A Once-in-a-Century Pandemic Yields
a Once-in-a-Generation Chance for Reform:

Introducing the 2021 Nursing Home PROTECT Plan

In light of the unspeakable tragedy that transpired in long term care facilities during the COVID-19 pandemic, a once-in-a-generation legislative reform effort has coalesced in Sacramento. An unprecedented series of bills and budget proposals focused on nursing home reform have been introduced by legislators and state agencies looking to improve long term care.

For the first time in years, nursing home residents have multiple champions in the state legislature fighting for better care. We applaud Senator Stern and Assemblymembers Muratsuchi, Jones-Sawyer, Kalra, Nazarian, and Reyes for responding to the nursing home crisis and introducing legislation that will improve state oversight, financial transparency, accountability, and ultimately enhance care for all residents. The commitment of so many great legislators to addressing the myriad problems in nursing homes proves the need for reform is truly compelling.

The proposals now moving through the legislature will alter the way nursing homes are bought and sold, how they treat their residents and staff, and how they are deterred from misconduct. As the horrific nursing homes crisis finally seems to be abating, now is the time to ensure there are no more nursing home nightmares in the future.

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CANHR News

COVID and CANHR Advocacy

While CANHR’s staff is still working remotely, we are definitely working hard. Our phones are up and running, and we are responding to calls and email inquiries as soon as possible. If our phones are busy or off, you can always email us at canhrmail@canhr.org. We always respond as soon as possible.

Visitation Saves Lives Campaign

CANHR has been working with other advocacy groups to lobby the state and federal governments to open up nursing homes to visitation. We are acutely aware of the profound impact such isolation has had on long term care residents throughout the country and the suffering and neglect resulting from isolation. Both the federal (CMS) and the State (DPH) governments have recently issued new guidance – sometimes contradictory – that significantly relax visitation for nursing homes residents and visitors. See News & Alerts on our Visitation Saves Lives website for the latest guidance on visitation.

COVID website

CANHR’s COVID site has served many thousands of visitors: CANHR’s COVID-19 website. The rapidly evolving website has hundreds of pages devoted to COVID-19 information and news and resources related to long term care. It contains CANHR alerts and recommendations, information on visitation rights, state and federal directives, links to outbreak data, media stories, webinar recordings and much more.

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.

Donate to CANHR

CANHR’s funding has significantly dropped as a result of the pandemic. A donation – however large or small - can make a difference in our advocacy. Please donate to CANHR.

DONATE TO CANHR
The PROTECT Plan

The core of the legislative reform efforts is the Prioritize Responsible Ownership, Treatment, Equity, and Corporate Transparency (PROTECT Plan). The PROTECT Plan is made up of the following seven bills:

1. SB 650 (Stern): Corporate Transparency in Elder Care. Requires nursing homes to submit audited consolidated financial reports so the public can see how much of its tax dollars are being spent on care for residents and how much is being spent on “related party” businesses the nursing home owns or controls.

2. AB 279 (Muratsuchi): Prohibiting Resident Eviction During the Pandemic. Prohibits intermediate care homes or nursing homes from terminating services to residents or from transferring a resident to another facility without consent during any declared state of emergency relating to the coronavirus disease 2019 (COVID-19).

3. AB 323 (Kalra): Nursing Home Citations. Provides a long-overdue inflationary boost to nursing home citation penalties and updates the criteria for AA citations (those that cause the death of a resident) from the old “direct proximate cause of death” standard to the clearer “substantial factor” standard.

4. AB 749 (Nazarian): Certification of Nursing Home Medical Directors. Requires nursing home medical directors to be certified by the American Board of Post-Acute and Long-Term Care Medicine.

5. AB 849 (Reyes): Nursing Home Resident Rights. Restores facility liability to up to $500 for each violation of a resident’s rights, undoing last year’s awful Jarman v. HCR Manorcare decision, which held that nursing homes could violate as many resident rights as it wants for $500.

6. AB 1042 (Jones Sawyer): Related Party Accountability. Establishes shared liability for entities that share ownership or control of nursing homes. Related parties will be liable for unpaid state monetary penalties for citations and unpaid Quality Assurance Fees.

7. AB 1502 (Muratsuchi): Nursing Home Ownership and Management Reform. Establishes suitability standards for persons and entities seeking to run nursing homes and ends nursing home squatting, where persons or entities run nursing homes with no approval from the state.

Other Key Legislation

In addition to the PROTECT Plan, there are other important bills aimed at persistent long term care concerns. AB 6 (Levine) would facilitate statewide health and safety guidelines for nursing homes to use during a pandemic when there is a surge in demand. AB 848 (Calderon) increases the nursing home personal needs allowance from a pitiable $35/month to $80 and adjusts it annually for inflation. AB 665 (Garcia) provides for internet access to RCFE residents. These are sensible bills that will enhance quality of life for residents. On the other hand, AB 1054 (Arambula) proposes to permit lowly trained, lowly paid feeding assistants to supplant the work of Certified Nursing Assistants (CNAs), a bad deal for residents that will lower the quality of care in nursing homes.

The most important of the bills outside of the PROTECT Plan is SB 460 (Pan). SB 460 creates a new statewide Office of the Patient Representative for unrepresented nursing home residents (those who lack decision-making capacity and surrogate decisionmakers). CANHR successfully sued the state for having an unconstitutional system for making health care decisions for unrepresented residents and the final court order required residents be assigned a patient representative. SB 460 will codify the court decision and introduce patient representatives throughout the state to assist unrepresented residents in their health care decisions. A separate budget proposal has been introduced to fund the patient representatives.
Introducing the 2021 Nursing Home PROTECT Plan

Another budget proposal would give the Department of Health Care Services (DHCS) the power to impose $1,000/day fines on underhanded nursing homes that have unlawfully evicted residents and refused to readmit them, despite having been ordered to by DHCS. Consequences for these recalcitrant facilities have long been needed.

Real Reform for Better Care

Californians should be heartened by the recent developments and momentum for change in the State Capitol. But introducing bills and pushing proposals is just step one of a long journey to improving care. Most of the bills will be vehemently opposed by the nursing home industry, which will be singularly focused on getting yet more taxpayer dollars while evading more scrutiny.

To counter the certain onslaught of opposition, nursing home reform will need public engagement like never before. Be on the lookout for CANHR’s legislative alerts which will rally support and opposition for proposals as needed. Check out canhrlegislation.com to stay up-to-date on the status of the reform efforts. Most importantly, provide your voice! Write to the key legislative committees, call into committee hearings, and talk to your state Assemblymember and Senator to make sure they are committed to reform. One bright spot of the pandemic has been to open committee hearings to residents of the whole state and not just those who live near Sacramento.

