CANHR’s Stop-Drugging Campaign Gains Steam

As CANHR’s campaign to stop the drugging of nursing home residents nears its second anniversary, it is a good time to consider how well it is working. The campaign began in the fall of 2010 after CANHR decided that its longstanding efforts to fight use of chemical restraints were inadequate. For years the rampant misuse of antipsychotics and other psychoactive drugs has been fueled by illegal marketing schemes, poorly trained nursing staff, inadequate staffing, absentee doctors, indifferent regulators, uninformed consumers and massive government funding of the drugs. Like an out-of-control wildfire, the pervasive drugging of residents has been very hard to put out.

In many ways, the campaign has been a great success. It has been especially so in educating consumers, thousands of whom have turned to resources on CANHR’s Stop-Drugging website or contacted CANHR advocates for help. Our Toxic Medicine guide, now in its second edition, has been widely distributed by ombudsman programs and others. We hear every day from families of residents, and sometimes residents themselves, that the information is helping them challenge drugging practices and to demand better dementia care.

Training of providers is another highlight. About 1,400 people – most of them long-term care providers – have attended one of the five stop-drugging symposia CANHR has co-sponsored around the state. In June, Dr. Jonathan Evans, the president-elect of the American Medical Directors Association, joined our training team for two very-well received symposia in San Diego and Los Angeles. Just as important as the training itself, the events have stimulated local advocacy efforts throughout California. Each event has been carefully planned and coordinated by local ombudsman programs and other CANHR partners, and their work on this issue continues after the training is over.

We’ve also succeeded, literally, in making a federal case out of the illegal drugging. In May, the Centers for Medicare & Medicaid Services (CMS) held a national press conference to announce a new initiative to stop the misuse of antipsychotic drugs and to improve dementia care in nursing homes. As part of the initiative, CMS set goals for antipsychotic reduction, posted information on Nursing Home Compare on antipsychotic use, and is working to strengthen enforcement of drugging-related laws and to improve training of surveyors. These are baby steps, perhaps, but very welcome nonetheless. These actions came about after CANHR joined forces with other advocates to establish a national advocacy coalition.

Even provider associations that have long been apologists for over-drugging are starting to see that there is a better way. For example, the July 2012 issue of Provider, a magazine published by the American Health Care Association and the National Center for Assisted Living, has a cover story on finding alternatives to antipsychotics for long-term care facility residents with dementia. The article urges staff members to understand behaviors as communication and to “play detective” to resolve them rather than turning to dangerous antipsychotic drugs to sedate residents who have dementia.

In California, there are modest signs that regulators may finally be waking up on this issue. The California
CANHR News

Staff News

CANHR is delighted to welcome the latest member of our team, Long Term Care Advocate, Shawna Reeves. With an MSW from Smith College and many years with the Council on Aging Silicon Valley, Shawna brings a wealth of expertise in elder financial abuse concerns and long term care advocacy among other skills. Shawna will be assisting consumers with financial abuse issues as well as residents’ rights and Medi-Cal. Welcome Shawna!

Special Thanks to Summer Interns!

CANHR was fortunate to have several interns this summer to help with research and other special projects that would not have been completed without their help. To Margot Parfitt, Daniel Madow, Kellie La and Brittney Washington, thank you for your time and talent!

CANHR is Growing!

CANHR is thrilled to announce that we are expanding our Southern California presence by opening a larger office in the South Pasadena area in the next few months. This is a wonderful opportunity to increase awareness of CANHR services, as well as grow our Family Council Project and promote more community education throughout the state. We will announce further developments as they become available.

Fall Workplace Giving

California Advocates for Nursing Home Reform is participating as a “non-affiliated beneficiary agency” in the United Way Work Place Giving Campaign for 2012. As A Certified Community Campaign Agency we are participating in:

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

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

In Memory - Tabi Katouzi

CANHR mourns the loss of our friend and colleague, Tabi Katouzi, who passed away June 21, 2012. Tabi, an estate planning attorney with Katouzi & Associates in Encino, was a long time member of CANHR’s Legal Information Network and a caring and dedicated advocate for her clients. Her warmth, humor and generous spirit will be sorely missed by all of us.
survey of investors age 55-64, 80% of respondents failed
to check their broker for previous law violations and
70% didn't even check to see if their broker was regis-
tered to sell the products they were offering.

How to stop abuse on the airwaves

We need to think outside the box when it comes to
warning seniors about financial abuse perpetrated by
these above-ground and seemingly respectable salesper-
sons. Writing articles for newspapers or senior magazines
about this underreported area of abuse is one way to
do this. At a minimum, we can talk to our loved ones
and clients to raise awareness of this aspect of elder
abuse, and, when we learn about a predator operating
in the community, file a complaint with the proper state
regulatory agency. This could be the Attorney General’s
Office, the Department of Insurance, the Department
of Real Estate, and/or the Department of Corporations.
If the perpetrator is a radio show host, you should also
send a formal complaint to that radio station.

