Wildfires raged across California once again this summer, and with them the realization that vulnerable elders in long term care facilities are in harm’s way. The wildfires and the mudslides they sometimes trigger threaten the lives of everyone in their path, but they pose extra dangers to elders who are too ill or frail to flee.

Well over 100,000 elders and persons with disabilities live in assisted living facilities, big and small, throughout California. Many residents of these facilities are not able to protect themselves during emergencies due to dementia, physical disabilities, chronic illnesses and frail health. Their lives are in the hands of owners, administrators and caregivers during and after emergencies.

The Governor and climate experts tell us that the extreme intensity, size and duration of the recent wildfires is the “new normal” in California. It is critical that assisted living facilities prepare accordingly. However, if there is one lesson to be learned from the recent disasters, it is that the precautions taken and preparations made by facilities are no match for the intensifying threats residents face.

Residents of some assisted living facilities have been subjected to grave dangers. For example, a May 20, 2018 report by the Mercury News examined body-camera videos captured by Santa Rosa police officers who responded to the October 2017 Tubbs Fire. The videos show officers rescuing scores of residents of Oakmont of Varenna (licensed as “Varenna at Fountaingrove”), a luxury continuing care 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.

On that same night, many residents barely made it out alive from Villa Capri, an Oakmont-owned facility next door to Varenna, before it burned to the ground. The facility is the subject of a recently settled wrongful death lawsuit that contended three elderly residents’ deaths were hastened by trauma caused by neglect and abandonment during the fire. Many more residents would have died had not a small number of family members heroically rescued them from the darkened, powerless building as it filled with smoke during the middle of the night. As a wall of fire approached Villa Capri, the family members had to break into the building, carry wheelchair bound residents down unlit stairwells, flag down police officers to arrange transportation, and drive residents to safety. Many of the terrified residents they rescued resided in a dementia unit.

On September 4, 2018, the California Department of Social Services initiated legal action to revoke the licenses of Varenna and Villa Capri and impose lifetime

In harm’s way .......................... (continued on page 4)
CANHR News

Staff News

That new voice that you hear on the phone is **Amber Roberts**, CANHR’s new receptionist/AA who started in July. CANHR also had pleasure of working with **Megan Cole** over the summer, an entering U.C. Santa Cruz student, who assisted CANHR staff with a number of projects. Welcome, Amber and thank you, Megan – good luck at university!

Leave a Legacy

CANHR is a 501c)(3) organization and we want to remind you to think of CANHR when you are doing your estate planning. Planned giving leaves a legacy to honor your memory and helps to ensure the future of CANHR. With careful planning, it is possible to reduce or eliminate income and estate taxes while turning appreciated assets into income for yourself or others. Planned giving can include gifts by will; gifts of life insurance or, by a revocable living trust or charitable remainder trust. Call the CANHR office or email **patm@canhr.org** to get more information and a free booklet on planned giving.

Fall Workplace Giving

California Advocates for Nursing Home Reform is participating as a “non-affiliated beneficiary agency” in the United Way Work Place Giving Campaign for 2018. As A Certified Community Campaign Agency we are 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**.

Send Us Your Feedback and Your Support!

We would like to hear from you. If you have questions you would like answered, comments on our web site or on services you recently received, you can contact CANHR through our new feedback form. Visit our web page at www.cahnr.org, click on “contact us” and tell us what you think. You may also make a secure online donation to CANHR through our website by clicking the “Donate Now” button and following the simple instructions.

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About CANHR

Since 1983, California Advocates for Nursing Home Reform (CANHR), a statewide nonprofit 501(c)(3) advocacy organization, has been dedicated to improving the choices, care and quality of life for California’s long term care consumers.

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Bay Area RCFE/Child Care Operators Charged with Human Trafficking

A family of four operating an adult residential and child care company in the Bay Area have been arrested and charged with human trafficking and other labor-related crimes, California Attorney General Xavier Becerra announced on September 7, 2018 at a news conference in San Francisco.

The four defendants, identified as Joshua, 42; Noel, 40; Gerlen, 38; and Carlina Gamos, 67, were charged with 59 criminal counts, including rape of a worker, stemming from the operation of their six Rainbow Bright care centers in South San Francisco, Daly City and Pacifica. Most of the facilities were residential homes, Becerra said. Four of the facilities provided adult residential care and two provided child care. The licenses for all of their facilities were pulled immediately by the Department of Social Services.

The defendants allegedly targeted members of the Filipino community, many of whom were new to the United States, for labor exploitation. While serving the arrest warrants, agents also seized 14 illegal assault weapons, including three “ghost” rifles without serial numbers. In addition, a loaded pistol was found on a table in the garage of a home used for child care with a blanket over it. Becerra said additional criminal charges will be filed related to the firearms.

Becerra said Rainbow Bright was also cheating taxpayers by failing to pay its fair share of state income taxes, workers compensation and state unemployment insurance. He said the number of workers exploited in this case could be in the hundreds and that the abuses took place over 10 years.

Rainbow Bright’s owners are accused of forcing employees to work nearly 24 hours a day and sleep on floors and in garages, and locking them outside in the rain when the owners were not home. The complaint alleges that Rainbow Bright executives deterred the employees from leaving by regularly threatening to turn them over to U.S. immigration officials and confiscating some employees’ passports.

The charges are the result of a year-long investigation by the Attorney General’s Office Tax Recovery and Criminal Enforcement (TRaCE) Task Force, and included several state and local law enforcement agencies. Since its creation in 2014, Becerra said, the task force has identified close to one-quarter of a billion dollars in unreported business income.

Becerra urged member of the public who may suspect similar crimes in their neighborhoods to contact the TRaCE task force at (855) 234-9949.

“What’s most painful as we discuss this is this is happening in neighborhoods,” Becerra said. “This could be happening in your backyard, in your neighborhood, with people you believe are living a regular life and being cared for.”

California’s Top Nursing Home Regulator Owns Interest in Nursing Home Chain

On August 12, 2018, Politico reported that Karen Smith – the Director of the California Department of Public Health – has ownership interest in Brookdale Senior Living, which operates many long term care facilities in California, including 10 nursing homes that are regulated by Smith’s Department. According to Politico, Smith denied her financial stake in Brookdale has any effect on her decisions.

The public might disagree. Under Smith’s watch, the Department has favored nursing home operators over nursing home residents at almost every opportunity. For example, Smith’s Department:

- is allowing unfit and unlicensed operators to acquire and run nursing homes;
- has developed a waiver system that will allow hundreds of California’s most poorly staffed nursing homes to ignore modest new staffing requirements;
- was blasted by the California State Auditor for endangering nursing home residents by failing to enforce nursing home standards;
- opposed legislation that would have required timely investigations of abuse and neglect reports filed by nursing homes; and
- continues to treat sexual assaults of nursing home residents as minor offenses.

Long Term Care News .................. (continued on page 4)
bans on the administrators of each facility. The State’s extraordinary actions reflect the grave harm residents faced due to Oakmont’s extreme neglect. See the related story on page 9.

What does it say that these luxurious assisted living facilities were so poorly prepared? They are stark warning signs that California’s standards for emergency preparedness are dangerously lacking.

A small step has already been taken. On September 11, 2018, the Governor signed an emergency preparedness bill sponsored by the assisted living industry (AB 3098) that requires quarterly disaster drills, staff training on emergency plans, and that makes modest improvements in emergency plan requirements. Vital recommendations by CANHR, the long term care ombudsman program, and other advocates were rejected.

Much stronger standards are urgently needed. Even the best planning will make little difference unless assisted living facilities have adequate numbers of trained staff at all times to execute emergency plans. Generic emergency plans won’t do; they must address known hazards and the specific needs of residents. Contracts with shelter locations and transportation providers should be detailed, in writing and updated at least annually. Provisions must be made to safely evacuate residents who are bedridden or non-ambulatory. Generators and other back-up power sources must actually be in place and sufficient to address emergency needs, such as powering elevators, oxygen equipment, and other systems needed to keep residents safe. Air conditioning must be available and working during heat waves. There must be strong coordination with local emergency officials and a meaningful system to evaluate emergency plans.

CANHR is developing a legislative proposal for 2019 that would address these and related concerns. If you have suggestions, call us at (415) 974-5171 or e-mail us at canhrmail@canhr.org. We would love to hear them. We would also like to hear from anyone whose life was affected by the recent disasters while living in an assisted living facility.

Thorough and thoughtful emergency planning must become the “new normal” for assisted living facilities in California. The lives and safety of their residents are at stake.

While complaints against nursing homes soared to levels never seen before and nursing home chains siphoned off hundreds of millions of dollars intended for resident care, Smith stood silent. It is more than fair to wonder whose interests she is protecting.

Federal Watchdog to Probe Enforcement of Nursing Home Staffing Standards

Quickly responding to a July 7, 2018 New York Times article written by Kaiser Health News – It’s Almost Like a Ghost Town, Most Nursing Homes Overstated Staffing for Years – the Inspector General at the Department of Health and Human Services in August launched an examination into federal oversight of nursing facility staffing levels. One of the issues it will investigate is whether the Centers for Medicare and Medicaid Services (CMS) is using the payroll-based staffing data it now collects from nursing homes to enforce federal staffing standards, including the requirement that a nursing home have a registered nurse on duty for at least 8 consecutive hours every day. According to the CMS data, hundreds of nursing homes are violating this requirement. Read the August 30, 2018 California Healthline story on the OIG investigation.

Curious About Nursing Home Staffing Levels in Your Community?

On August 8, 2018, the Long Term Care Community Coalition (LTCCC) – a New York based advocacy group for long term care facility residents – published updated data on nursing home staffing. The data are presented in easy-to-use charts for each state that show a nursing home’s census, its direct RN, LVN and CNA staffing levels, and the amount of staff care hours per resident, per day. City and county information is included to facilitate local searches. The data is derived from payroll-based data collected by the Centers for Medicare and Medicaid Services (CMS) for the first quarter of 2018. Read the alert from LTCCC.

The LTCCC charts present quarterly average staffing levels for each nursing home. For those who are interested in reported daily staffing levels at a federally certified nursing facility, it is available directly from CMS on its website.
Past Speaking Engagements, Panel Discussions and Training Sessions

- **June 8:** Julie Pollock gave in-service training to the attorneys at Kato, Feder & Suzuki LLP on “Spousal Impoverishment Protections for Home and Community-Based Services.”

- **June 12:** Tony Chicotel presented to the staff of Sage Elder Care in Burlingame about long term care myths and realities.

- **June 21:** Prescott Cole gave a presentation at the Alameda County Multi-Disciplinary Team about the CANHR Restitution Guide “Filling the Gap for Professional Working with Seniors.”

- **June 21:** Prescott presented to the North Bay California Society of Enrolled Agents on financial elder abuse, the CANHR Restitution Project and the Home Equity Protection Program.

- **June 23:** Julie Pollock gave a presentation at the Antioch Caregivers Forum on “What You Need to Know about Long term Care.”

- **July 23:** Julie Pollock and Pauline Mosher attended a stakeholder meeting with Governor Brown’s office to discuss the Assisted Living Waiver Program.

- **July 25:** Jody Spiegel participated in the RCFE Advocates Quarterly Meeting with Community Care Licensing.

- **July 26:** Julie Pollock and Pauline Mosher gave a lunchtime presentation to the Caregiver Support Group at PG&E in San Francisco.

- **July 27:** Jody Spiegel gave a presentation to Orange County HICAP regarding Long Term Care Medi-Cal Eligibility and Recovery.

- **August 3:** Julie Pollock conducted a free webinar for social workers called “Advocating for Your Clients on Medi-Cal.”

- **August 8:** Julie Pollock conducted a social worker training at Alta Bates Hospital in Berkeley on Long Term Care Resident Rights.

- **August 18:** Executive Director Pat McGinnis gave a presentation on pending and future legislation and CCRC issues to the Tamalpais Family Council.

*CANHR On The Move .................... (continued on page 6)*
• **August 28:** Executive Director Pat McGinnis presented a webinar on skilled nursing facilities and Medi-Cal eligibility to staff of the Long Term Care Ombudsman Services of San Luis Obispo County.

• **August 29:** CANHR’s legal staff met with representatives of Attorney General Becerra to discuss the State’s largely untapped ability to improve nursing home care in California.

