At the outset of the COVID pandemic, government authorities shut down all visitation between long term care residents and their families. The ban on visitation was meant to create a “moat” around facilities, through which COVID could not pass. The problem has been that scores of facility staff members pass through each moat every day, bringing the virus with them. Consequently, well more than half of all nursing homes and hundreds of assisted living facilities have had COVID-19 outbreaks and thousands of residents have died. The visitation ban, which failed to prevent COVID outbreaks in long term care facilities, has had profound deleterious effects on residents by causing severe depression, neglect, and poor health. We will never know exactly how much resident harm and suffering was caused by the immense loss of family connections and care oversight that visitation enables, but it is sure to be equivalent to, if not greater than, the harm and suffering caused by COVID itself.

#VisitationSavesLives: The Ongoing Fight to Restore Visitation in Long Term Care Facilities

“Our hearts are broken and we fear that the next time we are able to touch my mother will be in a coffin.” - family member of California nursing home resident

COVID-19 has killed more than 5,000 residents in California’s long term care facilities, 37% of all the state’s reported fatalities. The fallout from COVID has been the greatest tragedy in the history of institutionalized long term care. The virus has harmed residents through more than just sickness and the horrific loss of life; there has also been widespread despondency from isolation due to federal, state, and local bans on resident visitation. The visitation bans adopted by public health regulators have compounded, not alleviated, the misery in long term care facilities, cutting residents off from critical care that sustains them and from the family interactions central to their life’s meaning. In the failed effort to save the lives of long term care residents from COVID-19, our public health officials have deprived them of the most important measure to keep them alive: their families.

Tragedy by Choice

At the outset of the COVID pandemic, government authorities shut down all visitation between long term care residents and their families. The ban on visitation was meant to create a “moat” around facilities, through which COVID could not pass. The problem has been that scores of facility staff members pass through each moat every day, bringing the virus with them. Consequently, well more than half of all nursing homes and hundreds of assisted living facilities have had COVID-19 outbreaks and thousands of residents have died.

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CANHR News

COVID and CANHR Advocacy

CANHR staff has been working remotely since mid-March and trying to keep up with all of the requests for services. Our office is still open for calls at (415) 974-5171 and our hotline at (800) 474-1116. We also answer numerous inquiries via email at webform@canhr.org. CANHR’s special COVID-19 News and Resources site can be found at https://canhrnews.com. Meanwhile, stay safe, stay well and let us know if we can help.

Donate to CANHR When You Shop on Amazon

It’s not just for the holidays! Any time of the year Amazon will donate 0.5% of the price of your eligible Amazon purchases to California Advocates For Nursing Home Reform whenever you shop on AmazonSmile. AmazonSmile is the same Amazon you know - same products, prices, and service. Support CANHR by shopping at smile.amazon.com. On your first visit to AmazonSmile you will need to select, “California Advocates for Nursing Home Reform” as the charitable organization to receive donations from eligible purchases before you begin shopping. Amazon will remember your selection, and then every eligible purchase you make at smile.amazon.com will result in a donation.

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.

This quarter, CANHR would like to thank the Dorothy L. Banker Trust and the Powell Special Needs Trust for their generous bequests.

Receiving Alerts and the Advocate by email

Because of the postal delays and problems with handling mail and because most of us are working remotely, CANHR is emailing copies of the Advocate and other publications rather than sending hard copies via USPS. 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, 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.

CANHR
650 Harrison Street, 2nd Floor
San Francisco, CA 94107
Tel: (415) 974-5171
Fax: (415) 777-2904

Consumer Hotline:
(800) 474-1116

www.canhr.org
canhrmail@canhr.org
#VisitationSavesLives: Restoring Visitation Urgently Needed

[continued from page 1]

While the visitation ban made sense as a radical emergency measure to protect residents at a time of great uncertainty, it does not work as a longstanding safety policy because:

1. Visitors not only provide psychological benefits of companionship to residents but significant health benefits as well. Family members and friends provide critical care to residents - such as helping them to eat and drink, assisting them with bathing and toileting, and changing their position in bed to alleviate pressure on their skin.

2. Many residents who benefited from the loving care that visitors provide are suffering terrible physical problems. We have heard from countless families about significant weight loss, bedsores, and other serious signs of neglect during the pandemic.

3. A complete ban on visitation does not reflect what we now know about the transmission of COVID-19: socially distanced meetings among people wearing masks in outdoor or large, well-ventilated indoor spaces, are safe. People around the country are reconnecting with their loved ones in this way. Long term care facility residents should not be left out.

4. Strict screening, PPE, and other virus mitigation measures have been adopted for facility staff members. These measures can be adapted to visitors, who often provide as much benefit to residents as do staff members.

**Time for a New Commitment to Visitation**

On September 17, the federal Centers for Medicare & Medicaid Services issued a memo to the states, restoring visitation in nursing homes. CMS is requiring facilities to permit visitation whenever a facility has had no new COVID outbreaks for 14 days and the community positivity rate is less than 10%. Facilities required to permit visitation are encouraged to have outdoor visitation, weather permitting, but are also required to accommodate indoor visitation, including in resident rooms, when outdoor visits are unavailable.

The new federal policy could be a transformational change for visitation. But residents and families have been burned before. On June 26, the California Department of Public Health mandated outdoor visitation in nursing homes. But many facilities did not yield. They continued to refuse visitation because they don’t like visitors, visitation requires oversight they don’t want to give, and there has been little enforcement of the mandate. Additionally, the state continues to defer to outdated visitation bans issued by county and city public health authorities. Finally, the Department of Social Services, which regulates assisted living facilities, has failed to update its confusing policy that gives cover to visitation bans.

Restoring visitation access has been unnecessarily slow and fragmented, leaving families heartbroken and residents devastated. Many have lost hope and have been irreparably harmed.

Instead of policies that reflect the immeasurable benefits of visitation and current information about the transmission of COVID-19, some public health regulators continue to adhere to policies that feel stuck in another era. We need to make a commitment to ensuring all residents have access to their loved ones and give resident well-being primacy over flawed infection control practices.

The visitation ban has long outlasted its usefulness. Virtual visits, through computer screens or phone calls, are impractical for many residents, especially those with cognitive impairments, and soulless for others. In-person visits with reasonable safety measures in place are finally mandated in all long term care facilities but until the state vigorously makes visitation a priority and we have meaningful enforcement of visitation rights, residents and families will needlessly suffer; condemned to never seeing or hugging one another again. There has already been so much tragedy in long term care as a result of COVID-19. Government inaction has been adding to it.

For more information or to join CANHR’s #VisitationSavesLives campaign, please go to www.visitationsaveslives.com
California Department of Public Health Issues New Visitation Guidance

On August 25, the California Department of Public Health (DPH) issued All Facilities Letter 20-22.4 outlining some significant changes to the State’s ever-evolving guidance relating to visiting nursing homes and other health facilities during the COVID pandemic.

The AFL makes clear that visitation restrictions cannot be absolute. Facilities may not bar any of the following:

- Visits by Ombudsmen: Facilities must permit ombudsmen in the facility. Any ombudsman representative entering the facility is subject to screening for fever and COVID-19 symptoms and must wear appropriate PPE.

- Visitors for legal matters: Visitors must be permitted for legal matters that cannot be postponed including, but not limited to, estate planning, advance health care directives, Power of Attorney, and transfer of property title. Any visitor entering the facility is subject to screening for fever and COVID-19 symptoms and must wear appropriate PPE.

The new AFL also makes clear that facilities must permit residents to designate one visitor per resident for inside facility visitation, so long as certain conditions are met:

- There is a decline in the number of new cases, hospitalizations or deaths in the community.
- There are no new COVID-19 cases in the facility for 14 days, among either residents or staff.
- There are no staffing shortages and the facility is not using a COVID-19 staffing waiver.
- The facility has a testing plan in place in compliance with AFL-20-53.
- The facility must maintain good regulatory compliance with a COVID mitigation plan.

CANHR suggests that if a facility justifies restrictions on the basis of any of the last three points residents and their families immediately bring the problem to the attention of the DPH, as inadequate staffing and lack of compliance with testing and mitigation plans is a cause for immediate concern.

The AFL states that even those facilities that cannot meet these conditions shall provide outdoor and other visitation options, including but not limited to:

- Scheduled visits on the facility premises where there is 6-feet or more physical distancing, and both residents and visitors where facial coverings with staff monitoring infection control guidelines. (i.e. large communal spaces, outdoor visits, drive-by visits or visit through a person’s window); and

- Offering alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.).

If a facility is not in compliance with these guidelines, residents and their families should send the facility administrator a letter asking that the facility follow the law and permit, at a minimum, outdoor visitation. A sample letter can be found here: https://visitationsaveslives.com/sample-letter-outdoor-visitaton/

Facilities sometimes invoke local county health department rules in restricting visitors. In such cases residents and their families should ask for and review local health department visitation guidelines, and ensure that local health departments are aware of DPH guidance. If visitation is still not permitted, residents and families should file a complaint with the state DPH invoking the new rules. A guide to the filing of complaints can be found here: http://www.canhr.org/factsheets/nh_fs/html/fs_NH_complaint.htm
The evolving Coronavirus Crisis has had a worldwide impact that will take a long time to become fully understood. At the beginning of the crisis, in an effort to keep you all better informed, we created a website,

https://canhrnews.com/

specifically for COVID-19 information, news and resources related to Long Term Care. For the duration of this crisis, we are posting frequent updates there. The website contains over 840 pages, and is growing daily.

