A 2020 New Year’s Resolution: Counter-Punching Bad Nursing Home Discharges

The recent NBC News documentary analyzing the rise of unsafe and inappropriate discharges has drawn new attention to the most ubiquitous problem in nursing homes: sending residents out too early or sending them out to places unable to meet their care needs. Bad discharges are now central to the nursing home business model: when residents’ lucrative Medicare coverage ends, usually around days 15-20 of their nursing home stay, caring for them becomes less profitable so they are subsequently forced to leave. The NBC News film, like prior national news stories, have exposed this model, and detailed its severely negative impact on residents. Bad discharges are the result of a system in which facilities are paid to take care of people without really ever caring about them.

The dawn of the new decade is a good time to review the four predominate types of bad discharges and to redouble the efforts being made to end them.

1. No Written Notice

A written notice prior to discharge has been a federal requirement in nursing homes for over forty years and, for that entire time, nursing homes have routinely violated the requirement. The provision of notice, with information regarding the resident’s right to appeal, is foundational to preventing inappropriate discharges. Consequently, facilities are loathe to comply. The last thing they want is residents sticking around after their lucrative Medicare coverage has ended.

Despite decades of massive noncompliance with the written notice requirement, there have been positive developments in the past few years. In 2016, new federal regulations required facilities to send a copy of every discharge notice to the long-term care Ombudsman program. In 2017, the California legislature made the failure to provide copies to the Ombudsman an automatic B citation. Since then, the state has issued scores of citations pursuant to the new law and compliance with notice requirements is improving.

[continued on page 3]
CANHR Welcomes New Staff Attorneys for 2020

CANHR is pleased to welcome Michael Stocker Dark, as a new staff attorney for Litigation and Legal Services Support. Michael brings many years of litigation experience to CANHR and will join our wonderful team of staff attorneys to provide advocacy support and technical assistance to legal services programs throughout California. CANHR also welcomes Dustin Roy Helmer, as the new staff attorney for our State Bar-funded Homeless Prevention project, to defend nursing home and RCFE residents from illegal evictions and transfers. Dustin has extensive experience in eviction defense having worked for the AIDS Legal Referral Service for the past several years. CANHR is fortunate to have found such talented and experienced attorneys, and we welcome Mike and Dustin.

Thank you for your support in 2019

We want to thank everyone who generously contributed money, time and/or resources to CANHR throughout 2019. A very special thank-you goes to those of you who volunteered to teach at our trainings and to write articles for our newsletters; thank you to those of you who wrote letters to legislators in support of our bills; and a special thank you to those who advocated on behalf of your family members and friends in long term care to make their lives better. We could not do our work without your support!

Leave a Legacy

Planned giving leaves a legacy to honor your memory or that of someone you love 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 take a number of forms, including gifts by will, gifts of life insurance or annuities or gifts via 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.

If You Want to Receive Alerts and the Advocate by email

Please make sure that CANHR has your correct e-mail address in order to send you our monthly News & Notes electronic newsletter, updates on legislation, Medi-Cal regulations and other policy issues throughout the year. Send your correct e-mail address to frontdesk@canhr.org.

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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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A 2020 New Year’s Resolution

In addition, residents who have not received written notices have begun filing class action lawsuits against the nursing home chains that failed them.

Sava Senior Care and Brookdale Senior Living are two chains that have been sued for violating the notice laws. Facilities increasingly know: failure to provide residents with their discharge notices is an invitation to legal problems.

2. Hospital Dumping

One common and exceptionally heartless way to evict unwanted nursing home residents is to send them to the hospital and refuse to take them back. The law prohibits this tactic but the lack of meaningful enforcement and the lure of profit has led to widespread disregard for the law. Hospital dumping and the state’s inaction to such illegal actions have gone on so long that residents and their advocates have been forced to try and step up. Private bar attorneys have filed lawsuits against offenders, including one terrible case where a resident was dumped for throwing plastic tableware and prevented from ever seeing her husband (who was a resident at the same nursing home) again because she died while fighting for her readmission.

In another case, a state appellate court made clear that nursing homes cannot evict residents via hospital dump. Fed up with the state’s do-nothing approach, three residents and CANHR filed a federal lawsuit in 2015 against the state to force it into action.

Last July, the Ninth Circuit Court of Appeals ruled that the state must ensure meaningful remedies for residents who are hospital dumped. Progress is being made, albeit slowly.

3. Unsafe Placements

The newest class of prominent wrongful discharges involves sending residents to places that are clearly ill-equipped to care for them. The most common unsafe placement is an unlicensed “room and board” home that provides a bed to sleep in and maybe meals but no nursing care, no assistance with activities of daily living, and no health management.

Countless residents with significant care needs are sent to these places and the outcomes are often terrible: bed sores, diabetic shock, and panicked 911 calls. Other residents are sent to more profoundly inappropriate places: homeless shelters, motels, and even Airbnb homes. For the lucky residents who are sent to actually licensed assisted living facilities, many are inexcusably sent to facilities they cannot afford and they have to move within a few months of their nursing home discharge.

For these egregiously unsafe discharges, state and local government agencies are reacting. DPH has issued a few A citations, along with 5-figure fines, in cases where residents were dumped onto sidewalks or at train stations. The state Attorney General prosecuted a nursing home administrator for sending residents to unsafe placements. In addition, local district attorney and city attorney offices have been pursuing unsafe placement cases. There is growing consensus that obviously unsafe discharges are on the rise and merit a strong enforcement response.

4. Premature Pushouts

By sheer volume, premature pushouts are by far the most pervasive type of inappropriate nursing home discharge. A premature pushout usually occurs when a resident’s Medicare coverage is ending and the resident is led to believe or expressly told that their residence is tied to the Medicare coverage - so they must leave when the coverage has ended. Nursing homes have a number of tactics to force residents out without having to “evict” them, from telling residents the facility doesn’t care for “long-term” residents to threatening to report their family members for “abandonment” if the resident stays past the Medicare coverage.

Facilities don’t want residents to know that ALL nursing homes provide long-term care (that is their job for heaven’s sake) and that most of them are certified to accept Medi-Cal reimbursement once Medicare coverage has run out.

[continued on next page]
A 2020 New Year’s Resolution

The premature pushout is so often successful because virtually all nursing home residents (who have a home to return to) want to return home as soon as possible. But returning home has to be carefully orchestrated to ensure residents continue to receive the care they need. Residents returning home will very likely need some form of home care, whether assistance with activities of daily living, chore provision, or case management. Many residents will require special medical equipment or home modifications to accommodate their needs, such as toileting, bathing, or ambulating by wheelchair. Setting up essential home care and modifying the home takes time, often weeks, but facilities are so impatient and badgering that residents will leave before the preparations have been completed.

The federal and state governments have been unwilling to undertake the kind of enforcement action that would end premature pushouts. As a result, the advocacy focus has been on resident education - ensuring that residents understand they should never agree to a discharge until they are ready and the discharge plan is safe and appropriate.

For more information about residents’ rights related to nursing home discharges, please see CANHR’s transfer/discharge fact sheet and What to Know Before You Go postcard. For individual case concerns, please contact CANHR at 800-474-1116.

Residents Learning and Asserting Their Rights

As long as nursing homes’ bottom line is tied to churning through sick and infirm residents within 15 - 20 days of their admission, there will be enormous pressure to evict residents, inappropriately and illegally. The federal and state governments have only nominally addressed the eviction crisis; consequently, residents and their attorney/advocates have been taking enforcement into their own hands, or dragging government into action. Residents knowing their rights is the most fundamental defense to bad discharges. Residents need to know they have the right to stay put until a safe and appropriate discharge plan is set and then steel themselves to rebuff the considerable pressure they will inevitably face. The arrival of the year 2020 is a good time to resolve to educate and support our residents and end the bad discharge epidemic.

Planned giving leaves a legacy to honor your memory and helps to ensure the future of CANHR.

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.
**CANHR Recommendations on Reforming Medi-Cal’s Nursing Home Payment System**

On July 31, 2020, California’s Medi-Cal payment system for freestanding skilled nursing facilities will sunset, giving the Legislature a golden opportunity to redesign the failed system to serve residents’ interests. Nursing homes currently receive about $5 billion per year from Medi-Cal through the system, more than enough to provide far better care and access to nursing homes than is currently the case.

CANHR recently published a report giving detailed recommendations on key reforms that are needed: [Bad Deal, Bad Care: It’s Time to Stop Dumping Money Into California’s Nursing Home Chains.](https://www.canhr.org/publications/bad-deal-bad-care-it-s-time-to-stop-dumping-money-into-californias-nursing-home-chains) The report is posted on CANHR’s website.