• **August 31:** Prescott Cole was a presenter at the 9th Annual National Summit on Elder Financial Exploitation in Anaheim where he spoke about recovering compensation of victims of elder financial abuse, CANHR’s HEPP Program, and the Grandmother Scam PSA Video featuring “Dr. Ruth” Westheimer.

• **September 10:** CANHR staff attended a stakeholder meeting at the Department of Social Services to discuss proposed changes to the RCFE Provider notice regarding treatment of SSI/SSP residents.

• **September 14:** Prescott Cole presented at the “Closing the Gap on Elder Financial Abuse” multi-disciplinary education training in Sacramento for law enforcement, APS, Ombudsmen, and Legal Services providers (see below).

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**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.
Dear Advocate,

My father was diagnosed with Alzheimer's disease last year. While I have been caring for him at home, his needs have changed and it has been a challenge providing him the care he requires. I have thought about finding an assisted living where he can receive the attention he needs. A friend of mine suggested I find a Memory Care Facility. Do you have any recommendations on how I can find the best Memory Care Facility?

Sincerely,

Interested in Idyllwild

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Dear Interested in Idyllwild,

It can be difficult to choose an assisted living for a loved one, particularly when, additional supervision and care is required. It’s important to note that the term “Memory Care Facility” is not an officially recognized classification for an assisted living long term care facility, and may be misleading. Instead of seeking a facility based on advertising catch phrases, with a bit of time and research, you can find the right facility for your father.

Ask the facilities you are considering if they are able to provide the type of care your father needs, and if they offer care to residents with similar diagnoses. Nothing substitutes for a personal visit to the facility. Once you narrow down the list of potential facilities that are able to meet your father's basic care needs, visit the facilities. Ask to see the entire facility. If you are looking at an Alzheimer’s Unit within a facility, ask what makes it different from the rest of the facility (especially if it costs more)! If the facility offers special safety systems to protect wanderers, ask if it is operational, and ask for a demonstration.

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Right to purchase your own drugs, supplies and medical equipment

California law, Health & Safety Code §1320, prohibits nursing homes from requiring residents to purchase drugs, or rent or purchase medical supplies or equipment, from any particular pharmacy or other source. Although the law does permit nursing homes to require a resident’s pharmacy to comply with policies and procedures reasonably necessary for the resident’s care or to comply with state or federal rules, the facility cannot impose unreasonable requirements or restrict your choice of pharmacy.

If controlled substances are prescribed, the facility can require they be dispensed in containers, such as a pill box or counting tray, that are suitable for being periodically counted by the facility. Although the facility may prefer “bubble packing,” it cannot be required. Ask the nursing home about its policies on packaging of medications and see if your pharmacy can meet them.

If the facility imposes unreasonable requirements or restricts your choice of pharmacy, you should file a complaint with the California Department of Public Health.
Residents' Right to Store Their Own Medication

Medication problems are common in assisted living care, in part because facilities are not required to have medical personnel on staff. “Assistance with taking prescribed medications” is listed as a core function of Residential Care Facilities for the Elderly (RCFEs) as part of its personal assistance requirements. (Sec. 87464(f)(4)) However, assistance does not mean “administering” medications. Residents are expected to “self-administer” their medications and RCFE staff are limited to helping with self-administration. (Sec. 87465(a)(6)) The roles of residents and staff are commonly described as follows: the staff can hand the medication to the resident and even guide the resident’s hand to his or her mouth if needed, but the staff cannot actually place the medication in the resident’s mouth. This creates a potentially awkward dance between staff and residents. But a key concept in the regulations covering medication administration is that residents, not RCFE staff, ultimately control the taking of medications in a facility.

A problem that is sometimes raised by RCFE residents is control over storing their medications, i.e., keeping their medications in their own rooms. Under Sec. 87465(h)(1), the presumption is residents generally control the storage of their medications:

Medications shall be centrally stored under the following circumstances:

a. The preservation of medicines requires refrigeration, if the resident has no private refrigerator.

b. Any medication is determined by the physician to be hazardous if kept in the personal possession of the person for whom it was prescribed.

c. Because of potential dangers related to the medication itself, or due to physical arrangements in the facility and the condition or the habits of other persons in the facility, the medications are determined by either a physician, the administrator, or Department to be a safety hazard to others.

Except in cases where refrigeration is needed or there are specific and documented hazards to self-storage, residents are permitted to keep their own medications.

The ability of residents to safely store their medications is supposed to be assessed prior to the resident moving in and every year thereafter. (Sec. 87458(b)(3); also see Form LIC 602A) If the resident’s ability to self-store medication has allegedly declined, the change in condition would have to be immediately reported to the resident or the resident’s responsible person. (Sec. 87463(b)) But even if the resident’s physician, facility administrator, or the Department of Social Services determines the resident’s medications should be centrally stored (controlled by the facility staff), the resident can always decline the service. After all, the medications are the property of the resident; they paid for them, they control them.

If residents wish to store their own medications, they should generally be allowed to do so, assuming they can responsibly manage them and keep them away from other residents. The facility may only insist on centrally storing medications when the criteria in Sec. 87465(h)(1) are satisfied. If the resident disputes whether the criteria are satisfied, they can refuse central storage. If problems persist, the resident can file a complaint with the RCFE regulatory agency, the Department of Social Services (844-538-8766), or call CANHR (800-474-1116) and ask to speak with an advocate.

*all Section numbers refer to 22 California Code of Regulations
State Sends Strong Message: RCFE & CCRC Facilities Must Prepare for Emergencies or Face the Consequences

In a bold action that sent a badly needed message to assisted living operators throughout California, the Community Care Licensing Division (CCLD) of the California Department of Social Services initiated legal action to revoke the licenses of two assisted living facilities operated by Oakmont Senior Living and ban their administrators from managing, operating, owning or working in California assisted living facilities for the rest of their lives.

The CCLD actions are the culmination of a nearly year-long investigation involving Oakmont of Varenna and Villa Capri, neighboring assisted living facilities where the lives of hundreds of residents were endangered by deadly wildfires that erupted on the night of October 8-9, 2017. CCLD issued its findings and enforcement actions in an accusation dated September 4, 2018. The CCLD issued its findings and enforcement actions in an accusation dated September 4, 2018.

The findings portray a shocking disregard for the lives of many residents. At Villa Capri, four caregivers were working overnight to care for 62 residents, 25 of whom lived on its dementia unit, and 47 who were considered non-ambulatory. The staff were not trained on emergencies and could not find keys to the facility’s vehicles. A large capacity bus went unused because of it. The substitute administrator on duty did not even know the facility’s evacuation plan. Two of the staff members were physically unable to help residents evacuate. The staff evacuated some of the residents but abandoned more than 20 elderly and infirm residents and did not come back. The Accusation states “these residents would have perished when the facility burned to the ground during the fire” if family members and emergency responders had not arrived to rescue them.

According to the findings, Deborah Smith, the administrator of Villa Capri, was basically missing in action. She was notified of the crisis at Villa Capri at 11:30 pm, began driving to the facility at about 1:30 am, but never arrived. While family members were risking their lives to rescue residents, she returned home and later drove to an evacuation center at about 6:00 am.

Next door at Varenna, only two caregivers were on duty to care for its 228 elderly residents. The caregivers were not trained in emergency evacuations. Varenna’s administrator, Nathan Condie, arrived about 12:30 am but gave no direction to the caregivers and two maintenance staff members on evacuations. Instead, he directed them to return residents to their rooms, stating “he did not want to cause issues or make trouble” for Oakmont. Condie later left the facility with a small number of residents, and the remaining staff soon followed him. They left behind more than 70 residents, who remained asleep in their rooms as the fire storm raged nearby. In extremely dire circumstances, about 100 residents were rescued by family members and emergency responders, who had to kick down locked doors throughout the large, darkened facility as it filled with smoke.

The CCLD Accusation also charged Oakmont with “False Claims” for trying to cover-up its negligence through a dishonest public relations campaign and by lying to State investigators. Oakmont made false and misleading claims on a website it created about the role of its staff in evacuating the residents. Additionally, two of its employees lied to investigators about three residents who had been left behind during the investigation.

Through its action, the State put assisted living operators on notice. Be prepared for emergencies or face the consequences if they put residents’ lives at risk. CANHR commends CCLD for its strong action and vitally important message.

Level of Care Transfer Disputes for CCRCs

Assembly Bill (AB) 713, sponsored by California Continuing Care Residents Association (CALCRA) and effective 1/1/18, requires a CCRC provider to use an assessment tool to determine the appropriateness of a level of care transfer and to provide the resident or the resident’s responsible person copies of the completed assessment. It also requires the Branch to determine whether the transfer is appropriate and necessary. The CCRC Branch just released a fact sheet for CCRC residents regarding the level of care dispute process. This and other CCRC fact sheets, as well as information on CCRC laws, can be found at: http://www.cdss.ca.gov/inforesources/Community-Care/Continuing-Care.
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:** Signed into law!

**Note:** This bill was sponsored by CANHR in honor of Tim Millar, our colleague and friend, who died waiting for a liver transplant.

**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:** Signed into law!

**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 requiring the state to evaluate the provider reimbursement methodology.

**Status:** Sent to the Governor

**Oppose**

**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

**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:** Dead

**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:** Sent to the Governor

**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.

**Status:** Dead

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**Status:** Dead

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*Legislation Update ...................... (continued on page 11)*
AB 2850 (Rubio) – Nursing assistant training programs: online and distance learning
This bill would undermine training requirements for certified nursing assistants (CNAs) by weakening qualifications for CNA instructors and allowing all classroom training to be provided online. It would sacrifice training standards for no good reason.
**Status:** Sent to the Governor

AB 3004 (Kiley) – Revocable Transfer on Death Deeds
This bill would prematurely delete the sunset provision for the Revocable Transfer on Death Deed (TOD).
**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 would require disclosures by an applicant for a license to operate a skilled nursing facility or by a skilled nursing facility licensee relating to an ownership or control interest of 5% or more in a corporation, sole proprietorship, or partnership, that provides, or is proposed to provide, any service to the skilled nursing facility.
**Status:** Signed into law!

**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:** Signed into law!

**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**

- Colette Brown, Colleen Adams
- Albert J. & Corrine A. Doig, David Doig
- Viola Goldan, Devane Goldan
- Tim Millar - We miss you!, CANHR Staff
- Michael Connors, who helped us!, Tilminbin Hudson
- Adelbert C. Heegt, Julie Annarella
- Father Bob and Gale Noble, Michelle Noble McCain
- Ronald Randolph, Ms. Brenda Williams
- Aniita Sargent, Maryann Sargent
- LaVerne Schwacher, Debra Vogler
- Lottie Shamis, Judith Betts
- Thomas Speer Walther, Anthony Moy
- Warren T. Stewart, Elizabeth Boileau
- My beloved mother-, Rita M. Twomey, Denise Twomey

**IN HONOR OF**

- Laticia Manina, David W Combs
- Patricia McGinnis, Donna Ambrogi
- Mary Lou Jones, Jeff Regan
- Julie Pollock, Paul Sinasohn
Citation Watch - Consumer Report

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

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

B $1200 Falls Supervision care plan 1/6/2018
A resident with a careplan that indicated the need for two staff persons to assist her was not provided with a second person to assist her on two occasions. Both times the resident fell and broke her leg. The facility failed to aid of two staff persons to prevent falls. Citation # 02001332.

Oakland Heights Nursing and Rehabilitation
2361 E. 29th Street, Oakland

B $1000 Neglect medication 4/16/2018
A resident was not provided with breathing medications that were ordered by the physician on 12/17/17 and 12/18/17. The resident’s careplan indicated that the licensed nurse was to provide breathing treatments as ordered by the resident’s physician. The LVN did not assess the resident’s breathing when notified of shortness of breath by a CNA on 12/18/17, nor administer her medication. Staff did not answer the resident’s signs of distress, and the resident had to call 911 herself at her bedside. The resident was transported from the facility by ambulance after making her own 911 call to report her own symptoms. Citation # 020014000.

Contra Costa

Moraga Post Acute
348 Rheem Blvd., Moraga

B $1200 Falls Supervision careplan 3/23/2018
A resident’s care plan indicated two staff persons were needed for assistance. A single staff person attempted to transfer a resident from a bed to a wheelchair without the assistance of a second person, resulting in a fall. The resident sustained blunt head trauma. The facility failed to ensure the safety of the resident. Citation # 020013929.