See the guide below for an overview of the many resources you can find there.
Urge Governor to Protect Nursing Home Residents from Deadly Power Outages

Please help support SB 1207 (Jackson) by urging Governor Newsom to sign it. This critical bill codifies federal standards that require skilled nursing facilities to have an alternative source of power to protect resident health and safety and maintain safe temperatures for 96 hours during any type of power outage. CANHR and Long Term Care Ombudsman Services of San Luis Obispo County are co-sponsoring SB 1207.

The Legislature gave final passage to SB 1207 on August 31 and sent it to the Governor for his signature. He has until the end of September to sign or veto it. Governor Newsom’s position on SB 1207 is unknown but the nursing home industry is fighting the bill. Its fate is uncertain.

You can use CANHR’s sample letter (Word document download) or write your own message to the Governor. Then fax your letter to the Governor at 916-558-3160.

If you do not have a fax machine, you can use the free GotFreeFax.com online service to send the fax. They don’t include any advertising or branding on their free faxes.

Another option is to email your message to Governor Newsom via his online contact form. Enter your name, email address and choose your subject – “SB 1207: Skilled nursing facilities: backup power system” – near the bottom of the drop-down menu. Then select your position (“Pro”), enter your message into the contact box and select “Send Message.”

Please send your messages immediately as the Governor could take action at any time. You can check CANHR’s website for updates on SB 1207’s status.

Read letter from CANHR and LTCOSSLOC to Governor Newsom on SB 1207.

Older and Overlooked: KQED Airs Series on Wildfire Risks to Residents of Long Term Care Facilities

During the week of August 10-14, KQED aired and published findings from its remarkable investigation into whether nursing homes and assisted living facilities in California are prepared to keep residents safe during emergencies. Its conclusion: Even after care homes abandoned residents during wildfires in recent years, California long term care facilities are still not prepared to keep residents safe during wildfires. Thousands of these facilities were found to be at risk for wildfire. The exceptional series, Older and Overlooked, is posted on the KQED website.

California Nursing Home Inspectors Fight Pandemic-Related Oversight Failures by CDPH

In recent weeks, California nursing home inspectors employed by the California Department of Public Health (CDPH) have exposed serious failures at CDPH and fought CDPH’s highly misguided plan to turn them into consultants to nursing home operators. At risk to their jobs, they have repeatedly drawn public attention to problems that endanger nursing home residents right now. Those who are speaking up are providing a badly needed public service by doing so.

Read More

Medi-Cal Aged and Disabled Income Disregard Increase Delayed until December

On July 31, the Department of Health Care Services issued a letter (ACWDL 20-02E) announcing it was pausing implementation of the increased income ceilings for the Aged, Blind and Disabled Federal Poverty Level program that were to have taken effect on August 1, 2020 under SB 104 (2019). At last word, the Department indicated that implementation would be delayed until December 2020. Once implemented, the change will eliminate a share of cost for thousands of aged and disabled beneficiaries on Medi-Cal by significantly increasing the income threshold for qualifying without incurring a share-of-cost. Currently, the countable monthly income ceilings for this program are $1,294 for a single person and $1,747 for a couple.

[continued on next page]
Facility Evictions Update

The Judicial Council of California voted to end the moratorium on housing evictions on September 1st, 2020. This means that courts will once again hear routine eviction cases so assisted living facilities and nursing homes may pursue court-ordered resident evictions after they have given proper written discharge notice.

Although AB 3088, which provides new COVID-related tenant protections, has been signed into law, the new statute will provide little assistance to most residents of long term care facilities in California. The statute provides some protections to residential and mobile home tenants who cannot pay their rents for reasons related to the COVID pandemic, but it does not address the plight of nursing home or assisted living residents who are being evicted for reasons unrelated to financial hardship resulting from the virus.

If you or a loved one is facing an assisted living or nursing home eviction please review our fact sheets (nursing homes here and assisted living here) or contact CANHR.

At Home Benefit – Deferred?

The California Department of Health Care Services (DHCS) has announced that it is not moving forward with its Long-Term Care at Home proposal at this time. Despite its promising name, the hastily conceived proposal was subject to many unanswered questions and concerns. Not least among them is the suspicion that it was intended to replace the Community Based Adult Services (CBAS) and Multi-Purpose Senior Services (MSSP) programs that the Governor unsuccessfully sought to eliminate in his May revise budget. While CANHR is very supportive of affordable and accessible home and community-based services, there were many questions about the quick pace of this proposal with few answers to the many questions asked.

New Research: Nursing Homes Inflate CMS “Quality Measures”

It should surprise nobody to hear that new research finds nursing homes inaccurately report the conditions of their residents when submitting “quality measure” data to the Centers for Medicare and Medicaid Services. The self-reported data is used as one of three major components to a facility’s federal 5-star rating. For years, nursing home resident advocates have argued that any ratings system should not rely on unaudited, self-reported data from the nursing homes themselves because they have an incentive to report inflated data. In the new research, quality measure data was compared to Medicare claims data for nursing home residents who were hospitalized. The comparisons demonstrated that nursing homes substantially underreport the number of residents who develop pressure sores while in the facility. The data also showed inaccurate reporting regarding urinary tract infections (UTIs) and resident falls.

CANHR’s instructional video for the establishment and functioning of family councils is now available for viewing on our website:

http://canhr.org/familycouncils/video/
Dear Advocate:

Me and my family members are increasingly concerned about care and staffing problems at my mother’s skilled nursing facility during the pandemic. We are planning to establish a family council to help address our concerns. Do we have the right to meet remotely via Zoom?

Concerned in Concord

Dear Concerned in Concord,

Yes. Family councils can meet in the setting and manner of their choice. It is perfectly permissible to meet online through video conferencing apps like Zoom. Due to visitation restrictions right now, family councils are not able to meet inside facilities as would be their right outside of the current emergency orders. Family councils are needed now more than ever to help address the isolation, care, staffing and safety concerns that have intensified during the pandemic.

California has among the strongest laws in the nation on family councils in nursing homes. The law gives family members the right to meet privately and prohibits interference with the formation, maintenance or promotion of a family council. You can learn more about the purpose and rights of family councils by reading CANHR’s family council fact sheet and our guide to organizing family councils.

Did You Know?

You can Check California’s COVID-19 Skilled Nursing Facility Outbreaks by County

The California Department of Public Health has an up-to-date data dashboard that tracks COVID-19 outbreaks at skilled nursing facilities. This dashboard includes cumulative and current data on residents and healthcare workers who have tested positive for the virus. This dashboard can be found under the California Department of Public Health’s COVID-19 updates, in the section titled, “COVID-19 Skilled Nursing Facilities.” Alternatively, one can use the following link: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/SNFsCOVID_19.aspx.

In addition, the Los Angeles Department of Public Health maintains a list of facilities with outbreaks on its website at the following link: http://publichealth.lacounty.gov/media/Coronavirus/locations.htm. It should be noted that neither list is totally reliable. One should ask facilities whether they have had residents or healthcare workers with COVID, whether they have had any COVID-related deaths, and what steps they take to ensure residents without COVID are not exposed to residents or workers who have been infected. One should also make sure that the facility regularly tests its healthcare workers for the virus and that it checks workers and residents for symptoms and temperature every day.
CANHR On The Move

- June 9: Pat McGinnis, CANHR’s Executive Director, testified before the Joint Assembly Committee Hearing on COVID outbreak in Skilled Nursing Facilities and the State’s Response.
- June 9: Staff attorney Prescott Cole attended the Veterans Benefits Protection Project.
- June 9: Prescott Cole attended the Legal Services and State Bar Quarterly Coordination Conference Call
- June 10: Staff attorney Tony Chicotel testified before the state Senate Special Committee on Pandemic Response about COVID-9 in long term care facilities.
- June 16: Long Term Care Advocate Amber Roberts gave a presentation on Long-Term Care Options and Medi-Cal for Covia’s Well Connected.
- June 20: CANHR Staff Attorney Jody Spiegel participated in the RCFE Advocates Quarterly Meeting with Community Care Licensing.
- June 23: Long Term Care Advocate Amber Roberts gave a zoom presentation for HICAP Volunteer Counselor Continuing Education / Center for Health Care Rights on Long Term Care Advocacy During the Pandemic.
- July 7: Julie Pollock gave a Zoom presentation to PGE Caregiver Support Group on Long Term Care during the Pandemic
- August 11: Julie Pollock gave an in-service training to Family Caregiver Alliance on COVID-19 issues.
- August 12: Pat McGinnis and Tony Chicotel hosted a townhall on “Getting Good Long Term Care in a Pandemic.”
- August 26: Prescott Cole presented a virtual Town Hall Event on COVID-19 Elder Abuse Scams
- September 8: Prescott Cole participated in the State Bar Legal Services Quarterly Coordination Conference Call
Voting during COVID-19
For Nursing Facility and Assisted Living Residents

There's a big election coming up in November. If you live in an assisted living or nursing facility, you should be aware that you do not lose your right to vote just because you move into long-term care. However, you might face a number of practical barriers to exercising your right to vote, and many of these barriers will be exacerbated in the context of COVID-19. Below is guidance for residents planning to exercise their right to vote this November.

