards to beneficiaries between April 2018 and April 2019. The new Medicare cards no longer include Social Security numbers. Beneficiaries should make sure their mailing address is up to date with the Social Security Administration. If beneficiaries need to update their address, they may contact Social Security at https://www.ssa.gov/myaccount/ or call 1-800-772-1213 (TTY 1-800-325-0778). Beneficiaries should beware of scammers calling as Medicare representatives regarding a charge for the new Medicare card and/or information about the new card number. Read more at https://cahealthadvocates.org/fraud-abuse/medicare-fraud-alerts/.

Medi-Cal Discrimination & Room-to-Room Transfers

Did you know that effective January 1, 2002, if a nursing home resident changes to Medi-Cal payment status, the nursing home is prohibited from transferring a resident to another room as a result of that payment change, with the exception of transferring a resident from a private room to a semi-private room (Welfare and Institution Code §14124.7). Nursing homes are also prohibited from seeking to evict residents simply because of a change from private pay or Medicare to Medi-Cal benefits, including those with a Medi-Cal application pending. These provisions were included in AB 1731 (Shelley) in an attempt to provide equity and dignity to those receiving long term care under Medi-Cal.

For more information, contact the CANHR office.
Mercury News Exposes Plight of Santa Rosa Assisted Living Facility Residents During Wildfire

An extraordinary May 20 report by the Mercury News examines the October 2017 Wine Country fires from the perspective of body-camera videos captured by Santa Rosa police officers as they sought to warn and rescue elders threatened by the raging fires. Among other heroic actions, the videos show officers rescuing scores of residents of Oakmont of Varenna, a luxury retirement community, with no staff or management in sight to assist in any way. Responding officers and firefighters had to break down resident doors, calm terrified residents, carry some residents down multiple flights of stairs, summon emergency transportation and evacuate residents through intense heat and smoke from nearby fires.

The report underscores the tremendous need to improve California’s barebone emergency preparedness requirements for assisted living facilities. Each facility must be prepared to protect, and not abandon, residents at their time of greatest need. Currently, the Legislature is considering an industry-sponsored bill on this topic, AB 3098 (Friedman). Although the bill is a step in the right direction, it does not go nearly far enough to strengthen emergency preparedness requirements for RCFEs.

Nursing Home Compare Shows Steep Drop in Nursing Home Staffing Levels

What caused average California nursing home staffing levels reported on CMS’s Nursing Home Compare to drop by half an hour in April? It is the outcome of a new reporting system – known as the Payroll-Based Journal (PBJ) – that CMS is using to collect and report data on direct care staffing in nursing homes. Nursing homes draw the PBJ data from payroll records and other auditable sources and report it electronically to CMS each quarter. The staffing data used previously was widely known to be inflated and inaccurate. After CMS posted the PBJ data to Nursing Home Compare in April, average California staffing levels dropped by 30 minutes per resident per day. Reported RN time went down 15 minutes and CNA time by the same amount. The impact, if any, on residents is unknown because it is very likely they never received the higher level of staffing care earlier reported.

Consumers should be aware that many nursing homes with deflated staffing levels continue to have very high (and very misleading) staffing ratings on Nursing Home Compare. It is not advisable to rely on these ratings in selecting a nursing home.

Additional Nursing Home Complaint Investigation Deadlines Take Effect on July 1, 2018

Nursing home residents and others acting on their behalf may have greater hope that their complaints will be investigated in a timely way under new deadlines that kick in on July 1, 2018. A 2015 budget law, SB 75, requires the Department of Public Health (DPH) to complete investigations of nursing home complaints received on or after July 1, 2018 within 60 days of receipt. Under extenuating circumstances, the completion deadlines can be extended up to 60 days. DPH must issue any citations resulting from its investigative findings within 30 days of the completion of the complaint investigation.

The Legislature established the completion timelines because of DPH’s historical failures to conduct timely investigations of nursing home complaints. It appears unlikely that DPH will fully comply with the new requirements as it is not in compliance with current standards requiring it to complete complaint investigations within 90 days.

Nursing home complaints are skyrocketing in California – the number of complaints has increased by over 40 percent over the last three years – indicating that living conditions in some facilities are becoming even more dangerous for residents.

If you have filed a nursing home complaint with DPH, CANHR is interested in hearing from you about the timeliness of DPH’s investigation.
**RCFE Corner**

**Administrative Advocacy**

One of the many ways in which CANHR helps long term care consumers to improve choices, care and quality of life is by working with the government agencies that license and regulate Medi-Cal, nursing homes and residential care facilities for the elderly (RCFEs). This type of work is generally known as “Administrative Advocacy.” CANHR’s administrative advocacy includes providing feedback regarding an agency’s regulations, policies, guidance and performance of its duties.

RCFEs are licensed and regulated by the Community Care Licensing Division of the California Department of Social Services (DSS). Over the past several months, CANHR has provided extensive feedback to the DSS on a variety of matters, a few of which are discussed below.

**Regulations**

In 2011, CANHR co-sponsored a bill in response to a statewide crisis of RCFE closures (SB 897), which was signed into law. Health & Safety Code section 1569.686. The purpose of the law was to provide RCFE residents with adequate notification to avoid harmful last-minute evictions and transfer trauma due to a facility’s severe financial distress or bankruptcy. In 2017, the DSS finally issued proposed regulations to implement the law, and CANHR submitted comments and recommended revisions. In 2018, the DSS incorporated all of CANHR’s suggestions into its proposed regulatory language. The DSS reissued the revised regulations for another public comment period, which period closed on May 9, 2018.

As the cornerstone of the RCFE Reform Act of 2014, CANHR co-sponsored landmark legislation creating a comprehensive bill of rights for RCFE residents (AB 2171). AB 2171 was signed into law, and became effective on January 1, 2015. Health & Safety Code sections 1569.261-1569.269. Initially, the DSS planned to incorporate the law by reference, rather than specifically setting forth its’ protections into regulations. The DSS then decided to include only certain sections of the law. In response to CANHR’s extensive comments, the proposed regulations now include all of the rights and protections in AB 2171. The DSS reissued the revised regulations for another public comment period, which period closed on June 1, 2018.

CANHR is hopeful that the regulations implementing both SB 897 and AB 2171 will be completed soon, and that the final regulations will accurately reflect the legislative intent to improve the health and safety of RCFE residents.

**Provider Information Notices (PINs)**

The DSS periodically issues PINs to provide information and guidance to RCFE operators. In response to concerns raised by CANHR and other advocates, the DSS recently issued and requested feedback for draft PINs regarding RCFEs and Supplemental Security Income (SSI), and RCFEs and Social Media. The PIN regarding RCFEs and SSI sets forth the legal requirements and rights of SSI recipients in connection with admission agreements, services/costs and evictions. The PIN regarding RCFEs and social media addresses the unauthorized taking and distribution of confidential information and images of residents. In April and May 2018, CANHR provided comments and proposed edits to the DSS regarding these PINs. It is CANHR’s understanding that the DSS will be issuing these PINs within the next few months.