The pandemic preyed on a broken nursing home care system as much as it preyed on the frail and elderly residents who live there. Despite an unprecedented lockdown to protect residents, the facilities were not up to the task due to years of cutting corners on infection control and other key health care practices, chronic understaffing borne of low pay and low morale for staff, and owners focused on taking care of their pocketbooks over taking care of residents. Partially as a result of this long-standing buildup of greed and neglect, over 9,000 California nursing home residents and staff members have died from COVID-19.

Do not let these deaths be in vain! Please join us and support the incredible reform efforts already underway. Where there is resident harm, there will be more justice, where there is poor care, there will be more accountability, and where there is darkness, there will be more light.

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.
While California has made strides towards vaccinating residents and staff in long term care facilities throughout the state, in the next months it will be crucial that these efforts continue even as vaccinations proceed outside congregate settings.

According to the State Department of Public Health, by the end of March 2021, most on-site vaccination clinics occurring at long term care facilities enrolled in the Pharmacy Partnership for Long-Term Care (LTC) Program will be complete, although the State has still not released data regarding the number of staff and residents who have been vaccinated at individual facilities.

State and federal health authorities have made it clear that it is important for all long term care facilities—even those that participated in the Pharmacy Partnership for LTC Program—to continue to receive COVID-19 vaccines for their residents and staff. The state advises that jurisdictions should develop plans to ensure facilities in their communities continue to have access to COVID-19 vaccines.

They can do this by transferring a portion of their vaccine allocation to a federal pharmacy partner to help vaccinate long term care facility staff and residents or by enrolling their local long term care pharmacies as COVID-19 vaccination providers to help vaccinate long term care staff and residents. For additional information, see https://www.cdc.gov/vaccines/covid-19/long-term-care/pharmacy-partnerships-access.html.

If residents of long term care or their families are aware of facilities experiencing difficulty with continuing access to vaccines, they should reach out to CANHR staff who can assist.
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.
Family Councils:
Making a Difference

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/

CA Attorney General Becerra and District Attorney Coalition Sue Brookdale Senior Living

On March 15, 2021, Attorney General Xavier Becerra and a coalition of district and city attorneys, led by Kern County District Attorney Cynthia Zimmer, sued Brookdale Senior Living, Inc. in Kern County Superior Court, alleging that Brookdale endangered residents of ten California skilled nursing facilities by failing to properly notify or prepare residents before transfers and discharges. The lawsuit also alleges that Brookdale over-reported staffing levels to the federal government, resulting in fraudulent increases to its federal star ratings for purposes of attracting potential residents. Brookdale is the nation’s largest senior living facility operator. Read the press release.

CANHR and Consumer Voice Sue CMS Over 2017 Guidance on Civil Money Penalties Imposed Against Nursing Facilities

A lawsuit filed January 18, 2021 by National Consumer Voice for Quality Long-Term Care (Consumer Voice) and California Advocates for Nursing Home Reform (CANHR) challenges a 2017 CMS policy change limiting the types of civil money penalties (CMPs) that can be imposed for deficiencies that occurred at nursing facilities but were corrected before the survey – so called “past noncompliance.” In the new guidance, CMS said that only per instance CMPs, not per day CMPs, could be imposed for past noncompliance. The plaintiffs allege that this policy change “encourage[s] nursing facilities to knowingly allow deficiencies to linger, unaddressed for multiple days, weeks, or even months until the next state survey, because the penalty will be the same regardless of whether the deficiency persisted for one day, thirty days, ninety days, or nine months.” Plaintiffs are seeking declaratory and injunctive relief. The two resident advocacy organizations are represented by attorneys with the AARP Foundation and Constantine Cannon. National Consumer Voice for Quality Long-Term Care v. Alex M. Azar II, Case No. 21-162 (D.D.C. filed Jan. 18, 2021), nat-consumer-voice-v-us-dept-hhs-complaint (aarp.org)

New York Times Slams Federal Rating System for Nursing Homes

A scathing March 13, 2021 article by the New York Times – In U.S. nursing homes, where Covid-19 killed scores, even reports of maggots and rape don’t dock five-star ratings – bluntly declared that the federal government’s five-star rating system for nursing homes “is broken.” The Times described five-star rated nursing homes with residents who had bone-deep bed sores and others who were reportedly raped, drugged, abused and seriously injured due to mistreatment. Moreover, it documented operators routinely gaming the ratings by submitting inflated staffing data and falsified resident care information that makes facilities seem cleaner and safer than they are. Because operators could score high ratings without improving their care, it concluded that nursing homes may have been unprepared for the pandemic. More than 130,000 U.S. nursing home residents have died of Covid-19, and the Times’s analysis found that people at five-star facilities were roughly as likely to die of the disease as those at one-star homes.
My mother is on Medi-Cal, and wants me to inherit her home after she dies without going through the time and expense of probate or trust administration. She is considering using a TOD Deed, but is concerned that Medi-Cal will make a claim against her home after she dies. Can Medi-Cal make a recovery claim against a home that is transferred via a Transfer on Death Deed ("TOD Deed")?

Son in Sunnyvale

Dear Advocate:

Dear Son:

Like most simple and inexpensive legal strategies, there are advantages and disadvantages to the TOD Deed. For more information, see CANHR’s Fact Sheet: Transferring Your Home with a Transfer on Death Deed (TOD) – What You Need to Know. However, if your mother does decide to transfer her home to you via a TOD Deed, she does not need to be concerned about a Medi-Cal recovery claim. For individuals who die on or after January 1, 2017, recovery is limited to only those assets subject to California probate. Since your mother’s home will pass to you via the TOD Deed, it will not be subject to probate, nor a Medi-Cal recovery claim.

Did You Know?

Role of Nursing Home Residents’ “Outside” Physicians

While nursing homes are required to employ medical directors to oversee the care of residents, under federal and state law residents are still legally entitled to rely on the recommendations of their own personal physicians outside the facility as well.

Pursuant to 42 Code of Federal Regulations (“CFR”) Section 483.21, initial care plans developed upon admission to a nursing home must address physician orders, while comprehensive care plans dictating ongoing treatment at the facility must be developed with not only facility staff but with “professionals in disciplines as determined by the resident’s needs or as requested by the resident.”

Furthermore, 22 California Code of Regulations (“CCR”) Section 72301 provides that a nursing home “shall ensure that all orders, written by a person lawfully authorized to prescribe, shall be carried out unless contraindicated.” This language is echoed by 22 CCR Section 72313(a)(2) which requires that “[m]edications and treatments shall be administered as prescribed.”

If a nursing home refuses to follow the orders of a resident’s outside physician, residents and their family members should reach out to CANHR staff, who can assist with filing a complaint with regulators.
CANHR On The Move

• 10/19/2020: CANHR Staff Attorney Jody Spiegel participated in the RCFE Advocates Quarterly Meeting with Community Care Licensing.