With a little vigilance and a couple of well-placed
complaints, we can all do our part to stop the swindling
of elders by unscrupulous radio show hosts and other
high profile financial predators.

We all know there’s no such thing as a free lunch, but
how about free financial advice from a radio show host?
If you really want to keep on top of the scam trends,
you don’t need to go to a free estate planning seminar
at your local restaurant or senior center. All you need to
do is spin the AM radio dial on a Saturday or Sunday
morning.

Last month, two former radio show hosts in Southern
California pleaded guilty to 28 felonies stemming from
real estate fraud they committed against elderly investors
who tuned into their weekly radio broadcasts “Money
Intelligence” and “The Academy of Real Estate.” Many
of the 15 victims ended up losing their life savings and
home equity. Perpetrator Kathryn Rose was sentenced to
12 years and 8 months in state prison, while her partner
Alan Powell was sentenced to 18 years in state prison.
The pair was ordered to pay nearly $8 million in restitution –
money the victims are unlikely to see, as Rose
and Powell both claim to be “destitute.”

The myth of the underground scammer

People tend to assume that financial predators stay out
of the public eye so as not to be caught. This assump-
tion is not supported by the evidence. Financial preda-
tors put out ads in newspapers, send mail, write articles
for senior magazines, go on television, host radio shows,
and are active in community organizations such as local
Senior Roundtables. In other words, they do many of the
things that legitimate professionals do in order to adver-
tise their businesses. This is what makes the predators
so dangerous - only an expert may be able to tell the
difference between a professional and a con artist.

Profile of an investment fraud victim: It
may surprise you

It helps to know who is most at risk for falling victim
to investment scams so that we can target our preven-
tion efforts to those most in need. According to a 2010
joint investigation by AARP and the Financial Industry
Regulatory Authority (FINRA), investment fraud victims
tend to be college-educated, married males between
the age of 55-65, who are financially literate and have
a higher-than-average income. They also tend to have
had a recent change in financial or health status. This
is in stark contrast to the profile of elder financial
victims promoted by the media – that of the low-wealth,
widowed female with little education on financial topics.

Many elder consumers are not taking the basic steps
necessary to protect themselves. In a 2007 FINRA
AG Reports Show Rampant Abuse and Neglect in Fourteen California Nursing Homes

In July, CANHR released reports issued by the California Attorney General’s “Operation Guardians” that detail widespread abuse, neglect, and generally terrible conditions in the fourteen nursing homes inspected since 2010.

Operation Guardians (OG) is a special program of the Bureau of Medi-Cal Fraud and Elder Abuse that conducts surprise, on-site inspections of California nursing homes in an effort to protect residents and improve care for elderly and dependent adult residents. Each inspection culminates in a report (often supplemented by physician findings) detailing the facility’s compliance with basic quality of care and sanitation standards.

CANHR released the reports after obtaining them through a Public Record Act request to the AG’s office. Previously, the public did not have access to these reports. Many of the reports describe inexcusable conditions, such as untreated bed sores, filthy environments, heavy misuse of antipsychotic drugs, residents left in feces and urine for hours and falsified medical records.

After each Operation Guardians’ inspection, the AG’s office filed a complaint with the California Department of Public Health (CDPH) so it could investigate and respond to the concerns. Despite the severe mistreatment, it appears that CDPH took little, if any, meaningful action in most of the cases.

Along with the reports, CANHR issued an executive summary which took great issue with the CDPH’s lackluster response to the inspection findings. The executive summary gives several CANHR recommendations, led by a call for CDPH to conduct prompt follow-up investigations at these facilities and to take strong and effective enforcement actions to protect the residents from further neglect and abuse.

Recommendations aimed at the AG’s office are to increase the number of Operation Guardian inspections, to publish the inspection reports, and to prosecute nursing home owners, managers and employees who are responsible for mistreatment and harm to residents.

To view the full OG reports and CANHR’s executive summary, visit CANHR’s website at http://www.canhr.org/operationguardians

CMS, ProPublica Unveil Nursing Home Inspection Reports

July was a good month when it comes to disclosure of nursing home inspection findings. On July 18th, the federal Center for Medicare & Medicaid Services upgraded its Nursing Home Compare website by adding links to the most recent inspection reports.

Previously, Nursing Home Compare only offered vague summaries of inspection findings that tended to understate the problems and violations inspectors found. Now the site allows visitors to open and read the actual inspection reports for each nursing home, giving them much greater insight on the type and severity of problems. Nursing Home Compare inspection reports can be found online at: http://www.medicare.gov/nhcompare/

Although this is a very welcome development, it should be noted that it is not a panacea for all of the problems consumers face in choosing a nursing home, or learning about their track records. The nursing home inspection reports found on Nursing Home Compare are sometimes long and difficult to read, and they are only as reliable as the inspections by the California Department of Public Health. If inspectors don’t identify or address serious problems, as is often the case, the reports can be incomplete and misleading. Furthermore, many California nursing home complaint investigations do not show up on Nursing Home Compare.