**RCFE Inspection Tool; Video Surveillance Guidance**

In the Spring 2018 issue of The Advocate, we provided an update on the DSS’ new RCFE inspection tool and video surveillance guidelines. CANHR has provided extensive comments to the DSS in connection with both of these matters. The RCFE Inspection Process is ongoing, and updates are available on the DSS website at [http://www.cdss.ca.gov/inforesources/Community-Care-Licensing/Inspection-Process](http://www.cdss.ca.gov/inforesources/Community-Care-Licensing/Inspection-Process). With respect to video surveillance, the DSS recently circulated revised guidelines regarding resident usage for feedback, and CANHR intends to provide additional comments.

For updates on these matters and other administrative advocacy by CANHR, please visit our website at www.canhr.org, or contact us at 800.474.1116.
Past Speaking Engagements, Panel Discussions and Training Sessions

• **March 5:** Tony Chicotel spoke to a group of visiting health care professionals from Norway about California elder abuse laws and long term care at UCSF.

• **March 15:** Yvonne Hernandez spoke to a group of seniors at the Mission Neighborhood Center in San Francisco about Medi-Cal for Long Term Care and Medi-Cal Recovery.

• **March 20:** Yvonne Hernandez made a presentation to the On Lok PACE center staff in San Francisco about CANHR services including tips on how to avoid Medi-Cal Recovery.

• **March 21:** Yvonne Hernandez hosted a CANHR information table at the Senior Food Bank Distribution hosted by the San Francisco Mission Neighborhood Center.

• **March 28:** Yvonne Hernandez was a guest on the Univision Retrato Hispano television show where she spoke about CANHR services, including tips on what to consider when looking for a nursing home and avoiding Medi-Cal Recovery.

• **April 04:** Julie Pollock presented a webinar on “Long Term Care Medi-Cal: Hot Topics” for qualified legal services programs.

• **April 09:** Prescott Cole guest lectured about Financial Elder Abuse to San Francisco State University Gerontology students.

• **April 18:** Prescott Cole lectured on financial elder abuse at Fremont Public Library’s “Be Alert to Financial Elder Abuse” program.

• **April 19:** Tony Chicotel made a presentation to the Ventura County Ombudsman program about good and bad dementia care.

• **April 19:** Yvonne Hernandez made a presentation to the LGBT Community Partnership hosted by Openhouse in San Francisco about CANHR services including education on Medi-Cal for Long Term Care, searching for a nursing home and Medi-Cal Recovery.

• **April 20:** Julie Pollock and Yvonne Hernandez presented at a CANHR social worker training “What You Need to Know about Long Term Care” at the California Endowment Conference Center in Oakland.

• **April 20:** Prescott Cole was a panelist at the TEXCOM Elder Financial Abuse Symposium in Indian Wells, California speaking on financial abuse, restitution and asset preservation.

• **April 23:** Jody Spiegel participated in the RCFE Advocates Quarterly Meeting with Community Care Licensing.

• **May 07:** Jody Spiegel gave a presentation to the Fountainview at Gonda Westside Resident Council Meeting on CANHR Services and Long Term Care Updates.

• **May 08:** Julie Pollock and Prescott Cole gave an in-service training on CANHR’s Home Equity Protection Program (HEPP) to Contra Costa Senior Legal Services.

• **May 09:** Pauline Mosher presented to South San Francisco Kaiser social workers about Long Term Care Facility Evictions.

CANHR On The Move .................. (continued on page 7)
CANHR On the Move …………… (continued from page 6)

• May 09: Marcus Nelson attended the 36th Annual Senior Information and Health Fair at the Richmond Memorial Auditorium.

• May 10: Efrain Gutierrez hosted a CANHR information table at the 2018 Mothers’ Day Senior Luncheon at the Los Angeles Convention Center, hosted by Los Angeles City District 8, 9, and 10.

• May 11: Legal Services of Northern California hosted a training on Long Term Care evictions by Tony Chicotel.

• May 14: Pauline Mosher and Julie Pollock presented to San Francisco State University Gerontology students about Home and Community-Based Services (HCBS) and the HCBS Spousal Impoverishment expansion.

• May 15: Tony Chicotel spoke at the California Ombudsman Coordinator Conference in Sacramento about nursing home staffing.

• May 17: Tony Chicotel spoke to the California Association of Superior Court Investigators about dementia care and chemical restraints.

• May 17: Julie Pollock gave an in-service training on Home and Community Based Services and Spousal Impoverishment for social workers at the Navy Medical Center in San Diego.

• May 18: Julie Pollock and Prescott Cole attended a multidisciplinary training organized by CANHR and the California District Attorney’s Association on Closing the Gap on Elder Financial Abuse. Prescott Cole presented at this training.

• May 18: Yvonne Hernandez made a presentation to the Aging and Disability Resource Center staff members at their monthly meeting hosted by the Institute on Aging in San Francisco.

• May 23: Executive Director Pat McGinnis and senior staff attorney, Prescott Cole gave a presentation on CANHR’s services and elder abuse issues to staff and volunteers at the Agency on Aging Area 4 in Sacramento.

• May 24: Efrain Gutierrez hosted a CANHR information table at the South Pasadena Senior Fair.

• June 01: Julie Pollock presented on Medi-Cal, Spousal Impoverishment and Resident Rights at the Legal Assistance for Seniors/HICAP office in Oakland.

• June 05: Julie Pollock presented on Nursing Home Resident Rights: Myths and Facts at a training for the American Case Management Association at Queen of the Valley Hospital in Napa.

CANHR Upcoming Events…

• August 10: Cerritos 16th Annual Senior Fair at Cerritos College, courtesy of Congresswoman Linda Sanchez.

• June 19: Yvonne Hernandez will be conducting a presentation at the San Francisco AIDS Foundation on Medi-Cal for long term care, Medi-Cal recovery and CANHR services.
The following citation summaries are compiled from the citations issued by the California Department of Public Health to California skilled nursing facilities and received by CANHR as of the publication of this issue of the Advocate. CANHR makes every effort to ensure that consumers are provided with accurate information. CANHR welcomes comments and suggestions or notice of errors. Please direct such comments to mis@canhr.org or by calling the CANHR office at (800) 474-1116.

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.