Orinda Care Center, LLC
11 Altarinda Road, Orinda

B $1500 Bed hold 4/3/2018
The facility failed to permit a female resident to return to the facility after hospitalization. On 1/26/18 the facility told the resident’s case manager there were no available beds, and therefore the resident may not return. However, facility records show that from 1/26/18-1/29/18 there were two available female beds, violating the policy that a resident may return to their previous room or be alerted at the first availability of a bed following a hospitalization or therapeutic leave. Citation # 020013953.

the outdoor smoking area on 6/18/17 in maximum 105 degrees F. and was diagnosed with heat exhaustion. The facility failed to provide sufficient supervision, resulting in the resident’s heat exhaustion. Citation # 020013932.
Fresno

Alice Manor Convalescent Hospital
8448 E. Adams Avenue, Fowler

B $2000 Mandated Reporting Physical Abuse Verbal Abuse 07/10/2018
On 3/5/18 at 5:20 am after a resident refused to leave the dining room, there was an altercation between the resident and a CNA. In an attempt to get the resident into a chair the CNA both pushed the resident away and then pushed the resident into a chair. After getting the resident into the chair, the CNA slapped the resident hard on the back of the head. The cook who witnessed this did not report the incident until 1:45 pm, resulting in increased anxiety and fear for the resident assaulted. The facility failed to protect its residents from abuse. Citation # 040014228.

North Pointe Healthcare Centre
668 E. Bullard Ave, Fresno

B $2000 Decubiti (Bedsores) Medication 5/23/2018
The facility was cited after staff failed to properly assess a resident’s level of pain or provide pain management medication, before, during and after a painful procedure to treat an open bedsore. As a result, the resident suffered prolonged, unrelieved pain. Citation # 040014089.

Sunnyside Convalescent Hospital
2939 S. Peach Ave., Fresno

In May of 2015, the facility owner/administrator borrowed money from resident trust accounts to meet payables and payroll. During an interview with the Department, the owner/administrator stated he was responsible for resident trust accounts. The owner/administrator said that when the residents’ checks would come in, he would deposit the checks in the residents’ trust account at the bank and provide each resident with a monthly statement of the account generated by the facility. Then the owner/administrator would transfer the money to his business account to pay bills. He stated, “I give them statements about what money should be in the account, not what is really in the account.” He stated he did not have a list of the suppliers and did not keep records of who they were or how much money he owed to them. He was not able to provide itemized receipts for 57 residents with money in their trust accounts. The facility failed to develop policies to prohibit misappropriation of residents’ property. Citation # 040012434.

Kern

Kingston Healthcare Center, LLC
329 North Real Road, Bakersfield

B $2000 Fiduciary Financial Abuse Theft & Loss 12/05/2017
Beginning in February 2017, a nursing home purchased items using personal funds in the trust accounts of two residents with severe cognitive impairment without authorization from the residents or the residents’ responsible parties. The facility alleged that it did so to maintain the residents’ Medi-Cal eligibility. The facility also planned to purchase items from the trust account of a third resident with severe cognitive impairment without authorization from the resident or her responsible party. The facility was cited for financial abuse of the two residents, and the potential for abuse of the third resident. Citation # 120013657.

Ridgecrest Regional Transitional Care and Rehabilitation Unit
1081 N China Lake Blvd, Ridgecrest

B $2000 Administration Mandated Reporting Notification Physical Abuse 07/18/2018
On 5/8/18 a family member stated to a caseworker that she would slap the resident on the hand when the resident reached for a purse. The caseworker told the family member that the action is a form of abuse and needed to be reported. The Administrator stated that he did not know about the incident. The Department determined the facility failed to report an allegation of physical abuse for a resident within 24 hours. The facility reported the allegation 15 days from when the incident happened. Citation # 120014234.

Valley Convalescent Hospital
1205 Eighth Street, Bakersfield

B $2000 Physical Abuse 07/17/2018
On 4/14/18, a resident got into an altercation with two staff persons and ended up with scratches on his shoulder, injury to his left eye, a scraped upper lip and a skin tear to the left hand which required first aid. On 4/27/18 the Department made an unannounced visit to investigate the incident after receiving an entity report. The facility was cited for “failure to report the injuries of unknown origin to the Department within 24 hours”. Citation # 120014233.
Kings

Hanford Post Acute
1007 West Lacey Boulevard, Hanford

A $20000 Fall Transfer 08/21/2018
On 2/23/18, two CNAs used a mechanical lift to transfer a 92 year old resident back into bed. They placed the resident in the sling and lifted her up out of the chair she was sitting in. The CNAs had failed to notice that the hooks connecting the sling to the lift were not secured. While suspended in the air, the resident slid out of the sling falling to the floor, fracturing her left femur and right tibia. She was transported to the hospital for treatment, then discharged to a new and unfamiliar skilled nursing home. The facility was fined for failure to keep the resident free from accidents when the CNAs failed to check the sling to see if it was securely attached to the lift before attempting the transfer. Citation # 040014340.

Kings Nursing & Rehabilitation Center
851 Leslie Lane, Hanford

A $20000 Fall 5/17/2018
In 2017, a 78 year old resident with muscle weakness, dementia and a history of falling had five falls at the facility during the year. The fifth fall occurred on 11/23/17, when the resident fell out of her wheelchair after being left unsupervised inside the dining room. She was taken to the hospital for evaluation, and diagnosed with fractures of her nasal bones, pelvic bone and sinus wall, and also damaged a tooth that required removal. The facility was cited for failing to keep the resident free from accidents when the CNAs failed to check the sling to see if it was securely attached to the lift before attempting the transfer. Citation # 040014340.

Lake

Evergreen Lakeport Healthcare
1291 Craig Avenue, Lakeport

B $2000 Injury Neglect 03/16/2018
On 8/17/17, a resident suffered a fractured foot when a nursing assistant tripped herself and stepped on the resident while transferring him from wheelchair into bed. The resident reported that he told the CNA he was hurting but she did not do anything or report it to a nurse. The fractures were not detected until four days after the incident, and even then the resident did not receive any treatment. On 8/21/17, his physician ordered a Velcro cast for eight weeks, but the facility did not follow the order, and it had not been implemented as of 10/3/17. Citation # 110013766.

B $2000 Medication Patient Care Patient Rights 03/16/2018
On 8/17/17, and unlicensed staff member tripped on her foot and accidentally stepped on a resident’s left foot. Three days later, on 8/20/17, after complaining of foot pain, an X-ray result confirmed an acute fracture of two of the resident’s toes. The physician ordered a Velcro cast for eight weeks minimum and then evaluation. The facility did not take the resident to the hospital for a cast and instead gave him pain medication for the pain. Although there was a Velcro boot in the room, the instructions did not say how or when to apply the boot. During the month of September, there were no staff initials or documentation regarding the Velcro cast on the treatment sheet. For the month of October, there were two signatures. The facility failed to give this resident his necessary care. Citation # 110013767.

A $20000 Dietary Services 7/19/2018
A male resident nearly died when he was served fish for lunch on 7/9/15 despite a known allergy to fish. The kitchen staff decided abruptly to change the scheduled lunch menu to feature jambalaya with fish. The change was not appropriately entered or approved by the facility’s dietitian, so it was not flagged to accommodate the resident’s allergy. He had to be hospitalized and treated for anaphylaxis. The facility was cited for failing to implement and revise an effective careplan for preventing falls. Citation # 040014084.

A $20000 Careplan Fall 5/17/2018
An 81 year old female resident fell from her wheelchair on 5/31/17, and broke her toe and collarbone. The resident was identified as a moderate fall risk on admission. She was subsequently often observed leaning forward in her wheelchair, “as if she was wanting to pick something up.” Despite these observations, her careplan was not updated. In addition, her tab alarm was disconnected before she fell on 5/31/17, and was thus non-operational. After her first fall, the resident’s careplan was still not updated and she fell again on 6/9/17. The facility was cited for failing to implement
Los Angeles

Affinity Healthcare Center
7039 Alondra Blvd, Paramount
AA $100000 Notification Deterioration Careplan 4/20/2018
A physician indicated that if a 56 year old male resident had an altered level of conscious, he should be given an injection and to notify the physician. The resident was moaning on 12/26/17, but staff did not check vital signs and blood sugar levels or alert the physician. Twenty five minutes later the resident was found unresponsive and later pronounced dead. The facility was cited for failure to assess the resident when change in condition occurred failure to report changes and failure to ensure that necessary care was provided after his condition deteriorated within two hours. Citation # 940013975.

Artesia Christian Home Inc.
11614 E. 183rd St., Artesia
A $16000 Supervision 1/12/2018
An 86 year old female resident fell in the bathroom at 7/12/17 unattended, sustained a blunt head trauma and a right hip fracture, and was transferred to an acute hospital and required surgery. The facility was cited for failure to follow the resident’s assessment and careplan, and failure to supervise the resident. Citation # 940013726.

Bay Crest Care Center
3750 Garnet Avenue, Torrance
B $2000 Physical Environment 4/19/2018
An unannounced visit on 3/11/18 found that that the main lobby was unlocked and two stations exit doors were locked from the outside, and when the door opened and the alarm went off no staff came to inspect who had entered the building. The facility failed to impose reasonable restrictions to protect the security of the centers residents and lock the center at night, failed to provide adequate training for nursing staff on how use the proper keys to lock the center, and did not have a sign in or other authorization check for entering persons. Citation # 910014009.

Bel Vista Healthcare Center
5001 E Anaheim St, Long Beach
A $20000 Careplan 3/9/2018
On 8/30/17 a 71 year old female resident’s physician diagnosed her with a break in her right leg/knee. Her care plan indicated that she needed a two person assist during transfers, but the facility only provided one, resulting in the mishandling that injured her. The facility was cited for failure to follow the facility’s procedure for transfers and failure to follow the resident’s care plan. Citation # 910013879.

Bell Convalescent Hospital
4900 E. Florence Ave, Bell
A $20000 Deterioration Neglect Notification Patient Care Supervision 3/23/2017
On 3/24/16, a 65 year old resident died in a nursing home following a heart attack. The resident’s condition progressively worsened during the day as manifested by weakness, refusal to eat and inability to swallow water given by teaspoon. The facility failed to assess the cause of the resident’s change in condition, notify his physician immediately, transfer the resident to a hospital in a timely manner and initiate CPR after he was found non-responsive. The facility was cited for failing to provide medical interventions and implement emergency procedures to ensure that the resident, who exhibited a significant change in condition, was provided with necessary care and services. Citation # 910014009.

Beachwood Post - Acute & Rehab
1340 15th Street, Santa Monica
B $2000 Mandated reporting 4/12/2018
A 92 year old female was transferred to the acute hospital on 11/29/15 with a swollen shinbone, where an x- ray revealed fracture that required surgery. The injury was not investigated and it was not reported to the Department of Public Health. This was a failure to implement abuse prevention policy, and potentially could put the residents and other residents at risk for abuse. Citation # 910014061.
A $20000 Deterioration Transfer 5/11/2018
On 5/30/14 a 78 year old man had a change in his condition was transferred the acute hospital via non-emergency ambulance. He was not transported from the facility for over five hours after the physician directed the transfer, resulting in delay of evaluation, diagnosis and treatment in which his condition worsened. The facility failed to follow discharge policy and ensure the resident was transferred to the nearest acute hospital in a timely manner. Citation # 910014060.

Artesia Christian Home Inc.
11614 E. 183rd St., Artesia
A $16000 Supervision 1/12/2018
An 86 year old female resident fell in the bathroom at 7/12/17 unattended, sustained a blunt head trauma and a right hip fracture, and was transferred to an acute hospital and required surgery. The facility was cited for failure to follow the resident’s assessment and careplan, and failure to supervise the resident. Citation # 940013726.

Bay Crest Care Center
3750 Garnet Avenue, Torrance
B $2000 Physical Environment 4/19/2018
An unannounced visit on 3/11/18 found that that the main lobby was unlocked and two stations exit doors were locked from the outside, and when the door opened and the alarm went off no staff came to inspect who had entered the building. The facility failed to impose reasonable restrictions to protect the security of the centers residents and lock the center at night, failed to provide adequate training for nursing staff on how use the proper keys to lock the center, and did not have a sign in or other authorization check for entering persons. Citation # 910014009.