In a related development, ProPublica, an independent, non-profit newsroom, unveiled a new search tool to examine the CMS nursing home inspection reports. The site, called Nursing Home Inspect, allows users to search through thousands of recent government inspection reports from around the country, most since the beginning of 2011.

Nursing Home Inspect allows searches by keyword and city, as well as by a home’s name, and allows searches across all the reports at once. Users can also search by state or by the severity level of the deficiencies cited. As of August 14, 2012, the underlying database covers nearly 118,000 deficiencies at 14,565 homes. As CMS releases newer inspection reports in the future, ProPublica plans to add them to its database. You can find Nursing Home Inspect and related articles at: http://projects.propublica.org/nursing-homes/

Long Term Care News ................... (continued on page 5)
Thousands found Ineligible for New Adult Day Health Care

Thousands of elders and dependent adults who were previously eligible for Adult Day Health Care have been found ineligible for the ‘replacement’ program – Community Based Adult Services (CBAS). CBAS began March 1 as part of a legal settlement between the state and advocates who sued over Governor Brown’s plan to eliminate Adult Day Health Care entirely. Under the agreement, the state was supposed to accept adults who qualified for Adult Day Health Care and who are considered at risk of institutionalization.

However, a July 2012 investigation by the San Francisco Chronicle found that in the six largest Bay Area counties, more than 65% of those who previously qualified for Adult Day Health Care have been denied eligibility under the new program. At some centers, the rate has reached 75-95%. The result has been thousands of hearings backlogged and extensive delays for new applicants who are required to undergo face-to-face evaluations, while those needing services are forced to go without, going to hospitals or are institutionalized – a result costing the state far more than the services that CBAS offers.

If you or someone you know has been denied Community Based Adult Services (CBAS), Disability Rights California has put together materials to help you understand these rights and how to file an appeal of the denial. To receive a copy of these materials, call 1-800-776-5746 or emailing darling@disabilityrightsca.org.

Spousal Impoverishment Relief On the Way for Same Sex Couples

The Medi-Cal Eligibility Division recently released a draft All County Letter that, once revised, will be sent to all county Welfare Departments instructing them on how to implement the new rules allowing same sex spouses and registered domestic partners to retain assets and income similar to that allowed opposite sex spouses when one of them enters a long term care facility and applies for Medi-Cal. The All County letter is a result of last year’s AB 641 (Feuer), which was signed by the Governor, and which extends the spousal impoverishment income and asset protections to same-sex Registered Domestic Partners or same-sex married couples.

The law was written to take effect retroactively to January 1, 2012, once the federal government confirmed that they would provide federal matching funds, and once the Department finalized the county implementation instructions. While the new provisions are a major step forward in that the community spouses of same sex spouses and registered domestic partners will now be able to retain the CSRA ($113,640) and the spousal income allocation (up to $2,841), this is only granted via a hardship avenue and not at eligibility like opposite sex spouses. Watch for a CANHR alert when the ACWDL is finally released, and, if you know any couples who would be affected by this new law, please tell them to contact CANHR.

Sonoma Development Center Survey Reveals Major Problems

A 495 page survey conducted by the Department of Public Health and completed on July 3, 2012 reveals major problems of poor medical care and failures to prevent abuse and investigate when patients are harmed. California Watch recently obtained a copy of the survey report, and an August 23 story in the Bay Citizen notes that the Center is in jeopardy of losing its certification for Medi-Cal and Medicare, which constitutes half of its annual budget. State regulators repeatedly faulted the in-house police force, the Office of Protective Services, for inadequate investigations, a failure that was the focus of an earlier series of stories by California Watch. Earlier this year, California Watch reported that detectives and patrol officers at the institutions routinely failed to conduct basic police work, even when patients died under mysterious circumstances. In case after case, detectives and officers delayed interviews with witnesses or suspects – if they conducted interviews at all. The state Department of Developmental Services operates five centers that house nearly 1,700 patients with cerebral palsy and other intellectual disabilities in Sonoma, Tulare, Los Angeles, Orange and Riverside counties. California is budgeted to spend about $314,000 this year per developmental center patient. The Bay Citizen article also links to the survey report:

http://www.baycitizen.org/crime/story/report-slams-state-institution-neglect/#.UDZsGLgEiEg.gmail
Before Signing the Contract

Before placing a loved one in a Residential Care Facility for the Elderly (RCFE), you should READ and STUDY the admission agreement very carefully. Do not rush, even if it’s a crisis. The admission agreement is a legal document, and it states the responsibilities of both the facility and the resident. Make sure you understand all pages and all documents referred to in the agreement (such as the facility’s rules and visiting policies). Ask for a copy of the contract and take it home. If you have questions, ask and make certain that all your questions are answered before signing the contract.