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

**Fruitvale Healthcare Center**
3020 E 15th Street, Oakland

**B $2000** Elopement Fall Physical Environment Supervision 3/14/2018
On 11/18/17, a resident with a diagnosis of dementia left the facility undetected and was found hours later by the police, three miles from the facility. The resident, who wore a Wanderguard device to prevent elopement, reported he fell while in the street and hurt his knees and fingers. A CNA assigned to the resident reported the door alarm did not sound when he left the facility. More than two months later, an investigator found that the front door alarm did not sound when three residents with Wanderguard devices were escorted through the door. The facility was cited for failing to supervise residents and to monitor the elopement alarm device. Citation # 020013900.

**Garfield Neurobehavioral Center**
1451 28th Avenue, Oakland

**B $1500** Careplan Sexual Abuse 8/1/2017
On 6/3/17, a nursing assistant walked into a female resident's room and witnessed the housekeeper with his pants down and penis in the resident's face. The resident was severely cognitively impaired, and had a history of childhood abuse, sexual exploitation, and rape, which put her at high risk for subsequent sexual abuse. The facility was cited for failing to protect the resident from sexual abuse. Citation # 020013399.

### Hayward Springs Care Center
21863 Vallejo St., Hayward

**B $2000** Physical Abuse 3/22/2018
On 2/20/17, a CNA hit a resident on the back of her head, and then hit her again on her back. The resident said: “I'm afraid to go to sleep as long as he is here.” The facility was cited for failing to protect the resident from physical abuse. Citation # 020013074.

### Kindred Nursing and Rehabilitation - Medical Hill
475 29th Street, Oakland

**B $2000** Injury Patient Care 10/18/2017
Staff failed to provide proper supervision or use assistive devices such as an EZ lift stand, or Hoyer lift to support a patient during transfer, as required by the patient's care plan. As a result, the resident fell, causing great pain and broken bones in her ankle. Citation # 020013549.

### Kyakameena Care Center
2131 Carleton Street, Berkeley

**B $1500** Medication 7/13/2017
On 3/24/16, a resident was admitted to the facility on hospice care with multiple diagnoses including prostate cancer, involuntary and repetitive muscle spasms causing twisting of body parts, and chronic and acute pain. Due to lack of assessment and appropriate pain management, the resident experienced unrelieved pain and unnecessary suffering. The facility was cited for failing to implement physician orders to assess and provide pain relief. Citation # 020013333.
Lake Merritt Healthcare Center Llc
309 MacArthur Blvd., Oakland

B $2000 Infection Medication Patient Care 8/1/2018
A female resident, who was hospitalized for sepsis (a life-threatening infection to the blood), was admitted to the nursing facility on 2/14/17 following the hospitalization. The facility was supposed to administer intravenous antibiotic treatment until 2/19/17. However, the facility failed to ensure the antibiotics were available and failed to administer the antibiotics. 17 hours after she was admitted to the facility, in the evening of 2/15/17, the resident was transferred back to the hospital emergency room to receive her antibiotic treatment. Citation # 020013386.

Oakland Healthcare & Wellness Center
3030 Webster St., Oakland

A $10000 Medication 10/27/2018
On 8/28/17, a CNA told a RN that a resident was asking for pain medication. The RN prepared a methadone solution and went into the wrong room and gave it to the wrong resident. The resident, who suffered from Alzheimer's, heart failure and chronic kidney disease, began vomiting and experience an altered level of consciousness that required a hospital stay and treatment for opioid overdose. The facility was cited for failing to ensure that the resident was free of medication error that jeopardized his health. Citation # 020013578.

Parkview Healthcare Center
27350 Tampa Avenue, Hayward

B $1500 Physical Abuse 9/6/2018
On 5/24/17, a CNA was feeding a quadriplegic resident, and shoved the plastic spoon so far into his mouth that he began gagging and screaming for someone to help him. The CNA then slapped him on his cheek. The resident asked to speak to the manager of the day, but no one ever came to talk to him. The facility was cited for failing to protect the resident from physical abuse. Citation # 020013456.

Windsor Post Acute Care Center of Hayward
25919 Gading Road, Hayward

B $1500 Careplan Fall 10/26/2016
On 12/1/15, a CNA attempted to transfer a resident with dementia and a history of falls from her wheelchair to bed without assistance. The resident slipped to the floor and landed on her left side. The resident sustained a hip fracture as a result of the fall, which caused her pain and rendered her unable to sit up in her wheelchair. The resident's assessment and care plan provided that the resident required two or more staff members to assist her in transferring. The facility was cited for failing to prevent an avoidable accident by not following the resident's care plan. Citation # 020012675.
Fresno County
Willow Creek Healthcare Center
650 West Alluvial Avenue, Clovis

AA $75000 Careplan Infection Neglect
Notification 4/6/2018
A 76 year old female resident died on 12/7/17 from an untreated UTI. The resident had been admitted on 11/27/17 following a urinary infection so she was known to be a high risk for UTI. A 11/30/17 urinalysis indicated an infection and the resident was later noted to complain about painful urination. She was given a medication for painful urination but not for treating the underlying infection. A 12/3/17 urinalysis again showed signs of a UTI. By 12/3/17, the resident began to refuse meals and medications and her health was declining rapidly. Her physician was not informed of her decline nor was any change of condition noted. She was hospitalized on 12/5/17 and treated for sepsis but died two days later. The facility was cited for failing to recognize, assess, and treat the resident's significant change of condition. Citation # 110012744.

Humboldt County
Seaview Rehabilitation & Wellness Center, LP
6400 Purdue Dr, Eureka

A $20000 Careplan Decubiti (Bedsores) 8/16/2016
A male resident with a significant risk for bed sores was admitted on 11/18/15. By 12/2/15, he had developed a bed sore on his sacrum. The resident's care plan did not include interventions to prevent bed sores. By 12/8/15, the resident had a fever and had to be hospitalized where he was treated for an infected Stage IV pressure sore requiring debridement surgery and six weeks of hospital care. The facility was cited for failing to provide necessary care and services to prevent a bed sore. Citation # 110012467.

A $20000 Decubiti (Bedsores) Notification 8/16/2016
A male resident developed a bed sore in November 2015 and was soon after found to have a fever. The resident's physician was not told until three days later. The resident's responsible party was not told about the bed sore. The facility was cited for failing to notify the resident's physician and responsible party of the resident's change of condition, resulting in a failure to alleviate a worsening condition that led to sepsis, surgical intervention, unnecessary pain, and a prolonged hospitalization. Citation # 110012472.

Kern County
Evergreen Bakersfield Post Acute Care
6212 Tudor Way, Bakersfield

B $2000 Mandated Reporting Verbal Abuse 4/11/2018
On 1/30/18 the Director of Nursing yelled at a patient and the facility failed to follow its policy and procedure to report the verbal abuse within 24 hours to the appropriate Department. The resident felt embarrassed after the incident and believes the DON yelled at him because he was speaking Spanish to a staff member. Citation # 120013917.