• 01/12/2021: Julie Pollock presented Medi-Cal Home and Community Based Services and Medi-Cal Estate Recovery at a Bay View Church Networking Meeting.

• 01/15/2021: Staff Attorney Mike Dark hosted a Zoom town hall for California residents of long-term care and their families, friends, and advocates to discuss the COVID-19 vaccine rollout in nursing homes and other long-term care facilities.

• 01/21/2021: Julie Pollock gave a presentation on long-term care advocacy and planning for care to the East Bay Daughterhood Circle.

• 01/21/2021: Prescott Cole participated in the U.S. Attorney General Northern Districts Elder Justice Task Force, San Francisco

• 02/02/2021: Amber Roberts presented on Cracking the CCRC Conundrum for UCR’s Osher LIFE Lecture Series

• 03/02/2021: Julie Pollock provided in-service training for Legal Services for Seniors (LSS) on Medi-Cal Estate Recovery

• 03/04/2021: Staff Attorney Mike Dark hosted family council organizational meetings at Sakura Intermediate Care Facility.

• 03/15/2021: Staff Attorney Mike Dark hosted a family council organizational meeting for Kei-Ai Los Angeles Health Care Center.

• 04/07/2021 - Long Term Care Hot Topics - Jody Spiegel & Advocates

• 04/14/2021- Incapacity - Tony Chicotel & Dr. Jonathan Evans

• 04/21/2021 - Elder Financial Abuse - Prescott Cole

• TBD - Medi-Cal Basics - Matt O’Donnell, Peter Stern, Carlos Arcos

UpComing Events

Legal Services Trainings

• 04/07/2021 - Long Term Care Hot Topics - Jody Spiegel & Advocates

• 04/14/2021- Incapacity - Tony Chicotel & Dr. Jonathan Evans

• 04/21/2021 - Elder Financial Abuse - Prescott Cole

• TBD - Medi-Cal Basics - Matt O’Donnell, Peter Stern, Carlos Arcos

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 March 2021. 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
CANHR has supported, opposed, and/or closely followed the below pieces of legislation this session. Please check www.canhrlegislation.com for updated details on legislation, and www.leginfo.ca.gov for information on specific bills.

SPONSOR

**AB 279 (Muratsuchi): Prohibiting Resident Eviction During the Pandemic**
Many residents of California skilled nursing facilities (“SNFs”) and Intermediate Care Facilities (“ICFs”) face a terrible prospect in the ongoing COVID pandemic: involuntary transfer to new facilities, sight unseen, far from their families and support networks. AB 279 would prohibit the owner of an ICF or SNF from ceasing to deliver or making significant changes to residential care services, or from transferring a resident to another facility, during any declared state of emergency relating to the coronavirus disease 2019 (COVID-19), except if the owner files for bankruptcy. The bill’s protections would expire one year after the cessation of states of emergency, to permit residents and their families to assess new facilities if their current homes are going to close.

**Status: Referred to Assembly Health Committee**

**AB 1502 (Muratsuchi): Skilled Nursing Facility Ownership and Management Reform**
California has a growing problem of nursing homes being operated by unsuitable, unapproved, and unaccountable persons and entities. AB 1502 would reform ownership and management of skilled nursing facilities by establishing suitability standards for persons and entities seeking to own, operate, or manage skilled nursing facilities in California and directing the California Department of Public Health (CDPH) to thoroughly screen all applicants and related parties. The bill would also require owners and operators to obtain prior approval from CDPH before acquiring, operating, or managing a nursing home and provide sanctions if they don’t. In addition, AB 1502 prohibits the use of management agreements to circumvent state licensure requirements and requires CDPH to post nursing home licensing applications on its website and to give the public an opportunity to comment on pending applications.

**Status: Referred to Assembly Health Committee**

**SB 650 (Stern): Skilled Nursing Facility Transparency and Accountability**
Californians are paying more for nursing home care, for fewer residents, than ever before and we are not getting our money’s worth. Despite spending nearly six billion dollars a year, complaints against facilities are at record highs and the care provided is often abysmal. Nursing homes are using complex ownership structures to siphon unprecedented amounts of money to “related parties,” allowing corporate home offices to hide their profits and support facilities’ claims for yet more public money. SB 650 requires nursing homes to file annual consolidated financial statements, giving the State and the public more transparency for nursing home payments. The bill also requires nursing home management and property companies to submit audited financial reports. The public has the right to know how much of its money is supporting nursing home residents versus how much is being spent on the lifestyles of billionaire nursing homes owners.

**Status: Referred to Senate Health Committee**
AB 323 (Kalra): Long-Term Health Facilities
This bill enhances the state nursing home enforcement system by: 1) increasing the penalties for state citations issued against nursing homes to keep up with inflation and 2) updating the criteria for AA citations (those that cause the death of a resident) from the old “direct proximate cause of death” standard to the more clear “substantial factor” standard used by courts.
Status: Referred to Assembly Health Committee

AB 749 (Nazarian): Skilled nursing facilities: medical director certification
This bill would prohibit a skilled nursing facility from contracting with a medical director if the person is not, or will not be within 5 years, certified by the American Board of Post-Acute and Long-Term Care Medicine as a Certified Medical Director.
Status: Referred to Assembly Health Committee

AB 849 (Reyes/Stern): Restoring the Enforcement of Nursing Home Resident Rights
Since 1982, California nursing home residents have had a “private right of action” (the ability to sue) for violations of their rights. Last year, the state Supreme Court ruled that nursing homes that violate the rights of residents may only be held liable for $500 maximum, regardless of how many rights a facility violates and how egregious those violations are. Nursing homes now routinely infringe multiple rights of residents and simply send the victims $500 checks as a license to violate. Poor care is officially profitable. AB 849 will restore facility liability to up to $500 per violation, so that offending facilities have to answer for every breach of resident rights it commits.
Status: Referred to Assembly Judiciary Committee

AB 1042 (Jones-Sawyer): Skilled Nursing Facilities: unpaid penalties: related parties
Establishes shared liability for entities that share ownership or control of nursing homes. Related parties will be liable for unpaid state monetary penalties for citations and unpaid Quality Assurance Fees.
Status: Referred to Health Committee

AB 6 (Levine): Health facilities: pandemics and emergencies
This bill would require the Department of Public Health and the Department of Social Services to establish health and safety guidelines for use by skilled nursing facilities, intermediate care facilities, and congregate living health facilities that are providing post-acute care during a pandemic, public health crisis, or other emergency.
Status: Referred to Assembly Health Committee

AB 470 (Carrillo): Medi-Cal Asset Test
This bill would eliminate the Medi-Cal asset test.
Status: Hearing in Assembly Health Committee on 4/6.