Bel Vista Healthcare Center
5001 E Anaheim St, Long Beach
A $20000 Careplan 3/9/2018
On 8/30/17 a 71 year old female resident’s physician diagnosed her with a break in her right leg/knee. Her care plan indicated that she needed a two person assist during transfers, but the facility only provided one, resulting in the mishandling that injured her. The facility was cited for failure to follow the facility’s procedure for transfers and failure to follow the resident’s care plan. Citation # 910013879.

Bell Convalescent Hospital
4900 E. Florence Ave, Bell
A $20000 Deterioration Neglect Notification Patient Care Supervision 3/23/2017
On 3/24/16, a 65 year old resident died in a nursing home following a heart attack. The resident’s condition progressively worsened during the day as manifested by weakness, refusal to eat and inability to swallow water given by teaspoon. The facility failed to assess the cause of the resident’s change in condition, notify his physician immediately, transfer the resident to a hospital in a timely manner and initiate CPR after he was found non-responsive. The facility was cited for failing to provide medical interventions and implement emergency procedures to ensure that the resident, who exhibited a significant change in condition, was provided with necessary care and services. Citation # 910014009.

Beachwood Post - Acute & Rehab
1340 15th Street, Santa Monica
B $2000 Mandated reporting 4/12/2018
A 92 year old female was transferred to the acute hospital on 11/29/15 with a swollen shinbone, where an x- ray revealed fracture that required surgery. The injury was not investigated and it was not reported to
the allegation to the state agency within 24 hours, and did not ensure the abuse investigation was reported to the department of health. Citation # 940014127.

**Briarcrest Nursing Center**
5648 Gotham Street, Bell Gardens
A $20000 Deterioration 2/16/2018
A 91 year old male resident sustained a toe injury when being transferred from chair to bed in July 2017, which never healed and required amputation on 10/20/17. They did not monitor the wound, and there was no documented wound care. The staff did not follow the physician’s orders, resulting in a diagnosis of sepsis and amputation of the left second toe. The facility was cited with failure to provide necessary care and service to attain or maintain wellness. Citation # 910013814.

**Burlington Convalescent Hospital**
845 S.Burlington Ave., Los Angeles
A $16000 Supervision Staff training notification 3/8/2018
A 64 year old female resident took off her wheelchair belt and slid out of it while in a van travelling to treatment, on 8/29/18. This resulted in a fracture to the left hip and hospitalization on 9/14/16. The staff had not been trained on accompanying residents during transportation to treatment and were not closely monitoring the resident. The facility was cited for failure to follow policy in supervision, failure to closely monitor the resident and failure of the staff to report the resident’s incident. Citation # 910013878.

**Country Oaks Care Center**
215 W. Pearl St., Pomona
A $19000 Careplan Fall Injury Patient Care Supervision 7/26/2018
On 3/26/18 a resident diagnosed with epilepsy, severe obesity and dementia fell out of bed when a CNA turned the resident without assistance. The fall caused a fracture of the right femur and the resident required hospitalization. The CNA said, “I did the best I could by myself.” The director of staff development stated that the CNA should not have turned the resident without assistance. The facility failed to provide two-person physical assistance during provision of care and failed to include necessary information regarding the care of the resident. Citation # 910014276.

**California Post-Acute Care**
3615 Imperial Hiwy, Lynwood
A $20000 Careplan 6/1/2018
A 72 year old male resident’s care plan indicated he was an elopement risk, and on 12/21/17, went missing for 35 days, and was found unresponsive intoxicated with alcohol by a police officer. The facility was cited for failure to follow procedure, failure to create a comprehensive plan for the resident’s elopement risk, and failure to adhere to the resident’s plan for high risk for elopement. Citation # 940014106.
A resident went to an acute hospital after an abnormal laboratory test result with the notification of the seven day bed holding policy. Six days later, on 2/1/18, the facility refused to re-admit the resident citing lack of payment. The resident was permitted to return to the facility on 4/12/18, after Medi-Cal was approved. The facility failed to let the resident return, despite their own policy which he had been following, resulting in an unnecessarily prolonged hospitalization. Citation # 910014120.

Culver West Health Center
4035 Grandview Blvd., Los Angeles
AA $75000 Notification Deterioration 6/6/2018
A resident’s physician was not consulted when that resident’s respiratory condition did not improve after treatment. The facility failed to monitor and assess his condition, did not recognize the need for emergency intervention and transfer to higher level of medical care, and did not evaluate the resident’s G tube feeding. This resulted in the resident’s death on 1/26/18. Citation # 910014094.

Del Rio Convalescent Center
7002 E Gage Avenue, Bell Gardens
A $20000 Deterioration Careplan Patient Care 5/8/2018
A physician instructed that a 62 year old female resident with a bump on her knee on 1/25/18, should receive an x-ray, which was not done. Staff did not carry out a wound consult, and the resident went multiple days in a row without wound assessments. As a result, there was a delay in treatment and evaluation which worsened and required two transfers to an acute hospital. The facility cited for failure to follow physician’s orders, failure to not implement the careplan on wound assessment and risk for bleeding, not following policy on assessment and neglect and abuse. Citation # 940014029.

Del Rio Gardens Care Center
7004 E Gage Avenue, Bell Gardens
AA $100000 Neglect Deterioration 6/8/2018
A 51 year old male resident with a history of fecal stasis and was on medication with side effects of constipation was transferred to the facility on 12/27/17. The facility failed to create a plan based on assessments and admission orders from a transferred skilled nursing facility failure to monitor bowel movements, and failure to monitor side effects of medications. He complained of abdominal pain for over a month was not seen by a physician about pain. As a result, he was admitted an acute hospital on 2/10/18, with abdominal pain, shortness of breath and nausea, dying two days later. Citation # 940014110.

Downey Care Center
13007 South Paramount, Downey
B $2000 Infection 4/12/2018
A 79 year old male was admitted to the acute hospital 1/18/18. A rash was diagnosed as scabies, which had not been treated by staff. On two occasions the facility did not follow physicians’ orders for skin consultation and failed to ensure the residents were free from pain due to the rash. The delay in treatment for scabies caused pain for resident, and placed residents, staff and visitors in facility at risk of being exposed. Citation # 940013964.
A 68 year old female resident on 1/18/18 reported another resident’s family member sexually assaulting her in the early morning. The visitor log was not monitored from 4 pm to 8 pm. The facility failed to ensure its visitation polices were implement to ensure staff were monitoring visitors and visitation times, and failure to ensure the residents were protected and free from abuse. Citation # 940013989.

Downey Community Health Center
8425 Iowa Street, Downey

Staff did not follow the physician’s orders given on 1/7/17 that a 95 year old resident’s A V shunt should be checked. This resulted in the resident’s shunt becoming clogged, which required surgery. The facility had seven residents with AV shunts with the potential for complications due to improper assessments. The facility was cited for failure to follow the plan of care and physician’s orders, and failure to ensure nurses were knowledgeable regarding the care and assessments of shunts. Citation # 940013709.

Intercommunity Care Center
2626 Grand Avenue, Long Beach

On 3/22/18, a female resident was crying and verbalized fear about a staff member who had punched her in the face and cursed at her. The facility was cited for failure to ensure the resident was free from physical and verbal abuse, resulting in the resident experiencing psychological and physical trauma. Citation # 910014116.

Intercommunity Healthcare & Rehabilitation Center
12627 Studebaker Rd., Norwalk

A 70 year old female resident went to receive dialysis on 8/24/17, and was transported back to the wrong facility. The facility did not report being unable to locate the resident. The incident resulted in the resident’s distress, and she expressed fear of returning to dialysis. The facility was cited for failure to follow procedure, failure to ensure the resident was not left unsupervised, and failure to report that the resident went missing to the Department of Public Health, the police, or the Ombudsman. Citation # 940013969.
Kei-Ai South Bay Healthcare Center
15115 S Vermont, Gardena
A $16000 Staffing Careplan Medications
4/2/2018
A 59 year old male missed nine doses of antibiotics due to lack of available qualified nurses. As a result, the resident complained of foot pain and had an abnormal x-ray which required a transfer to the acute hospital on 10/18/17. The facility was cited for failure to follow policy, failure to follow physician’s orders, failure to implement resident’s plan of care and failure to ensure adequate staff with appropriate competencies. Citation # 910013948.

La Paz Geropsychiatric Center
8835 Vans Avenue, Paramount
A $20000 Physical Abuse Injury Supervision
1/26/2018
A 67 year old female resident punched and dragged another resident in a hallway with no staff supervision on 4/15/17. The assaulted resident required a transfer to an acute hospital with facial injuries. The facility was cited for failure to implement the resident’s plan of care concerning potential aggressive behavior and to ensure adequate supervision was provided and failure to ensure the abused resident was free from abuse. Citation # 940013760.

Lakeview Terrace
831 S Lake Street, Los Angeles
B $2000 Evictions Notification Transfer
07/12/2018
A resident was transferred to a hospital on 2/6/18, after allegedly chasing and hitting staff members in the facility. The long-term care Ombudsman office was not notified of the resident’s transfer as the law requires. The facility did not have a policy for notifying the Ombudsman of resident transfers and discharges. Citation # 910014237.

Lakewood Healthcare Center
12023 S. Lakewood Blvd, Downey
B $2000 Physical Abuse Verbal Abuse 1/19/2018
On 3/9/17, a staff member slapped and cussed at a 49 year old male resident. The staff member was suspended and resigned. The facility was cited for failure to follow policy in protecting residents from abuse and failure to ensure the resident was free from verbal and physical abuse. Citation # 940013742.

A $20000 Supervision Injury 3/16/2018
A 75 year old female resident put a pen in her mouth on 6/11/17, and staff members later found her unresponsive with face injuries in another resident’s room. She was transferred to the acute hospital where she was placed on a ventilator. The facility was cited for failure to remove the ink pen from her mouth, and failure follow the her careplan which indicated the need for supervision. Citation # 940013902.

Las Flores Convalescent Hospital
14165 Purche Avenue, Gardena
B $2000 Verbal Abuse Dignity 4/6/2018
A CNA told a 63 year old female resident to “sit like a dog” on 12/15/1. The facility terminated and reported the CNA. The incident occurred in front of staff and residents, potentially resulting in other residents feeling abused. The facility failed to follow procedure on abuse prevention, and failed to ensure the staff did not verbally abuse the residents. Citation # 940013963.

Lancaster Health Care Center
1642 W Avenue J, Lancaster
A $10000 Careplan 1/24/2018
The facility failed to develop a careplan to address the fall risk and prevention of a resident, and failed to modify the plan after falls on 9/6/17 and 9/9/17. The failure to revise the careplan caused a third fall on 9/23/17, when the resident was found on the floor after a fall, and was transferred to an acute hospital. The resident sustained an injury which required surgery. Citation # 920013756.

Las Flores Convalescent Hospital
14165 Purche Avenue, Gardena
A $10000 Supervision notification 5/18/2018
On 1/14/18, an 84 year old female resident who required oxygen and a pureed diet left the facility with a visitor without staff supervision or oxygen and ate regular textured food. Hours later, back at the facility, the resident was unresponsive, was transferred to an acute hospital and died four days later. The facility failed to notify the physician and the family members about the resident’s assessments and requirements, resulting in the incident. Citation # 910014080.
Lomita Post-Acute Care Center
1955 W. Lomita Blvd, Lomita
A $16000 Careplan Fall Supervision 2/28/2018
The staff did not supervise an 82 year old male with a history of falls and standing up unassisted. This resulted in a fall while unattended which fractured his right hip on 10/27/17. The facility failed to follow its supervision policy and failed to implement the residents careplan. This presented imminent danger that death or serious harm or a substantial probability of death or serious harm would result. Citation # 910013816.

Long Beach Care Center
2615 Grand Avenue, Long Beach
A $16000 Bedsores 1/4/2018
An 85 year old male resident’s physician progress note on 4/22/14, indicated for the staff to plan hygienic care including application of bacitracin, which was not followed by the staff. There were no skin assessments recorded from 5/14 to 7/14, and no visit with a wound care specialist. The resident died on 8/21/14. The facility was cited for failure to use pressure relieving devises, failure to follow both the residents’ plan of care and physician’s orders, and the failure to provide good hygienic care to the resident. Citation # 940013708.