Los Angeles County
Ararat Nursing Facility
15099 Mission Hills Road, Mission Hills

A $20000 Careplan Fall Neglect 5/23/2018
A female resident with dementia and vision loss fell on 12/30/17 and broke her femur, requiring surgery. The resident had no care plan to prevent falls despite ambulatory problems and a history of falls. The facility was cited for failing to develop and implement a fall prevention plan for the resident and for failing to provide an adequate monitoring system. Citation # 920014097.

A $20000 Careplan Fall 5/23/2018
A female resident with dementia and Parkinson's disease fell and broke her hip on 2/4/18, requiring surgery. The resident had a history of falls and was considered a fall risk. She had a position alarm to alert facility staff when she was getting out of bed but it was not in use when she fell. The facility was cited for failing to develop a plan to prevent falls and failing to prevent the resident's fall. Citation # 920014096.
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Good Shepherd Health Care Center Of Santa Monica  
1131 Arizona Avenue, Santa Monica  
B $2000 Patient Care Theft & Loss 3/02/2018  
After a resident’s wheelchair was stolen, the facility failed to provide the resident with assistance in and out of bed to use a replacement wheelchair so that she could resume social activities, or to support the resident in acquiring a new customized wheelchair to meet her medical needs. These failures resulted in the resident becoming more isolated, sad and depressed.  
Citation # 910013872.

B $2000 Nutrition 3/02/2018  
On 1/8/18, a resident who had Parkinson's and dysphagia (difficulty with swallowing) was observed lying in bed sipping water from a cup she could barely hold onto, and there was a lunch tray in front of her but no staff assisting her. On 1/9/18, the resident was observed in bed with a breakfast tray at her side with no staff assisting her. On 1/10/18, the resident was observed barely touching her dinner tray. After having eaten less than five percent of her dinner, a CNA entered the room and took tray away. An investigation determined that the resident had lost 23% of her body weight in six months. The facility was cited for failure to maintain acceptable parameters of nutrition for the resident.  
Citation # 910013877.

Green Acres Healthcare Center  
8101 E. Hill Drive, Rosemead  
B $2000 Elopement 4/11/2018  
On 12/9/17, a 42 year old resident walked out of a secured facility with locked doors, climbed over a gate and jumped out. The resident was later found by the police. The facility was cited for failing to ensure that CNAs made actual resident rounds, provided care and monitored the resident at least three times per shift, and that the resident did not leave the facility unsupervised.  
Citation # 950013976.

Griffith Park Healthcare Center  
201 Allen Ave., Glendale  
B $2000 Administration Careplan Neglect  
Patient Care Supervision Transfer 1/19/2018  
On 11/10/2017 a resident of the facility was left alone at the train station to go home to a different city. This deficient practice resulted in the resident not arriving home and she was missing for 6 days. The resident's diagnoses included schizophrenia and major depression. The resident was taking antipsychotic medications. The administrator stated that he took the resident to the train station without a train ticket and did not know whether the resident rode the train. The administrator stated, "I trusted her." The family received a call from a police officer from a different city. The resident was found nude wandering the streets. The facility failed to safely discharge resident.  
Citation # 920013753.

Green Acres Healthcare Center  
8101 E. Hill Drive, Rosemead  
B $2000 Elopement 4/11/2018  
On 12/9/17, a 42 year old resident walked out of a secured facility with locked doors, climbed over a gate and jumped out. The resident was later found by the police. The facility was cited for failing to ensure that CNAs made actual resident rounds, provided care and monitored the resident at least three times per shift, and that the resident did not leave the facility unsupervised.  
Citation # 950013976.

Highland Park Skilled Nursing & Wellness Centre  
5125 Monte Vista St., Los Angeles  
B $2000 Mandated Reporting Mental Abuse Verbal Abuse 2/26/2018  
Facility staff failed to properly report a resident allegation of verbal abuse by a staff member, who he reported called him ugly. Staff did not follow policy for the 24-hour reporting required by law for investigation and to prevent potential for further abuse.  
Citation # 940013852.

Landmark Medical Center  
2030 N. Garey Ave., Pomona  
B $2000 Mandated Reporting Sexual Abuse Supervision 3/30/2018  
A male resident with a documented history of inappropriate sexual behaviors assaulted a female resident while unsupervised on 12/3/17. The female resident entered his room when he told her he wanted to pray for her family. The male resident took his pants off, groped her breasts, held her down on his bed, bit her neck, and masturbated in front of her. The female resident was able to free herself but stated that no staff entered the room to help her. The facility was cited for failure to adequately supervise the male resident pursuant to his care plan, and failure to conduct a timely investigation of the allegation of sexual assault.  
Citation # 950013949.
Palazzo Post Acute
5400 Fountain Ave, Los Angeles
A $18000 Careplan Deterioration Dietary Services
Feeding Nutrition Patient Care 3/28/2018
A resident experienced a 30 pound severe progressive weight loss. The resident was admitted to the facility on 12/10/17 and weighed 169 pounds. Within two months, on 2/10/18 the resident weighed 139 pounds. The facility failed to monitor the resident's poor meal consumption, monitor the resident's weight, implement the nutritional plan of care and notify appropriate staff of poor meal intake and weight loss. Citation # 920013935.

Park Avenue Healthcare & Wellness Center
1550 N. Park Ave., Pomona
B $2000 Patient Care 3/21/2018
A resident with type 2 diabetes and difficulty walking was left in his own waste, several times for up to five hours. The resident described one incident where a CNA said, "You shit again?" and the CNA walked angrily out of the room. The man felt ashamed as if he was "below a human being". The CNA continued to harass the resident while changing this diaper, lowering his self-esteem. The DON said that the CNA's care of the resident was unprofessional, and that the CNA behaved badly. The facility failed to report allegations of abuse to the department. Citation # 950013923.

Pomona Vista Care Center
651 N. Main Street, Pomona
A $20000 Patient Care 3/2/2018
A resident with Alzheimer's and known to be at high risk for pressure ulcers was left to lie on her back for long periods of time. The resident's pressure ulcers on her back worsened. The CNA used the wrong type of diaper on the resident causing the wound on her lower back to get infected. The facility had to update their policy and procedures when assessing for appropriate bed repositioning and pressure ulcer prevention. The facility failed to provide the necessary CNA training for care and services to prevent ulcer development. Citation # 950013862.