Register to Vote

When you move into a nursing home or assisted living facility, your address changes. Make sure you are registered to vote at your current address by visiting https://registertovote.ca.gov or calling the Secretary of State's toll-free Voter Hotline at (800) 345-VOTE (8683) to receive a paper voter registration application.

Once you’ve registered to vote, make a voting plan based on the options below. There are many alternatives to voting in person in California. Talk with your facility Administrator or Social Services Designee in advance to tell them you plan to vote, and find out what they will do to ensure that happens. If you are not receiving help from the facility, contact CANHR at (800) 474-1116 or the California Department of Public Health (CDPH) to file a complaint.

Accessibility for Persons with Disabilities

If you are unable to travel to a polling location, California offers a number of alternatives to voting in person:

Vote-by-Mail (also called “Absentee Ballots”): In California, every voter may vote by mail. This year, Governor Newsom issued Executive Order N-64-20, which requires that every voter be mailed a Vote-by-Mail ballot prior to November 3, 2020. There are many ways to return your Vote-by-Mail ballot:

• Return your ballot in the mail, with no postage required. If you have concerns that the Postal Service may not be able to deliver Vote-by-Mail ballots on time, you have other options:

• Deposit your Vote-by-Mail ballot at a Dropbox location prior to 8pm on November 3, 2020. If you cannot leave the facility to drop off your Vote-by-Mail ballot yourself, you can authorize someone to drop it off for you by filling out the “authorization section” on the back of the envelope.

• Tip: We understand the serious and tragic situation residents are experiencing with bans on visitation. Barriers to visitation may cause problems with something as simple as arranging for a family member to pick up a Vote-by-Mail ballot. Speak with your family members, the facility administrator, and if necessary, CDPH in advance to ensure that your facility has a plan to facilitate -- rather than obstruct -- your Vote-by-Mail ballot pick-up. Nursing homes and assisted living facilities have a duty to facilitate residents’ rights, including voting.

• You or your authorized representative can also return your ballot at an early voting station.

• You or your authorized representative can also return your ballot to any polling location by 8 pm on November 3rd.
Voting during COVID-19

**Remote Accessible Vote by Mail (RAVBM)** Effective January 1, 2020 Remote Accessible Vote-by-Mail (RAVBM) must be available in every county in California. See Disability Rights California for more information.

**Emergency Medical Ballot** A registered voter who is unable to vote in person due to a medical emergency can fill out a form up to six-days prior to an election to authorize someone to go to the Elections Office to pick up a ballot for them. See Disability Rights California for more information.

**Leaving and Returning to the Facility: COVID-19** If you plan to leave the facility to vote in person on November 3 or to drop off your ballot, be mindful that during COVID-19, many facilities have placed restrictions on residents’ coming or going to reduce the spread of the virus. Many facilities require mandatory quarantine for residents upon return to the facility, and have implemented additional restrictions that would not be permissible under normal circumstances outside of COVID-19. So, if you would like to leave the facility to vote, make sure you clearly understand the consequences of leaving. Talk with the facility Administrator in advance and ask to see the facility’s written policy on resident egress.

**Voters with Cognitive Impairment**

You do not lose your right to vote based upon another person’s perceptions of your abilities, or even a doctor’s diagnosis of dementia or other cognitive impairment. In California, you retain the right to vote unless a court determines you are not competent to do so and specifically revokes your right to vote.

For voters who are under a conservatorship, Elections Code 2208 establishes a presumption of competency to vote regardless of conservatorship status. A person may be declared mentally incompetent and therefore disqualified from voting only if a court or, in certain cases, a jury finds by clear and convincing evidence that the person cannot communicate, with or without reasonable accommodations, a desire to participate in the voting process and the person is subject to a conservatorship or is gravely disabled.
Governor Newsom has until September 30 to sign or veto bills passed this year by the Legislature. 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 for updated details on legislation, and www.leginfo.ca.gov for information on specific bills.

**SPONSOR**

**AB 2408** (Grayson) – Reverse Mortgage Suitability Worksheet Bill
This legislation will improve the existing Reverse Mortgage Suitability Worksheet by addressing additional areas of concern: problems for the non-borrowing spouse, communication problems with loan servicers, and property tax problems due to home improvement contracts.
Status: **DEAD**

**SB 1207** (Jackson) – The Nursing Home Resident Safety Act of 2020
This bill would require a skilled nursing facility to have a backup power system that maintains safe temperatures and power to all critical systems for resident health and safety for no less than 96 hours during any type of power outage. It aims to protect nursing home residents from the life-threatening consequences of the massive blackouts PG&E and other utility companies are now using in an effort to prevent wildfires during periods of extreme weather. The bill is co-sponsored by CANHR and Long Term Care Ombudsman Services of San Luis Obispo County.
Status: **Sent to the Governor**

**SUPPORT**

**AB 2377** (Chiu): Adult Residential Facilities: Closures and Resident Transfers
This bill would strengthen resident protections during closures of Adult Residential Facilities (ARFs).
Status: **Sent to the Governor**

**SB 214** (Dodd): California Community Transitions Program
This bill would make it easier for Medi-Cal beneficiaries who have been in a nursing facility for fewer than 90 days to enroll in the California Community Transitions Program, which facilitates transitions from institutional to home or community-based settings.
Status: **Sent to the Governor**

**SB 908** (Wieckoswki): Debt Collectors: Licensing
This bill would require the debt collection industry to be licensed in California.
Status: **Sent to the Governor**

**SB 1016** (Wieckowski): Limited Conservatorships
This bill will clarify that the proper function of a conservatee’s attorney is to advocate for the expressed wishes of the conservatee. Currently, some attorneys advocate for what they believe are the conservatee’s best interests, regardless of what their client is instructing.
Status: **DEAD**

**SB 1043** (Pan/Jackson) – Decisionmaking for Unrepresented Nursing Home Residents
This bill will update and improve Health and Safety Code Section 1418.8 after it was found to be constitutionally defective by the California Court of Appeal in CANHR v. Smith (37 Cal. App. 5th 814 (2019)).
Status: **DEAD**
**OPPOSE**

**AB 1971 (Voepel): Reverse Mortgages**
This legislation would dilute consumer protections for seniors considering a reverse mortgage, by reducing the mandatory waiting period between loan counseling and completion of the application from seven to three days.
Status: DEAD

**AB 2664 (Diep): Disability access: statutory damages: small businesses**
AB 2664 is an erosion of accessibility protections for individuals with disabilities in construction-related claims. This bill would change the definition of what constitutes an exempted small business from 50 employees to 100 employees.
Status: DEAD

**AB 3138 (Waldron): Residential care facilities for the elderly: electronic monitoring.**
This bill imposes restrictions on residents of Residential Care Facilities for the Elderly seeking to use video cameras to monitor activities inside the resident’s living space.
Status: DEAD

**WATCH**

**AB 2644 (Wood): Skilled Nursing Facility: Deaths: Reporting**
In the event of a declared emergency related to a communicable disease, this bill would require a skilled nursing facility to report each disease-related death and suspected disease-related death to the Department of Public Health within 24 hours of that death. This bill would also require a skilled nursing facility to have a full-time dedicated Infection Preventionist staff member, as specified, who is either a registered nurse or a licensed vocational nurse.
Status: Sent to the Governor

**AB 2926 (Calderon): Referral Agencies for Residential Care Facilities for the Elderly**
This bill would require agencies that refer individuals to residential care facilities for a referral fee to provide with certain disclosures and would make the employees of the referral agency a mandated reporter.
Status: DEAD

**SB 1259 (Hurtado): Adult Residential Facilities and Residential Care Facilities for the Elderly**
This bill would establish a task force to evaluate how to meet the needs of SSI/SSP recipients, and to assess the unmet demand for placement in facilities for SSI/SSP recipients.
Status: DEAD

**SB 1305 (Roth): Revocable Transfer on Death Deeds**
This bill would move the sunset date back a year for California’s Revocable Transfer on Death Deed, from January 1, 2021 to January 1, 2022.
Status: Sent to Governor
**Rate Increases and New Charges: What’s Permitted?**

Some RCFEs are trying to pass along increased costs from the COVID-19 pandemic to their residents. The higher costs can take the form of a rate increase for current items and services, or charges for new items and services. Whether it is legal for the RCFE to increase a resident’s rates or add new charges depends on several factors discussed below.