AB 636 (Maienschein): Financial Abuse of Elder or Dependent Adults
This bill would authorize information relevant to the incident of elder or dependent adult abuse to be given to a federal law enforcement agency
Status: Hearing in Assembly Aging & LTC on 4/6/21

AB 848 (Calderon): Medi-Cal: Personal and Incidental Needs
This bill would increase the monthly maintenance need allowance for long-term care Medi-Cal beneficiaries from $35 to $85.
Status: Passed Assembly Health Committee and Referred to Appropriations Committee

AB 895 (Holden): Residential Care Facilities: Conditions
This bill would require DSS to post on its website inspection reports for every licensed RCFE for 5 years, and also to administer a pilot program to test the appropriate criteria to evaluate the quality of RCFEs.
Status: Referred to Senate Human Services Committee
AB 665 (Garcia): Residential Care Facilities for the Elderly: Basic Services: Internet Access
This bill would require that residential care facilities for the elderly (RCFEs) that have internet service provide at least one internet access tool with microphone and camera function to residents, as a basic service.
Status: Referred to Assembly Human Services

AB 714 (Maienschein): Communicable Disease Reporting
This bill would require health facilities, including skilled nursing facilities, to report communicable disease data to the department, patients or residents of the health facility, and their representatives and family members. It would also require the department to post data relating to the total number of disease-related deaths and suspected disease-related deaths reported from the health facilities on its website on a weekly basis.
Status: Referred to Assembly Health Committee

SB 56 (Durazo): Medi-Cal Eligibility
This bill would extend eligibility for full-scope Medi-Cal benefits to undocumented individuals who are 65 or older.
Status: Passed Senate Health Referred to Appropriations Committee

SB 281 (Dodd): California Community Transitions Program
This bill would make the California Community Care Transitions Program permanent, and reduce the time needed for an applicant to be considered “institutionalized” to 60 days spent in a Skilled Nursing Facility.
Status: Passed Senate Health and Referred to Appropriations Committee

SB 460 (Pan): Office of Patient Representative
This bill would create the Office of the Patient Representative to train and oversee patient representatives to protect the rights of nursing home residents who allegedly lack capacity to make decisions and have no surrogate decisionmaker available.
Status: Hearing in Senate Human Services on 3/23/21

SB 447 (Laird): Civil Actions: Decedent’s Cause of Action
This bill would permit damages for a decedent’s pain, suffering, or disfigurement to be recovered in an action brought by the decedent’s personal representative or successor in interest.
Status: Referred to Senate Judiciary Committee

SB 664 (Allen): Hospice Moratorium
This bill responds to a remarkable investigation and series of articles by the Los Angeles Times on audacious, widespread fraud by hospices in Los Angeles County, which has seen explosive growth of for-profit hospices that has given it the highest concentration of hospices in the nation. SB 664 would impose a qualified moratorium on the issuance of new hospice licenses until 365 days after the California State Auditor publishes a report on hospice licensure or when it is repealed on January 1, 2027, whichever is soonest.
Status: Referred to Senate Health Committee

SB 724 (Allen): Conservatees: Legal Counsel
This bill would allow Conservatees to seek representation by their preferred attorney, even if the attorney is not on the court’s list of approved attorneys.
Status: Hearing in Senate Judiciary Committee on 4/13/21
AB 574 (Chen): Guardian Ad Litem: Mental Illness
AB 574 would allow a probate court to appoint a guardian ad litem (GAL) with many of the powers of a conservator, but without the due process and supposed “oversight” required in a conservatorship.
Status: Referred to Assembly Health Committee

AB 1313 (Bigelow): COVID-19: Immunity from Civil Liability
This bill would exempt a business from liability for an injury or illness to a person due to coronavirus (COVID-19) based on a claim that the person contracted COVID-19 while at that business, or due to the actions of that business, if the business has substantially complied with all applicable state and local health laws, regulations, and protocols. Status: Referred to Assembly Judiciary Committee

AB 499 (Rubio): Referral Source for Residential Care Facilities for the Elderly
This bill would require an RCFE referral agency to provide a senior with written, electronic, or verbal disclosures that include the referral source’s privacy policy, and to maintain a minimum amount of liability coverage.
Status: Hearing in Assembly Human Services on 4/7

AB 1300 (Voepel): Residential Care Facilities: Electronic Monitoring
This bill would allow residents of a residential care facility for the elderly (RCFE) to use electronic monitoring devices in their rooms.
Status: Referred to Assembly Human Services

SB 648 (Hurtado): Care Facilities
This bill would permit adult residential facilities (ARFs) and residential care facilities for the elderly (RCFEs) with at least 75% SSI recipients to be eligible to receive up to 60 hours of IHSS.
Status: Hearing in Senate Human Services on 4/20

SB 769 (Becker): Housing rental vouchers: Skilled Nursing Facility Patients
This bill would create a pilot program, from January 1, 2023, to January 1, 2026, to provide housing rental-related subsidies to skilled nursing facility patients who, but for a lack of housing, would be discharged from the facility.
Status: Hearing in Senate Housing Committee on 4/29

BUDGET ITEMS OF CONCERN

DHCS Trailer Bill: Long-Term Health Care Facility Penalties for Improper Discharges
This proposal would authorize the Department of Health Care Services (DHCS) to issue a monetary penalty against a Skilled Nursing Facility for failure to comply with a hearing decision ordering a SNF to readmit a resident after an improper transfer, discharge, or failure to readmit from the hospital. CANHR has suggested a number of amendments to the trailer bill language, including: making the fines mandatory, rather than permissive; instituting a suspension of payments for new admissions to the SNF until the facility complies with the hearing decision; eliminating the financial hardship waiver; and adding a statement regarding the resident’s right to stay in the hospital pending the readmission.
RCFE Admission Agreements Provisions: Legal v. Illegal

RCFE admission agreements are contracts that specify the rights and responsibilities of both residents and the facility, and must comply with California laws and regulations. The RCFE admission agreement is the most important document for addressing concerns and resolving disputes. However, many admission agreements contain illegal and unenforceable provisions. Before signing an admission agreement, read it carefully and make sure that you understand its provisions. If you have questions, address them with the facility and make sure that the questions are answered to your satisfaction.

Below are examples of several common illegal provisions in RCFE admission agreements:

### REASONS FOR EVICTION

**Legal:** There are only five legal reasons for eviction from an RCFE:

1. Non-payment
2. Failure to comply with state or local laws
3. Failure to follow facility policies that are for the purpose of helping residents to live together
4. Facility cannot meet a resident's changing needs
5. Facility is no longer operating as an RCFE

[HSC 1569.269(a)(22); 22 CCR 87224(a)]

**Illegal:** Although an RCFE is prohibited from modifying the reasons for eviction in its admission agreement, [22 CCR 87507(g)(10)], facilities often list numerous impermissible reasons, such as:

- “You have a communicable disease.”
- “You are not elderly and have needs in conflict with other residents or the programs of services offered, or require more care and supervision than other residents.”
- “You would require a greater amount of care and supervision than other residents at FACILITY, or if you cannot generally benefit from the program of services available at FACILITY.”
- “You refuse to accept services required in order for FACILITY to meet your needs.”
- “You have health care needs that cannot be met at FACILITY, for reasons such as licensure, design or staffing.”
- “Your personal physician has determined that you require services not available at FACILITY.”
- “Any misrepresentation or omission made by you or on your behalf, whether written or verbal, should be grounds for termination of this agreement.”