Ramona Nursing & Rehabilitation Center
11900 Ramona Blvd., El Monte
A $20000 Careplan Fall Injury Patient Care Supervision 1/12/2018
A 67 year old resident was left sitting on a wheelchair by himself, lost his balance and fell on the floor on 9/9/17. The resident was transferred to the general acute care hospital and discharged with a diagnoses that included a lumbar spine vertebral fracture due to a fall from a wheelchair. The facility failed to follow the therapist's recommendations not to transfer the resident to a wheelchair, provide assistance to the resident when he was in a sitting position and failed to develop a care plan that addressed his activities of daily living. Citation # 940013734.

Rio Hondo Subacute & Nursing Center
273 E Beverly Blvd, Montebello
A $20000 Patient Care 3/8/2018
The facility failed to properly provide treatment and services to promote healing of pressure ulcers and prevent the development of additional ulcers. Staff did not properly assess or monitor the resident's skin condition, leading to the development of multiple ulcers on the resident's hip, heels, and pelvis. Staff failed to inform the physician, or develop a care plan, leading to the worsening of the existing ulcers. As a result, one ulcer grew significantly in size, without any plan for treatment, or the prevention of additional ulcers. Citation # 940013881.
Royal Palms Post Acute
630 W. Broadway, Glendale

B $2000 Patient Rights Transfer 1/26/2018
Facility administrators failed to follow policy when they failed to readmit a resident within the 7-day bed hold period, after the resident was transferred to a general acute care hospital due to a change in his condition. The administrator did not readmit the resident after discovering that he was a sex offender under parole. Citation # 920013768.

B $2000 Injury Mandated Reporting Physical Abuse Security 2/7/2018
A 57 year old resident alleged he was attacked by a certified nursing assistant and sustained a scratch on 8/14/17. The facility was cited for failing to report the incident to the appropriate state department within 24 hours and conduct a thorough investigation of the abuse. Citation # 920013788.

A $20000 Patient Care 4/6/2018
On 2/14/18, the records for a sample of 27 residents were examined during an unannounced re-certification survey. It was determined that the facility had not been properly managing the blood sugar level of a 68 year old resident who was experiencing hypoglycemic episodes which could possibly lead to death or serious harm. The facility was cited for deficient practices. Citation # 920013960.

A $20000 Careplan Deterioration Decubiti (Bedsores) Infection Injury Neglect Notification Patient Care 4/6/2018
The facility failed to ensure that a 62 year-old resident received the appropriate wound care, assessment, and treatment he needed. On 12/1/17 the resident was noted with signs of grimacing and moaning and did not receive pain relief medication. The resident's wounds progressed from redness to unstageable pressure injuries. As a result, he was admitted to an intensive care unit at a general acute care hospital on 12/5/17 and diagnosed with sepsis, skin rash and ulcers. He was intubated on a ventilator. Citation # 920013967.

A $20000 Careplan Dietary Services Hydration Infection Patient Care 4/6/2018
A 62 year-old resident who weighed 64 pounds suffered insufficient fluid intake, dehydration, septic shock, and a urinary tract infection. The facility was cited for failing to monitor the resident's fluid intake and output and ensure he received the recommended fluid intake as his physician ordered. On 12/5/17 the resident was transferred to an acute care hospital due to shortness of breath and oxygen desaturation and was intubated on a ventilator. Citation # 920013968.

A $15000 Fall 4/06/2018
At 9:00 am on 2/8/18, a 95 year old resident was trying to use the call light for assistance on the toilet but nobody came. He fell from the toilet and fractured his hip. At 4:30 pm he was X-rayed and the physician misread the results. The resident continually complained of pain and on 2/12/18 he received at CAT scan at the hospital where it was determined that he had a broken hip which was then operated on. It was noted in the investigation that the resident's family was paying a private caregiver to care for the resident because the nursing staff were too busy to attend to the resident's needs. The facility was cited for failing to adequately supervise and assist the resident. Citation # 920013961.

San Marino Manor
6812 N. Oak Street, San Gabriel

A $20000 Careplan Fall Injury Medication Neglect Patient Care Patient Records Physical Environment Supervision 3/3/2018
A resident diagnosed with cancer, muscle weakness, and hypertension fell and broke her arm while trying to sit down on her chair. The resident's medical record reported that she fell fourteen times. Based on interview and record review, the facility failed to provide necessary care, and supervision to prevent accidents, and falls. The facility failed to follow their policy and procedure for "Fall Program and Fall Procedure", by not updating the resident's care plan. Citation # 950013874.

Santa Anita Convalescent Hospital
5522 Gracewood Avenue, Temple City

A $10000 Patient Care 3/9/2018
The facility was cited for failing to assess and monitor a resident's skin rashes, administer the prescribed medication to treat infestation of scabies, and to decrease inflammation and relieve itching. The LVN stated he was aware of the resident's complaints of itching but did not not assess for rashes and no care plan was made for his rashes and itching. These failures resulted in unnecessary suffering and experiencing discomfort and skin injuries form intense itching and scratching. Citation # 950013882.
Shadow Hills Convalescent Hospital  
10158 Sunland Blvd, Sunland  
B $2000 Careplan Hydration Infection Patient Care 4/12/2018  
The facility failed to to ensure a resident, who was at risk for urinary tract infection was provided with treatment and services to prevent UTI. The facility failed to monitor the resident's fluid intake and output, revise his care plan and address repeated UTI's caused by E.coli. As a result, the resident was transferred to a General Acute Care Hospital three times in six months due to UTI. Citation # 920013995.

York Healthcare & Wellness Centre  
6071 York Blvd., Highland Park  
A $16000 Careplan Dietary Services Feeding Hydration Notification Nutrition Patient Care 1/30/2018  
A resident lost 24 pounds in approximately 20 days. The facility failed to conduct accurate eating and physical assessments, provide one-on-one feeding assistance, refer resident to the Registered Dietitian in a timely manner, notify her physician regarding RD's recommendations and continued decline in food intake and weight loss. Citation # 940013769.

Monterey County  
Kindred Nursing and Transitional Care-Pacific Coast  
720 East Romie Lane, Salinas  
B $2000 Elopement 4/3/2018  
On 3/8/18, the day of her admission, a resident with dementia asked the receptionist to call a taxi for her. Thinking she was a visitor, the receptionist did so and the resident took the taxi to her daughter's house. The facility was cited because its lack of supervision compromised the resident's safety. Citation # 070013954.

Windsor Monterey Care Center  
1575 Skyline Drive, Monterey  
B $2000 Careplan Medication Patient Care 4/12/2018  
The facility failed to provide 10 residents with routinely ordered medications such as medications to control multiple sclerosis, skin rash, pain and blood pressure. This failure put the residents' health and safety at risk. Citation # 070013984.