A few of its key recommendations are to ban self-dealing schemes that nursing homes use to siphon off funds intended for care and staffing; to set a safe staffing standard; to improve access to those on Medi-Cal by requiring nursing homes to give them equal access; and to rebalance Medi-Cal spending towards consumer-preferred, lower cost alternatives to nursing homes.

**CDPH Denies Licenses to Expanding Nursing Home Chain with a History of Abuse and Neglect**

On December 12, 2019, the California Department of Public Health (CDPH) sent letters to Crystal Solorzano denying her companies’ applications for licenses to operate three nursing homes: Holiday Manor Care Center in Winnetka, Mesa Glen Care Center in Glendora and Herman Health Care Center in San Jose. The licensure applications would have changed the names of each facility.

The CDPH denial letters cite poor compliance at other nursing homes owned, managed or operated by Solorzano in the last three years. Among other findings, they describe appalling conditions in eight facilities that were cited for “immediate jeopardy” level deficiencies during that time. For example, the letters state that the Griffith Park Healthcare Center in Glendale was cited for immediate jeopardy in 2019 after a resident alleged she was raped by a certified nursing assistant (CNA) during the middle of the night.

Another factor in the CDPH denials is the revocation of Solorzano’s nursing home administrator license, which the CDPH letters state it revoked on May 10, 2019 for “using fraudulent documents in applying for your nursing home administrator license.”

CDPH records indicate that entities owned by or affiliated with Solorzano are operating at least 20 California nursing homes, all acquired since 2015. Six of them are skilled nursing facilities with pending licensure applications before CDPH.

CANHR has urged CDPH to deny the pending applications due to the extraordinarily dangerous conditions it has documented in nursing homes owned, managed, operated by or affiliated with Solorzano.

**CCLD Launches New Inspection Tools for RCFEs**

In November 2019, the Department of Social Services’ Community Care Licensing Division (CCLD) launched the new inspection tools for Residential Care Facilities for the Elderly (RCFE) statewide. Thus, CCLD staff are no longer using the Key Indicator Tools (KITs) to conduct inspections at RCFEs. To develop the new RCFE statewide tools, CCLD revised the pilot RCFE tools and processes based on review by stakeholders, subject matter experts and California State University, Sacramento (CSUS), licensee surveys and LPA focus groups.

The standardized inspection tool covers a range of requirements, organized by domains, to assess the overall health of a facility. The new inspection tool contains approximately 500 requirements. About half of those make up the standard tool, whereas the rest are additional domain focused requirements that LPAs check based on identified deficiencies. CCLD has also developed a stand-alone pre-licensing tool. The Department’s Inspection Process Project [webpage](https://www.canhr.org/publications/ccld-launches-new-inspection-tools-for-rcfes) provides additional information about the new inspection process, tools and other pertinent information on the project.

**Dumped: NBC News Explores the Rising Number of Bad Nursing Home Discharges**

Problems for Seniors with Home Energy Improvement Loans

The Property Assessed Clean Energy Program (PACE) is a homeowner loan that offers up-front financing for energy-efficient home improvements, payable through a special property tax assessment. While sanctioned by local governments, these loans are largely administered by private lenders, and can be particularly dangerous loans for fixed income elders as they provide few consumer protections. These loans have given rise to an array of abuses that can lead to default and foreclosure.

- Too often, PACE loans are unsuitable for older adults and are marketed heavily in low-income neighborhoods. California contractors peddling PACE loans have faced multiple lawsuits in 2019 for defrauding homeowners who are elderly and who do not speak English as their first language. These trends lead to the destabilization of communities and a siphoning of home equity in areas where the home is often the primary asset for families. With every five foreclosures in a residential area, the neighbors’ home values decrease by five percent.

- Advocates are deeply concerned that the population of economically insecure, older homeowners are aggressively targeted by predators who convince them to take out PACE loans for home upgrades for substandard or unnecessary “energy-efficient” upgrades. In some instances, PACE loans have led to foreclosures. California currently has the largest population of older adults in the country, and three out of ten adults aged 62 and older do not have sufficient income to meet their basic needs, making these loans tempting to low income seniors, because little documentation as to income is needed.

- **Contracts:** When a homeowner signs a PACE loan, they will receive an assessment contract that sets forth the property owner’s obligation to repay the PACE financing over time, along with their regular property tax payments. The assessment contract clarifies the various terms of PACE financing. This assessment is levied each tax year and included on the building owner’s property tax bill. The payments are due at the same time as regular tax payments.

  Before moving forward with the loan, there are some key features you need to know about:

  - **Lien on your property:** Should you enter into this assessment contract, a lien in the amount of the total amount you are financing will be recorded against your property.
  
  - **Selling your home:** If you decide to sell your home, it is likely that the buyer or the buyer’s mortgage company will require you to pay off the assessment contract in full.
  
  - **Increase in taxes:** Your payments for this PACE assessment will be ADDED to your yearly property tax bill. You need to know how much your tax bill will increase.
  
  - **Increase in Mortgage:** If you pay your property taxes through an impound account, the PACE assessment will increase the amount your lender pays for property taxes. Your lender will in turn increase your monthly mortgage payment.
  
  - **Late fees & Penalties:** If your property tax bill is late, the entire amount of your increased property tax payments (the assessment contract plus your regular property tax bill) will be subject to a 10% late fee and a 1.5% per month interest penalty. If payment is not made, your home could be FORECLOSED ON.
  
  - **Read before signing:** Always request and receive a paper copy of the PACE assessment contract BEFORE signing anything.

Clearly more consumer protections are needed for those entering into these loans. While they can be tempting to consumers in need of cash, they can end up costing you your home. CANHR will be working hard over the next year to ensure better consumer protections are in place for consumers of these loans.
Rate and Cost Increases Effective 1/1/2020

There will be a 1.6% Cost of Living Increase (COLA) in 2020.

2020 Medicare Rate Increases: See Medicare website: www.medicare.gov

MEDICARE PART A
Hospital Deductible (Day 1-60): $1,408.00 (up from $1,364.00)

Coinsurance per day:
Day 61-90 $352.00 (up from $341.00)
Day 91-150: $704.00 (up from $682.00)
All cost for each day beyond 150 days.
Skilled Nursing Facility (SNF) Coinsurance: $176 per day for days 21-100 (up from $170.50)

MEDICARE PART B
Premium per month: $144.60 - $491.60 (based on income)
Deductible per year: $198.00 (up from $185.00)

2020 Medi-Cal Resources Rates:
Community Spouse Resource Allowance (CSRA): $128,640.00
Minimum Monthly Maintenance Needs Allowance (MMMNA): $3,216.00
Average Private Pay Rate (APPR): $9,337.00 (effective January 1, 2019 – new rate won’t be known until February or March 2020)

Supplemental Security Income (SSI) & State Supplemental Program Rates (SSP):

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<th>Single</th>
<th>Couple</th>
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<tr>
<td>Aged or Disabled: **</td>
<td>$943.72</td>
<td>$1,582.14</td>
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<tr>
<td>Blind: **</td>
<td>$1000.23</td>
<td>$1,751.00</td>
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<tr>
<td>One is Blind, One is Aged or Disabled **</td>
<td>$1,675.65</td>
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<td>** Rates noted are for independent living only.</td>
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SSI Non-Medical Board and Care Rate:

Total Payment: $1,206.37 (up from $1,194.37)
Amount Payable to RCFE for Basic Services: $1,069.37 (up from $1,058.37)
Personal and Incidental Needs Allowance: $137 (up from $136)

Aged and Disabled Federal Poverty Level Program: Effective 4/1/2019:

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<tr>
<td>Individual:</td>
<td>$1,271.00</td>
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</table>
| Couple:     | $1,720.00  | (up from $1,682.00)
Dear Advocate:

How can I file a complaint against my mother’s nursing home? She is often neglected because the nursing home does not have enough staff to care for her and other residents.

Distressed in Daly City

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Dear Distressed:

You can file a complaint with the California Department of Public Health (CDPH), the state agency that licenses and oversees nursing homes. Complaints can be filed by phone, in writing or online with its district offices that are located throughout the state.

By law, CDPH must begin an onsite investigation within ten working days of receiving your complaint, or within 24 hours if it involves a threat of imminent danger of death or serious bodily harm. Investigations must be completed within 60 days of receipt unless there are extenuating circumstances, in which case the deadline can be extended by up to 60 additional days. CDPH must notify you of its findings in writing and provide you an opportunity to appeal if you are dissatisfied with them. CA Health & Safety Code §1420.

For more information on how to file a complaint against a nursing home, see CANHR’s fact sheet on this subject: [http://canhr.org/factsheets/nh_fs/PDFs/FS_NH_Complaint.pdf](http://canhr.org/factsheets/nh_fs/PDFs/FS_NH_Complaint.pdf)

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Did You Know?