### Rate Increases

In general, RCFEs are free to set their own rates and charge whatever amount residents are willing to pay. However, California law requires that facilities comply with certain notice requirements for rate increases to be valid. Specifically, RCFEs are required to give at least 60 days prior written notice of an increase in any rate for services, except for an increase in rate due to a change in level of care for a resident.* The written notice must include the amount of the increase, the reason for the increase, and a general description of the additional costs. (Health & Safety Code section 1569.655(a).) Additionally, some admission agreements may provide additional requirements for rate increases that are even more protective than the above laws, i.e., all rate increases must be signed by the Executive Director, the facility will not raise rates during the first year of admission, or the facility will raise its rates no more than once a year.

Unfortunately, there is no prohibition against RCFEs passing along COVID-related costs. For example, if a RCFE proposes to increase the monthly fee for all residents by $200 a month to cover the cost of PPE for residents, staff and visitors, the increase would be legal if it complies with the written notice requirements discussed above, and any additional protections set forth in the admission agreement.

### New Charges

The rates that a RCFE may charge for basic services and additional items and services may vary, depending on the services that the resident needs and uses. For all residents, the admission agreement must clearly indicate what the charges are and what services are provided for the charges.

**No fee may be charged that is not clearly stated in the admission agreement.** (Health & Safety Code section 1569.884(a)-(c); Cal. Code of Regulations, Title 22, section 87507(g)(3).) If an RCFE wants to charge a resident for a new item or service that was not available at the time the agreement was signed, it must give a list of the new items/services and corresponding charges to the resident for his or her acceptance or refusal. The RCFE must also attach to the admission agreement a signed and dated statement acknowledging the resident’s decision regarding the purchase of the new items or services. (Health & Safety Code section 1569.884(c); Cal. Code of Regulations, Title 22, section 87507(g)(3)-(5).)

[continued on next page]
Here are a few tips for challenging rate increases and new charges.

1. **Read the Admission Agreement!** When it comes to RCFE rates and rate increases, there is nothing more important than the admission agreement. If the item or service and corresponding charge is not included in the agreement, or not adequately described, it may be disputed. (Health & Safety Code section 1569.884; Cal. Code of Regulations, Title 22, section 87507.). Also, check to see whether the admission agreement include additional protections involving rate increases, and make sure that the RCFE has complied with these requirements.

2. **Review the Rate Increase Notice.** As discussed above, all rate increases require written notice, and are subject to limits based on percentage and frequency. (Health & Safety Code section 1569.655; Civil Code section 1947.12.). Review the rate increase notice to determine whether it complies with these resident protections.

3. **Is Withholding Payment an Option?** If a resident has a good faith dispute over a rate increase, refusing to pay the increase may be an option. The facility could then sue the resident to obtain payment or, more likely, pursue an eviction for nonpayment. However, evictions for nonpayment are limited to failure to pay for “basic services,” and basic services are broadly defined under California law to include living accommodations, meals, personal assistance and care, observation and supervision. (Cal. Code of Regulations, Title 22, sections 87224, 87464.) If a charge is related to a non-basic service, nonpayment should not be grounds for an eviction. The resident may still have to pay pursuant to the terms of the admission agreement, but the RCFE should not be able to evict the resident for nonpayment.

* Unlike general rate increases, a RCFE that offers different levels/tiers of care may increase a resident’s rate due to a change in the level of care by providing written notice within two business days after initially providing services at the new level of care. The notice must include a detailed explanation of the additional services to be provided at the new level of care and an itemization of the charges. Health & Safety Code section 1569.657(a).

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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.
Testing/Visitation & COVID in CCRCs

In a June 26, 2020 Provider Information Notice (PIN 20-23), Community Care Licensing provided updated guidance to RCFE licensees on testing, visitation guidelines, infection control and the use of face coverings in facilities. A paragraph on the first page of the PIN – in bold – reads: **Residents in Continuing Care Retirement Communities (CCRC) who live independently are generally exempt from testing requirements and visitation restrictions.** Exceptions to being exempt from testing requirements include the person being symptomatic for COVID-19, exposure to a person who has tested positive for COVID-19, are moving into the facility, or are returning from being treated in the hospital. The guidance continues to note that, if there are contradictory requirements between the most current CDC, CDPH, CDSS and local health department guidance or health orders, providers should follow the strictest requirements. It should be noted that almost all of these requirements by all of these agencies are contradictory.

In short, then, CCRC residents are **not exempt** if the local health department restricts visitation. This has become a particularly difficult and exacerbating issue for CCRC residents who spent a great deal of their savings and spend a great deal of their monthly income to live independently. In one recent case, the family was prohibited from visiting a resident, even though no one was COVID positive, symptomatic or around anyone who was exposed or returning from a hospital visit. The daughter (a nurse) and her husband (a doctor) wanted to see her mother and the mother wanted to see her daughter. Of course, they had planned to keep the visit restricted to the resident’s unit, but the local health department said no, so their visit was denied. Should you have problems with visitation issues in a CCRC, please let us know. PIN 20-23-ASC

Oakmont Senior Living Settles Lawsuit After Abandoning Residents

The operators of two Sonoma County senior living facilities that abandoned residents in the Tubbs fire of 2017, have paid $500,000 to settle a civil suit filed by the Sonoma County District Attorney and California’s Attorney General’s office.

In addition to the $500,000, the settlement requires the Windsor-based companies, Varenna LLC, Oakmont Management Group LLC and Oakmont Senior Living LLC to create “enhanced” emergency and disaster evacuation plans and orders the companies to hire an independent monitor for five years to ensure compliance with the settlement’s requirements.

When the Tubbs fire tore through the Fountaingrove area in Santa Rosa in October 2017, staff at Varenna, a CCRC, and Villa Capri, an assisted living facility, abandoned close to 100 residents. First responders and family members evacuated them. Villa Capri burned to the ground, while Varenna was damaged but survived. Nevertheless, the trauma and after-effects of this tragedy led to the deaths of some residents and disappointment for many family members whose loved ones were abandoned and who felt that the actions of the operators were criminal. Oakmont, of course, admits no guilt and originally blamed fire responders and the family members and are now trying to blame the county.

Front Porch and Covia to Affiliate

In June 2020, the Board of Front Porch and Covia, two large senior living operators, voted in to affiliate. The affiliation by Front Porch, which operates five CCRCs and five independent living communities, as well as affordable housing units, and Covia, which operates six CCRCs along with other senior housing, will create one of the largest non-profit senior living providers in the country. The affiliation still has to be approved by regulators. The proposed nonprofit transaction is being reviewed as required by Corporations Code section 5920 et seq. The terms of the proposed transaction are set forth in the written notice to the Attorney General. The written notice is available online on the Covia website at [https://covia.org/affiliation/](https://covia.org/affiliation/). Whether this will result in undermining the care and services at their current sites remains to be seen. Meanwhile, The California Attorney General will conduct a public meeting starting on September 17, 2020 at 10:00 AM PDT by teleconference on the proposed Affiliation between Covia Group, Covia Communities, Covia Affordable Communities, the Covia Foundation and Front Porch Communities and Services. This notice of the public meeting is posted on the Attorney General’s website with links and instructions on how to attend the public meeting BlueJeans videoconference: [https://oag.ca.gov/charities/nonprofithosp](https://oag.ca.gov/charities/nonprofithosp)
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**

- **Kristin Stenehjem**  
  Patricia Stenehjem
- **Sandra Rivera**  
  Raquel Rivera
- **Maricor G.**  
  Cemone Khan

**In Memory Of**

- **George Meissenburg**  
  Jeannette Santage
- **Pat & Chet Brown**  
  Linda Johnson
- **Donna Ambrogi**  
  Donna Calame
- **Ronald Randolph**  
  Brenda Williams
- **Jan Madden**  
  Jenny Lanning
- **Romeo Garaniel**  
  Jack & Valerie Nguyen

This booklet outlines the applicable rules of the Medi-Cal Recovery laws before and after January 1, 2017. It has been revised to provide additional information on Medi-Cal recovery laws effective for individuals who die on or after January 1, 2017.

We revised the booklet again in June 2019 with the latest applicable information, which is still current as of September 2020. You can order printed copies of the updated version, or download it for free as a PDF document at:

http://canhr.org/publications/Consumer_Pubs.html
The following citation summaries are compiled from the citations issued by the California Department of Public Health to Northern 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.

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**Marin County**

**Professional Post Acute Center**
81 Professional Center Pkwy, San Rafael

**AA $100000 Decubiti (Bedsores) Deterioration Infection Neglect 3/13/2020**

A resident who was admitted on 7/31/15 died less than three weeks later of septic shock and an infected pressure sore due to neglect at the facility. The resident had a sacral area pressure sore upon admission that deteriorated and became infected due to multiple failures by the facility. It failed to clarify pressure ulcer treatment orders with her attending physician, failed to implement pressure ulcer prevention precautions, and failed to follow its own policies and procedures related to the prevention and treatment of pressure ulcers. She was hospitalized on 8/15/15 in the intensive care unit and died on 8/19/15 of septicemia and infection of the pressure sore. The violations by the facility were the direct proximate cause of the resident’s death.