A $20000 Physical Environment 2/6/2018
An unanchored swing compromised a resident’s safety when it was used to transfer the resident from wheelchair to bed on 10/25/13, resulting in a fall and causing damage to his leg, immobilizing him for six weeks. The facility failed to follow the policy in using a mechanical lift which requires two staff at all times during the lift. The facility was cited for failure to ensure the residents’ environment remained free from accident. Citation # 910013774.

Long Beach Healthcare Center
3401 Cedar Avenue, Long Beach
A $20000 Bedsores Neglect 1/12/2018
A 47 year old female resident developed a left food pressure ulcer and a 74 year old female resident developed a pressure ulcer near the tailbone and later a left heel pressure ulcer. The facility failed to ensure the resident’s careplans were followed for prevention of pressure sores, and did not follow the physician’s orders on 3/10/17, to offload pressure. They also failure to complete accurate skin assessments for the residents. Citation # 940013727.

A $20000 Supervision Careplan 1/26/2018
On 2/20/17, a 90 year old man was unsupervised and walked into two other residents’ rooms where he attempted to hit one, resulting in the 90 year old falling and hitting his head. He sustained injuries which required transfer to two acute hospitals and a higher level of care. The facility failed to follow the careplan which outlined the resident’s aggressive behavior and wandering, and failed to provide adequate supervision. Citation # 940013758.

A $20000 Careplan Fall supervision 3/22/2018
A 69 year old female resident required a Hoyer Lift with two persons to assist as indicated by her careplan. The resident’s Change in Condition form dated 11/21/17, stated the she fell from the Hoyer Lift with one staff member present, and was transferred to the acute hospital with multiple injuries including a lacerated liver, two bones broken in her arm and three broken leg bones requiring a nine day ICU stay. The facility was cited for failure to follow Hoyer Lift supervision as well as manufacture guidelines for use of two person assist, and failure to implement the residents’ health plan. Citation # 910013920.

A $20000 Deterioration Bedsores Careplan 1/26/2018
A 61 year old male was admitted to the facility on 3/24/17, and the staff did not give him a complete skin assessment. He was not given treatment or barrier cream for pressure sores during April 2017, and necessary treatments and assessments were not completed. The resident’s wound deteriorated from Stage I to unstageable, and he was admitted to an acute hospital 34 days later. The facility was cited for failure to perform initial and ongoing accurate assessments, failure to follow physicians would treatment orders and the dietician’s recommendations to draw protein levels. Citation # 940013759.

Marina Care Center
5240 Sepulveda Blvd, Culver City
A $16000 Supervision 5/22/2018
On 12/4/18, a 73 year old male resident had visitors after hours and was using drug paraphernalia, which resulted in an opioid overdose that required hospitalization. The facility failed to adequately supervise and make routine checks on the resident during after hour visitation, and failed to ensure that illegal drugs were not used in the facility. Citation # 910014093.
Maywood Skilled Nursing & Wellness Centre
6025 Pine Avenue, Maywood
B $2000 Bed hold 3/2/2018
On 11/13/17, the facility refused to readmit a resident after the 84 year old was discharged from the acute hospital where she was treated for a tailbone infection after four days. According to the facility’s policy, medical residents are allowed a seven day bed hold. The resident’s notification rights were violated and she was displaced, which could potentially violate other residents’ rights. The facility was cited for failure follow policy regarding transfers, discharges and bed holds. Citation # 910013859.

Montebello Care Center
1035 W Beverly Blvd, Montebello
A $20000 Careplan Medication 1/4/2018
The staff did not assess a 77 year old female resident and did not thoroughly review her clinical records when admitting her to the facility on 11/5/17. She did not receive insulin for three days, and did not have a plan of care regarding monitoring and assessing blood levels as well as possible UTIs. As a result, she was transferred to the hospital due to high blood pressure and UTI on 11/8/17. Citation # 940013711.

Mountain View Convalescent Hospital
13333 Fenton Avenue, Sylmar
A $20000 Deterioration Infection Neglect 07/15/2016
A resident died on 2/24/16, following the facility’s failure to provide needed assessment, care and timely hospitalization. The resident was admitted on 2/19/16, in stable condition but vomited during the night. During the following 42 hours, the resident’s oxygen saturation levels were not monitored as ordered and his condition declined. His doctor then ordered hospitalization but it was delayed by 1.5 hours because responders were not informed of the resident’s need for urgent medical attention. The hospital emergency department diagnosed him as having severe sepsis, pneumonia, and altered mental status. The resident was hospitalized and died two days later. Citation # 9200141335.

Northridge Care Center
7836 Reseda Bl, Reseda
B $2000 Careplan Medication Patient Care 6/12/2018
On 2/9/18, the facility failed to implement the physician’s order and resident’s plan for pain assessment/management by inconsistently evaluating the resident’s pain and irregularly administering morphine. This resulted in unnecessary, severe back pain for the resident who suffered from chronic pain. Citation # 920014145.

WMF $2000 Medication Neglect Patient Records 6/12/2018
On 2/9/18, and 3/6/18, two licensed nurses falsely recorded that they administered morphine to a resident at 7:30 am as prescribed and falsely recorded that by 8:00 am he had no pain on those dates. In the first case on 2/9/18, the resident suffered severe pain because the medication was not available at the facility and not administered until 10:00 am. On the second occasion on 3/6/18, the medication nurse did not even see the resident until 9:40 am, at which time he was again suffering from severe pain. The facility was cited for Willful Material Falsification of the resident’s records. Citation # 920014146.

Osage Healthcare & Wellness Centre
1001 South Osage Ave., Inglewood
B $2000 Sexual Abuse Physical Restraints 4/19/2018
A staff member forcibly restrained and kissed a 68 year old male resident on 10/18/16. The staff member was subsequently terminated. The facility was cited for failure to follow its policy and procedure on resident abuse, and failure to ensure the resident was free from physical and mental abuse from the staff person. Citation # 910013971.

Pacific Villa, Inc.
3501 Cedar Avenue, Long Beach
A $16000 Careplan Supervision 4/27/2018
A 56 year old female used illegal drugs on 9/4/17, and 10/29/17, which resulted in an altered mental state and a transfer to an acute hospital. The facility failed to adequately supervise the resident, and failed to adhere to policy and develop a careplan to ensure that she was free from illegal drug use. Citation # 940014021.
Pacifica Hospital Of The Valley D/P SNF  
9449 San Fernando Rd, Sun Valley  
B $2000 Mandated Reporting 5/22/2018  
A 43 year old female resident reported abuse on December 2017. The facility did not find evidence of the allegation and did not report the complaint to the Department. The facility was cited for failure to report allegations of abuse to the Department of Health Services within 24 hours by phone or written notice within 72 hours. Citation # 930014092.

Palazzo Post Acute  
5400 Fountain Ave, Los Angeles  
A $20000 Neglect 3/28/2018  
A February 2018, inspection found that a resident suffered unnecessary, untreated and unrelieved pain on an ongoing basis because the facility did not provide her with the ordered range of motion exercises for her legs to treat contractures and osteoarthritis. Despite the resident’s continuing complaints of pain, the facility also failed to administer ordered pain medication as needed and to develop a careplan for pain management. Citation # 920013934.

A $18000 Decubiti (Bedsores) 3/28/2018  
A February 2018, inspection found that a resident developed a deep tissue injury to her lower left leg due to the facility’s failure to provide needed care. Black and brown dead tissue was present at the injury site. The resident – who had been admitted without any pressure sores – required preventative care because she was completely immobile and confined to her bed. The nursing staff had not detected or treated the deep tissue injury prior to the inspection and was unable to explain how they missed it. The facility was cited for failing to prevent, detect and assess the deep tissue injury. Citation # 920013933.

Pasadena Meadows Nursing Center  
150 Bellefontaine St, Pasadena  
B $2000 Mental Abuse Mandated Reporting  
Dignity 5/2/2018  
A resident made complaints during a 3/12/18, about how a staff member rough handled him, made fun of him when soiled with feces and left him soiled. These allegations were not reported to the department within 24 hours. The facility was cited for failure to ensure alleged violations involving neglect and mistreatment are reported and investigate thoroughly. As a result, the resident was humiliated and in fear of the staff member. Citation # 950014043.

Pine Grove Healthcare & Wellness Centre, LP  
126 N San Gabriel Blvd, San Gabriel  
B $2000 Medication Deterioration Notification 1/10/2018  
On 10/23/17, an assessment of a resident concluded that the resident had rashes, orders were placed for medication and daily skin checks. The facility failed to assess and monitor his skin conditions, and he was not seen by a dermatologist. His condition worsened when his rashes spread and sustained skin tears, a change in condition which was not reported to the physician. The physicians order to administer Benadryl was not followed. These failures resulted in suffering, skin injuries and scratching. Citation # 950013725.

Playa Del Rey Center  
7716 Manchester Ave, Playa Del Rey  
A $20000 Supervision Careplan Fall 3/16/2018  
On 10/17/17, the staff left a 67 year old male resident unsupervised without a wheelchair alarm despite his careplan indicating he needed one. He fell, sustaining a thighbone fracture. The facility was cited for failure to follow fall management policy, failure to implement the resident’s careplan, and failure to provide supervision. Citation # 910013898.

Primrose Post-Acute  
515 Centinela Ave., Inglewood  
B $2000 Mandated Reporting 2/23/2018  
A 70 year old female resident called the police on 11/2/17, and stated a staff member was rough and tossed crackers at her. The administrator stated there were no documentation of the allegations in the computer system. The facility did not report an abuse incident to the Department of Public Health within 24 hours. The facility as cited for failing to follow its policy investigate and report an allegation of abuse, potentially putting the resident and other residents at risk for further harm. Citation # 910013815.

Rosecrans Care Center  
1140 West Rosecrans, Gardena  
A $20000 Careplan Supervision Deterioration 2/16/2018  
On 10/22/17, a 91 year old female resident was found unsupervised on the floor and transferred to the acute hospital with a cervical fracture and several lacerations on his head. On 10/23,17 he was unsupervised and lying on the floor again, with reopened forehead lacerations and was sent to the acute hospital. His health declined, and he required hospice care until his death on 11/21/17. The facility failed to follow policy
regarding supervision, did not implement the resident’s care plan which indicated the assistance of 2-3 persons, and failed to monitor and follow physician’s orders concerning his neck fracture. Citation # 910013818.

Santa Fe Convalescent Hospital
3294 Santa Fe Avenue, Long Beach
A $20000 Physical environments Neglect
3/15/2018
On 12/27/17, two vital sign machines were broken, and two blood pressure machines did not have attachments, and staff did not provide necessary assessments. During this period three residents had changes in condition, one of which had to be transferred to the acute hospital. The facility was cited for failure to follow physicians’ orders monitoring blood pressures, failure to ensure blood pressure cuffs were functional, and failure to ensure nursing staff were competent in assessing residents’ vital signs. Citation # 940013897.

Santa Fe Heights Healthcare Center LLC
2309 N Santa Fe Ave, Compton
A $20000 Supervision Security Fall 4/4/2018
A 79 year old male resident left the facility in a confused state unsupervised and sustained injuries after a fall on 12/2/17. He was found by the police and admitted to an acute hospital. The Department of Public Health was not notified. The facility was cited for failure to provide adequate supervision and failure to follow policy regarding reporting unusual occurrence like elopements. Citation # 940013958.

Socal Post-Acute Care
7931 Sorenson Avenue, Whittier
A $20000 Physical Environment Falls 3/28/2018
On 1/14/17, an 81 year old female being transferred for bed to wheelchair using a Hoyer Lyft fell when two straps broke. She was transferred to the acute hospital in pain with acute fractures. There was no record to indicate the sling and straps were inspected routinely. The facility was cited for failure to provide supervision, failure to implement the resident’s careplan and failure to ensure assistive devises were in safe working condition. Citation # 950014141.

Sunny View Care Center
1428 S. Marengo Ave., Alhambra
B $2000 Mandated Reporting Fall 6/12/2018
On 10/2/17, a resident who required a wheelchair stood up and fell, resulting in her death. This was not reported to the Department of Health within 24 hours, delaying the investigation of the unusual occurrence of the death from an accidental fall. Citation # 950014141.