**Just Don’t Go!**

If you are admitted to a nursing home after a hospital stay, and the facility tells you to leave once your Medicare days run out – you have a right to stay.

It is a common practice among California nursing homes to accept residents for short-term rehabilitation (covered by Medicare) and then tell those residents that there are no “long-term care beds” or “custodial beds” once the Medicare days run out. These phrases are euphemisms for Medi-Cal, and this practice stems from the discrepancy between reimbursement rates for Medicare and Medi-Cal. The fact is, every nursing home in California must provide long term care, and if a nursing home is certified for Medi-Cal, all of their beds are Medi-Cal beds. Rampant Medi-Cal discrimination needs to stop.

If a nursing home proposes a discharge after your Medicare runs out and you still need care: 1) just don’t go and 2) tell the nursing home you do not agree with the discharge, and that they must serve a [30-day advance written notice](http://canhr.org/factsheets/nh_fs/PDFs/FS_NH_Complaint.pdf) and meet all other legal and procedural requirements to go forward. Check to see if they are [Medi-Cal certified](http://canhr.org/factsheets/nh_fs/PDFs/FS_NH_Complaint.pdf), and if so, you may apply to Medi-Cal to cover your stay.

So - just don’t go. Make it clear to the nursing home that you know what your rights are. State and federal laws are very protective against illegal discharges for nursing home residents, and the burden is on the facility to show they’ve met the requirements for a discharge.
Focus On Nursing Home Complaints

New DPH Campaign to Eliminate Complaint Backlog
Raising Many Questions and Concerns

On December 23, 2019, the California Department of Public Health (CDPH) issued an All Facility Letter to nursing homes and other health facilities (AFL 19-42) announcing an initiative to investigate and close all backlogged complaints and facility reported incidents by the end of 2021. The “Debt Free 2021 Campaign,” as CDPH is calling it, could help make California nursing homes more dangerous places to live, or less so, depending on how it is implemented.

Its subject is of tremendous importance for nursing home residents. As of midyear 2019, CDPH had a backlog of nearly 40,000 complaints and facility reported incidents, 17,309 of them involving nursing homes and other long-term care facilities. The average age of open complaints was 562 days. Residents often die or suffer serious harm before CDPH gets around to investigating complaints that they are being abused or neglected.

CDPH’s longstanding failure to investigate nursing home complaints in a timely manner is nothing less than scandalous. It’s been addressed and condemned in a scathing state audit, legislative oversight hearings, multiple lawsuits, media investigations, CMS sanctions, and more. Several years ago, the Legislature added hundreds of additional positions at CDPH and the Los Angeles County DPH to address the backlog after State and County auditors blasted their failures. And yet the backlog and delays in investigating complaints have continued to grow.

Without question, addressing the backlog is worthy of a campaign. What isn’t clear is whether the newly announced campaign will make things better or worse.

One red flag is that the campaign was planned without involvement by consumers or advocates. Another is that the All Facility Letter (AFL) announcing it is aimed at the facilities that are the subject of the complaints rather than the people who filed them.

There have been no communications to complainants about new procedures for handling their complaints.

Then there is the shocking news from CDPH that the complaint backlog dropped by about 15,000 cases before the campaign even started. According to CDPH, this was accomplished by “cleaning up” its complaint database. Aside from serious questions on the credibility of this assertion, one has to wonder how the managers responsible for such egregious mismanagement can be trusted to implement the new campaign in a manner that would serve the public’s interests.

CANHR’s top concern with the campaign is that CDPH District Offices and their investigators might get the message that backlogged complaints and facility reported incidents are to be swept under the rug. Nothing could be more unfair to residents who have been subjected to mistreatment. It would likely trigger yet another exodus of resident-oriented investigators at CDPH and empower the managers and investigators who are inclined to protect nursing home operators rather than residents.

The complaint backlog is far more than a symptom of CDPH’s dysfunction. It is a reflection of the extremely poor care in many California nursing homes, and a warning sign that abuse and neglect are growing. California nursing homes have nearly the highest rate of complaints in the nation, with complaints more than doubling since 2012.

What California nursing home residents really need from CDPH is a serious campaign to make nursing homes “Neglect and Abuse Free.” You can help CANHR monitor the CDPH campaign by letting us know about your experiences with complaints that are pending before the Department. We are also very interested in hearing from CDPH investigators, surveyors and managers about their experiences. Email CANHR at canhrmail@canhr.org.
Supplemental Security Income/State Supplementary Payment (SSI) is a program funded by the federal and state government that guarantees a minimum monthly income to people who are over 65, blind or disabled, and have limited income and resources. If an RCFE resident receives SSI, California law limits the monthly rate that the facility may charge the SSI recipient.

Under 2020 SSI payment rates, an RCFE resident with no income other than SSI will receive $1,206.37 per month, and must pay the RCFE $1,069.37 per month. This leaves the resident with $137 per month for personal needs ($1,206.37 - $1,069.37 = $137). If the RCFE resident has other income besides SSI, the RCFE may charge the resident an extra $20 per month, e.g., $1,089.37, but only if it is stated in the RCFE’s Admission Agreement.

### RCFEs and SSI: Fact vs. Fiction?

**Fiction**

- An RCFE can charge more than the SSI monthly rate to a resident who is an SSI recipient.
- An RCFE can charge more than the SSI monthly rate to a resident who was not on SSI when the resident entered the facility, but later became an SSI recipient.
- An RCFE can charge more than the SSI monthly rate to an SSI recipient whose family stops making voluntary contributions to the facility.
- An RCFE can evict a resident for nonpayment when the resident runs out of savings and becomes an SSI recipient, and reduces his or her payment to the SSI monthly rate.
- An RCFE can require a resident to waive his or her right to receive SSI benefits in its Admission Agreement.

**Fact**

- An RCFE may not charge a resident who receives SSI more than the SSI monthly rate. Section 87464(e) of Title 22 of the California Code of Regulations states that if a resident is receiving SSI, “then the basic services shall be provided and/or made available at the [SSI] basic rate at no additional charge to the resident.”
- When a resident becomes an SSI recipient after admission to an RCFE, the RCFE must continue to provide basic services to the resident at the SSI monthly rate. See California Code of Regulations, Title 22, Sections 87464(e) and 87101(b)(1). After the resident becomes an SSI recipient, the RCFE must lower its fees to the SSI monthly rate.
- Although an RCFE may not charge a resident receiving SSI more than the SSI monthly rate, California law allows a family member or friend to make a “voluntary contribution” to the RCFE. California Code of Regulations, Title 22, Section 87464(e)(1). However, the RCFE is required to provide necessary services to a resident receiving SSI at the SSI monthly rate, whether or not a family member or friend makes a voluntary contribution.
- An RCFE must provide basic services to a resident receiving SSI at the SSI monthly rate, no matter when the resident became an SSI recipient. Accordingly, an RCFE cannot evict a resident for nonpayment when, due to declining resources, the resident becomes an SSI recipient and reduces his or her payment to the SSI monthly rate. See California Code of Regulations, Title 22, Sections 87464(e) and 87224(a)(1).
- Admission Agreement language which requires a resident to waive his or her right to receive SSI is illegal and unenforceable. (See, e.g., California Health & Safety Code Sections 1569.883(b), 1569.884(e), 1569.888(a); California Welfare & Institutions Code Sections 11006.9, 12002, 12004, 12350; California Code of Regulations, Title 22, Sections 87464(e).)
Dramatic new changes in Medicare reimbursement for physical therapy may have dire consequences for the quality of rehabilitation care being delivered in skilled nursing facilities. Residents and their advocates should scrutinize the delivery of these services to ensure that resident needs, not reimbursement schemes, are shaping care plans.

Physical therapy plays a central role in the care delivered by skilled nursing facilities, ranging from assistance in re-learning dressing and toileting, to interventions intended to help residents regain mobility or speech after a stroke. Therapy can be delivered on an individual basis or in a group setting, defined for Part A of Medicare as “the treatment of 2-6 residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals.” (Centers for Medicare and Medicaid Services Concurrent and Group Therapy Fact Sheet, posted 8/30/19).

Under the old Medicare payment methodology known as Resource Utilization Groups Version IV, the medical condition and care needs of residents were used to assign them to one of 66 casemix groups that determined reimbursement rates. A vulnerability of this system was that facilities could exaggerate the care needs of residents—and increase reimbursement-- by providing more minutes of individual physical therapy.

Partly in an effort to address such systemic abuses, on 10/1/2019, CMS rolled out the new Patient Driven Payment Model (PDPM) to make reimbursement a more “value based” system. Under the new PDPM, facilities can conduct up to twenty five percent of physical therapy in group sessions. This new case-mix classification model will be used under the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) for classifying SNF patients in a Medicare-covered Part A stay.