Orange County  
Laguna Hills Health and Rehabilitation Center  
24452 Health Center Drive, Laguna Hills  
A $4000 Feeding Nutrition 4/23/2018  
A resident was hospitalized on 1/12/18 due to severe weight loss. He lost 33 pounds in 26 days, an 18 percent weight loss since his admission. The facility was cited because it failed to assess and respond to the severe weight loss and rapid decline in his nutritional status. Citation # 060014012.

Villa Valencia  
24552 Paseo De Valencia, Laguna Hills  
B $2000 Neglect 3/19/2018  
On 1/12/18, a resident died after the facility failed to provide basic life support in accordance with his full code status. An RN initiated CPR after the resident was found unresponsive in bed, but stopped CPR without 911 being called. Upon being informed that the resident had passed away, the director of nursing (DON) instructed the RN to resume CPR and another nurse to call 911. County emergency records showed this contact was not made until about 20 minutes after the resident was found unresponsive. This failure resulted in the resident not receiving CPR timely and continuously until EMS personnel arrived. Citation # 060013909.

Riverside County  
Providence Orange Tree  
4000 Harrison Street, Riverside  
A $15000 Careplan Fall Injury Physical Abuse Supervision 4/12/2018  
A 63 year-old male resident with a diagnosis of bipolar disorder, schizophrenia and blindness, had a history of physically aggressive behavior and was known to "run over anybody in the path of his wheelchair." On 10/10/17, the 63-year-old resident ran over a 92-year-old female resident while unsupervised, resulting in a broken hip and broken thigh bone for the 92-year-old resident. Four days after surgery to repair the hip, the resident died. The facility was cited for failure to provide adequate supervision and failure to develop and implement a care plan to monitor the resident's 63-year-old behaviors, resulting in abuse that led to a
On December 29, 2017, a female resident who was a previous victim of sexual abuse was left in the dining room without staff supervision. A male resident, who had previous incidents of inappropriately touching other female residents, grabbed her breasts and vagina, and lifted her shirt and put his mouth on her breast. A third resident screamed for help, and the abuser ran away. The facility was cited for failing to ensure the resident’s right to be free from abuse.

The facility was cited for failing to ensure the resident’s right to be free from abuse.

On 11/20/17, a resident who had elopement behavioral issues with periods of confusion and a history of multiple falls including once jumping from a balcony, leapt off of the facility's roof and sustained multiple injuries.

The facility was cited for failing to provide adequate supervision.

On May 16, 2017, a resident told a staff member that another staff member had “sat on her chest” and “broken all her ribs.” On May 18, the resident complained of rib pain and had x-rays taken which indicated rib fractures of the 6th and 7th ribs of indeterminate age. On May 22, six days after the incident, the facility notified CDPH. The facility was cited for failing to report the alleged abuse to CDPH within 24 hours.

On 5/1/18, a female resident who was paralyzed due to a stroke was abused by a male caregiver at the facility. A registered nurse saw the male caregiver holding the resident's wrists down on her bed and stating "I'm going to hit you." Then, the registered nurse heard a thump. She went to check the resident and noted redness on the resident's upper left chest and right hand. The facility was cited for failure to ensure that the resident was free from abuse.

On 01/22/18, a female resident wandered into another resident's room while a CNA was providing care. The CNA tried redirecting the resident, but when the resident began fighting and hitting the CNA, he did not call for help and began slapping the resident. The facility was cited for failing to prevent an incident of physical abuse from CNA to the resident. This caused or occurred under circumstances likely to cause significant humiliation, indignity, anxiety, or other emotional trauma to residents.

On 4/3/18, a resident with paraplegia signed out "on pass" to go to the store. That night, he called the facility and told a nurse he could not make it back because he had no transportation. He indicated his intent to return and on 4/4/18 he reiterated his intent. The facility "discharged" the resident at midnight on 4/5/18 for failing to return from his "pass." The resident was hospitalized four days later. The facility did not comply with several discharge laws and was cited for prohibiting the resident from returning home and discharging him without a physician's order.
Cupertino Healthcare & Wellness Center
22590 Voss Avenue, CUPERTINO

B $2000 Patient Care Physical Abuse Verbal Abuse 2/22/2018
The facility was cited for failing to ensure a resident was not subjected to physical and verbal abuse. On 1/21/2018 a Certified Nursing Assistant cursed at a resident and threw ice water on him "to shut him up." Citation # 070013807.

B $2000 Mandated Reporting Mental Abuse
Verbal Abuse 3/30/2018
In January 2018, a certified nursing assistant said, "If you were in the Philippines, you will be treated like a dog" to a 96-year-old male resident with no cognitive impairment. The facility was cited for failure to report the incident of alleged verbal abuse to the Department of Public Health. Citation # 070013938.

Gilroy Healthcare And Rehabilitation Center
8170 Murray Avenue, Gilroy

B $2000 Medication Notification Patient Care 3/30/2018
On 11/16/17, facility staff received, but overlooked an incomplete laboratory report to monitor the Dilantin level of a resident with epilepsy. The resident had a seizure episode and was taken to the hospital by paramedics and treated for a low Dilantin level. The facility was cited for failing to follow through on the incomplete laboratory report and communicate the results to resident’s physician. Citation # 070013939.

Palo Alto Sub-Acute And Rehabilitation Center
911 Bryant Street, Palo Alto

B $2000 Medication Patient Care Patient Records 4/18/2018
On 4/18/18, the facility was cited for failure to account for a controlled substance drug, Lorazepam, which is a psychotropic medication. The staff failed to sign the medication administration record when administering Lorazepam to a resident on more than a dozen occasions between August 2017 and April 2018, resulting in a discrepancy between the amount of medication on hand and the administration record. Citation # 070013999.

Valley House Rehabilitation Center
991 Clyde Avenue, Santa Clara

B $2000 Careplan Notification Other Patient Care 2/23/2018
A resident's right foot pressure ulcer evolved into a deep tissue injury. The facility failed to provide appropriate care and treatment, had no treatment order obtained from his physician, have a nurse assess the ulcer, was not care planned and was left untreated for over a week. Citation # 070013840.

Solano County
Windsor Vallejo Nursing & Rehabilitation Center
2200 Tuolumne, Vallejo

A $20000 Patient Care 12/28/2018
On 4/1/13, an 85 year old resident was admitted into the facility for rehabilitation for hip surgery. The facility was supposed to monitor her blood sodium level for being in a range of between 135-145. On 4/2/13, her labs showed her at a level of 128, then steadily dropping each day after that. On 4/6/13, she was found on the floor and sent to the hospital with a blood sodium level of 112. The facility was cited for failing to notify her physician of the abnormally low laboratory results which indicated a heath deterioration that lead to an emergency hospitalization. Citation # 110012568.