What Needs to Be in an Admission Agreement?

The law requires that admission agreements describe the types of services that the facility will offer and their costs. The agreement must also state how, when and to whom the rates will be charged, how changes in the rates will be determined, and any conditions for refunds. Admission Agreements should also have the following:

- Description of resident rights
- Right of residents to execute advance directives
- Eviction conditions and notification procedures
- Visiting policies
- Theft and loss policies
- Procedure for making complaints or grievances
- House rules or policies
- Availability of special telecommunication devices for residents who are deaf, hard of hearing, or who have other disabling conditions
- Description of other services not provided directly by the facility but offered at the facility through another provider
- Authority of the licensing agency to inspect the facility and to review records
- Provisions for terminating the agreement

Signing the Contract as Resident’s Agent v Legal Responsible Party v Responsible Person

In order for the document to be legally binding, it must be entered into voluntarily, signed and dated by both the facility and the resident (or the resident’s agent or legal representative). This also applies to any attachments to the admission agreement. Any future changes in the agreement must also be in writing, signed by both parties and dated.

If someone other than the resident signs the agreement, make sure that this person does NOT become a legal responsible party. The legal responsible party is the one held personally responsible for paying the facility’s fees. If you are the Agent under a Power of Attorney for Finances, you can cross out “responsible party” and write in “Agent under Power of Attorney.” As the Agent you are only responsible for paying the facility’s fees with the resident’s money, not your own. If you do not have a Power of Attorney, you can still sign as the resident’s responsible person. The regulations (CCR §87101 (r)(6)) defines a “Responsible Person” as an individual or individuals, including a relative, health care surrogate decision maker, or placement agency, who assist the resident in placement or assume varying degrees of responsibility for the resident’s well-being.

How Do You End the Agreement?

In order to end the agreement and leave the facility, the resident or resident’s agent or legal representative has to give written notice. Most facilities require 30-days notice, but some facilities require up to 60 days. The agreement will automatically be terminated upon the death of the resident unless stated otherwise in the agreement. The resident or responsible person will not be liable for any payment beyond what is due at the date of death unless agreed to in the admission agreement or ordered by the court. If payment is required after death in a resident’s admission agreement, make sure you are aware of the amount that you or your loved ones will be charged. Some agreements require a 30-day notice even from date of death.

Pertinent RCFE Admission Agreement requirements can be found in Health & Safety Code Sections 1569.880-1569.888 and California Code of Regulations Section § 87507
Family Council Corner

What Can California Learn From Other States’ Family Council Laws & Experiences?

California*, the leader in state law promoting the formation of family councils, may have some important lessons to learn from other states. CANHR’s recent 50 state survey revealed the following ways that the California law might be strengthened:

Notification of Right to Form a Family Council: Some states (Arkansas, Massachusetts, Texas, and Rhode Island) help promote family councils by mandating that families and friends of residents receive information at the time of admission about their right to form family councils if one does not already exist.

- Notification of Existence of Family Councils: California, like many other states, requires new and current residents to be informed if a family council has been formed. Illinois requires information about the existence of a family council be made available not only to new and current residents but also to prospective residents. Rhode Island also requires facilities to notify the long term care Ombudsman if a family council exists.

- Right to Form Family Councils: In addition to family members, friends or resident representatives, Illinois grants the right to form family councils to the long term care Ombudsman.

- Content of Notification: In California, facilities are allowed to create the information residents receive about any regularly scheduled family council meetings, e.g., date, time, and contact person. Illinois allows family council members or ombudsmen to create the information that others will receive about the family council.

- Facility Response to Family Council Concerns: Facilities in Massachusetts and Texas are required to respond to family council concerns in five (5) days, compared to California’s ten (10) day response period.

- Family Councils Role with Regulatory Agencies: In Minnesota, all facilities are required to have family councils or prove that lack of family interest is the reason why they have failed to form. Family councils in Minnesota must be interviewed during facility surveys and invited to participate in the surveyors exit conference. Similarly, Texas allows a representative of the family council to discuss council concerns with surveyors.

In follow up interviews with several state long term Ombudsmen and advocates, we also discovered a renewed commitment to supporting the development of effective, independent family councils. Family councils are viewed as a critical bridge to the community and the community’s involvement in ensuring quality of care in a weak regulatory enforcement environment. The concerns of residents in nursing homes can no longer be thought of as only the responsibility of families and close friends but of the entire community as expressed through church and civic groups. This is especially true for residents without families, or due to advanced age, have outlived their relatives and friends. Family council involvement offers an unique opportunity for community groups to positively affect the lives of the majority of residents in nursing homes, and provides a way to sustain family councils when family members leave when their loved ones die.