From the outset, advocates raised alarms that these changes might result in residents being treated in a group setting simply because group services could be delivered more profitably than individual therapy. This may result in declining therapeutic benefits and slower recoveries, especially when residents placed in a group have highly varying levels of function.

CMS acknowledged these concerns in issuing the new rule, stating that it recognized that the change in therapy reimbursement under PDPM may incentivize providers to furnish more group therapy for financial, rather than clinical reasons, but asserted that the 25 percent combined cap would limit abuses. CMS also reminded providers that “PDPM does not change the care needs of SNF patients, which should be the primary driver of care decisions, including the type, duration, and intensity of skilled therapies, made on behalf of SNF patients.” (PDPM FAQ posted 8/30/10).

Notwithstanding this aspiration, many of the concerns about the effect of the new reimbursement system are already coming to pass. Even before the effective date of the new rules, nursing home chains laid off thousands of physical therapists — despite the fact that homes were treating the same residents, with the same care needs, that they had served before the change in reimbursement. (https://www.mcknights.com/news/pdpm-s-arrival-brings-reports-of-therapist layoffs-cuts/).

Moreover, anecdotal reports have emerged that some facilities are requiring therapists to ensure that twenty five percent of physical therapy be conducted in a group setting, effectively turning CMS’ cap into a requirement, regardless of the needs of residents. (https://www.nytimes.com/2019/11/29/health/new-old-age-medicare-physical-therapy.html).

Residents who find themselves placed in group therapy despite their care needs are not without recourse, however. In exchange for Medicare payments, certified nursing homes agree to help each resident attain or maintain the highest practicable level of physical, mental and psychosocial well-being. Care, treatment and therapies must be used to maintain and improve health to the extent possible, subject to the resident’s right to choose and refuse services. (http://www.canhr.org/factsheets/nh_fs/html/fs_CareStandards.html).

Residents and their advocates are encouraged to reach out to CANHR to report instances of inappropriate placement in group therapy in a skilled nursing setting.
**CANHR On The Move**

- **October 1**: Tony Chicotel gave a presentation on “Realities of Long Term Care” at Collabria Care in Napa.

- **October 3**: Prescott Cole participated in the U.S. Attorney General Northern Districts Elder Justice Task Force, San Francisco.

- **October 7**: Prescott Cole attended the Coalition for Elder and Disability Rights meeting with representatives from the California Attorney General’s office to talk about advocacy initiatives.

- **October 9**: Efrain Gutierrez gave a presentation on elder financial abuse scams at WLCAC/Alice Manor.

- **October 9**: Prescott Cole taught a class on Long-Term Care Medi-Cal at UC Hasting’s Law School Medical-Legal Partnership for Seniors.

- **October 10**: Tony Chicotel and Julie Pollock trained legal services and long term care Ombudsman staff about evictions from nursing homes and assisted living facilities. The training was hosted by Legal Assistance for Seniors in Oakland.

- **October 23**: Tony Chicotel was at the state long term care Ombudsman conference in Folsom, Tony presented on care standards in assisted living facilities.

- **October 23**: Tony Chicotel spoke to a group of physicians from UCSF about the legal and ethical concerns in locked door dementia care facilities at the Institute on Aging in San Francisco.

- **October 25**: Prescott Cole made a presentation on Restitution at the California District Attorneys Association / CANHR “Closing the Gap on Elder Abuse” training in Santa Barbara.

- **November 6**: CANHR Staff Attorney Jody Spiegel participated in the RCFE Advocates Quarterly Meeting with Community Care Licensing.

- **November 22 & November 23**: CANHR hosted its 23rd annual Elder Law Conference at the Monterey Plaza Hotel with a capacity crowd of private bar and legal services attorneys.

- **December 6**: Pauline Shatara presented to Stanford Hospital Social Workers about transfer and discharge rights.

- **December 8**: Amber Roberts attended a family council meeting at Kokoro Assisted Living in San Francisco.

- **December 17**: CANHR staff visited Chaparral House in Berkeley CA to visit with residents and sing holiday carols.

- **December 17**: Prescott Cole presented a webinar on financial abuse restitution for the California District Attorneys Association in Sacramento.

**Upcoming Events**

- **February 5**: Social Worker Webinar on Medi-Cal and Home and Community Based Services.
- **Legal Services Webinar Series** (*March: 4th, 11th, 18th, 25th*)
- **Spring Attorney Webinar Series** (*April: 8th, 15th, 22nd*)

**CANHR Senior Staff Attorney Prescott Cole (right)  Attorney General of California Xavier Becerra (left)**

**CANHR Staff and mascots Chloe and Fozzy at Chaparral House**
CANHR welcomes memorial and honorary gifts. This is a great way to honor a special person or a loved one, while helping those who are long term care residents. Recent gifts have been made in the names of the following persons:

**In Honor Of**

Mary Gerber  
Janette Tom  
Rosemarie E Dittrich  
Sabita Goswami  
Subrata Goswami  
All those that live in nursing homes  
Stephanie Levine  
Linda A Swanson, Esq.

**In Memory Of**

Sherry O. McIlwain  
Gloria McIlwain & Sharon Roberts-Cagle  
Dolores Sakaue  
Kim Sakaue  
LaVerne Schwacher  
Debra Vogler  
Bruno Wartman  
Patricia Moran  
Wayola B. Larson  
Mr. Paul Larson  
Syd Clarke  
Ardis Shubin  
My husband  
Gene Taylor  
Penny Deleray Taylor  
Danny and Esme Springer  
Alan Springer  
Lee Kraemer  
Geraldine Murphy  
Richard Miller  
Steven Higaki  
Gudrun Donaldson  
Gail Donaldson  
Sheila Lillian Krieger  
Robyn Krieger  
Catherine Gibbons Lynch R.N.  
Judith Lynch-Kenney  
Lee Kraemer  
Geraldine Murphy  
Mrs. Lucille Labat  
Louis Labat  
Dr. Roger Acey  
Jeannette Santage  
Donna Smith & Luther B. Denson  
Ruth Holland  
Sonia Isabel Noriega  
Cesar Noriega  
Mary W Ballantyne  
Robert Peterson  
Catherine Gibbons Lynch R.N.  
Judith Lynch-Kenney  
Lee Kraemer  
Geraldine Murphy  
Tim Millar  
Daniel Rossi  
Roy Johnson  
Elizabeth F Massie  
Geraldine Murphy  
Alice and Tom Riley  
Barbara B Riley  
Sita D. Findley  
Paul Findley  
Therese Serezlis  
Nola R Serezlis-Slattery  
Miriam Feld  
Michelle Feld  
Rich Schoner  
Ron Richards  
Josephine Luckjohn  
Georgia Riportella  
Ronald Randolph  
Penny Deleray Taylor
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### Calaveras County

**AVALON HEALTH CARE - SAN ANDREAS**

900 Mountain Ranch Road, San Andreas

**B $1000 Mandated Reporting Notification Transfer 9/9/2019**

The facility repeatedly failed to send the Long-Term Care Ombudsman “Notice of Proposed Transfer/Discharge” notifications when they made emergency transfers of residents to a general acute care hospital. This was also a violation of their own Notice Requirement policies and procedures. They potentially endangered residents by depriving them of the rights protections provided by the Ombudsman.

Citation # 030015344

**B $1000 Mandated Reporting Notification Transfer 9/9/2019**

The facility repeatedly failed to send the Long-Term Care Ombudsman “Notice of Proposed Transfer/Discharge” notifications when they made emergency transfers of residents to a general acute care hospital. This was also a violation of their own Notice Requirement policies and procedures. They potentially endangered residents by depriving them of the rights protections provided by the Ombudsman. An unnamed resident thus potentially did not receive prompt assistance from the Ombudsman in returning to the facility and was not protected from being inappropriately transferred or discharged.

Citation # 030015349

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### Marin County

**NORTHGATE POSTACUTE CARE**

40 Professional Center Pkwy, San Rafael

**B $1000 Patient Rights Transfer 09/09/2019**

On 6/4/19, 6/21/19 and 7/15/19, a resident was sent from the facility to the local Emergency Room without notification to the Ombudsman of the transfer. The facility was cited for failing to send a copy of the “Notice of Proposed Transfer/Discharge” to the Ombudsman, potentially resulting in the resident not receiving prompt assistance from the Ombudsman in returning to the facility and not being protected from being inappropriately transferred or discharged.

Citation # 030015345

**B $1000 Patient Rights Transfer 09/09/2019**

Prior to 8/7/19, the facility failed to send copies of notices of proposed transfers or discharges to the long-term care ombudsman for facility initiated transfers of residents to hospitals as required.

Citation # 030015346

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B $1000 Evictions Notification 08/07/2019
The facility failed to provide a copy of a resident’s discharge notice to the local long term care Ombudsman program, as required by law. The resident was discharged on 11/27/18.