Tarzana Health And Rehabilitation Center
5650 RESEDA BOULEVARD, Tarzana
A $2000 Mental Abuse Patient Care Patient Rights Verbal Abuse 07/27/2018
On 12/7/17, a resident diagnosed with osteoporosis that required extensive physical assistance with bed mobility, dressing, toilet use and personal hygiene was verbally abused by an LVN. The LVN stated that she told the resident, “You have a bad attitude. This is why you will be crippled all your life.” The LVN admitted her behavior was not appropriate. After that incident, the LVN was removed from the care areas, and suspended while the investigation was conducted. The facility failed to ensure the resident was free from verbal and mental abuse. Citation # 920014290.

Valley Palms Care Center
13400 Sherman Way, North Hollywood
B $2000 Careplan 2/1/2018
On 10/1/17, a staff member served a resident hot soup which spilled and caused second degree burns. The facility was violating the resident’s careplan for Parkinson’s by not providing the resident with assistance eating and serving hot soup, which was specifically not allowed. Citation # 920013780.
Vernon Healthcare Center
1037 W Vernon Ave, Los Angeles
B $2000 Careplan Mental abuse Dignity
1/19/2018
On 4/26/17, an 88 year old male resident became agitated when a staff member attempted to undress him without using a translator, which resulted in the resident sustaining a skin tear and mental anguish. The facility was cited for failure to prevent abuse, and failure to implement the resident’s careplan which stipulated the need for Spanish speaking staff. Citation # 940013731.

West Covina Healthcare Center
850 S. Sunkist Ave., West Covina
A $16000 Falls Careplan Supervision 5/3/2018
The staff did not evaluate a resident with a high fall risk’s care plan for effectiveness to prevent falls and minimize injuries. The resident experienced three unwitnessed falls within two weeks and sustained multiple fractures, requiring a transfer on 9/22/17, to an acute hospital and surgery. The facility was cited with failure to evaluate and develop the residents care plan, and failure to ensure she was assisted and supervised. Citation # 950014031.

Whittier Nursing and Wellness Center, Inc.
7926 S Painter Ave, Whittier
A $20000 Supervision Fall 4/4/2018
An 82 year old male resident who was an elopement and fall risk left the facility on 11/17/17 and 11/18/17. The second day he had an unwitnessed fall and bled from the head. The faculty was cited for failure to supervise the resident, failure to follow policy reporting unusual occurrences, and failure to implement the careplan. Citation # 940013956.

Windsor Care Center of Cheviot Hills
3533 Motor Avenue, Los Angeles
B $2000 Neglect Patient Care Physical Abuse Verbal Abuse 6/22/2018
The facility was cited for failing to ensure two residents were free from neglect, physical, verbal and mental abuse. This citation is regarding two separate residents with unrelated incidents. A licensing evaluator interviewed a 74-year-old male resident on 5/6/18. The resident stated he had not showered since he was admitted on 4/18/14, because the facility did not have shower gurneys, he only showered through bed baths. Additionally, he stated that the CNAs ignored his call lights for assistance and left him lying in wet urine and on two occasions when the CNA changed his wet incontinent brief, she left him lying on his back, over his pressure sore, which caused excruciating pain. On, 5/3/18 a male resident had an eight out of ten level of abdominal pain. Staff did not respond for 45 minutes after the resident pressed the call light to inform the nurse that his abdominal wound was bleeding and that he needed pain medication. The nurse came to check on him at 1:00 am and told him his medications were not ordered, by 4:00 am, the nurse administered two Tylenol. Citation # 910014186.

Windsor Gardens Convalescent Center of Hawthorne
13922 Cerise Avenue, Hawthorne
A $16000 Care plan Deterioration Neglect 3/2/2018
The staff failed to monitor an 81 year old female’s blood sugar on 11/1/17, despite the indication on her plan of care of regular monitoring. The resident had a change in condition and blood sugar marked critically high that was not checked for over 11 hours. She was transferred to acute hospital where a week later was diagnosed with sepsis, acute pneumonia and respiratory and kidney failure as a result of not receiving her insulin and being dehydrated. The facility was cited for failure to provide necessary care and series to attain well-being to ensure physician’s orders were followed in monitoring blood sugar and administering insulin in accordance with comprehensive assessment and plan of care. Citation # 910013857.
B $2000 Neglect Dignity 4/18/2018
On 3/29/17, the staff left a 70 year old male resident in a wet diaper for hours, and was handled roughly and rudely when the change finally occurred. The residents’ personal needs were not met and he was neglected by the staff for several hours. The facility failed to ensure the resident’s activities of daily living were met, and ensure that he would not be treated rudely and roughly during personal care. Citation # 910014008.
B $2000 Physical Abuse 4/26/2018
On 1/3/17, a staff member slapped a 91 year old female resident’s legs as punishment when the resident could not control her bowel movements. There was a delay in investigation, putting the resident and others at risk for potential further abuse. The facility failed to ensure the resident was not abused, and didn’t to follow policy to ensure the residents were free from abuse. Citation # 910014030.
Windsor Gardens Convalescent Center of Long Beach
3232 E Artesia Blvd, Long Beach
A $20000 Physical Restraints Mental Abuse
8/11/2016
On 3/18/16, a staff member wrapped and tied a resident who required extensive assistance to her wheelchair with a cloth sheet so she couldn’t get up, resulting in increased anxiety and fear. The facility was cited for failure to ensure that she was not tied to her wheelchair for staff convenience. Citation # 940014232.
A $20000 Fall 4/27/2018
A 70 year old female resident with a history of falls had an unwitnessed fall from her bed to the floor on 11/20/17. An alarm was not used, and the resident required a transfer to an acute hospital for six days. The facility was cited for failure to follow policy and adhere to the careplan for fall prevention, and the failure to use floor mats and a bed alarm. Citation # 940014014.
A $20000 Supervision Falls 5/11/2018
A 50 year old male resident who would consume alcohol and was prescribed narcotics fell on 1/3/18 and refused hospitalization. Six hours later the resident was found on the intoxicated face down with blood on the floor and was transferred to the ER. The facility was cited for failure to follow policy and ensure an environment free of accidents, failure to supervise the resident and ensure medication were not given in the presence of adverse consequences such as being under the influence of alcohol. Citation # 940014068.

Windsor Palms Care Center of Artesia
11900 East Artesia Blvd, Artesia
B $2000 Verbal Abuse Mandated Reporting Supervision 4/27/2018
On 12/29/17, a male resident who required staff evaluation for aggressive behavior verbally abused a 68 year old resident. Staff witnessed the incident, but didn’t intervene, and did not report the incident. This resulted in mental anguish, and the potential to jeopardize the wellbeing of residents in the facility. The facility was cited for failure to implement its abuse policy for the 68 year old and ensure he was free from abuse and intervene during a verbal altercation, investigate his abuse allegation, and report the incident to the Department of Public Health within 24 hours. Citation # 940014068.

A $20000 Notification Careplan 6/1/2018
A 95 year old female resident did not have a careplan for receiving Lovenex, which required monitoring for potential bleeding, and the staff did not routinely order stool softener as ordered by a physician. The facility did not monitor her laboratory blood test for baseline results, did not implement her plan of care for constipation. On 1/20/18 she was vomiting, and required hospitalization. The facility did not follow policy about change in condition contact the physician and family. As a result, there was a delay in diagnosis and treatment. Citation # 940014112.
A $20000 Bedsores Nutrition 6/1/2018
The staff failed to record a 95 year old female resident’s food intake and fluid intake multiple times, and did not revise her careplan to take care of her need to monitor meal and fluid intake as per the dietitian’s recommendation. They did not perform weekly skin checks, and did not reposition her every two hours or provide a pressure-reducing device. As a 1/30/18, she was admitted to the acute hospital with weight loss and a pressure ulcer, which the facility failed to identify and report. Citation # 940014113.

Windsor Terrace Healthcare Center
7447 Sepulveda Blvd., Van Nuys
B $2000 Patient Rights Sexual Abuse 07/06/2018
On 3/28/14, a CNA penetrated with his finger the vagina of two residents while providing care. The abuse investigation report indicated that on the same night the CNA entered each resident’s room in the dark. The CNA applied ointment to his hand and started putting the ointment on the abdomen, down the inner thighs, then to their vaginal area. Both of residents began feeling his fingers inside their vaginal area. The CNA asked one of the residents if it felt good and she replied, “No, I feel uncomfortable.” The CNA then removed his fingers and left the room. The facility failed to ensure two residents were free from sexual abuse. Citation # 920014224.

Woodruff Convalescent Center
17836 S Woodruff Ave, Bellflower
B $2000 Bed Hold Transfer 4/26/2018
A 56 year old female resident had a Bed Hold Notification form which indicated her desire for a bed hold upon transfer from the facility. was transferred to an acute hospital on 10/6/17, and was not given a bed hold notification. The facility was cited for failure to follow their seven day bed hold policy, and failure to readmit the resident within the seven day bed hold from an acute hospital admission. This resulted in the resident being denied readmission to the facility within seven days. Citation # 940014033.
Madera

Golden Livingcenter - Chowchilla
1010 Ventura Avenue, Chowchilla

A $20000 Security Supervision 6/20/2018

A 72 year old resident who was cognitively impaired and had known elopement behavior left the facility in her wheelchair unnoticed and unsupervised on 3/31/18, and 4/21/18. The facility failed to ensure that the resident’s alarm system was functioning properly and was therefore unable to promptly respond when alarms sounded, if at all, as their security system did not always alarm. The second exit made by the resident on 4/21/18, resulted in a fall that left a 2 cm cut on her face and a large bruise. The facility failed to maintain a monitoring plan. Citation # 040014167.

Marin

Kindred Nursing and Transitional Care-South Marin
1220 S. Eliseo Drive, Greenbrae

B $2000 Elopement Fall Injury Patient Care Security Supervision 6/5/2018

A 97 year old resident who was wearing her wander guard transmitter, left the building unnoticed on 3/4/18, walked down the street, fell to the ground and suffered a broken arm. The facility failed to maintain the resident’s safety. Citation # 110013978.

Mariposa

Avalon Care Center - Sonora
19929 Greenley Road, Sonora

A $20000 Notification careplan 4/20/2018

On 1/17/17, facility staff failed to report to a resident’s change in condition. The resident was treated with blood thinners, and at approximately 8:00 am had difficulty breathing and had blood in her mouth. The facility did not supply the physician with the information that would have prompted her transfer. At 2:00 pm a family member called 911. The resident died later that day. Citation # 030014010.

Monterey

Cypress Ridge Care Center
1501 Skyline Drive, Monterey

B $1000 Evictions 07/26/2016

A male resident with dementia was discharged to his home on 5/20/16 but did not have a key to enter. The facility van driver placed the resident through a window into a couch. Two days later, the resident was in the hospital. The facility was cited for failing to ensure a safe discharge for the resident. Citation # 070012424.

Windsor Skyline Care Center
348 Iris Drive, Salinas

B $2000 Careplan Patient Care Sexual Abuse Supervision 07/30/2018

On 7/1/18, a nursing assistant found a male resident sexually assaulting his roommate. The male resident was trying to insert his penis into the buttocks of his roommate. The resident had pulled down his roommate’s pants and was thrusting behind him. The nursing assistant separated the two residents, and then immediately left the room, leaving the residents alone and unsupervised. Five minutes later, another staff member entered the same room and found the resident sexually assaulting his roommate again. The aggressor had pulled down his roommate’s pants and was attempting to penetrate him again. The resident who committed the assault had a documented history of sexually inappropriate behaviors, including exposing his genitals, masturbating, and grabbing individuals on their private parts. The facility was cited for failure to provide supervision following an incident of sexual assault, resulting in a repeat incident between the same resident five minutes later. Citation # 070014285.

Orange

Lake Forest Nursing Center
25652 Old Trabuco Road, Lake Forest

B $1800 Dignity Patient Care Patient Records Patient Rights 06/29/2018

On 5/14/18, a family member of a resident stated that a CNA must not remove a rubber band from the resident’s braided hair and told the CNA not to cut off the resident’s braided hair. Regardless of this, the CNA cut the resident’s braided hair off. The incident was reported to the facility Administrator. The Administrator had no record of the event and could not provide any documented evidence that she spoke with the CNA about the incident. The resident stated that she was devastated and did not want to leave her room. The facility acknowledged the incident and did not assign the CNA to the resident again. The facility failed to provide care and promote dignity and respect for the resident. This violation had a direct relationship to the resident’s health, safety and security. Citation # 060014195.
Park Anaheim Healthcare Center
3435 W. Ball Road, Anaheim
A $2000 Fall 8/1/2018
On 5/22/18, a CNA was attempting to provide incontinence care for an entirely dependent, cognitively impaired resident. The resident rolled off of her bed landing on her left side causing an acute brain hemorrhage, a fractured femur and skin tears to both of her feet. The resident’s records noted that she weighed over 200 pounds and required assistance from two or more staff. The facility was cited for failing to ensure that the resident was provided adequate assistance. Citation # 060014294.