Citation # 110012745

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**Monterey County**

**Cypress Ridge Care Center**
1501 Skyline Dr, Monterey

**B $2000 Sexual Abuse 03/09/2020**

On 2/29/20, a CNA told a LVN that another CNA had sexually battered two residents. He “spanked” a resident on her bare buttocks, and pinched the breast and twisted the nipple of a second resident. The reporting CNA was working with the other CNA to change a resident, and heard a slapping sound and the resident saying “stop hitting my butt” when she returned to the room after leaving to get a pad. The CNAs then went to another resident’s room to help her change her top, and she witnessed the CNA pinching the resident’s nipple and saying “titty twist.” The facility was cited for failing to ensure two residents were free from sexual abuse.

Citation # 070015789
**Golden Living Center - Hy-Pana**
4545 Shelley Court, Stockton

**Santa Clara County**
Woodlands Healthcare Center
14966 Terreno De Flores Ln, Los Gatos

**AA $100000 Elopement Supervision 12/23/2019**

On 8/3/19, a male resident was found dead after being struck by a train one day after he left the facility unsupervised. The resident had dementia, a traumatic brain injury and a history of leaving his previous residence unsupervised. He was drugged with Neudexta and later Depakote for “aggressive” behavior. The resident had only been at the facility for one day when he left but had been noted to repeatedly attempt to go outside. The facility’s Director of Nursing stated, “he should have had a staff member with him at all times until we got to know him better due to his mental status [confusion] and physical ability [ambulatory].” The door the resident left through was supposed to be locked with an alarm but surveillance footage showed it was not locked and no alarm went off. The facility was cited for failing to provide the direct supervision the resident needed. This failure resulted in the resident’s death.

Citation # 030015623

**Golden Living Center - Hy-Pana**
4545 Shelley Court, Stockton

**B $2000 Medication 02/27/2020**

On 2/13/20, the facility failed to maintain a proper system for disposing of unused medication, including narcotics.

Citation # 070015750

**Yolo County**

**River Bend Nursing Center**
2215 Oakmont Way, West Sacramento

**A $20000 Careplan Medication Patient Care 02/25/2020**

When a patient presented with symptoms of elevated blood sugar followed by a progressive worsening of her mental status and breathing over 36 hours, the facility failed to notify physicians of these changes, and failed to completely assess or intervene on time. The patient became unresponsive and died shortly after being transferred to the hospital.

Citation # 030015745.

**River Bend Nursing Center**
2215 Oakmont Way, West Sacramento

**A $20000 Careplan Notification Patient Care 02/25/2020**

On 9/27/19, the facility transferred a resident with mental illness, dementia and severe memory impairment to the acute care hospital, but did not provide notice of the transfer to the ombudsman until 18 days later on 10/15/19. The DON stated “We notify the ombudsman on a monthly basis of our hospital transfers, this is our arrangement with the ombudsman office....” The facility was cited for failing to notify the Long-Term Care Ombudsman of the transfer as soon as practicable.

Citation # 030015698

**Wagner Heights Nursing And Rehabilitation Center**
9289 Branstetter Place, Stockton

**B $2000 Sexual Abuse 02/04/2020**

On 10/29/19, a male resident with known behavior problems was seen rubbing the breasts of a female resident with severe memory impairment. Approximately three weeks later, on 11/21/19, the male resident pulled down his pants in front of another female resident with severe memory impairment, and took her hand and rubbed it up and down his penis. The facility was cited for failing to protect two residents from sexual abuse.

Citation # 030015715
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Fresno County

**Dycora Transitional Health - Community Care**
3672 N 1st St, Fresno

**B** $2000 Sexual Abuse 6/12/2020

On 3/2/20, a resident reported witnessing a male resident touching a 48 year old female resident with cognitive disabilities and traumatic brain injury on the breast. When this was reported to the facility’s director of nursing (DON), she was dismissive. The abusive resident had been noted for having prior sexually inappropriate behaviors but his care plan was not changed. The facility was cited for failing to adequately supervise the abusive resident and failing to address his inappropriate sexual behavior. Citation # 910015900

Los Angeles County

**Bay Crest Care Center**
3750 Garnet St, Torrance

**A** $16000 Fall 7/23/2020

On 11/4/19, during a “one-person physical assist,” an 80 year old totally dependent resident who required two or more persons physical assist fell from his bed and hit his head on the bedside table. The CNA had been attempting to clean the resident. When she pulled the sheet to turn the resident on his side, he rolled off of the bed. The resident was sent to the emergency room where it was determined he had sustained bleeding within the brain and a fractured left leg. The facility was cited for failing to properly implement the resident’s care plan, which indicated the resident required a two-person physical assist during care. Citation # 910015947

**Bel Tooren Villa Convalescent Hospital**
16910 Woodruff Ave, Bellflower

**B** $2000 Sexual Abuse 6/12/2020

On 3/2/20, a resident reported witnessing a male resident touching a 48 year old female resident with cognitive disabilities and traumatic brain injury on the breast. When this was reported to the facility’s director of nursing (DON), she was dismissive. The abusive resident had been noted for having prior sexually inappropriate behaviors but his care plan was not changed. The social services designee at the facility stated he was “disgusted” and “could not believe the facility was covering the truth” and that a similar incident had happened before with another resident “but the DON and administrator did nothing about it.” The facility was cited for failing to adequately supervise the abusive resident and failing to address his inappropriate sexual behavior. Citation # 910015900

**California Post-Acute Care**
3615 E Imperial Hwy, Lynwood

**B** $2000 Fiduciary 02/14/2020

On 3/20/19, a resident complained to a LVN that a CNA had borrowed money and did not return it. An investigation revealed that the CNA had borrowed money from two residents for school payments, flight tickets, rent and orthodontic services and used one of their bank cards for a total amount of $10,699.88. The investigation also uncovered two other residents who had their bank cards used to make online purchases by an unknown person. The facility was cited for failing to implement its abuse policy to protect Resident being financially abused. Citation # 910015747
A **$20000** Medication Patient Care 4/9/2020

A 56-year-old female resident was admitted to the facility on 4/28/19 with a fracture in her left leg, bone cancer, difficulty walking, difficulty swallowing, and use of a G-tube. In November 2019, the resident reported to her psychiatrist that she was in pain and had a fear of dying. The resident frequently yelled out in pain and cried. The staff failed to conduct an accurate pain assessment, implement a pain management plan, or notify the resident’s physician when the resident continued to cry. Instead, the facility staff overmedicated the resident with Xanax, an anti-anxiety medication, every eight hours. There was no physician’s order for Xanax every eight hours, and the resident’s responsible party observed the resident sedated on several occasions with her eyes rolling to the back of her head. On 11/14/19, the resident was lethargic and drowsy. She had a loss of alertness and was transferred to the hospital on 11/15/19. She died on 11/17/19 of cardiopulmonary arrest.

Citation # 910015834

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**COUNTRY VILLA BELMONT HEIGHTS**

**HEALTHCARE CENTER**

1730 Grand Ave, Long Beach

A **$20000** Fall 4/3/2020

A 99-year-old female resident with a dementia diagnosis who was a high risk for falls, suffered three falls on 7/7/19, 9/29/19 and 10/8/19. During the last unsupervised and unobserved fall on 10/8/19, the resident was found alone on the bathroom floor with blunt head trauma and bleeding of the brain. She died 18 days later. The facility was cited for failure to provide supervision to prevent falls, failure to implement the resident’s care plan to prevent falls, and failure to revise the resident’s care plan after 7/7/19 to prevent future falls.

Citation # 910015834

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**COUNTRY VILLA NORTH CONVALESCENT CENTER**

3233 W Pico Blvd, Los Angeles

B **$2000** Infection Physical Environment 3/5/2020

The facility failed to ensure an effective pest control program to prevent a cockroach infestation in the facility’s kitchen. This was determined by heavy fecal spotting, cockroach eggs, live and dead cockroaches, cockroaches crawling on the floor, and 25 dead cockroaches on the shelves around the plate warming equipment. This put the facility residents at risk for vector-borne illnesses.

Citation # 920015782

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**COUNTRY MANOR HEALTHCARE**

11723 Fenton Ave, Sylmar

A **$15000** Fall 12/28/2019

The facility failed to keep a resident’s environment free of accident hazards and failed to provide adequate supervision and assistance for a resident who was at risk for falls. The facility’s nurse left the resident in the shower room sitting in a shower chair alone without supervision when the resident stood up from the shower chair, fell onto the floor, and sustained a left hip fracture on 8/20/19. The facility put the resident at risk and its failure had a direct correlation to the resident’s injury.

Citation # 920015639

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**COUNTRY VILLA REHABILITATION CENTER**

340 S Alvarado St, Los Angeles

A **$20000** Patient Care 5/15/2020

On 2/14/20, a diabetic resident was found unresponsive and transferred to the hospital and diagnosed with kidney failure, sepsis, and pneumonia. The resident’s blood sugar level was at 410 milligrams, with the normal range being 80 to 100. During an interview with the Director of Nurses, the DON stated that the physician should have been notified of the resident’s elevated blood glucose on 2/11. Despite the maximum supportive measures taken by the hospital, the resident died on 2/18/20. The facility was cited for failing to inform the physician on time of the resident’s elevated blood sugar level.