Sonoma County
Cloverdale Healthcare Center
300 Cherry Creek Rd., Cloverdale

B $2000 Mandated Reporting Sexual Abuse 6/1/2017
A female resident with major depressive disorder reported to a nurse on 3/18/17 that she was raped by three men the previous night. The facility staff failed to remove the accused employees from care of any resident, and failed to perform an examination of the resident or conduct a thorough investigation of the incident. The alleged abuse was reported to the police and the resident's physician on 3/20/17. The facility was cited for failure to implement their abuse policies for reporting, investigation, and protection of residents, and failure to develop a policy for specific procedures for reporting and management of residents related to allegations of sexual assault. Citation # 110013108.
On 4/14/16, a resident told staff she felt like she was having a stroke. Staff told the resident that her face wasn't drooping and that she was fine. The resident had a history of strokes and each time "she knew it was happening" according to family. Nearly six hours after notifying staff, the resident was transported to the acute care hospital and was diagnosed as having had a stroke. The facility was cited for failing to promptly notify the physician of the resident's change of condition and provide the necessary care and services the resident needed. Citation # 110012498.

The facility failed to cut a resident's food into small bite size pieces as ordered by her physician. The resident choked on a piece of steak while eating lunch on 9/5/16. As a result, the resident was transported by ambulance to an acute care hospital and admitted to the intensive care unit. Citation # 110012614.

The facility was cited for failing to notify the department when the fire alarm went off on four occasions, over a three day period. On two of the four occasions, facility staff reset (turned off) the alarm without reading the alarm panel display. On the fourth time, the Administrator deactivated the alarm without reading the fire alarm panel. The facility did not have the fire protection system professionally inspected until six days after the initial alarm went off. These failures prevented the department from being aware of a potentially unsafe situation at the facility and from conducting a timely, independent investigation of the incident. Citation # 110013922.

The facility failed to treat four of 31 residents with dignity and respect when the Administrator and other staff held a meeting with residents and informed them the facility was closing in approximately 60 days. The administrator did not invite the Ombudsman or the resident's family or friends. This failure contributed to residents feeling shocked about the facility's closure and feeling upset at the thought of losing their homes. In addition, this failure prevented residents from having support from family, friends and the Ombudsman when they were first informed they would be moving from their home. Citation # 110013921.
CANHR is supporting, opposing and/or closely following the following pieces of legislation this session. This list is subject to change. Please check [www.canhr.org](http://www.canhr.org) for updated details on legislation, and [www.leginfo.ca.gov](http://www.leginfo.ca.gov) for information on specific bills.

### Sponsor

**AB 3211 (Kalra) – Improved Organ Donor Choices in Advance Directives**

This bill updates California's statutory Advanced Healthcare Directive to simplify the choices related to organ donation and encourage a more complete explanation of the principal's preferences. In addition, the bill increases the likelihood that adults who wish to make an anatomical gift are given the opportunity to do so. Nearly 23,000 Californians are awaiting lifesaving organ transplants – the revised AHCD in AB 3211 provides an excellent opportunity to better identify organ donors and give them a better chance of expressing and effectuating their wishes.

**Status:** Senate Judiciary Committee

### Support

**AB 1785 (Nazarian) – Medi-Cal Eligibility: Assets**

This bill would exclude the principal and interest of a 529-college savings plan from consideration for purposes of a resources test to determine eligibility for Medi-Cal benefits.

**Status:** Senate Health Committee

**AB 2233 (Kalra) – Assisted Living Waiver**

This bill would improve the Assisted Living Waiver (ALW) Program by increasing the number of participant slots, expanding the geographic service area, and revising the provider reimbursement methodology. The ALW gives seniors and persons with disabilities the choice to receive Medi-Cal services in an assisted living facility or public subsidized housing, rather than a nursing home.

**Status:** In Senate

**AB 2324 (Rubio) – Public Shaming of Elder and Dependent Adults**

Given the recent media coverage of the widespread taking and sharing of pictures of naked nursing home residents, this bill clarifies that the taking, transmission, or dissemination of an image of an elder or dependent adult that degrades or humiliates them is abuse.

**Status:** Dead

### Oppose

**AB 2430 (Arambula) – Medi-Cal: Program for Aged and Disabled Persons**

This bill would raise the income level of the Aged and Disabled Medi-Cal program (A&D program) to 138% Federal Poverty Level (FPL), creating parity between senior and disabled Medi-Cal beneficiaries, and other adult Medi-Cal beneficiaries.

**Status:** In Senate

**SB 1152 (Hernandez) – Hospital Patient Discharge Process: Homeless Patients**

This bill addresses a practice known as “patient dumping,” and will help ensure that hospitals provide safe discharges for homeless patients. It requires hospitals to develop written plans for coordinating services and referrals for homeless patients that take into account their unique medical and social service needs.

**Status:** In Assembly

**AB 2033 (Choi) – CCRC Repayable Contracts.**

Yet another attempt to make detrimental changes to the laws governing Continuing Care Retirement Communities (CCRCs) in California by changing the definition of “repayable contracts,” this bill is clearly intended to pave the way for Erickson Living – not even an operator in the CCRC industry in California – to avoid and weaken current statutory requirements regarding Continuing Care Retirement Communities in California.

**Status:** Dead

**AB 3004 (Kiley) – Revocable Transfer on Death Deeds**

This bill would prematurely delete the sunset provision for the Revocable Transfer on Death Deed (TOD). In 2016, AB 139 (Gatto) created the TOD as a simple way for individuals to transfer real property upon death. AB 139 also directed the Law Review Commission to study the impact of the TOD and make recommendations to the Legislature by 1/1/20. This bill attempts to delete the sunset provision prematurely, before the Commission has the opportunity to do its job. The Commission has already

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*Legislation Update .........................  (continued on page 9)*
found numerous procedural problems with the TOD, along with concerns that TODs open up the possibility of an increase in financial elder abuse.

**Status: Dead**

**SB 1336 (Morrell) – Public Health: End of Life Options Act**

The End of Life Option Act authorizes an adult who has been determined to be suffering from a terminal disease to make a request for an aid-in-dying drug. SB 1336 would dilute the End of Life Options Act by creating additional barriers for terminally ill patients attempting to access this treatment.

**Status: Dead**

**CANHR Watch**

**AB 1953 (Wood) – Nursing Home Self-Dealing**

This bill is intended to respond to the findings of a nearly completed audit by the State Auditor on self-dealing by nursing home chains. Chains are increasingly siphoning off public funds by doing business with companies they own or control at inflated rates. The looting of public funds leads to windfall profits, understaffed nursing homes and neglect. The bill’s language is preliminary pending the State Auditor’s recommendations.