Citation # 110015151

PINE RIDGE CARE CENTER
45 Professional Center Pkwy, San Rafael

B $2000 Physical Abuse 09/17/2019
On 10/13/18, a resident’s sister notified the facility that she received a call from the resident telling her that a staff person had slapped the resident. The resident had told her sister that she was hit in the face when she was making noise and wouldn’t be quiet. The resident suffered from an anxiety disorder, chronic pain and had awareness and memory breakdown. When the staff interviewed the resident, she could not recall who had slapped her. The facility notified law enforcement and the ombudsmen but failed to contact the State Department of Public Health (DPH) within 24 hours. The facility was cited for failing to report in a timely manner.

Citation # 110015299

PROFESSIONAL POST ACUTE CENTER
81 Professional Center Pkwy, San Rafael

B $2000 Decubiti (Bedsores) 10/10/2019
On 4/12/19, a resident was sent to an acute care hospital with a fractured hip and after the repair was readmitted back to the facility. The resident’s records indicated a decline in bed mobility, transfer, gait, balance, posture alignment, skin integrity and a risk for developing pressure sores. On 5/19/19, the resident was sent to the hospital with a UTI and a pressure ulcer on the left heel. The interviewer from the Department was told that when the CNAs were assigned to too many residents it was hard for them to reposition them every 2 hours or give them showers, so they’d passed them on to the next shift. The facility was cited for failing to implement policies for the prevention of pressure injuries.

Citation # 110015325

WINDSOR GARDENS REHABILITATION CENTER OF SALINAS
637 E Romie Ln, Salinas

B $2000 Medication 08/19/2019
The facility failed to ensure that anti-convulsive medications were available to six residents who were prone to seizures and convulsions. Over the course of several months, the facility would run out of medications because the pharmacy, located three to four hours away, would have issues receiving and delivering the orders. The facility was cited for not having certain medications available and for failing to reconcile when medications ran out.

Citation # 070015282

B $2000 Patient Care Supervision 09/03/2019
The facility staff failed to provide adequate supervision for a resident diagnosed with dementia who was left unattended on the patio in the sun. As a result, the resident suffered from heat stroke and second degree burns from prolonged sun exposure.

Citation # 070015357

B $2000 Decubiti (Bedsores) Neglect Patient Care 10/29/2019
On 7/29/19, a resident developed a facility acquired pressure ulcer on her tailbone. Subsequently, the pressure ulcer declined and became unstageable. The facility was cited for: failing to ensure that treatment was provided after the pressure ulcer was identified; failing to implement the wound doctor’s treatment recommendations for offloading and repositioning; and failing to apply ointment as ordered by the physician.

Citation # 070015481

WINDSOR SKYLINE CARE CENTER
348 Iris Dr, Salinas

B $2000 Careplan Neglect Notification Patient Care 11/06/2019
From 9/17/19-9/20/19, an 89 year old resident was hospitalized for “acute blood loss anemia” and received a blood transfusion, because the facility failed to provide appropriate treatment and care. The facility was cited for the following: nursing staff did not immediately communicate resident’s critically low laboratory test result to a physician; nursing staff failed to assess, monitor and report the resident’s change of condition; and nursing staff did not make a careplan for the resident’s anemia diagnosis.

Citation # 070015483
Sacramento County

Asbury Park Nursing and Rehabilitation Center
40 Professional Center Pkwy, San Rafael

B $2000 Mandated Reporting Physical Abuse Sexual Abuse Verbal Abuse 08/13/2019
From 4/10/18 to 4/13/18, after a federal recertification survey, the facility was cited for failing to report an allegation of abuse to the Department of Public Health within 24 hours, which prevented the Department from performing investigations on three different incidents. One was a resident who was yelled at by a CNA for attempting to get back into bed by herself. The resident slid to the floor and the CNA refused to help her because it was the end of her shift. The other two incidents involved two female residents who experienced sexual abuse from two male residents. One of the female residents was touched inappropriately by a male resident in the facility hallway, and the other was in her room while a male resident masturbated in front of her bed. The resident called the staff for help, but it took an hour for someone to respond. The facility’s failure to report these incidents increased the risk of abuse towards vulnerable residents in the facility.

Citation # 030015271

Manorcare Health Services (Citrus Heights)
7807 Uplands Way, Citrus Heights

B $2000 Mandated Reporting Mental Abuse Physical Abuse 07/11/2019
Facility staff failed to properly report an incident of alleged abuse when a resident stated that a nurse hit her and made her wait over 5 hours for assistance to the toilet. The staff person did not immediately notify facility administrators, which resulted in a 3 day delay in an investigation, and potentially put the resident at risk for additional abuse.

Citation # 030015194

Eskaton Care Center Fair Oaks
11300 Fair Oaks Boulevard, Fair Oaks

B $2000 Mandated Reporting Mental Abuse Physical Abuse 07/10/2019
A facility staff member allegedly witnessed another staff member being “rough” with a resident, but did not report the incident immediately to administrators, which resulted in a 5 day delay for an investigation of the incident. This delay possibly exposed the resident and others to potential abuse.

Citation # 030015217

Norwood Pines Alzheimers Center
500 Jessie Avenue, Sacramento

B $2000 Patient Rights Transfer 08/14/2019
On 3/12/19, a male resident was discharged back home because his insurance was no longer able to pay for the care he needed. The ombudsman was not notified of the discharge because the facility failed to create any policy requiring the notification to an ombudsman, which prevented the resident an advocate who could have educated him on what he could do in response to his insurance’s inability to pay.

Citation # 030015302

B $2000 Dignity Mental Abuse Patient Care Physical Abuse Physical Restraints 06/28/2019
On 1/24/18, while changing a resident who was soiled with urine and feces, three CNAs placed a pillowcase over her head to prevent her from spitting on them. The resident had Alzheimer’s Dementia and severe cognitive impairment. The facility was cited for failing to prevent staff abuse resulting in the escalation of the resident’s agitation and causing psychosocial harm to a cognitively vulnerable resident.

Citation # 030015196

B $2000 Mandated Reporting Physical Abuse Verbal Abuse 06/28/2019
On 3/16/18, a certified nursing assistant (CNA) witnessed another CNA hit the back of a resident’s head with an open hand and call the resident, who had advanced dementia, a derogatory expletive. The facility was cited because it did not report the alleged abuse to the Department of Public Health until three days later.

Citation # 030015201
On 2/25/19, a female resident, diagnosed with post traumatic stress and anxiety, was verbally abused and threatened by a male resident, diagnosed with personality and mood disorders with potential to disrupt others by provoking them with verbal aggression to lead to physical aggression. The female resident was told by her nurse to “ignore” the male resident’s comments, and another resident, who witnessed the incident, stated that the activity assistants were too scared to do anything. The facility did not report the abuse until three days after the incident had taken place, which violated their policy of having to report abuse within two hours of the incident. The facility failed to provide a safe environment to ensure that the female resident was free from verbal and mental abuse.

Citation # 030015351

A facility staff person failed to report an alleged incident of verbal abuse toward a resident from a staff member within the required 24 hour period to the proper authorities, as required by law.

Citation # 030015227

On 7/22/18, a resident was taken to the hospital after suffering a bruise and cut to her head when she fell out of a bed while a certified nursing assistant (CNA) was changing her clothes and cleaning her. The resident needed two-person assistance for this type of care, but only one CNA was helping her at the time of the fall. The facility was cited for failing to provide adequate supervision to the resident.

Citation # 030015300

The facility failed to order a therapeutic dose of Warfarin for a resident. This failure resulted in harm to the resident when she received a sub-therapeutic dosage of Warfarin. As a result, the resident suffered a stroke on 2/27/19. The facility nurse practitioner stated, “Actually, I didn’t see the resident. I signed the lab report, and I didn’t change the dose. We are responsible, I assumed and did not verify the lab report and failed to act. We take responsibility for the dosage when the order is placed.” This failure had a direct relationship to the health, safety and security of the resident.

Citation # 030015362

On 1/1/19, a resident who had dementia and difficulty swallowing was left unsupervised while eating lunch in the dining room. This failure resulted in the resident choking on a latex glove that was removed by paramedics who were unable to save the resident’s life. The ambulance company report stated: “Removed an entire medical glove from the patient’s mouth covered in blood.” The resident died the following day at the hospital due to asphyxiation caused by the blockage of his throat. A physician at the hospital reported the resident “was in full arrests when he got here. He was already gone. Several minutes of no oxygen is all it takes.” Contrary to the facility’s policy, there was no licensed nurse in the dining room at the time of this meal. Life support interventions were delayed while nursing staff moved the resident to his room. The failure to provide adequate supervision in accordance with the resident’s needs and care plan was a direct proximate cause of his death.