Citation # 920015880
Crenshaw Nursing Home  
1900 S Longwood Ave, Los Angeles  

A $20000 Careplan Elopement Physical Environment 3/27/2020

The facility failed to implement its policy and resident care plan to ensure close supervision was provided to prevent a 68 year old male resident from eloping the facility on 8/4/19, 8/20/19 and 9/25/19. The resident had diagnoses of schizophrenia, brain disease, hypertension and an immune compromise disease, as well as, wandering behavior and history of elopement. The resident’s care plans for elopement and wandering included monitoring the resident at frequent intervals and redirecting the resident to alternate activities; however, no changes were made to these care plans after the resident’s elopement on 8/4/19 and 8/20/19. The facility’s door alarms were not functioning on 9/25/19, and at 7:30 PM, a LVN found the resident missing. Local police found the missing resident two days after and returned him to the facility on 9/27/19 where he was transferred to the hospital with swelling and redness on the lower leg. The resident returned to the facility with diagnoses of cellulitis and sepsis. The facility failed to monitor the resident at frequent intervals and redirect the resident to alternative activities; failed to ensure that the facility’s door alarms were functioning; and failed to reassess and change the resident’s care plan to meet his needs, which directly resulted in the resident spending two nights missing and being diagnosed with cellulitis and sepsis.

Citation # 910015831

Four Seasons Healthcare & Wellness Center  
5335 Laurel Canyon Blvd, North Hollywood

B $2000 Careplan Medication 04/06/2020

On 2/20/20, the facility staff failed to provide a resident with 17 doses of a medication prescribed to treat the resident’s breathing problems. As a result, the resident was placed at risk to experience significant harm including respiratory arrest.

Citation # 920015827

Four Seasons Healthcare & Wellness Center  
5335 Laurel Canyon Blvd, North Hollywood

B $2000 Administration Medication 04/06/2020

The facility staff willfully falsified the administration of the prescribed Lantus insulin to a resident. Three licensed nurses entered the initials of their names in the Medication Administration Record (MAR) to indicate they gave the resident a total of eight doses for eight consecutive days from 2/14/20 to 2/21/20 when the pharmacy had not delivered it to the facility. As a result, the resident’s clinical record falsely reflected the care provided to the resident, having a direct relationship to the health and safety of the resident.

Citation # 920015826

Green Acres Healthcare Center  
8101 Hill Dr, Rosemead

A $20000 Fall 3/19/2020

An 84 year old resident, diagnosed with spinal stenosis, dementia, schizophrenia and abnormalities of balance and walking, fell while ambulating on 7/13/19, and again on 9/24/19. The resident’s care plan required the facility to place his room close to the nurses’ station and required staff to redirect him when he is walking. After the two falls, the resident complained of continuing pain and was transferred to the acute care hospital where it was discovered that he had a hip fracture. The resident’s public guardian preferred that the resident not return to the facility because of their inadequate supervision to prevent falls. The facility was cited for failure to adhere to the resident’s care plan to prevent falls and injury.

Citation # 950015814
CANHR Advocate
FALL 2020
CITATIONS SOUTH

GOLDEN CROSS HEALTH CARE
1450 N Fair Oaks Ave, Pasadena

B $2000 Feeding Hydration Infection Neglect Patient Care 6/30/2020

An investigation in May 2020 found that the facility was neglecting three residents who had coronavirus and resided in a COVID-19 unit. A 79 year old resident was found in bed with a soiled gown and linens, blackened fingernails, and uncombed hair. He complained of thirst and discomfort. The resident had wounds on his buttocks and hip and black discolored toes. His physician had not come to look at the wounds and had no treatment orders for his toes. Facility nurses stated he and other residents were not given showers and were not repositioned as needed. The neglect put the resident’s wounds at risk of infections and delayed healing. A second resident, age 54, told investigators the staff had forgotten him. He was found wearing a T-shirt with dark red blood stains. The resident reported he had not showered in two weeks and his clothes were not washed or changed. He stated he felt overwhelmed and sad by the neglect. A third resident, age 78, who said she was sad and stressed, stated staff did not routinely provide drinking water and she frequently had to ask for it. This put her at risk of dehydration. A nursing assistant reported that the facility did not provide fresh water to the residents because the kitchen staff would not step inside the COVID-19 unit to bring water. The Interim Administrator stated she could not oversee the care of residents at the COVID-19 Unit because she did not want to get infected.

Hyde Park Healthcare Center
6520 West Blvd, Los Angeles

A $20000 Fall Supervision 02/12/2020

On 9/17/19, during an investigation of an unrelated complaint, a 59 year old male resident with mental illness was observed in the facility pacing with bleeding from the left side of his face and body. The resident had been left unsupervised on a patio for smoking and fell while trying to pick up discarded cigarette butts. The resident was found a day later face down in the street, 12 miles from the facility. His core body temperature had dipped to 78.8 degrees Fahrenheit. In addition to hypothermia, the resident suffered multiple scrapes on his knees, chest, hand, and face, upper body bruises, blunt trauma to the head, and fractured ribs. The resident died shortly after being hospitalized. The resident had declined in the days leading up to 12/25, refusing all of his medications and expressing discomfort and frustration. He was seen sleeping in the facility lobby at 4 AM on 12/25. The charge nurse had mistakenly left the front door key in the door. At 4:30, the resident was missing. The facility was cited for failing to 1) provide appropriate interventions when the resident began refusing care; 2) implementing a plan of care to obtain a psychiatric consultation; 3) develop a care plan for “elopement”; and 4) securing the facility entrance.

Citation # 920015896

HOLLYWOOD PREMIER HEALTHCARE CENTER
5401 Fountain Ave, Los Angeles

B $2000 Evictions Patient Rights 6/18/2020

On 5/26/20, the facility transferred a resident who had dementia to the hospital and refused to allow him to return when he was ready to be readmitted on the next day. The resident, who had lived in the facility for over eight years, remained in the hospital until at least 6/15/20 due to the facility’s failure to readmit him. The facility stated it would not readmit the resident because he did not have COVID-19. It told the investigator it was only admitting COVID-19 positive residents because the facility had become a Designated COVID-19 facility. This action conflicted with a local Public Health directive. The facility was cited because the resident was subjected to an extended and unnecessary hospitalization due to its failure to respect his bed hold and readmission rights.

Citation # 920015905

Citation # 950015913

HOLLYWOOD PREMIER HEALTHCARE CENTER
5401 Fountain Ave, Los Angeles

A $20000 Elopement 6/23/2020

A male resident with severe cognitive impairment walked out of the facility unnoticed in the early hours of Christmas morning, 12/25/2019. He was found a day later face down in the street, 12 miles from the facility. His core body temperature had dipped to 78.8 degrees Fahrenheit. In addition to hypothermia, the resident suffered multiple scrapes on his knees, chest, hand, and face, upper body bruises, blunt trauma to the head, and fractured ribs. The resident died shortly after being hospitalized. The resident had declined in the days leading up to 12/25, refusing all of his medications and expressing discomfort and frustration. He was seen sleeping in the facility lobby at 4 AM on 12/25. The charge nurse had mistakenly left the front door key in the door. At 4:30, the resident was missing. The facility was cited for failing to 1) provide appropriate interventions when the resident began refusing care; 2) implementing a plan of care to obtain a psychiatric consultation; 3) develop a care plan for “elopement”; and 4) securing the facility entrance.

Citation # 920015896

Citation # 910015737

Citation # 920015905

Citation # 920015905

Citation # 950015913

Citation # 910015737

Citation # 920015896

Citation # 920015905
The facility staff failed to properly assess and create a care plan for a resident who had a history of self-harm and elopement. Within 14 hours after admission, the resident left the facility and found wandering the streets by the police. The resident was placed on a 5150 psychiatric hold at another facility.

Citation # 910015703

On 8/12/19, a 61 year old male resident, who was wheelchair-bound and who had blood clots and colostomy, was found dead in an unlicensed facility after being discharged from the skilled nursing facility on 7/10/19. The resident’s death was discovered during a facility investigation for discharging residents to make room for Medicare residents. The deceased resident required extensive care that an assisted living facility was not able to provide. The resident’s physician ordered to discharge the resident and discontinued his blood thinner medication, despite the resident’s history of blood clots. The resident was sent to the unlicensed facility with four colostomy bags and no discharge plan. On, or about, 7/26/19, the resident was sent back to the nursing facility because he had run out of colostomy bags. The facility called the police on the resident and a police officer transported him back to the unlicensed facility. The facility’s staff later admitted that the resident’s discharge was botched. The former social services designee stated, “the facility had a pattern of discharging residents who were not ready for discharge in order to admit new residents.” An internal facility email indicated the nursing facility made payments to the unlicensed facility before sending residents there. The nursing facility was cited for discharging the resident without justification, a plan or appropriate placement.