Since these reasons are not any of the five authorized reasons for eviction, it is illegal for an RCFE to include them in its admission agreement.
LEGAL: Admission agreements must clearly specify the basic services required to be provided to each RCFE resident, any optional services that are available, and the corresponding charges. No fee may be charged that is not clearly stated in the admission agreement. [HSC 1569.884; 22 CCR 87507(g)]

ILLEGAL: Although admission agreements are required to clearly describe all services and charges, most agreements include inadequate or ambiguous descriptions of services and/or charges, such as:

“Resident is responsible for telephone installation and service.”

Since RCFEs are required to have telephone service on premises, and residents have the right to reasonable access to telephones, [22 CCR 87311, 87468.1(a)(14)], the provision is deficient because it fails to clearly specify the nature of the telephone installation and services the resident is responsible for, and the cost for those items. Additionally, since RCFEs are required to provide residents with access to telephones, the RCFE cannot refuse to provide telephone service even if the resident fails to pay for it.

“Personal supplies – Cost +”

This provision is deficient because it does not define the terms “personal supplies,” nor “cost +,” to ensure that residents know what items they are agreeing to pay for and the cost of those items.

SECURITY DEPOSITS

LEGAL: An RCFE may not require or accept any funds that constitute a deposit against any possible damages by the resident. [HSC 1569.651(c)]

ILLEGAL: Although security deposits are illegal, many RCFE admission agreements require residents to pay them by describing them in connection with refunds, such as:

“After Apartment has been vacated and property removed, FACILITY will refund any unused portion of the final monthly fee minus any expense incurred in repairing damage caused by you to the Apartment.”
WAIVER OF RIGHTS: THEFT OR LOSS OF PERSONAL PROPERTY

LEGAL Admission agreements cannot require residents to waive benefits or rights to which they are entitled by federal or state law. [HSC 1569.269(c)]

ILLEGAL Although an RCFE is prohibited from requiring residents to give up benefits or rights, many admission agreements include hold harmless provisions, such as:

“You agree to hold us, our associates and agents harmless for any damages, injury or other loss of personal property.”

This provision is illegal, because an RCFE is required to make reasonable efforts to safeguard residents’ property. If it fails to do so, it must replace or pay for the stolen or lost property at its current value. [HSC 1569.152(a); 22 CCR 87218(a)(2)]

Do not let RCFEs get away with trying to enforce illegal provisions in admission agreements! If you have concerns about the legality of specific provisions, either before or after you sign the agreement, please contact CANHR. If the admission agreement contains an illegal provision, file a complaint with CCL and send a copy of the complaint to CANHR.

For more information, please see CANHR’s fact sheets on RCFE Admission Agreements, and Filing Complaints.
**Vaccines, Visitation & COVID in CCRC**

In a March 4, 2021 Provider Information Notice (PIN 20-43), Community Care Licensing provided updated guidance to RCFE licensees on vaccines, as well as a fact sheet for residents. [https://cdss.ca.gov/Portals/9/CCLD/PINs/2021/ASC/PIN-21-14-ASC.pdf](https://cdss.ca.gov/Portals/9/CCLD/PINs/2021/ASC/PIN-21-14-ASC.pdf). The notice includes a reminder that all individuals, including those who have been vaccinated, should continue to wear a mask, practice frequent hand hygiene, maintain at least six (6) feet distance from others, and avoid attending gatherings of groups of people until the end of the pandemic.

As far as visitation goes, the rule still stands that independent CCRC residents are exempt from testing, quarantine and isolation guidelines, except when the independent CCRC resident is:

- Living with a resident who is receiving assisted living services;
- Commingling with residents who receive assisted living services or live in assisted living unit by, for example, participating in communal dining or activities or using common facility amenities;
- Presenting symptoms for COVID 19; or
- Exposed to a person who tested positive for COVID 19.

Should you have problems with visitation issues in a CCRC, please let us know.

**Arbitration Clauses in CCRC Contracts**

The Department of Social Services, CCL, released PIN 21-02-CCR to inform CCRC providers of a recent court decision that held continuing care contracts are subject to Civil Code § 1953(a) (4) and held that CCRCs may not enforce pre-dispute arbitration clauses affecting “disputes arising from or related to the tenancy provisions of a continuing care contract.” In [Harris v. University Village Thousand Oaks, LLC (2020) 49 Cal. App. 5th](https://www.youtube.com/watch?v=CMrC6o6Rm04), the Court of Appeals construed section 1953 broadly to protect the rights of tenants, especially tenants who may not fully understand a lease or rental agreement. This could apply to almost all CCRC contracts, since few CCRC residents fully understand the lengthy and complicated contracts.

While the Department is requiring all CCRC providers to review their contracts to ensure compliance with the Harris decision, we’ll have to get more details from the Department to see how they intend to enforce this.

**In Memory – Professor Lillian Hyatt**

CANHR is sad to announce the death of Lillian Hyatt, a CANHR Advocate correspondent for CCRC issues for many years and an AARP Public Policy specialist on CCRC issues.

Professor Hyatt was an articulate and passionate advocate for the rights of Continuing Care Retirement Community residents. In addition to writing columns about CCRCs and resident rights for CANHR and for the newsletter of the National Association of Social Workers-California Chapter, Ms. Hyatt was also the plaintiff in a groundbreaking lawsuit that challenged the discriminatory practices at the Sequoias, the CCRC where she lived.

Lillian, or “Professor Hyatt,” as she was known to all, can be seen on Youtube on the USC School of Social Work Channel at: [https://www.youtube.com/watch?v=CMrC6o6Rm04](https://www.youtube.com/watch?v=CMrC6o6Rm04)

Her columns on CCRCs for the CANHR Advocate can be read at: [http://canhr.org/CCRC/CCRCcorner.html](http://canhr.org/CCRC/CCRCcorner.html)

Goodbye Lillian. All of us at CANHR will miss you.