Strengthened laws and increased community involvement open up new paths for developing and sustaining family councils, and through independent and effective family councils, improving the quality of care and life for nursing home residents.

*California’s Family Council Laws can be found in California’s Health and Safety Code §1418.4 for Skilled Nursing Homes and §1569.158 for Residential Care Facilities for the Elderly. Federal laws pertaining to Family Council’s can be found in Title 42 Code of Federal Regulations §483.15.

Start organizing a Family Council today!

Request a free DVD – Organizing Family Councils - and download a guide to “Organizing Family Councils in Long Term Care Facilities” by going to: http://www.canhr.org/familycouncils/
**CANHR Sponsored**

**AB 2149 (Butler): Prohibition of Gag Orders in Elder Abuse Settlement Agreements**

This bill would provide that an agreement to settle a civil action for physical abuse, neglect, or financial abuse of an elder or dependent adult shall not include any provision that, among other things, prohibits contact or cooperation with the county adult protective services agency, the long-term care ombudsman or any governmental entity. The bill would provide that any such provision is void as against public policy. **Status**: Senate Floor.

**SB 1170 (Leno): VA Benefit Scams/Senior Insurance**

This bill would expand the definition of advertisement related to the sale and marketing of insurance products to seniors; add veterans organizations and the Department of Veterans Affairs to the list of those entities that cannot be used in deceptive or misleading advertising; and add the term “veteran” to those words deemed a senior designation. **Status**: Assembly Floor.

**SB 1184 (Corbett): Veterans Benefits/Senior Insurance**

This bill would prohibit an insurance broker or agent from participating in, being associated with, or employing any party that participates in, or is associated with, the obtaining of veterans benefits for a senior, unless the insurance agent or broker maintains procedural safeguards designed to ensure that the agent or broker transacting insurance has no direct financial incentive to refer the policyholder or prospective policyholder to any government benefits program. **Status**: On Governor’s Desk.

**CANHR Support**

**AB 1710 (Yamada): Nursing Home Administrator Act of 2012**

This bill makes the Nursing Home Administrator Program (NHAP) self-sustaining by revising accounting procedures, eliminating the cap on fee increases, and requiring the Department to report projected costs annually to the Legislature. **Status**: Assembly Floor.

**AB 1747 (Feuer): Life Ins. Consumer Protections**

This bill includes a number of consumer protections against cancellation of life insurance policies due to lapses in payment of premiums, including a requirement that every life insurance policy issued or delivered in this state contain a provision for a grace period of not less than 60 days from the premium due date that provides that where the premium owed is paid fully within the grace period the policy remains in force and a provision that gives the applicant the right to designate at least one individual, in addition to the applicant, to receive notice of lapse or termination of a policy for nonpayment of premium. **Status**: on Assembly Floor.

**SB 345 (Wolk): Long Term Care Ombudsman**

This bill would strengthen the role and independence of the state long term care ombudsman office by requiring it to represent the interests of long-term care facility residents before governmental agencies and calling for the office to submit an annual advocacy report describing how it has carried out these duties and its future plans to do so. **Status**: on Assembly Floor.

**AB 1823 (Yamada): Notice to VA Facility Residents**

This bill would require clarifying changes in the current quarterly statements regarding cost of care charges provided to residents of California Veterans facilities and would provide elderly and disabled veterans with a better understanding of the charges and an opportunity for planning. **Status**: Signed by the Governor.

**SB 924 (Price, Walters and Steinberg): Direct Access to Physical Therapy**

This bill would specify that patients may access physical therapy treatment directly, and would, in those circumstances, require a physical therapist to refer his or her patient to another specified healing arts practitioner if the physical therapist has reason to believe the patient has a condition requiring treatment or services beyond that scope of practice, to disclose to the patient any financial interest he or she has in treating the patient, and, with the patient’s written authorization, to notify the patient’s physician and surgeon, if any, that the physical therapist is treating the patient. The bill would prohibit a physical therapist from treating a patient beyond 30 business days or 12 visits, whichever occurs first, unless the physical therapist receives a specified authorization from a person with a physician and surgeon’s certificate. **Status**: In Assembly Appropriations.

**AB 1875 (Gatto): Time limit for Depositions**

This bill limits the time allowed for depositions to one day of seven hours in duration, except when longer sessions are agreed to or ordered by the court. This bill aligns California’s deposition time limits with limits already in place in federal courts. **Status**: In Assembly.

**AB 1775 (Wieckowski): Wage Garnishment Limits**

This bill would raise the minimum floor of a judgment debtor’s wages that are exempt from garnishment from 30 times the federal minimum hourly wage to 40 times the California minimum hourly wage. **Status**: Enrolled, to the Governor’s Desk.