Citation # 910015723

On 3/19/20, a 62 year old facility resident who had dementia died during an investigation of an unrelated complaint. Upon subsequent investigation of the resident’s death, it was determined that on the day of her death a nurse falsely documented providing evaluation and treatment for a wound on the resident’s coccyx that had not been provided. The failure to provide the ordered treatment could have resulted in delayed healing or increase in the size of the wound. The facility was cited for falsifying the resident’s wound treatment records on 3/19/20, the day of her death.

Citation # 910015894

The facility failed to properly administer medication to multiple residents in the facility. Between 6/6/19 and 3/2/2020, the staff failed to administer 414 doses of an HIV medication to a resident. Between 1/18/20 and 3/3/20, the staff failed to administer 176 doses of Atrovent inhaler to a resident with breathing problems. Between 12/5/19 and 3/4/20, the staff failed to administer 60 doses of Lantus insulin to one of twenty randomly observed residents. Between 2/27/20 and 3/2/20, the facility failed to provide the necessary doses of Potassium Chloride for residents with low potassium levels to one of twenty randomly observed residents. The facility was cited for failure to administer medications in accordance with physician’s orders.

Citation # 920015864
An investigation uncovered several incidents where the staff had falsified records of giving residents their medication even though there was no such medication at the facility. One resident with HIV was supposedly given 654 doses of Norvir 100 mg between 4/6/20/19 to 3/2/20 when there were only 240 doses in the facility. Another resident with heart failure was given 176 doses of Atrovent inhaler even though the facility didn’t have the medication. The director of nurses stated that she wished that the nurses in the facility realized that they are dealing with human life and that not giving the residents their medications as ordered can kill them. The facility was cited for willful falsification of medication administration records.

Citation # 920015863

A female resident with end stage renal disease requiring dialysis, dementia, and requiring moderate to extensive assistance with activities of daily living was discharged to an independent living home on 7/15/19 despite not being able to care for herself. The discharge notice provided to the resident was incomplete. The facility did not notify the independent living home that the resident required dialysis to survive. The facility’s medical records did not indicate the resident’s family was involved in the discharge planning. On 7/18/19, the resident had to be hospitalized, near-death, because she had not had dialysis for five days. The resident remained hospitalized for twelve days. The facility was cited for failing to develop a safe discharge plan, ensure an effective transfer to a lower level of care and ensure the resident’s physician properly evaluated the resident for discharge.

Citation # 920015863

Facility staff failed to follow a physician’s orders or care plan for a resident, and as a result, did not provide the resident with needed doses of a medication to lower the amount of ammonia in the blood. Due to the uncontrolled and elevated ammonia levels, the resident had episodes of altered mental status requiring multiple general acute care hospitalizations.

Citation # 910015736

On 11/21/19, one resident, who required long-term care and wished to remain in the facility, was discharged to a hotel. Two days later, the resident was admitted to the hospital with chest pains. On 3/4/2020, another resident became homeless for eight days after being discharged from the facility onto the street against his wishes. On 3/12, the second resident was admitted to the emergency room with chest pain and underwent surgery to insert a heart catheter. The facility was cited for failing to adhere to the property policy and procedures to ensure transfers and discharges were appropriate and safe for the two residents.

Citation # 910015952

On 11/11/19, a male resident with a diagnosis of major depressive disorder, schizophrenia and anxiety disorder attempted suicide while unsupervised, cutting himself on the left side of his neck with an unknown object. The resident was transferred to an emergency room and then to a trauma center for sutures on both sides of his neck. The hospital noted he had multiple stab wounds upon admission, including on the left side of his neck. The resident had a history of self-harm and was not supposed to have access to silver utensils, although he likely did on the day of the incident. The facility was cited for failure to prevent the resident from cutting himself. The facility was also cited for failure to ensure two additional residents at high risk for self-harm did not have access to metal utensils that could cause bodily harm.

Citation # 910015832
LONG BEACH CARE CENTER  
2615 Grand Ave, Long Beach

A $20000 Neglect Notification Other Patient Care 4/20/2020

On 5/3/19, a resident’s condition began to decline and exhibited poor oral intake, weight loss, sleepy with a blank stare, hypoxia, elevated temperature and generalized weakness. Her physician was notified and ordered “STAT” blood work and a urinalysis. On 5/4/19, a physician’s assistant issued an order to transfer the resident to an urgent care center. On 5/5/19, the resident was transferred to the hospital by paramedics due to an altered mental status and difficulty breathing. She was diagnosed with a heart attack, infections of the urinary tract and bladder, and a stroke, and hospitalized for 13 days. Subsequently, the resident was discharged to another skilled nursing facility and passed away 4 days later. The facility was cited for: failure to obtain immediate laboratory test ordered by the physician; failure to recognize and assess the resident’s stroke-like symptoms and change of condition, and notify her physician when labs ordered were not completed; and failure to recognize, intervene and promptly transfer her to a higher level of care resulting in a 48-hour delay in her receiving necessary care.

Citation # 910015852

MARINA POINTE HEALTHCARE & SUBACUTE  
5240 Sepulveda Blvd, Culver City

B $2000 Bed Hold Evictions 02/14/2020

A 77 year old female resident with COPD had a history of leaving the facility on passes for brief periods. On 12/5/19, while on pass, the resident had to be hospitalized for difficulty breathing. The facility treated the resident’s absence as a discharge even after learning the resident had been hospitalized and was ready to return to the facility. The facility was cited for failing to honor the resident’s bed hold and right to return to the facility following a hospitalization.

Citation # 910015741

MARLORA POST ACUTE REHABILITATION HOSPITAL  
3801 E Anaheim St, Long Beach

A $20000 Injury Medication Neglect Patient Care 4/24/2020

On 11/16/19, a newly admitted resident developed acute respiratory distress as a result of a facility failing to administer medications and respiratory treatments ordered by a physician. The resident’s family member called 911, and the resident was transferred and readmitted to the hospital within 24 hours of having been discharged to the skilled nursing facility. The resident required emergency intubation and was admitted to the ICU. The facility was cited for its deficient practices, including 1) Failure of the nurses to monitor and document the resident’s condition for over 10 hours following admission; 2) Failure to administer the resident’s medications and respiratory treatments; 3) Failure to monitor the resident’s oxygen saturation; and 4) Failure to place the resident on CPAP (a form of positive airway pressure ventilation) as prescribed by the physician.

Citation # 910015859

MEMORIAL HOSPITAL OF GARDENA D/P SNF  
1145 W. Redondo Beach, Gardena

B $2000 Injury Mandated Reporting 5/11/2020

A resident developed an injury on 9/21/19 of unknown origin which resulted in a bump on the resident’s head with discoloration. The facility failed to report this incident to the Department of Public Health within 24 hours. The facility failed to implement its abuse policy and procedure, putting the resident at risk for the potential of further injuries.

Citation # 930015855

PACIFIC PALMS HEALTHCARE  
1020 Termino Ave, Long Beach

B $2000 Elopement 01/24/2020

On 8/30/19, the Department received a complaint regarding a resident’s eloping from the facility. The 77 year-old resident, who suffered from a brain disorder and was known to be a high risk for wandering, was found two days later and brought back by police. The facility did not notify the Department about the elopement as required. The facility deemed this elopement as a non-reportable event because they did not detect any injuries, bruises or skin tears when the resident was returned and assessed. The facility was cited for failure to properly implement its policy and procedures for reporting the elopement within 24 hours after the discovery of the incident.

Citation # 910015702
A $20000 Careplan Fall Injury Neglect Patient Care 4/27/2020

On 3/29/19, a resident fell out of bed while trying to reach for the call light for assistance. The resident’s adult brief was wet and needed to be changed, the door to her room was closed, and she yelled repeatedly for help and nobody came. The resident was incontinent of bowel and bladder, and could not get out of bed without assistance. As a result of the fall, the resident broke her right hip and experienced unbearable pain in her hip, hand and wrist, and was transferred to the hospital for hip surgery. The facility was cited for failing to 1) Accurately assess the resident for risk of falls; 2) Develop a plan of care for the resident’s risk of falls based on the accurate assessment, including a time frame, measurable goals, and interventions; 3) Implement an intervention to ensure a call light was placed within the resident’s reach; and 4) Have a system in place to monitor the resident every shift to ensure the resident’s safety and appropriate call light placement.

Citation # 910015860

B $2000 Notification Patient Rights 05/08/2020

On 2/12/20, the facility failed to immediately notify a male resident’s physician of the declining change in his condition; failed to recognize that the resident’s oxygen level was below normal and required immediate emergency transport; and failed to recognize that the resident’s condition for low oxygen level required assessments by a RN or DON, not a LVN. As a result, the resident, with diagnoses of diabetes and congestive heart failure, suffered from cardiopulmonary arrest and pneumonia and died on 2/12/20 at 10:50 PM. Citation # 950015872

Regency Oaks Post Acute Care Center 3850 E Esther St, Long Beach

B $2000 Physical Abuse 2/14/2020

On 11/30/19 two residents got into a physical altercation. A licensed vocational nurse separated the two residents and informed the administrator. The administrator failed to implement the policy for reporting abuse to the Department of Public Health within two hours of the incident putting both of the two residents at risk.