**Status: Senate Health Committee**

**AB 2850 (Rubio) – Nursing assistant training programs: online and distance learning**

This bill previously contained language that would have created “geriatric medication technician” as a subcategory of a certified nurse assistant (CNA), diluting the qualifications of caregivers who administer medications and providing nursing homes an opportunity to replace licensed nurses with lesser-paid CNAs. However, the bill was substantially amended on 4/18/18 and now relates to classroom training requirements for CNAs. In its current form, the bill would authorize classroom training hours to be offered through online or distance learning classes.

**Status: In Senate**

**AB 3098 (Friedman) – RCFE Emergency Training**

Sponsored by the assisted living industry, this bill is a very limited attempt to improve RCFE preparedness for emergencies by requiring periodic training and drills on emergency plans. It does not address any of the serious shortcomings in RCFE emergency plans that were exposed during the wildfires, mudslides and other natural disasters that struck California in the last year.

**Status: In Senate**

**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: Senate Judiciary Committee**

It's Time to Regulate (continued from page 1)

use the assessments to guide licensing, oversight and enforcement actions. The ongoing assessments should take a broad look at chain performance, examining staffing levels, use of chemical restraints, complaint histories, inspection and investigation findings, citations and other enforcement penalties, criminal and civil actions involving elder abuse and fraud, audit findings, labor actions, media reports and indicators of financial instability.

To stop the diversion of public funds intended for care, self-dealing should be banned and operators should be required to spend public funds in a manner that directly benefits residents.

Poorly performing nursing home chains must be held accountable. These chains and individuals associated with them should be disqualified from obtaining future licenses. Regulators must impose escalating penalties when patterns of neglect are found within a chain. When residents are endangered on an ongoing basis, receivership and temporary management should be initiated to install competent, independent managers.

California’s public nursing home website should identify each chain, who owns it, how to contact it, the facilities it operates, and the performance of individual facilities and the chain.

To be sure, a system to regulate chains will not come easily in a state where the nursing home industry controls regulators and is a significant financial benefactor of legislators. But easy or not, it is time for California’s leaders to act with conviction to put residents’ interests first.

Owning a nursing home must be treated as a privilege, not a right, and those entrusted with this honor must demonstrate that they can and will provide first-class care.
CCRCs Residents Should Be Aware of Disability Discrimination

Over the years, a number of CCRCs have been sued for their attempts to bar residents with disabilities from communal areas such as dining rooms. In an attempt to appear “disability free,” some CCRCs have banned walkers and wheelchairs from dining rooms in violation of the Americans with Disabilities Act, while others refused to make “reasonable accommodations” as required by the Fair Housing Act.

In Hyatt v. Northern California Presbyterian Homes, a resident claimed that the policy of banning the use of walkers in the communal dining room constituted discrimination under the FHAA, the ADA, and the relevant California statutes. Residents using walkers were to give them to staff who would store the walkers during the meal, thus preventing residents from using their walkers to access the buffet. The resident alleged that the “reasonable accommodation” offered by the CCRC was to grant her access to the buffet tables, but only after 5:45 p.m., an offer she refused. The case eventually settled out of court.

In Weinstein v. Cherry Oaks Retirement Community, the Colorado Court of Appeals held that a policy requiring residents who used wheelchairs or walkers to transfer to ordinary chairs when taking meals in the communal dining room violated the Colorado Fair Housing Act (a law almost identical to the FHAA).

In 2015, the U.S. Justice Department obtained a settlement against a CCRC in Illinois, that resolved allegations that the owners and managers of a CCRC known as Sedgebrook violated the Fair Housing Act by instituting policies and maintaining practices that discriminated against residents with disabilities at the facility. The complaint alleged that Sedgebrook had instituted a series of policies that prohibited, and then limited, residents’ ability to dine in the communal dining rooms of the independent living wing of the facility if they required assistance eating due to a disability.

The complaint also alleged that Sedgebrook maintained a policy prohibiting residents of the independent living wing from hiring live-in caregivers and refused to grant reasonable accommodations to that policy that would have allowed Sedgebrook residents with disabilities to use and enjoy their apartments. Under the settlement, Sedgebrook paid $210,000 into a settlement fund to compensate residents and family members who were harmed by these policies and also paid a $45,000 civil penalty to the United States. In addition, Sedgebrook agreed to appoint a Fair Housing Act compliance officer and to implement a new dining and events policy, a new policy applicable to residents’ private employment of caregivers, and a new reasonable accommodation policy. Additionally, Life Care Services LLC, the company that manages Sedgebrook and was a named defendant in the lawsuit, agreed to take steps to implement similar policies at the over 100 independent living and continuing care retirement communities it owns or manages across the country.

The federal Fair Housing Act prohibits discrimination in housing based on race, color, religion, national origin, sex, disability, and familial status and prohibited discrimination includes a “refusal to make reasonable accommodations in rules, policies, practices or services when such accommodations may be necessary to afford (those with disabilities) an opportunity to use and enjoy a dwelling.” Americans with Disabilities Act Title III prohibits discrimination on the basis of disability in the activities of places of public accommodations (this includes CCRCs) and requires newly constructed or altered places of public accommodation—as well as commercial facilities (privately owned, nonresidential facilities such as factories, warehouses, or office buildings)—to comply with the ADA Standards. CCRCs may want to hide the fact that they are licensed as Residential Care Facilities for the Elderly, but, under state and federal laws, they can’t force their residents to hide.

For more information on CCRCs in California, visit our CCRC section on our website at [http://www.canhr.org/CCRC](http://www.canhr.org/CCRC) where you will find helpful links to:

- **Find a CCRC**
- **List of For-Profit Providers**
- **List of Non-Profit Providers**
- **CCRCs by County**
- **Resident’s Right to Submit a Complaint**
- and much more.

Complaints can be received by phone (1-916-654-0591), email (ecclccb@dss.ca.gov) or mail (744 P Street, MS 8-16-91, Sacramento, CA 95814)
CANHR welcomes memorial and honorary gifts. This is a great way to honor a special person or a loved one, while helping those who are long term care residents. Recent gifts have been made in the names of the following persons:

**In Memory Of**

Ronald Randolph
Brenda Williams

Bruno Wartman
Patricia Moran-Johnson

In Loving Memory of my Brother, Ronald Randolph
Bob Williams

**In Honor Of**

Barby
Kim Carley

Tony Chicotel, Michael Connors, and Prescott Cole
Jennifer & Julie Van Nghiem

Maria Chiricosta
Mr. and Mrs. Dominick

Mary Moton
Sean Moton

**Planned Giving Leaves**

**A Legacy to Honor Your Memory and Helps to Ensure the Future of CANHR.**

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- gifts by will
- gifts of life insurance
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Call the CANHR office or email patm@canhr.org to get more information and a free booklet on planned giving.
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12  CANHR Advocate  Summer 2018
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