Please check the CANHR Web site for updated details on legislation.
My mother is in a nursing home on Medicaid in Florida, and we no longer have any family living there. I would like to bring her to a nursing home closer to me in California. How can my mother become a California resident, and will her home still be considered exempt even if she becomes a California resident?

Sincerely,
Confused in California

Dear Advocate,

My mother is in a nursing home on Medicaid in Florida, and we no longer have any family living there. I would like to bring her to a nursing home closer to me in California. How can my mother become a California resident, and will her home still be considered exempt even if she becomes a California resident?

Sincerely,
Confused in California

Dear Confused in California,

As long as she is physically living in California with the intention to remain permanently or for an indefinite period of time, she will be considered a California resident. (22 CCR § 50320) Her home in Florida will still be considered exempt if she declares in writing that she intends to return to the property to live. (22 CCR § 50425) These two statements may seem conflicting, however as far as Medi-Cal is concerned, property rules and residency requirements are considered separately. (ACWDL No. 95-47)
I recently requested that the Chair of the Assembly Committee of Aging in California conduct a hearing on the Department of Social Services, Community Care Licensing’s Continuing Care Contracts Branch, directed at why the CCRC Branch withholds financial information about the financial condition of the corporations that own and operate Continuing Care Retirement Communities (CCRCs).

Residents are the last in line after every other creditor claim is satisfied. How will residents be able to move to another facility to meet long term care needs when the contract promising life-long care is not honored? Chances are, most residents will not have the ability to come up with the lost investment for their long term care again.

When I contacted the DSS, Community Care Licensing office, I could not get any answer to my questions regarding how applicants to CCRCs and residents would be notified if the corporation owning the CCRC where they either lived or were applying for admission if the corporation were in a severe deficit position. I still need to have the answer to the question: what mechanism is in place to inform and protect a resident’s substantial investment in long term care when there are no reserves to fulfill a resident’s long term care contract? I waited all day for three days to get the answer to that question and it never came. No one returned my call even though staff repeatedly assured me that the call would be returned.

I finally got the names and phone numbers of two Financial Analysts in the CCRC Contract’s Branch and one of them tried to answer my questions but claimed someone else had worked on the audited financial report. I had to fight hard to get a phone number for these people. It was obvious to me that the information was not disclosed freely, but was disclosed only after repeated questions and persistence.

Administrators that provide long term care claim that they are over regulated. If so, why are good laws on the legislative books not being enforced? One reason is the limited funding for inspectors and reporting. As the best disinfectant is sunlight, disclosure of financial information about the corporations that own CCRCs deserves careful public scrutiny. A public hearing on these issues in the legislature is long overdue.

(Ms. Hyatt is a resident of a CCRC and an AARP Policy Specialist on CCRCs)

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**A Consumer’s Guide**

Continuing Care Retirement Communities in California

*Is One Right for You?*

This consumer’s guide provides essential information to make an informed decision regarding whether a Continuing Care Retirement Community (CCRC) is right for you.

To order: visit www.CANHR.org or call (415) 974-5171
CANHR on the Move...

**Past Speaking Engagements, Panel Discussions and Training Sessions**

- **June 2**: CANHR hosted elder law training at Pickwick Gardens Conference Center in Burbank on Medi-Cal, the DRA and 2012 Long Term Care Issues.

- **June 6, 13, & 20**: CANHR hosted three attorney webinars on Special Needs Trusts and Medi-Cal Basics.

- **June 22**: Prescott Cole participated in the CFPB Briefing Call on RFI for Financial Frauds Targeting Veterans and Military Retirees National conference call.

- **June 25**: Prescott Cole attended the Oregon State Long Term Care Insurance Advisory meeting.

- **June 26**: Anthony Chicotel presented to the Alameda County Ombudsman on resident rights issues.

- **June 27**: Prescott Cole participated in the CFPB Briefing Call on RFI for Reverse Mortgages Stakeholder Meeting National conference call.


- **July 27**: Long Term Care Advocate Deborah Espinola attended Assembly member’s Mary Hayashi’s Senior Fair in Hayward. Deborah distributed information about Long Term Care Medi-Cal, RCFEs and SNFs.

- **August 1**: Prescott Cole presented at the Central California Legal Services “Reverse Mortgage Abuses” seminar in Fresno.

- **August 8**: Pauline Mosher, Long Term Care Advocate, represented CANHR at the 11th Annual Healthy Aging Fair at Chabot College in Hayward.

- **August 17**: Tony Chicotel and Mike Connors represented CANHR at the CMS/DPH sponsored planning meeting in San Francisco to establish an action plan to stop nursing home misuse of antipsychotic drugs and to improve care for residents with dementia.