Citation # 220015419
Santa Clara County

**Courtyard Care Center**
340 Northlake Dr, San Jose

**B $2000 Patient Care 08/02/2019**
On 5/27/19 at 12:23 pm, STAT (meaning without delay; immediately) blood tests and urine analyses were ordered for a resident because he looked weak and complained of abdominal pain without any other symptoms. The resident had diagnoses of blocked urine drainage, kidney disorder, major depressive disorder and bleeding that occurs outside of the brain, which causes loss of consciousness for an unknown amount of time. According to the facility’s policy for STAT orders, the laboratory staff has two hours to perform the tests after they receive the order. The resident did not receive any tests until five and a half hours later at 6:48 pm. The facility was cited for its failure to follow its policy on STAT orders and not implementing a STAT blood test until five and a half hours later.

Citation # 070015248

**Cupertino Healthcare & Wellness Center**
22590 Voss Ave, Cupertino

**B $2000 Medication Neglect Notification Patient Care 09/25/2019**
On 7/17/19, a resident was transferred to the hospital for uncontrolled hip and back pain. During the five weeks that the resident was in the facility, it failed to: assess resident’s post-medication pain level; notify the physician when resident’s pain was severe for three consecutive days prior to hospitalization; follow the physician’s order regarding resident’s pain medication; and prepare weekly summaries to evaluate resident’s pain management. The facility was cited for failing to ensure that the resident’s pain control was monitored and reviewed effectively.

Citation # 070015410

**Invigorate Post Acute of Los Gatos**
16605 Lark Ave, Los Gatos

**B $2000 Dignity Patient Rights 09/25/2019**
A facility staff member did not treat residents with respect and dignity, pulling the covers off of one resident in the middle of the night, leaving the resident without blankets and pushed another resident’s shoulders back against the back of the toilet while assisting her to go to the bathroom.

Citation # 070015369

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Empress Care Center, LLC
1299 S Bascom Ave, San Jose

**B $2000 Patient Rights 07/29/2019**
On 7/9/19, a resident, diagnosed with multiple mental health disorders, muscle weakness and diseases of the heart, was refused readmittance to the facility after his hospitalization, dated 6/20/19. The facility claimed they were low-staffed, but a review of their “Census and Direct Care Service Hours per Patient Day,” a method used to calculate how much time was spent caring for a resident, indicated that the facility met the state requirement of overall direct resident care hours meaning that the facility was functioning without any sign of staff shortage. Because of this, the facility was cited for failing to readmit the resident after his hospitalization.

Citation # 070015245

Milpitas Care Center
120 Corning Ave, Milpitas

**B $2000 Dietary Services Staffing 07/02/2019**
The facility failed to hire a full-time employee who met the educational requirements for the position of dietary services supervisor. This failure resulted in a lack of overall direction in the kitchen to oversee the production of the food services in the kitchen to residents. The facility did not have a dietary supervisor since the year prior when the previous supervisor left in July of 2018. A CNA was acting part time as a nurse in the facility and part time training in the kitchen. This failure had the potential to put residents at risk.

Citation # 070015191

Sunnyvale Post-Acute Center
1291 S Bernardo Ave, Sunnyvale

**B $2000 Administration 08/15/2019**
On 7/5/19, a resident, diagnosed with type two diabetes, unspecified psychosis and other behavioral issues, was denied readmittance to the facility because of his behavior. The facility was cited for its failure to readmit a resident after a hospitalization.

Citation # 070015305
Santa Cruz County

Driftwood Healthcare Center - Santa Cruz
675 24th Ave, Santa Cruz

B $2000 Elopement Supervision 09/03/2019
On 8/10/19, a wheelchair-bound resident with cognitive impairments and other serious health problems eloped from the facility. He was not found until six days later by a police department in a distant city about 80 miles away from the facility. The resident had a history of elopement and had left the facility several times during the prior two weeks. An off-duty employee who lived nearby alerted the facility on 8/10/19 about his elopement but the assigned nursing assistant did not go and look for him and did not tell anyone he was out on the street. The facility was cited for failing to provide adequate supervision.

Citation # 070015331

Solano County

Windsor Vallejo Nursing & Rehabilitation Center
2200 Tuolumne St, Vallejo

B $2000 Evictions Notification Transfer 10/04/2019
On 4/2/19, the facility discharged a resident to his home. The facility failed to provide a copy of the “Notice of Discharge” to the State Long-Term Care Ombudsman, and was cited for its conduct.

Citation # 110015274

Sonoma County

Friends House
684 Benicia Drive, Santa Rosa

B $2000 Mandated Reporting Notification Transfer 9/20/2019
The facility failed to notify the Long Term Care Ombudsman when a resident was transferred to the acute care hospital following a fall. This failure had the potential for the resident to be discharged or transferred inappropriately.

Citation # 110015343
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Kern County

**Kingston Healthcare Center, LLC**
329 Real Rd, Bakersfield

**A $20000 Hydration Patient Care 11/13/2019**
The facility failed to develop and update a care plan for a 72 year old resident to address his fluid intake and nutritional needs. After the resident repeatedly refused food and water, facility staff did not provide proper interventions, resulting in the resident requiring transfer to an acute hospital for treatment of dehydration.

Citation # 120015458

**A $20000 Hydration 11/13/2019**
After an unannounced visit on 9/19/19, the facility was cited for its failure to contact a resident’s physician and registered dietitian (RD) after observing that the resident was not ingesting enough fluids as calculated by the RD. The resident, who had been diagnosed with chronic leg wounds, peripheral artery disease and chronic kidney disease, was sent to an acute hospital after not drinking the necessary amount of liquid per day for the prior week.

Citation # 120015447

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Los Angeles County

**Beverly West Healthcare**
1020 S Fairfax Ave, Los Angeles

**B $2000 Careplan Neglect 11/07/2019**
On 8/26/19, a female resident who required careful pain management due to neuralgia was observed banging on the side rails of her bed and screaming in pain. The staff mistakenly thought the resident had received medication to treat her pain when she had not. The resident’s care plan for pain management was defective, as it did not specify how often staff should assess the resident’s pain, and what should be done when pain levels were severe. The facility was cited for failing to provide pain management as ordered by a physician.

Citation # 920015515

**The Rehabilitation Centre of Beverly Hills**
580 S San Vicente Blvd, Los Angeles

**B $2000 Patient Care 6/13/2019**
On 6/29/16, the facility failed to ensure that a resident, diagnosed with severe blood flow to his legs, was seen by a vascular surgeon who would have been able to give him expert recommendations on treatment. Due to this failure, the resident was transferred via 911 due to increased congestion and change of level of consciousness.

Citation # 920015160
A $20000 Elopement Fall Injury 11/14/2019
On August 8th, 2019, a 66 year old resident of California Post-Acute Care in Paramount, California climbed a ladder while attempting to get over a barbed-wire topped wall. He then got stuck on the wire and fell from a height of 8 to 10 feet. This resulted in a total of seven bone fractures and a deep laceration in his right armpit. The injuries required surgeries for the breaks (including the application of a surgical nail) and staples for the laceration.

The resident was a known risk for elopement and therefore wore a WanderGuard bracelet, which was meant to alert the staff if he attempted to walk through an exit. However, the staff had disabled the alarm at the laundry exit door for six months for their convenience. The facility was therefore cited for its failure to follow its own policy prohibiting the deactivation of door alarms for the convenience of staff and visitors.

Citation # 910015535

B $2000 Careplan Neglect Patient Care 5/9/2019
An 89 year old resident on a ventilator was found unresponsive on 5/23/17 and was pronounced dead minutes later. The resident’s chest was not rising and falling, indicating the ventilator was not working. The resident’s care plan called for visually checking the resident and his ventilator alarm in case of malfunction every two hours, but documentation of these checks was missing between 5/21/17 and 5/22/17. There was also no documentation that the ventilator filter had been cleaned regularly and replaced as needed. The facility was cited for: 1) failing to ensure the ventilator was working properly; 2) failing to follow the ventilator manufacturer’s guidance regarding cleaning and replacing the filter, and 3)failing to ensure the resident and his ventilator alarm were checked every two hours.

Citation # 920015056

B $2000 Physical Abuse 10/24/2019
On 5/25/19, a 66 year old resident allegedly waved a wire hanger in a threatening manner toward staff members. The resident was later hospitalized and told emergency room staff that a nursing home employee had punched him in the face. The resident was noted to have bruising and swelling near his eye. Despite knowing about the possible battery, the nursing home did not investigate. Hallway video surveillance showed two staff members entering the resident’s room on 5/25/19. Shortly after, a third staff person who remained in the hallway suddenly reacted to something she saw in the room and began laughing. The facility was cited for failing to perform a thorough investigation of possible resident abuse as directed by its own policy.