Citation # 910015738

Rose Garden Healthcare Center 1899 N Raymond Ave, Pasadena

B $2000 Careplan Elopement Fall 5/1/2020

On 12/24/19 and 2/3/20, the facility admitted a 72-year old man with seizures, schizophrenia, diabetes, and childhood developmental delay. His care plan identified him as being at risk of wandering and elopement but did not indicate how facility staff would monitor him for these risks. In the afternoon of 2/14/20, he left the facility. That afternoon a good Samaritan found the resident about a mile from the facility, on the sidewalk and bleeding after a fall. He was admitted to an acute hospital where he was diagnosed with a closed head injury. The facility failed to provide adequate supervision to the resident which affected the resident’s health, safety, or security.

Citation # 950015866

Rose Garden Healthcare Center 1899 N Raymond Ave, Pasadena

A $ Notification Patient Care 05/08/2020

On 2/12/20, the facility failed to immediately notify a male resident’s physician of the declining change in his condition; failed to recognize that the resident’s oxygen level was below normal and required immediate emergency transport; and failed to recognize that the resident’s condition for low oxygen level required assessments by a RN or DON, not a LVN. As a result, the resident, with diagnoses of diabetes and congestive heart failure, suffered from cardiopulmonary arrest and pneumonia and died on 2/12/20 at 10:50 PM. Citation # 950015872
**Royal Palms Post Acute**  
630 W Broadway, Glendale

**B $2000** Injury Mandated Reporting 3/12/2020

On 12/7/19, the family member of a 79 year old nursing home resident reported to the nursing staff that he had a dark discoloration on his forehead. The resident had severely impaired cognitive skills and a history of falling. The Director of Nursing stated that the facility did not report the resident’s injury to the Department of Public Health, because his roommate said he saw the resident hit himself on the bedrails. However, the roommate stated that the curtain was closed, and he did not see the resident hitting himself. The facility was cited for failing to report the resident’s injury to the Department immediately (not less than two hours).

Citation # 950015803

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**West Gardena Post Acute**  
16530 S Broadway, Gardena

**B $2000** Mandated Reporting Verbal Abuse 5/21/2020

A 52 year old female resident was subjected to verbal obscenities from a CNA during an altercation on 12/21/19. Two other CNAs witnessed the exchange but did not report it despite a mandate to report any verbal abuse. The facility was cited for failing to protect the resident from abuse and failing to timely report the abuse as required by law.

Citation # 910015885

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**Windsor Palms Care Center of Artesia**  
11900 Artesia Blvd, Artesia

**B $2000** Infection Physical Environment 3/27/2020

On 12/13/19, one out of 275 residents tested positive for Legionnaire’s disease after being transferred to the hospital for shortness of breath, chest pain, low oxygenation and weakness. Legionnaire’s disease is caused by legionella bacteria that thrives in water, and once aspirated by a person, can turn into pneumonia. The facility failed to establish and maintain an infection prevention and control program to prevent the development and transmission of Legionnaire’s disease in the facility’s water system.

Citation # 910015830

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**Vermont Healthcare Center**  
22035 S Vermont Ave, Torrance

**B $2000** Careplan Infection Neglect Patient Care 03/06/2020

On 12/11/19, The Department received a complaint regarding a resident alleging the facility was not treating her fairly and was hitting her. The resident was admitted to the facility on 11/14/19 with diagnoses that included fractured right femur, pressure sores, difficulty walking, diabetes, and dementia. The goal was for the resident’s pressure wound to improve without complications and keeping the resident clean and dry and turning every two hours. On 12/12/19 resident’s family member stated the staff would not turn or reposition the resident for over four hours unless she requested the resident to be turned. CNA and LVN said they had been providing care to the resident and had never turned or repositioned the resident because she was never asked by a CNA to assist in repositioning. The facility failed to ensure the resident, who was admitted to the facility with a Stage 1 pressure ulcer, receive the necessary care and services to prevent the pressure ulcer from worsening.

Citation # 910015790

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**Vermont Healthcare Center**  
22035 S Vermont Ave, Torrance

**B $2000** Infection Neglect Patient Care 5/1/2020

On 2/27/20, a 78 year old resident who had an indwelling urinary catheter was sent to the hospital via 911 in respiratory distress and an altered level of consciousness. The hospital observed and documented that the resident’s catheter had “spots of blood/clogs of thick substance” in the tubing and that it was coated with a slimy dark grayish substance towards the tip of the catheter. A licensed nurse at the facility falsely documented providing care and treatment for four days after he had been transferred to the hospital. Another nurse was suspended, then terminated for failing to follow orders from the patient’s physician.

Citation # 910015870
Orange County

**BUENA VISTA CARE CENTER**  
1440 S Euclid St, Anaheim

**B $2000 02/14/2020**

On 12/2/19, a resident was admitted to the acute hospital for a reoccurring infected pressure ulcer. After an investigation, it was determined that the facility had failed to assess, measure, obtain a wound treatment order for their resident and implement the necessary interventions to prevent further skin breakdown. As a result of these failures, the resident’s pressure ulcer continued to deteriorate and led to the development of deep tissue injury. The facility was cited for failure to ensure that the necessary care and services were provided to prevent the development of pressure ulcers.

Citation # 060015734

**EXTENDED CARE HOSPITAL OF WESTMINSTER**  
206 Hospital Cir, Westminster

**B $2000 Physical Abuse 03/11/2020**

The facility failed to ensure two residents were free from abuse when a nurse attempted to resolve an altercation on 12/14/19. The nurse inflicted bruising, scratching and skin tears on two residents. The facility’s failure resulted in the residents suffering multiple injuries.

Citation # 060015791

Riverside County

**CHERRY VALLEY HEALTHCARE**  
5800 W Wilson St, Banning

**B $2000 Bed Hold Evictions 10/24/2019**

On 6/17/19, a resident, diagnosed with a traumatic brain injury, was hospitalized for a psychiatric evaluation. The resident’s family member accepted a bed hold offer from the facility during the hospitalization. The resident was deemed to return on 6/21/19, but the facility refused to readmit the resident. He had been living at the facility for seven years. The resident was readmitted to the facility on 7/22/19 after his appeal was granted. The facility was cited for failure to honor the resident’s bed hold and failure to readmit the resident as required by law.

Citation # 250015404

**CORONA HEALTH CARE CENTER**  
1400 Circle City Dr, Corona

**B $200 Transfer 3/4/2020**

On 11/18/19, the facility failed to ensure that notification of a transfer or discharge was provided to the local long term care ombudsman when a patient was transferred to the general acute care hospital on 9/23/19. Facility employees acknowledged that the facility did not have a process to ensure the local long-term care ombudsman was notified of a patient’s transfer. The State concluded that this failure increased the potential for the patient to be transferred from the facility without having an advocate to ensure a safe and effective transition of care.

Citation # 250015566

**CORONA HEALTH CARE CENTER**  
1400 Circle City Dr, Corona

**B $200 Transfer 7/14/2020**

The facility failed to ensure proper notification of transfer or discharge was provided to the local long term care ombudsman when a resident was transferred from the facility to the hospital on 9/29/19.

Citation # 250015567

**MURRIETA HEALTH AND REHABILITATION CENTER**  
24100 Monroe Ave, Murrieta

**B $2000 Mandated Reporting Patient Rights Physical Abuse Sexual Abuse 03/12/2020**

The facility failed to properly report, or investigate an alleged incident of abuse, after a resident reported that another resident touched her inappropriately without her permission.

Citation # 250015604
Ramona Rehabilitation And Post Acute Care Center  
485 W Johnston Ave, Hemet

B $2000 Patient Care 8/3/2020

The facility failed to ensure a resident did not develop a pressure ulcer from being left on a bedpan for an extended period of time. This failure resulted in the resident developing a pressure ulcer on his left and right buttock which was observed on 7/22/19.

Citation # 250015506

San Bernardino County

Yucca Valley Nursing  
57333 Joshua Ln, Yucca Valley

A $10000 Careplan Mandated Reporting Medication Mental Abuse Verbal Abuse 6/15/2020

After a resident returned to the facility from the emergency room, staff failed to properly assess her condition, and failed to provide her with medication for severe abdominal pain and vomiting. Staff failed to report the resident’s condition to a doctor, and failed to provide medication to address elevated blood sugar levels. While the resident yelled in pain and vomited through the night, staff failed to properly clean her, and called her a “bitch.” The resident suffered unnecessary pain, verbal and emotional abuse, and died within 8 hours of returning to the facility.

Citation # 240015899

Ventura County

Victoria Care Center  
5445 Everglades St, Ventura

B $900 Administration Notification 01/06/2020

The facility posted inaccurate facility rating data when an inspector saw multiple signs throughout the facility indicating it had a 5 star rating from Centers for Medicare & Medicaid Services (CMS), when in fact it had a 4 star rating.

Citation # 050015570
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