**Tamalpais Family Council – The Book**

Elizabeth Phillips, Joan Hauck and Lucy Wait, residents of the Tamalpais Retirement Life Care Community, a CCRC in Marin County, started a Family Council at their community over six years ago. With over 150 members, it has grown to be the largest, most active Family Council in California. The “History of the Tamalpais Family Council,” a book written and edited by the Mses. Phillips, Hauck and Wait, is available from CANHR. We have about 100 copies, so let us know if you would like a copy.
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**

**Pat McGinnis**  
Rosie Dittrich

**Rosa Cheung**  
William Liu

**JH Davis**  
Susan Wehrle

**Skilled Nursing / Assisted Living Staff**

- Elizabeth Malloy
- Luana Ratliff  
  Karman Guadagni Esq.
- The Kwong Family  
  Jacqueline Kwong

**Mary Gerber**  
Janette Tom

**Josephine Kleidon**  
Judith Dunham

**Koko Komatsu**  
Domingo A. Magwili

**In Memory Of**

**Lillian Hyatt**  
CANHR staff

**Therese Serezlis**  
Nola R. Serezlis-Slattery

**Josephine Luckjohn**  
Georgia Riportella

**Naomi Wood**  
Marion Wood

**Joyce Vanlandingham**  
James L. Cunningham, Jr.

**Julius Schnall**  
Jean Schnall

**Aunt Jan**  
Jenny Lanning

**Helen Drachkovitch**  
CANHR staff

**Donna Smith & Luther B. Denson**  
Ruth Holland

**Bery DuBois**  
Candie Brady

**Eugene Taylor and Larry Roth**  
Penny Deleray Taylor

**Catherine Gibbons Lynch, RN**  
Judith Lynch-Kenney

**Virginia Davis**  
Susan Wehrle

**Constantine J. Hassakis**  
Greta A. Hassakis

**Jim Murad**  
CANHR staff

**Pat Haight**  
James T Haight

**Sherry O. McIlwain**  
Gloria McIlwain

**Tim Millar**  
Daniel Rossi

**Mr. Yim Lau**  
Sarah Lee

**Eunice Stuart**  
Kathleen Stuart Stuart

**Donna Ambrogi**  
Donna Calame

**LaVerne Schwacher**  
Debra Vogler

**Dorothy Dally**  
Sheila Buska
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 miss@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.

MonteRey COunTy

Ave MarIa ConValescent HoSpIal
1249 Josselyn Canyon Rd, Monterey

B $1000 Infection; Mandated Reporting; Notification 11/9/2020

The facility failed to timely report COVID-19 Survey Data on three separate occasions. This failure resulted in incomplete data reported to the Department necessary to respond to the COVID-19 outbreak. these failures had the potential to compromise the residents’ medical health and safety.

Citation # 070015970

GiROY HEALTHCARE AND REHABILITATION CENTER
8170 Murray Ave, Gilroy

B $1000 Infection; Patient Care 8/10/2020

The facility failed to timely report COVID-19 survey data on three separate occasions. This failure put residents’ health and safety at risk.

Palo Alto Sub-Acute and Rehabilitation Center
911 Bryant St, Palo Alto

B $1000 Infection; Patient Care 8/27/2020

The facility failed to timely report COVID-19 survey data on three separate occasions. This failure put residents’ health and safety at risk.

Vi at Palo Alto
600 Sand Hill Rd, Palo Alto

B $1000 Administration; Mandated Reporting 9/28/2020

The facility failed to timely report COVID-19 Survey data on three separate occasions: 8/16/20, 8/28/20 and 9/14/20. These failures resulted in incomplete data reported to the Department of Public Health necessary to respond to the COVID-19 outbreak. These failures had the potential to compromise the residents’ medical health and safety.

Citation # 070016064

SaNTa ClArA COunTy

CuPertiNO HeathCARE & WeLLNeSS CENTER
22590 Voss Ave, Cupertino

B $1000 Infection; Patient Care 7/20/2020

The facility failed to timely report COVID-19 survey data on three separate occasions. This failure put residents’ health and safety at risk.

Citation # 070015930
Santa Clara County

VISTA MANOR NURSING CENTER
120 Jose Figueres Ave, San Jose

B  $1000  Administration; Mandated Reporting
11/3/2020

The facility failed to timely report COVID-19 Survey data on three separate occasions: 6/2/20, 8/14/20 and 10/15/20. These failures resulted in incomplete data reported to the Department of Public Health necessary to respond to the COVID-19 outbreak. These failures had the potential to compromise the residents’ medical health and safety.

Citation # 070016132

Santa Cruz County

SANTA CRUZ POST ACUTE
1115 Capitola Rd, Santa Cruz

B  $1000  Administration; Mandated Reporting
11/10/2020

The facility failed to timely report COVID-19 Survey data on three separate occasions: 6/6/20, 8/3/20 and 10/9/20. These failures resulted in incomplete data reported to the Department of Public Health necessary to respond to the COVID-19 outbreak. These failures had the potential to compromise the residents’ medical health and safety.

Citation # 070016145

Solano County

LAUREL CREEK HEALTH CENTER
2800 Estates Dr, Fairfield

B  $2000  Mental Abuse; Physical Abuse 1/12/2021

The facility failed to protect a resident from abuse, when an unlicensed staff grabbed the resident’s arms, forcibly walking them backwards and pushing them down into a chair. The resident, diagnosed with dementia, was distressed and crying after the incident.

Citation # 110016088

Tulare County

MERRITT MANOR CONVALESCENT HOSPITAL
604 E Merritt Ave, Tulare

A  $20 000  Physical Abuse 9/8/2020

An 86 year old resident with dementia was repeatedly attacked by two other residents, who also suffered from cognitive impairments. The resident was hospitalized on 10/29/19 after having sustaining scratches, skin tears to the forearm, eyebrows, and the top of his head. The facility was cited for failure to protect the resident from physical abuse when two other residents attacked him during three separate incidents.

Citation # 120015652
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--- KERN COUNTY ---

**Valley View Care Center**
729 Browning Rd, Delano

**B $2000 Fall Injury 1/6/2020**

On 8/29/19, a 68 year old male resident, with amputations on both legs below the knee, fell from his wheelchair while trying to get a cigarette from his shirt pocket. The resident had mildly impaired cognition and required supervision for smoking and assistance with going to the designated smoking area, but he was found by himself with no supervision at the time of the incident. The fall caused heavy bleeding to his left stump and was transferred to the emergency room. The facility failed to ensure that the resident had adequate supervision when smoking and while being outside in the smoking area.  

Citation # 120015569

--- LOS ANGELES COUNTY ---

**Lakeview Terrace**
831 S Lake Street, Los Angeles

**B $2000 Evictions; Notification 7/9/2020**

On 4/7/20, a resident with dementia and impaired decision-making capacity was discharged to an independent living facility despite his needs for assistance with various activities of daily living. The resident’s responsible party was not informed of the discharge. Before a day had passed, the resident left the independent living facility, did not return, and was declared missing. The resident’s discharge notice was given the day of his discharge, not reasonably in advance as required by law. The facility was cited for numerous violations of the required procedures related to resident discharges.  