- **August 29**: CANHR volunteer Clair Lomax represented CANHR at the Tri-City Coalition and City of Fremont Human Services Department’s Four Seasons of Health Expo in Fremont. Clair distributed information about Incapacity, Caregiving, Long Term Care Medi-Cal, and Long Term Care Facilities.
CANHR welcomes memorial and honorary gifts. This is a great way to honor a special person, or a loved one who has been a nursing home resident, while helping those who are nursing home residents. Recent gifts have been made in the names of the following persons:

**MEMORIALS**

- **Eleanor Bell of San Diego, CA**
  - Harriet Kounaves
- **My Mother, Mrs. Lula C. T. Bishop**
  - Gwendolyn Bishop
- **Diane Buck**
  - Lynne Edington
- **Jean Day**
  - Trevor & Marilyn Rowland
- **Maxine & Ernie Gallo**
  - La Vonne Gallo
- **Margaret Mizner Glidden**
  - Nancie Glidden
- **Richard**
  - Sylvia Healy
- **Robert A. MacInnes**
  - Gail MacInnes
- **Arthur Macofsky**
  - Felice Urban
- **Honey Marine**
  - Julius Schindler
- **Johanna Emma Marine**
  - Hazel Steingrube-Reed
- **Johanna Marine**
  - Martha Curry
- **Nica Bell’s mother**
  - Jean Woodward
- **Dr. & Mrs. R. T. Muller**
  - Helen Drachkovitch
- **Mary Nagel**
  - Ann & Franz Tittiger
- **Rosalie Ortega**
  - Shirley Ortega
- **Olga Panos**
  - Louis Panos
- **Margaret Parker**
  - Anne Brooks
- **Thomas Spear Walther**
  - Anthony Moy
- **Bruno and Evelyn Wartman**
  - John & Paddy Moran

**IN HONOR OF**

- **Kathy Taylor**
  - Selma Hemiup
- **On behalf of CA**
  - Thutam Vu
- **Pat McGinnis**
  - Edward Long
- **Mary Nagel**
  - Ann & Franz Tittiger
- **Rosalie Ortega**
  - Shirley Ortega
- **Olga Panos**
  - Louis Panos
- **Margaret Parker**
  - Anne Brooks
- **Thomas Spear Walther**
  - Anthony Moy
- **Bruno and Evelyn Wartman**
  - John & Paddy Moran

**CANHR Upcoming Events**

**September 22, 2012: Senior Health & Wellness Fair:**
- CANHR will be hosting a table at the Senior Health & Wellness Fair from 10:00 AM to 2:00 PM located at the San Mateo Senior Center, 2645 Alameda de las Pulgas San Mateo, CA 94403. The vendors will be offering FREE health screenings, demonstrations and resource information. For those interested there will be a walk at Beresford Park, on Sept. 22nd, with 1/2 or 2 mile courses. Registration begins at 8:30 AM. For more information call the senior center at (650) 522-7490.

**September 25: Presentation on Financial Abuse of Reverse Mortgages and Veterans’ Benefits:**
- Prescott Cole and Shawna Reeves will be giving a presentation on financial abuse associated with reverse mortgages and veterans benefits to the Sacramento County Financial Abuse Specialist Team (FAST). The presentation will be held at the Weintraub Tobin Law Firm at the Wells Fargo Building in Sacramento. It will not be open to the public.

**October 24, 2012: Marin Senior Information Fair:**
- CANHR will be hosting an information both at the Marin Senior Information Fair from 9:00 AM to 3:00 PM, located at Marin Exhibit Hall, 10 Avenue of the Flags, San Rafael, CA 94903. For more information go to www.marinseminorinformationfair.org
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CANHR prohibits the use of its name for the purpose of advertisement by attorneys, financial planners or any other organization or entity.
The following citation summaries are compiled from the citations issued by the California Department of Public Health to skilled nursing facilities and received by CANHR as of the publication of this 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 Advocate. Appeals of citations and collection of fines can take up to three years. For up-to-date information on any citation or facility, visit the Nursing Home Guide through CANHR’s web site: www.canhr.org or call the CANHR office.

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 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.

Amador County

Kit Carson Nursing & Rehabilitation Center
811 Court Street, Jackson

B $1000 Administration Mandated Reporting Patient Care Physical Abuse Transfer 07/12/2012
On 10/23/08, the resident sustained a skin tear on her right elbow while being transferred from her wheelchair to her bed. Prior to the transfer, the two CNAs assigned to her were aware that she needed two people to assist her during transfers, however one CNA decided to do the transfer the resident by himself. The facility’s administration wasn’t notified of the incident until four days later. The facility was cited for failing to report the incident to the administrative staff as directed in their Reporting Abuse to Facility Management Policy. Citation # 030009390.