Placer
Roseville Care Center
1161 Cirby Way, Roseville
B $2000 Careplan Deterioration 6/1/2018
A 79 year old man with high blood pressure, diabetes and previous heart attack had no care plans addressing risk of blood clots prior to 11/18/17. The facility failed to assess, monitor, intervene and report changes the resident, leading to the delay of physician services, treatment and subsequent amputation of the right lower leg on 11/21/17. As the resident’s circulation worsened the facility failed to notify his family and his physician in time to change his careplan and avoid this amputation. Citation # 030014086.

Roseville Point Health & Wellness Center
600 Sunrise Avenue, Roseville
B $2000 Transfer 4/26/2018
The facility refused to take back a resident who had the capacity for making healthcare decision and was in the acute hospital. There was no documentation that “Notice of Proposed Transfer and Discharge” dated 1/20/18 was received by the resident, meaning the facility failed to re-admit the resident after the transfer to the acute hospital without giving proper notification. Citation # 030014015.

Riverside
Alta Vista Healthcare & Wellness Centre
9020 Garfield Ave., Riverside
B $2000 Evictions Transfer 08/07/2018
An 84 year old male resident was dumped into an unlicensed room and board home that was woefully underequipped to care for him. The resident was admitted on 3/7/18, for rehabilitation and had dementia and was unable to care for himself. On 5/4/18, he was sent to the room and board home. His daughter was told he was going to a licensed board and care home, but she found out he was sent to a different facility, owned by the same person, but unlicensed. The resident was hospitalized shortly after the transfer. The facility was cited for unsafely discharging the resident. Citation # 250014296.

Desert Regional Medical Center D/P Snf
1150 N. Indian Canyon Drive, Palm Springs
B $100 Patient Rights Transfer 6/7/2018
The facility failed to notify the Long-Term Care Ombudsman before a discharge that took place on 5/8/18. The resident who has Parkinson’s disease and suffered a stroke required maximum assistance in mobility skills and activities of daily living. The resident had impaired decision-making and a low degree of understanding regarding how to manage illness. This facility’s failure to notify resulted in the resident’s discharge without a clear knowledge of his appeal rights. Citation # 250014098.

Hemet Valley Healthcare Center D/P Snf
371 N. Weston Place, HEMET
B $2000 Mandated Reporting Notification Verbal Abuse 5/22/2018
A nurse at the facility stated that a resident reported verbal abuse from a CNA. The facility did not report this incident because the CNA was thought to be only joking. The Director of Nursing stated that she did not follow up their abuse policy and did not report the allegation of abuse to the Department within 24 hours. The facility failed to comply with the requirements, and the violation of this regulation had a direct relationship to the health and safety of the resident. Citation # 250014026.

Life Care Center of Menifee
27600 Encanto Drive, Sun City
A $10000 Medication 06/29/2018
An 87 year old female resident with a high risk of harm from blood thinner medication suffered severe blood loss and hemorrhagic shock when a blood test was not completed. As a result of the missed test and continued use of the medication, she was overdosed, resulting in bleeding so severe, “it was not possible to say if [it] was vaginal or rectal bleed” and an emergency hospitalization on 3/26/18. The facility was cited for failing to properly manage the resident’s care and for improperly administering medication. Citation # 250014125.
Murrieta Health and Rehabilitation Center
24100 Monroe Avenue, Murrieta
B $2000 Evictions Notification Transfer 7/10/2018
In March 2018, a nursing home issued Notices of Transfer/Discharge for two residents but failed to provide copies of the Notices to the ombudsman office. The Notices stated that the residents were discharged to their homes, with an effective date of 3/16/18. The facility was cited for failing to ensure the long-term care ombudsman office was notified of its plan to discharge the two residents. Citation # 250014163.

Providence Mt. Rubidoux
6401 33rd Street, Riverside
B $2000 Careplan Patient Care 8/16/2018
On 5/15/18, a resident was observed sitting by himself on a bench in front of the facility smoking a cigarette. The resident had a portable oxygen tank beside him and was unsupervised. The resident stated that he carried his lighter and cigarettes. The Director of Nursing was aware of the resident’s smoking outside with his oxygen tank and said, “I should have” been more aggressive, more firm with him regarding not bringing his oxygen tank outside to smoke. The facility failed to provide adequate supervision and ensure a safe environment for the resident. Citation # 250014187.

Riverside Heights Healthcare Center, Llc
8951 Granite Hill Dr, P.O. Box 3156, Riverside
B $2000 Sexual Abuse Supervision 5/11/2018
On 12/20/17 the facility failed to provide an environment free from sexual abuse when the staff left a female resident unsupervised in the dining room with a male resident with known behavior of sexual inappropriateness. A restorative nurse assistant witnessed the male resident groping and putting his mouth on the female resident’s breast, and stated there were other residents present but no staff person. The facility failed to ensure the resident’s right to be free from sexual abuse. Citation # 250013993.

AA $50000 Dietary Services Feeding Neglect Supervision 07/09/2018
On 7/1/17, a 58 year old resident died, 19 days after he suffered irreversible brain injury at the facility caused by choking on a meatball. The resident had a swallowing impairment due to dementia, had failed multiple swallowing tests at the facility and was known to be at high risk for aspiration if he swallowed food. Physician orders directed he not be given any food by mouth. On 6/12/17, the resident was found unresponsive and blue in another resident’s room, where he had attempted to ingest the other resident’s meal. Paramedics transported him to the hospital after facility staff attempted the Heimlich maneuver and CPR without success. The resident died on 7/1/17 after life support was withdrawn. The facility was cited because it repeatedly failed to closely monitor and supervise the resident despite the resident’s known needs and care plan. These failures were a direct proximate cause of his death. Citation # 250014128.

B $2000 Evictions Transfer 08/03/2018
On 11/2/17, the facility discharged a 77 year old resident who had dementia and bipolar disorder to an unlicensed room and board facility that was not able to meet his needs. The resident’s physician had authorized discharge to a licensed board and care facility where he was supposed to receive help with personal care and managing his medications. Instead, he was discharged to an unlicensed room and board facility that Community Care Licensing determined was operating in violation of the law. The facility was cited for the unsafe discharge. Citation # 250014226.
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Villa Health Care Center
8965 Magnolia Ave., Riverside
B $2000  Mandated Reporting  Patient Care Supervision   06/21/2018
A 69 year old male resident with a history of heroin and meth use was found unresponsive in his room on 2/26/18. He died of a drug overdose in the hospital on 2/27/18. A nurse stated that on 2/26/18, a male visitor went into the resident’s room at 7:00 am, and two hours later, the resident was found unresponsive in his room, with syringes on his chest which a police officer said, “looked like heroin.” The facility was cited for failure to report the incident to the Department within 24 hours. Citation # 250014104.

Sacramento

Arden Post Acute Rehab
3400 Alta Arden Expressway, Sacramento
B $ Mandating Reporting   3/16/2018
According to a facility nurse’s notes from 8/5/17, one cognitively intact resident verbally abused and poured milk on the head of his roommate who was judged to have a cognitive communication deficit. The nurse failed to file a report of this abuse with the Administrator nor the Director of Nursing immediately or within 24 hours, as is mandated by the state. Citation # 030013907.

Eskaton Care Center Greenhaven
455 Florin Road, Sacramento
A $15000  Nutrition Hydration Notification Careplan   3/15/2018
The facility did not provide a resident with enough fluid to maintain hydration needs as assessed by the Registered Dietician, resulting in his death on 12/24/15, three days after his last known significant consumption of food or liquid. The facility failed to provide the resident with a trial period of artificial nutrition, did not modify the care plan after a change in condition, and did not monitor him for signs of dehydration. The resident’s family was not notified about his change in condition. Citation # 030013908.

Norwood Pines Alzheimers Center
500 Jessie Avenue, Sacramento
B $2000  Theft and Loss   4/6/2018
The facility failed to protect two residents from property theft by a facility employee. On 1/24/18 the two residents did not attend their allotted, smoke breaks, but their allotted cigarettes were gone. The CNA in charge of the break produced the cigarettes belonging to the residents from his personal bag when the Administrator questioned where the cigarettes had gone because they were not returned to the receptionist as is standard procedure when a resident chooses not to take a smoking break. The facility failed to protect the two residents from the facility employees. Citation # 030013957.

Saint Claire’s Nursing Center
6248 66th Avenue, Sacramento
B $2000  Bed hold   1/4/2018
A resident eloped from the facility on 5/16/16. Two days later police located the resident and brought him to the acute care hospital on 5/18/16. After being medically cleared by physicians, the hospital called the facility to arrange the resident’s return, as desired by the resident’s family member. The facility refused to accept him back, violating the resident’s right to reasonable and advance notice for discharge or transfer. Citation # 030013706.

Sherwood Healthcare Center
4700 Elvas Avenue, Sacramento
B $2000  Physical abuse Injury   4/4/2018
A resident sustained bruising and swelling to the face as a result of rough handling by a CAN on 12/19/17. The CAN abruptly turned the resident with undue force towards the siderail while moving her. The siderail bruised the resident’s face, causing swelling in her left cheek and around her left eye. The facility failed to protect the resident from physical abuse which resulted in harm and discomfort. Citation # 030013950.

San Bernardino

Healthcare Center of Bella Vista
933 E. Deodar St., Ontario
A $15000  Fall Patient Care   1/18/2018
The facility failed to implement safeguards to prevent accidents when on 10/15/17, a certified nurse assistant unfamiliar with a resident’s inability to assist during repositioning led to the resident falling off the bed and requiring hospitalization and surgery. On 10/31/17, the resident slid off her unlocked bed and sustained injuries to her amputated left leg. The facilities failure to ensure safeguards were in place resulted in two falls which resulted in injuries. Citation # 240013795.
Medical Center Convalescent Hospital
467 E. Gilbert Street, San Bernardino
**B $1000 Physical abuse 2/8/2018**
The facility failed to ensure a resident was free from abuse when a Certified Nursing Assistant slapped him and washed him with cold water against his will on 12/5/17. This caused him emotional distress, and the violation occurred under circumstances likely cause significant humiliation, indignity, anxiety, or other emotional trauma to patients. Citation # 240013794.

Sierra Vista
3455 E. Highland Avenue, Highland
**A $5000 Sexual Abuse 7/2/2018**
The facility failed to ensure an environment free from abuse, which resulted in four patients experiencing sexual abuse and exploitation from a staff member. A resident reported she had sex with a staff member on 4/4/18, in exchange for an amphetamine. Two other residents reported they had sexual encounters with the same staff member, and another resident reported she was sexually harassed by him. These acts are characterized as sexual abuse and exploitation, and these violations have a substantial probability of death or serious harm to the residents. Citation # 240014210.

Sky Harbor Care Center
57333 Joshua Lane, Yucca Valley
**B $1000 Mandated Reporting 6/28/2018**
The facility failed to report to the California Department of Health on three occasions that their residents were being abused. A resident was found being physically abused by a family member on 4/20/18, a second resident was verbally abused by a physician in March 2018, and a third resident experienced mental abuse and retaliation from staff members in multiple incidents during his stay at the facility. These facility failures had a direct or immediate relationship to the health and safety of the patients in the facility that resulted in harm. Citation # 240014190.

San Diego

**Village Square Healthcare Center**
1586 W. San Marcos Blvd., San Marcos
**B $2000 Careplan Fall Injury Neglect Patient Care 11/30/2017**
On 7/3/17, a resident with limited coordination fell while being transferred from a toilet to a wheelchair by a CNA. As a result, the resident experienced pain and discomfort from a right knee fracture. The resident stated that the CNA lifted her into a standing position but couldn’t support her weight. The resident fell to her knees. The wheelchair and bathroom grab bar were too far to reach. The CNA did not use a gait belt to help lift and balance the resident. The director of nursing acknowledged there was no careplan in place regarding the resident’s transfer needs. The facility failed to implement transfer policies by not using a gait belt and the correct use of wheelchair placement for transfer. Citation # 080013648.