Citation # 910015476

B $1500 Mandated Reporting Physical Abuse Verbal Abuse 9/20/2019
The facility failed to report an incident of verbal and physical abuse to the Department of Public Health and Ombudsman. A resident was observed approaching another resident’s wheelchair, kicking at the left side of the chair, grabbing the resident’s left wrist and trying to hit the resident. The resident who was being attacked cursed at the attacker. A nurse separated the two and put them at opposite sides of the activity room. The nurse did not believe the altercation was considered abuse, so he did not report the incident. This failure reflected the potential for reoccurrence of abuse.

Citation # 910015405
B $2000 Evictions Notification 03/21/2019
On 12/19/18 a facility unsafely transferred a resident with diabetes, partial paralysis and general weakness to an independent living facility that lacked the staff to assist the resident with blood sugar checks and other assistance that he required. Shortly after his transfer, the resident was hospitalized. A myriad of problems with the discharge were identified and cited, including discharge to an inappropriate level of care, incomplete and untimely discharge notice, failure to provide a copy of the discharge notice to the long term care Ombudsman and insufficient discharge planning.

Citation # 950014903

Fountain View Subacute And Nursing Center
5310 Fountain Ave, Los Angeles

B $2000 Neglect Patient Care 4/22/2019
A 6/7/17 complaint investigation confirmed the facility was leaving residents soiled for extended periods. Multiple residents complained that the facility was understaffed, and that they were forced to wait hours to be cleaned after soiling themselves. One resident reported feeling anger and frustration and cried from waiting so long. Another resident was observed lying on a urine-soaked sheet for hours. The facility was cited for failure to provide necessary care and failing to provide for the comfort and dignity of its residents.

Citation # 920014970

La Brea Rehabilitation Center
505 N La Brea Ave, Los Angeles

B $2000 Careplan Fall Injury Mandated Reporting Notification Patient Records 12/04/2019
On 9/3/2019, a resident known to have muscle weakness, major depressive disorder, and pain was crossing a street by himself and was struck by a semi-truck. The resident was taken to an acute hospital due to significant injuries. The facility did not inform the California Department of Public Health, and the investigation was delayed. The resident suffered a scalp bruise and a six-inch tear on the central buttocks. The resident required surgeries to repair his anus.

Citation # 920015542

Lawndale Healthcare & Wellness Centre, LLC
1400 W Glenoaks Blvd, Glendale

AA $100000 Fall Neglect Staffing 10/23/2019
An 82 year old resident with partial paralysis, muscle weakness, and cognitive impairments fell from her bed on 7/17/19 and sustained significant injuries that put her in a persistent vegetative state. The resident had a high risk for falls and was supposed to receive special care to prevent her from rolling out of her bed. Nonetheless, her bed was not lowered on 7/17/19 and she fell due to a “slippery mattress” while receiving care. The resident was being cared for by one nursing assistant despite requiring two-person assists. After the fall, the resident was vomiting and bleeding and a nurse practitioner ordered she be sent to the acute hospital. The nurse on duty did not believe the situation was an emergency, however, and called a non-emergency transportation service. The resident was therefore not sent to the hospital until three hours after her fall. The resident suffered skull and cervical fractures, severe cerebral hemorrhaging and required neck surgery, a tracheostomy, and a ventilator for breathing. Eventually, the resident’s life support treatment was terminated and she died on 9/5/19. The facility was cited for numerous failures, including failing to follow the resident’s care plan, failure to maintain adequate staffing, and failure to attend to the resident after her fall.

Citation # 910015473

Olympia Convalescent Hospital
1100 S Alvarado St, Los Angeles

A $20000 Careplan Elopement Injury Patient Care Supervision 10/04/2019
On the morning of 10/4/18, a resident with cognitive impairment and a high risk for wandering was exhibiting “wandering behavior,” telling the staff she needed to go home. The resident subsequently rolled herself in her wheelchair from the nurse’s station to the lobby, opened the facility’s glass doors, rolled down a ramp outside the facility, and hit her head on a wall. She sustained a fracture around her eye, a knee fracture, abrasions on her forehead and a bleeding eyelid and nose. She was transferred to the acute hospital and required a cast on her left leg from mid-thigh to the ankle. The staff did not have an explanation why the resident was able to open the facility front door while in a wheelchair and elope without being noticed by staff.

Citation # 920015428
Lomita Post-Acute Care Center
1955 Lomita Blvd, Lomita

B $1500 Verbal Abuse 10/24/2019
On 9/14/19, a resident verbally threatened his roommate by saying he would rip apart and kill him. The facility moved the resident to a different room, but his former roommate felt threatened, feared for his safety, and was having trouble sleeping. The incident was not reported to law enforcement. The Administrator stated he did not report the incident that took place because the problem was resolved. The facility was cited for failing to report the abuse to the proper authorities as required by law. Citation # 910015480

Royal Oaks Care Center
3565 E Imperial Hwy, Lynwood

B $2000 Careplan Infection Patient Care 10/09/2019
The facility was cited for failure to implement proper infection control for six out of six sampled residents. For example, a resident’s urinary drainage bag was observed touching the floor. Staff members failed to wear gloves and protective gowns when providing care for residents with known infectious conditions, who were on “contact isolation.” Staff members were also observed failing to wash their hands before entering a contact isolation room. Citation # 910015445

Western Convalescent Hospital
2190 W Adams Blvd, Los Angeles

A $20000 Careplan Neglect 11/08/2019
On 8/16/19, the facility was cited for its failure to implement its own policy, a physician order, a resident care plan and standards of practice for the monitoring of pacemakers. As a result, four residents did not receive their daily pulse assessment. After one female resident was assessed she was determined to be unresponsive and pronounced dead on 5/15/19 at 12:38 am after showing signs of a heart attack. Citation # 910015525

Penn Mar Therapeutic Center
3938 Cogswell Rd, El Monte

B $2000 Careplan Injury Neglect Patient Care Patient Rights Physical Abuse Physical Restraints Retaliation Against Resident Supervision 8/17/2018
On 2/21/18, an unannounced visit was conducted at the facility to investigate a complaint about staff physically abusing residents. When a resident refused to take a shower, five male CNAs used unnecessary force, restraint and seclusion to keep the resident in a locked room until he agreed to take a shower. The resident complained about pain throughout his body due to the struggle and facial bruising. The resident’s medical records stated that he is diagnosed with schizoaffective disorder. The facility was cited for failure to ensure that the CNAs respected the resident, failure to implement its policy on resident’s rights, failure to refrain from holding down the resident’s arms and legs and failure to ensure the resident was free from abuse. Citation # 950014344

Windsor Care Center of Cheviot Hills
3533 Motor Ave, Los Angeles

A $20000 Patient Care 10/30/2019
On 6/25/19, a resident who was unable to come to standing position independently, required hands-on assistance to move from place to place and was a high risk for falling slid out his wheelchair. The resident’s physician was notified, and an order was made for the resident to be monitored for 72 hours after the fall per the physician’s order, including vital signs and neurological signs. The next day the resident was found nonresponsive in his bed. The resident was declared dead by the paramedics who responded to the 911 call for assistance. A review of the resident’s clinical record indicated that there was no documented evidence to indicate the resident was being monitored for 72 hours per the physician’s order. The facility was cited for failing to monitor the resident properly. The death certificate indicated the cause of death was cardiopulmonary arrest with underlying causes, including sepsis and a urinary tract infection. Citation # 920015500
A $20000 Evictions Neglect Notification Transfer 06/14/2019
An 81 year old resident with diabetes, a Stage 2 pressure sore, and a colostomy bag was discharged to a board and care home that was unable to meet her needs on 11/20/18. A facility nurse claimed the resident’s physician ordered the resident be discharged when stable. The resident’s pressure sore “reopened” the day before her discharge but that did not change the facility’s discharge plan. Twenty-nine days after her discharge, the resident was found unconscious at the board and care home with low blood sugar and a large Stage 4 pressure sore that required extensive surgical treatment. Several facility staff members stated the discharge was inappropriate because the resident needed more care than the board and care home could provide. The resident’s physician stated the resident had been discharged without his knowledge or consent. The facility was cited for failing to: 1) properly discharge the resident; 2) notify the resident’s family member and power of attorney agent about the discharge; and 3) obtain a physician’s order to discharge the resident to a lower level of care. Citation # 910015162

B $2000 Bed Hold Evictions 07/03/2019
A 49 year old resident was refused readmission, despite his bed hold, after being hospitalized on 5/22/19. The resident was cleared for readmission by his treating doctor on 5/23/19. The facility initially refused to readmit the resident but eventually did on 5/24/19 after being pressured by the hospital case manager. The facility was cited for delaying the resident’s readmission and failing to hold his bed.
Citation # 910015182