Citation # 920015923

--- LAKEVIEW TERRACE ---

**Lakeview Terrace**
831 S Lake Street, Los Angeles

**B $2000 Evictions; Notification 7/9/2020**

On 4/7/20, a resident with dementia and impaired decision-making capacity was discharged to an independent living facility despite his needs for assistance with various activities of daily living. The resident’s responsible party was not informed of the discharge. Before a day had passed, the resident left the independent living facility, did not return, and was declared missing. The resident’s discharge notice was given the day of his discharge, not reasonably in advance as required by law. The facility was cited for numerous violations of the required procedures related to resident discharges.  

Citation # 920015923

--- VERNON HEALTHCARE CENTER ---

**Vernon Healthcare Center**
1037 W Vernon Ave, Los Angeles

**B $2000 Patient Rights 7/17/2020**

On 4/10/20 the resident was transferred from Vernon Healthcare Center to a general acute care hospital for evaluation and treatment of a fever. On admission to the acute hospital, the resident was determined to be without fever and the general acute hospital attempted to discharge the resident back to Vernon Healthcare Center, but the facility refused. The facility failed to readmit the resident after hospitalization and participated in “hospital dumping.”  

Citation # 910015940
In May 2020, a resident who had end-stage renal disease and was dependent on hemodialysis treatment was placed at risk of severe bleeding and potentially life-threatening emergency when he bled from his arteriovenous (AV) shunt. The staff did not come to the resident’s assistance immediately when the resident called for help, and the resident had to stop the bleeding himself by applying pressure on the dialysis access site with his bare hand for more than 20 minutes while staff looked for supplies to stop the bleeding. The resident said he did not feel safe in the facility. The facility was cited for failing to monitor the dialysis access site on the resident’s arm and for not having nursing staff readily available to assist the resident when he was bleeding.

Citation # 950015969

The facility failed to provide a safe and sanitary environment to help prevent the development and transmission of COVID-19. The facility failed to cohort positive residents, have an infection preventionist, to ensure a resident wore a face mask outside her room and failed to have the nurse wear gloves and a gown while wheeling said resident. This failure put all residents in the facility at risk for COVID-19 transmission.

Citation # 950015975

The facility failed to provide a safe and sanitary environment to help prevent the development and transmission of COVID-19. The facility failed to cohort positive residents, have an infection preventionist, to ensure a resident wore a face mask outside her room and failed to have the nurse wear gloves and a gown while wheeling said resident. This failure put all residents in the facility at risk for COVID-19 transmission.

Citation # 950015975

A complaint investigation initiated on 5/14/20 found that unsafe, unsanitary, substandard care in the facility resulted in 71 residents and 32 staff members contracting COVID-19 and 16 residents dying (11 related to COVID-19 and 5 unknown) as of 5/31/20. The facility failed to oversee the care provided to the residents and failed to follow infection control standards of care and guidelines provided by the Department of Public Health and the Center for Disease Control during the COVID-19 crisis. The investigation documented numerous infection control failures including the facility failing to have licensed/certified staff in the facility to oversee infection control practices, failing to use PPE properly, failing to assign dedicated staff to care for infected residents, failing to isolate infected residents, failing to train staff on the use of PPE, failing to cohort residents properly and failing to provide leadership during the crisis or oversight by a medical director.

Citation # 950015964

The facility failed to separate COVID-19 positive residents from the residents who had tested negative. This failure resulted in 45 residents testing positive for COVID-19.

Citation # 950015987

On 5/26/20, a resident died two days after being transferred to the ER and with severe malnutrition, sepsis and dehydration, and Stage IV pressure ulcers. Based on interview and record review, it was determined that the resident was at risk for dehydration, the risk for weight loss, and required extensive assistance with eating because of swallowing difficulty. During the RN interview, it was apparent that the nursing staff wasn’t measuring the resident’s fluid intake and output, and there wasn’t proper monitoring of the resident’s condition. The facility was cited for failure to provide the necessary care and services for the resident.

Citation # 950015976
Montrose Springs Skilled Nursing & Wellness Center
2635 Honolulu Ave, Montrose

B $2000 Infection; Patient Care 9/18/2020

On 7/9/20, the facility was cited for failing to implement interventions to prevent and control the spread of COVID for eight residents by failing to: Cohort four residents who tested positive for COVID 19 from four residents who tested negative for COVID 19; hire a full time Infection Prevention Nurse to monitor, prevent and control the spread of COVID 19 in the facility; ensure the phlebotomist wore a gown when she collected bodily fluid specimens from residents with COVID 19, and removed her soiled gloves before entering the area in which residents without COVID 19 resided; ensure a resident who tested positive for COVID 19 wore a mask while sharing the same room with two residents who both tested negative for COVID 19; and ensure the area housing residents with COVID 19 had designated restroom, breakroom for staff who take care of COVID 19 positive residents, and placed signage to remind staff to wash their hands, and to don and doff PPE before and after providing care to the residents.

Citation # 950016040

Lakeview Terrace
831 S Lake Street, Los Angeles

A $20 000 Evictions 10/13/2020

A resident with severe mental health problems was sent to an unlicensed boarding home on 11/14/29 with no plan in place for maintaining and monitoring his Clozaril prescription. Clozaril requires extensive blood testing and many pharmacies are unable to fill a prescription for it. The licensed facility did not provide any medication management. Within weeks, the resident’s condition deteriorated and he stopped speaking and began eating his feces. He developed sepsis, was hospitalized and died on 12/16/19. The physician who cleared the resident for discharge stated “it’s not my fault, it’s the nursing home’s fault.” The resident’s family described the resident as a loving person who overcame tremendous challenges, became a licensed nurse, and aspired to become an addiction counselor. The facility was cited for failing to report an allegation of abuse to the Department of Public Health and the ombudsman within 24 hours (the allegation was not reported until two days later on 8/3/20). The facility also was cited for failing to implement its abuse prevention policies and procedures, including immediately reporting an allegation of physical abuse to the Administrator or Director of Nursing; and suspending the CNA pending the outcome of the abuse investigation.

Citation # 920016109

Miracle Mile Healthcare Center LLC
1020 S Fairfax Ave, Los Angeles

B $2000 Mandated Reporting; Physical Abuse 10/21/2020

On Saturday 8/1/20, a resident reported to facility staff that a CNA told him to “‘Shut up and be quiet,’” and tried to hit him. The resident felt threatened and called the police. The Registered Nurse Supervisor stated she did not know what to do for an allegation of abuse, and the Director of Nursing stated that no one called her about the incident and she did not hear about it until the following Monday. The facility was cited for failing to report an allegation of abuse to the Department of Public Health and the ombudsman within two days (the allegation was not reported until two days later on 8/3/20). The facility also was cited for failing to implement its abuse prevention policies and procedures, including immediately reporting an allegation of physical abuse to the Administrator or Director of Nursing; suspending the CNA; and conducting an investigation.