San Joaquin

**Windsor Hampton Care Center**
442 Hampton Street, Stockton
**B $2000 Mandated Reporting Retaliation against Resident 3/23/2018**
On 3/25/17, a “Grievance/Compliant Report” was filed at the facility, which detailed the retaliation of a CNA against a resident by withholding care. The Social Services Designee, a mandated reporter, failed to send this report of an instance of alleged abuse to the Department of Public Health within 24 hours, as is required by the Health and Safety Code. It was not received by the department until 4/3/17. Citation # 030013890.

San Luis Obispo

**Mission View Health Center**
1425 Woodside Drive, San Luis Obispo
**A $17000 Supervision Physical environment 2/27/2018**
The facility failed to provide adequate supervision and intervention to prevent a resident from being accidentally burned. The resident, who was not a designated independent smoker, and had an impaired mental state, had a lighter to play with. On 11/6/17, while unsupervised in the designated smoking area, he lit his clothes and wheelchair on fire, and his injuries required surgery. The failure presented imminent danger that death or serious harm would result. Citation # 050013770.

San Mateo

**Millbrae Skilled Care**
33 Mateo Avenue, Millbrae
**B $2000 Bed Hold Evictions 07/15/2016**
A female resident was sent to the hospital on 4/14/16, after allegedly verbalizing a desire to kill herself. She was not notified of her bed hold right and was illegally refused readmission from the hospital. Her
psychiatrist found her “ability to do any harm to herself is minimal, if nonexistent.” The resident had lived in the facility for seven years. The facility was cited for failing to readmit the resident when her hospitalization was over. Citation # 220012396.

Santa Clara

A Grace Sub Acute & Skilled Care
1250 S. Winchester Boulevard, San Jose
B $2000 Medication 7/31/2018
On 7/6/18, the facility administered an antibiotic intravenously twice to a resident, rather than once as ordered. The facility also subjected another resident to medication errors on several occasions in June and July 2018 when it administered much stronger dosages of morphine than had been ordered. The facility was cited for failing to ensure that residents were free from significant medication errors. Citation # 070014299.

Amberwood Gardens
1601 Petersen Avenue, San Jose
B $2000 Fall Injury Physical Restraints
06/06/2018
A resident diagnosed with end-stage kidney failure and paralysis was on her way to dialysis in a gurney van. The resident reportedly was not securely restrained in the van. The driver came to a hard stop, and the resident fell and hit her head. The resident suffered a laceration to the back of the head and a fractured spinal bone when she struck a metal bar. The facility failed to fasten the resident in the transport van securely. Citation # 070014124.

B $2000 Fall Supervision 07/18/2018
On 3/4/18, a resident stood up without assistance and fell sustaining a hip fracture. The resident’s assessment indicated she required one person’s physical assistance for transfer. Staff who observed her standing up stated they were unaware she needed assistance with transferring. The facility was cited for failing to provide adequate physical assistance to prevent a fall. Citation # 070014254.

Cupertino Healthcare & Wellness Center
22590 Voss Avenue, CUPERTINO
B $2000 Dignity Physical Abuse Verbal Abuse
2/22/2018
On 1/21/18, an LVN threw cold water on a resident five times to get him to be quiet. Afterward, she instructed a CNA not to change the resident if he did not want to be changed. Another LVN at the facility stated that this LVN “always,” screamed at residents when they kept “bugging” her. The facility failed to ensure residents were free from abuse. Citation # 070000013.

Milpitas Care Center
120 Corning Ave., Milpitas
B $1000 Mental Abuse Patient Care Physical Restraints Supervision 07/17/2018
A female resident with a diagnosis of Alzheimer’s disease and breast cancer was tied to her wheelchair with a bed sheet on 7/3/18, because she was “agitated.” A family member visited the facility and found the resident by the nurse’s station, tied down to her wheelchair to restrict her ability to move. The facility was cited for failure to treat the resident with dignity and respect. Citation # 070014244.

Our Lady of Fatima Villa
20400 Saratoga-Los Gatos Road, Saratoga
B $2000 Administration Careplan Fall Injury Neglect Patient Care Patient Records Supervision 8/2/2018
On 6/26/18, a resident with known dementia and difficulty walking was found on the floor close to her bathroom in her room. The CNA reported that the resident’s walking was impaired and she could not walk unassisted. Two hours after the fall the resident complained of severe pain to her right hip and wrist. The facility sent the resident to the hospital where X-rays found a fracture to the right hip and right wrist. When reviewing the resident’s careplan the Department discovered that the resident’s bed alarm was discontinued on 6/6/18 by the assistant director of nursing. There was no documented evidence that staff closely monitored the resident after that. The facility failed to provide bathroom assistance for the resident when the resident was found on the floor. This is a direct relationship to the health and safety of the resident. Citation # 070014286.

Palo Alto Sub-Acute And Rehabilitation Center
911 Bryant Street, Palo Alto
B $2000 Mandated Reporting Notification Patient Care Physical Abuse 7/14/2017
On 6/18/17, a resident witnessed a CNA treating another resident roughly while the CNA changed the resident’s brief by force. The resident reported the incident to another CNA, but she did not report it. The CNA stated that she did not take the allegation seriously. The facility’s executive director stated the CNA that
handled the resident too roughly was terminated on 6/23/17. The facility failed to report the allegation of resident abuse in a timely manner when a staff member did not notify appropriate sources after being informed of alleged abuse. Citation # 070013342.

San Jose Healthcare & Wellness Center
75 N. 13th Street, San Jose
A $5000 Fall 06/30/2016
At 11:45 pm on 4/22/16, a CNA heard the sound of a walker falling and when he checked the resident’s room he found the resident on the floor with a bleeding head. The resident, who was a known fall risk, told the CNA she went to the bathroom and lost her balance and said she was in pain. At 8:38 am the next morning she was transferred to the ER where it was determined she had bleeding in her brain. The facility was cited for failing to implement proper toileting protocols. Citation # 070012318.

Santa Cruz
Watsonville Nursing Center
535 Auto Center Drive, Watsonville
B $2000 Physical environment supervision 4/20/2018
The facility failed to provide safety smoking practices for ten residents. During an observation on 4/2/18, ten residents smoked without supervision and without the necessary procedures to prevent accidents. This resulted in an environment with a plethora of potential accidental hazards, endangering the health, safety and security of the residents. Citation # 070013985.

B $2000 Physical Environment 4/20/2018
The facility failed to ensure the environment was free of pests. Insects were seen on 4/2/18 flying in the kitchen, several resident rooms and staff areas. Flying insects have the potential to spread infection to residents. The failures directly correlate to the health, safety or security of the residents. Citation # 070003986.

Sonoma
Brookdale Fountaingrove
300 Fountaingrove Parkway, Santa Rosa
A $20000 Decubiti (Bedsores) Patient Care 02/16/2017
On 9/16/16, a 94 year old resident was admitted into the hospital with decubitus ulcers (bedsores) on both feet. The staff had noticed that the resident, who was admitted into the facility without pressure ulcers, had been rubbing his feet on the bed and was developing heel blisters. The staffs’ attempted solution was to put a pillow under his legs to keep the heels off the bed and to put on “booties.” This did not solve the problem, and they did not attempt other methods indicated in the facility’s Skin and Wound Care Protocols. The facility was cited for failing to prevent the development avoidable of pressures ulcers. Citation # 110012907.

B $2000 Patient Care Careplan 6/18/2018
The facility failed to develop patient careplans to meet the needs of two residents who were a high risk for falls. The 75 year old fell and injured her head and neck on 9/23/16, and the 69 year old fell and fractured his leg on 9/22/16. Both falls were a result of care plans that failed to include specific frequency of implementation to enable staff to reduce the risk of falls and didn’t take into consideration the ability of the residents to participate in their own care. Citation # 110013457.

B $2000 Careplan Fall 6/18/2018
On 6/23/16, a resident was standing on a wet floor with no assistance. She was not provided with a safe environment and she fell and broke her lower leg. The facility failed to develop a written fall prevention plan intervention that reflected the functional status development of the resident. This violation had a direct of immediate relationship to the safety and security of residents. Citation # 110013899.

Golden Living Center - London House Sonoma
678 2nd Street West, Sonoma
B $2000 Evictions Patient Rights Transfer 7/5/2018
On 3/16/18, a resident with dementia was transferred to the Veteran Affairs Hospital in San Francisco, 45 miles away because the facility could no longer absorb the cost of his sitter. They failed to notify the local ombudsman which prevented the ombudsman from advocating for the resident. Citation # 110014174.

B $2000 Evictions Notification Transfer 07/05/2018
A 75 year old male resident was transferred, without any notice or preparation, to another facility 45 miles away on 3/16/18. He was transferred because the facility did not want to “absorb the expenses” of providing adequate care. In a telling twist, the resident’s transfer was handled by the facility’s business manager instead of the social services designee. The facility
also failed to notify the resident’s responsible party about the transfer. The facility was cited for failing to provide sufficient preparation and orientation before the resident’s transfer. Citation # 110014173.

**Healdsburg Senior Living Community**

725 Grove Street, Healdsburg

**B S2000 Careplan Patient Care Physical Abuse Sexual Abuse 7/10/2018**

From 6/11/14, through 6/13/15, a resident was the victim of three occasions of physical aggression from a second resident, and four incidents of inappropriate sexual touching by a third resident. The victim was admitted to the facility on 6/13/13, with diagnoses including dementia, depression and delirium. The physical aggression involved strikes to her back and arm, and the sexual touching involved her breasts and groin area. The facility was cited for failing to develop careplans for the three residents based on an identification of care needs on initial and continuing assessments with effective interventions to protect the victim from physical aggression and inappropriate sexual touching. Citation # 110011875.

**Sonoma Developmental Center D/P SNF**

P.O. Box 1493, Eldridge

**A $10000 Careplan Infection Neglect Patient Care 03/06/2014**

A male resident with cerebral palsy and a high risk for skin breakdown was hospitalized on 7/14/12, for an abrasion on his right finger that was left untreated at the nursing facility for seven days. The wound was first observed on 7/2/12, and covered with gauze, but was left untreated and unobserved from 7/7/12, until he was hospitalized on 7/14/12. By the time the resident was hospitalized, the bone on his finger was exposed and he had to undergo surgery. The facility was cited for failure to observe the wound or implement interventions to treat the wound. Citation # 150009750.

**Stanislaus**

**Hy-Lond Health Care Center - Modesto**

1900 Coffee Road, Modesto

**B S2000 Evictions Transfer 08/08/2018**

A 54 year old female resident was discharged on 3/26/18, to an independent living facility, despite needing assistance with many of her activities of daily living. The resident stated the nursing home staff had told her that she was visiting the independent living facility to “check it out” as a potential placement. The social worker left her there, prompting the resident to observe, “she dumped me here.” The resident was left without physician-ordered home health treatment and did not receive bathing, grooming and continence care for weeks. The facility was cited for failing to develop and implement a proper discharge plan and failing to prepare and orient the resident before discharge properly. Citation # 040013418.

**Tulare**

**Merritt Manor Convalescent Hospital**

604 E. Merritt Avenue, Tulare


On 3/26/18, during an unannounced revisit survey of a dedicated dementia facility, the Director of Staff Development verified that the side rail assessment and evaluation forms for several residents were incomplete. She also confirmed that various measurements did not meet the guidelines included on the form and that she was not trained to assess side rail safety risks. The facility was cited for failing to assess five of five sampled residents for risk of entrapment from side rails before their installation, and failing to ensure that three of five sampled residents’ side rails met federal safety standards. Citation # 120014107.

**Ventura**

**Simi Valley Care Center**

5270 E Los Angeles Avenue, SIMI VALLEY

**B S1900 Bed Hold Evictions 7/19/2017**

A resident was sent to the emergency room due to a “bloodshot” eye on 1/18/17. When a hospital nurse spoke to the facility about making arrangements for the resident’s return, the facility abruptly stated it would not accept the resident back. Further discussions with the facility proved fruitless. The facility was cited for failing to honor the resident’s mandatory bed hold and permit the resident to return. Citation # 050013213.
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