B $2000 Evictions Transfer 09/20/2019
A 71 year old female resident was discharged to a transitional living facility with no nursing staff in June 2019. The resident was discharged despite having a significant wound with bone exposed on her left leg. The discharge occurred without the resident’s physician’s authorization. The facility was cited for an inappropriate discharge for moving the resident before she was medically stable and without her physician’s approval.
Citation # 910015402

Orange County

B $2000 Evictions Notification Transfer 06/28/2019
A 65 year old resident with dementia and bipolar disorder and who required physical assistance with transfers for sitting and standing was discharged on 3/30/19. The resident had a responsible party who had signed the resident into the facility and made decisions on his behalf. The responsible party had declined multiple proposed discharges to unlicensed room and board homes. On 3/25/19, the facility allegedly removed the responsible party’s contact information from the resident’s record, claimed the resident was “self-responsible” (despite evidence of continued cognitive incapacity), and discharged him to a family member’s home without notifying the responsible party. A couple of months later, the resident had to be hospitalized on a mental health hold after an altercation that caused injuries. The facility was cited for discharging the resident without adequate preparation and assistance or coordinating the discharge with the responsible party.
Citation # 910015209

A $15000 Fall 11/21/2019
On 10/2/19, a resident who was not capable of holding himself upright was seated in a shower chair having his hair cut by two CNAs. One of the CNAs left the room and the other, noticing a kink in the resident’s indwelling urinary drainage catheter tubing, moved to the side of the resident’s chair to adjust the tubing. During this time, the resident lost his balance and fell forward onto the floor and landed on his face. As a result of the fall, the resident sustained blunt force facial trauma, including a dislocated jaw and fractured nose. The resident was sent to the acute care hospital for oral surgery and sutures to his nose. The facility was cited for failing to provide the necessary care and services to ensure adequate assistance and supervision.
Citation # 060015546
B $2000 Decubiti (Bedsores)  10/14/2019
In September of 2019, the Department conducted an extended recertification survey, which resulted in the issuance of a Class B Citation. The facility was fined for failing to prevent pressure ulcers from developing on two residents who had been admitted into the facility without bedsores. One resident had developed a right heel Stage 3 pressure ulcer (discovered on 9/4/19) then a second Stage 3 two days later. The other resident had developed an unstageable pressure ulcer (a full-thickness tissue loss when the actual depth of the ulcer was observed). The citation noted that as to this resident the facility failed to carry out a physician’s order to not let the resident sit in a wheelchair for more than an hour at a time.

Citation # 060015446

Newport Nursing and Rehabilitation Center
1555 Superior Ave, Newport Beach

B $2000 Medication Patient Care  10/07/2019
On 6/7/18, a resident was admitted to the facility from an acute hospital with physician orders for a single dose of two 50 mg tablets of prednisone. Instead of one dose, the facility gave the resident 100 mg of prednisone on 6/8/18, and again from 6/10 to 7/5/18, for a total of 26 doses of prednisone 100 mg daily. From 7/5 to 7/7, the resident was hospitalized secondary to increased weakness and possible sepsis, and the physician was concerned that the high doses of prednisone were masking infectious symptoms. The resident was transferred back to the acute hospital from 7/8-8/4/18 with a diagnosis of necrotizing pneumonia based on sepsis. The facility was cited for failing to ensure that the resident was free from excessive dose and duration of steroid medication contributing to resident’s already compromised immune system and weakened body’s defenses against infectious organisms.

Citation # 060015429

Park Anaheim Healthcare Center
3435 W Ball Rd, Anaheim

B $2000 Transfer  09/09/2019
On 7/26/19, the Department interviewed a resident’s family which complained that their family member, who had been a resident at the facility for over five years, had been sent into the acute hospital three months earlier and wasn’t being allowed back. The resident’s family member was told the facility did not have a bed available due to the resident having an infection that required a private isolation room. A review of the facility’s admissions indicated that eight residents had been admitted into the facility’s subacute unit since 5/29/19. The facility was cited for failing to permit the resident’s return.

Citation # 060015372
Riverside County

Blythe Post Acute LLC
285 W Chanslor Way, Blythe

**B $2000 Mandated Reporting  Physical Abuse 07/03/2019**
The facility failed to properly report an allegation of sexual abuse after a visitor saw a male resident with his hand up the shirt of a female resident in the dining room. The facility did not report the incident to the Department of Public Health, as required by law, delaying possible corrective action, and potentially putting other residents at risk of abuse.

Citation # 250015009

Corona Post Acute Center
2600 S Main St, Corona

**B $2000 Mandated Reporting  Patient Rights 11/01/2019**
An alleged incident of sexual abuse was not properly reported to the California Department of Public Health as required by law, after a resident stated that a facility staff member massaged her back and kissed her on her cheek.

Citation # 250015438

Extended Care Hospital of Riverside
8171 Magnolia Ave, Riverside

**B $2000 Mandated Reporting  Mental Abuse 10/16/2019**
A CNA convinced a resident with impaired brain function to write a check for $2,400 so the CNA could pay for surgery. The CNA then told the resident that she could not tell anyone about the check and cashed the check. The resident reported feeling unsafe at the facility. The facility failed to ensure the resident was free from misappropriation of property.

Citation # 250015413

Manorcare Health Services-Palm Desert
74350 Country Club Dr, Palm Desert

**B $2000 Injury  Physical Abuse  Sexual Abuse 09/23/2019**
On 3/15/19 a resident diagnosed with cognitive impairment, muscle weakness, confusion and difficulty in walking and moving was sexually and physically assaulted by a facility-contracted sitter. Another resident witnessed the abuse and described that the female resident was screaming and trying to push the sitter’s hands away from underneath her sheets. When the female resident tried to get away, he would throw her legs back on the bed so hard that the witness thought she would fall off the bed. The facility failed to ensure that the female resident was safe from physical and sexual abuse.

Citation # 250015309

Miravilla Care Center
9246 Avenida Miravilla, Cherry Valley

**B $2000 Administration  6/21/2019**
A resident reported to an RN that she didn’t get all her medications that morning. She felt neglected, and she was in pain. The resident also stated her blood sugar was not checked before her lunch tray was served. During a complaint investigation conducted on April 12, 2019, it was determined that the facility failed to implement its plan of correction and provide adequate RN supervision for an LVN with a probationary license. This failure resulted in the lack of oversight to the LVN, delayed administration of medications by the LVN for five residents. It was determined that the facility administration failed to ensure the LVN, whose license was placed on probationary status, received adequate on-site supervision from a registered nurse.

Citation # 250015170

Ramona Rehabilitation And Post Acute Care Center
9246 Avenida Miravilla, Cherry Valley

**B $2000 Patient Rights  Transfer 10/2/2019**
On 4/17/19, the facility failed to provide a written notice to a resident on her transfer and discharge rights when she was transferred to a hospital and failed to send a copy of the transfer notice to the local long-term care ombudsman as required.

Citation # 250015380
Murrieta Health and Rehabilitation Center
24100 Monroe Ave, Murrieta

A $15000 Careplan Deterioration Neglect 09/25/2019
A 65 year old resident admitted with a broken leg and hip replacement was noted to have an arm swelling on 3/21/18. A subsequent ultrasound identified extensive blood clots in the arm, but no specific nursing assessments were implemented, such as measuring the arm to gauge the swelling. On 3/21/18, the resident’s white blood cell count began to show possible infection, but no nursing interventions were undertaken. On 3/31/18, the resident began having respiratory problems, prompting some treatment, but many common nursing interventions were not documented. The resident was hospitalized, at the urging of his family, on 4/2/18 for shortness of breath. The resident was diagnosed with pneumonia and septic shock, suffered cardiac arrest, and died on 4/3. The facility was cited for failing to: 1) assess and note a change of condition 2) develop and implement proper nursing interventions, and 3) request assistance from the resident’s physician when his condition changed and failed to improve with interventions. Citation # 250015378

Santa Barbara County

The Californian
2225 De La Vina St, Santa Barbara

AA $90250 Elopement Fall Injury Neglect Supervision 09/19/2019
On 2/10/19, a resident wandered into a dark facility patio without outdoor lighting after 11:30 pm, fell from his wheelchair onto a concrete floor, sustained blunt force trauma to his face and head, and died. EMS personnel were summoned and pronounced him dead at about 11:57 p.m. The resident had memory problems, was confused and disoriented, was at risk for falls and injuries, had wandered at the facility and had twice attempted to elope from the facility that same month. Just prior to his death on 2/10/19, the staff observed him wandering in a confused manner between 11 pm and 11:30 pm. Notwithstanding these facts, the facility failed to assess the resident’s risk for elopement, failed to establish goals and interventions related to wandering and elopement and failed to provide adequate supervision and assistance. These violations were a direct proximate cause of his death. Citation # 050015132
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