Citation # 920016109

Monte Vista Healthcare Center
802 Buena Vista St, Duarte

B $2000 Careplan; Fall; Patient Care 11/4/2020

On 6/15/20, an 89 year old woman was admitted to the facility with diagnoses including congestive heart failure and schizophrenia, and placed on hospice care. She also was assessed at high risk for falling due to confusion, gait/balance problems and use of psychoactive medications. On 6/24/20, the resident had an unwitnessed fall and was found on the floor by the foot of her bed. On 7/19/20, the resident had another unwitnessed fall and was noted to have purplish discoloration around both eyes and in the middle of her forehead. The facility was cited for failing to review, evaluate, update and implement care plan interventions after the resident had multiple falls to prevent future falls and injuries, and conduct a medication review after the fall that would include the resident’s physician and facility pharmacist.

Citation # 950016135
A female resident, with a high risk of falls due to impaired balance, muscle weakness and low safety awareness, fell on 7/2/20 when she was walking in the hallway unattended. The resident was supposed to have at least one staff person accompany her on walks but she did not have anyone accompanying her at the time of her fall. Multiple staff persons observed the resident walking unattended before her fall but did not intervene. The resident suffered a broken femur that required extensive surgical repair. The facility was cited for failing to implement the resident’s care plan to provide one-person assistance to the resident while she walked.

Citation # 920016148

Kei-Ai Los Angeles Healthcare Center
2221 Lincoln Park Ave, Los Angeles

A $20,000 Fall; Neglect 11/13/2020

On 5/19/20, a resident complained of moderate level abdominal pain and had bladder distention (stretching of the bladder due to excessive urine). The resident was transferred to the hospital, where over 700 ml of urine was drained from the resident. The citation noted that the bladder capacity ranges from 300 to 600 milliliters. The resident was diagnosed with acute renal failure (kidneys stop working) due to obstructive uropathy (when your urine cannot flow due to some obstruction). On 6/20/20, the resident was discharged to his home, where he died three weeks later, on 6/25/20. The facility was cited for failing to manage the resident’s pain and properly implement his plan of care.

Citation # 920016240

Foothill Heights Care Center
1515 N Fair Oaks Ave, Pasadena

B $2000 Hydration; Patient Care 11/25/2020

On 10/1/20 the facility failed to keep its centralized air conditioning units in a working condition. The temperatures inside residents’ rooms ranged from 84 to 92 degrees Fahrenheit. This failure put residents at risk for dehydration and possible heat stroke.

Citation # 950016170

Country Villa Westwood Convalescent Center
12121 Santa Monica Blvd, Los Angeles

A $20,000 Fall; Injury; Supervision; Staffing 1/15/2021

A resident who was dependent on staff for care and supervision and at high risk of falls died on 7/2/20 after suffering multiple falls at the facility. She sustained a laceration and bruise to her neck and face in a fall on 6/18/20. Ten days later on 6/28/20, she fell again and sustained a head injury requiring transfer to a hospital, where she was diagnosed with chronic subdural hematomas. After return to the facility, she was found on 6/29/20 with her upper body touching the floor while her lower body was still hanging on the bed. On 6/30/20, her physician ordered a one-to-one (1:1) nurse by the bedside for fall prevention at all times. She sustained an unwitnessed fall on 7/1/20 at 12:20 pm, when she was found on the floor facing the window. That same evening (7/1/20) around 11:05 PM, she was found alone on the floor. The resident died later that night. The Director of Staff Development stated she did not have enough staff to provide a 1:1 sitter. The facility was cited for failing to ensure adequate supervision to prevent avoidable accidents and for not providing one-to-one supervision per the physician’s order.

Citation # 920016262

Country Villa Terrace Nursing Center
6070 W Pico Blvd, Los Angeles

B $2000 Infection 2/5/2021

The facility failed to maintain an infection control program to prevent the spread of COVID-19 from 12/8/20 to 12/10/20 by failing to ensure the kitchen staff used personal protective equipment, ensure the Licensed Vocational Nurses removed contaminated personal protective equipment and performed hand hygiene before leaving a resident’s room, and ensure that certain staff members wore N95 masks. As a result of these failures, the facility put all residents and staff at an increased risk for contracting COVID-19.

Citation # 920016262
Two residents were dumped by the facility into unlicensed boarding homes that were completely unequipped to provide the care they needed. The first resident, who was conserved and determined by a judge to be gravely disabled, was sent to an unlicensed home on 2/18/20. The home did not provide the services the resident needed. Neither the resident nor her conservator was told of the discharge in advance. She left the unlicensed home unnoticed and was missing for six days and then again left unnoticed and was missing as of the date of the state’s investigation. The second resident, who used a wheelchair and had extensive care needs, was sent to an unlicensed home (also on 2/18/20) that did not have wheelchair access. She was then sent to a second unlicensed home that did not accept her, and she was abandoned in the front yard and found crying and scared. She was eventually sent to the hospital. The facility was cited for dumping residents into inappropriate locations and failing to give discharge notice to the residents, their surrogates, and the Long term care Ombudsman program. 

Citation # 060015990

On 2/19/2020, a male resident was transferred to a distant nursing home without legal justification or written notice. The resident had been admitted one month earlier and required extensive assistance for many activities of daily living. The resident’s family was also not notified and would no longer be able to visit the resident because the new nursing home was too far away. The facility’s social services designee acknowledged the discharge was inappropriate because the resident continued to need the same care. The facility was cited for an unnecessary transfer, with no appropriate justification and for failing to give notice and orientation as required by law.

Citation # 060015988

On 9/9/20, a resident choked to death while eating breakfast. An LVN who was in the room assisting the resident’s roommate observed the resident choking. The facility failed to attempt to call 911 for emergency medical services when their efforts to clear the food blockage from the resident’s airway were unsuccessful. The Director of Nurses stated to investigators that they didn’t call 911 because the resident was a DNR (Do Not Resuscitate). It was determined that this failure contributed to the resident’s untimely death, and the facility was cited for failing to supervise and assist the resident properly. The resident care plan noted that the resident was at risk of aspiration/choking distress related to a diagnosis of dysphagia, and her care plan required supervision during meals due to episodes of difficulty swallowing.

Citation # 060016162

On 6/23/20, a 61 year old resident who suffered from diabetes and bedsores was 5150’d into a hospital after throwing a lunch plate into the hallway, and a urinal and trash can at the Director of Nurses (DON). The resident had a history of yelling and throwing objects at staff during his care. On 6/25, the hospital notified the facility that the resident was stabilized and ready to be discharged. The DON informed the discharge planner that he would not accept the patient back due to his behaviors. When asked if most residents were allowed to return to the facility after hospitalization, the DON stated residents who return to the facility do not throw objects at the staff. The facility was cited for failure to provide the resident with a 7-day bed hold notice and for refusing to accept him back into the facility.

Citation # 240015997
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