Butte County

Country Crest
50 Concordia Lane, Oroville

B $500 Mental Abuse 07/06/2012
The facility was cited for failing to ensure that a 73 year old resident was free from verbal abuse when a licensed nurse spoke harshly to the resident on 4/28/12 and demanded that she use the toilet instead of a bedpan. Another resident who overheard the interaction reported that the resident began to cry when the nurse made her get out of bed and use the toilet. This interaction resulted in psychological distress for the resident. Citation # 230009326.

B $500 Verbal Abuse 07/06/2012
The facility was cited for failing to ensure that a resident was free from verbal abuse. On 3/17/12, a nurse spoke to a resident in a rude manner when the resident was found walking without her assistant device. The incident caused the resident emotional distress. Citation # 230009369.

Cypress Healthcare Center
1633 Cypress Lane, Paradise

B $1000 Physical Abuse 05/16/2012
On 11/15/11, an 89 year old resident was standing behind her bedroom door when another resident began pushing it open. The 89 year old’s shouting to stop was ignored and the other resident continued pushing causing the 89 year old to fall and be injured. The resident who pushed the door open had an extensive history of aggression towards others and was known to wander into residents’ rooms, taking items that didn’t belong to her and striking residents and visitors. According to the Director of Nursing, that resident was a danger to herself and to others in the facility. The facility was cited for failure to provide a proper care plan with interventions to ensure sufficient supervision of that resident. Citation # 230009304.

Olive Ridge Post Acute Care
1000 Exec. Parkway, Oroville

B $2000 Retaliation Against Resident 04/25/2012
A 60 year old female resident was given a discharge notice because she refused to sign an agreement to adhere to a new smoking policy. At least two other residents had been threatened with discharge if they did not sign the agreement. The facility management admitted to “trying to scare (the resident) into compliance” by telling her she was going to a homeless shelter unless she signed the agreement. Citation # 230009003.

Pine View Care Center
8777 Skyway, Paradise

B $1000 Chemical Restraints 06/07/2012
A 69 year old male resident was given three sedating drugs, including two psychotropics, simultaneously on 3/11/12. Despite a high risk for extreme drowsiness, the resident was not monitored more closely than usual and was found unresponsive and lying face up on the floor of his room later that morning. The resident was rushed to the hospital and treated for drug overdose, cuts, and a broken nose. The facility was cited for unnecessarily drugging the resident. Citation # 230009248.
B $1000 Evictions 06/07/2012
A 58 year old male resident, who was admitted to the facility on 4/1/12, was given a discharge notice on 4/12/12 for alleged behavioral outbursts. The resident’s records did not state why the resident’s needs could not be met in the facility or why the discharge was necessary. The facility administrator stated she did not know that such documentation was required to support the proposed discharge. Citation # 230009230.

Windsor Chico Creek Care and Rehabilitation Center
587 Rio Lindo Ave., Chico
B $1000 Sexual Abuse 05/24/2012
On 12/9/11, a resident was discovered sexually molesting a 66 year old Alzheimer's resident in a room across from the nurse’s station. The resident had been placed there in her wheelchair to watch the television. The incident was brought to the staff’s attention by a visitor, then witnessed by a LVN who saw the Alzheimer’s victim being kissed and fondled by a male resident. The LVN wrote an incident report and gave it to the nursing supervisor. The report was not relayed to The Department as required by law. The Department found that facility’s failure to relay the report had been because the facility had determined that it was an “innocent gesture”, and therefore a report to DPH was unnecessary. The Department cited the facility for failure to report this incident of alleged abuse within 24 hours as required by law. Citation # 230009004.

B $1000 Patient Care Physical Abuse Sexual Abuse 05/24/2012
On 12/9/11, an LVN stated she found a resident bending over another resident with his mouth over hers and his hand on her clothes over her breast. The LVN added that the resident would not have been able to call out for help or push the other resident away from her due to impaired physical and cognitive skills. The facility did not follow its policy and procedure in investigating the event which had the potential to allow further abuse. The facility was cited for failure to investigate the incident according to policy and procedure. Citation # 230009071.

Humboldt County

Granada Rehabilitation & Wellness Center, LP
2885 Harris Street, Eureka
B $1000 Injury Mandated Reporting Patient Care Patient Rights Physical Abuse 05/02/2012
During a visit to the facility on 12/9/10, a resident’s relative noticed there was bruising on the resident’s right arm, as well as a skin tear between the resident’s left thumb and first finger. The relative had stated the marks were not there when she left the night before, and the staff did not know how the marks got there. The relative then took the resident home with her overnight, stating she was fearful to leave the resident at the facility. The facility was cited for failing to report the allegation of abuse to the State licensing and certification agency. Citation # 110008826.

Marin County

Marin Convalescent & Rehabilitation Hospital
30 Hacienda Dr., Tiburon
B $1000 Dietary Services Patient Care 03/08/2012
The facility violated the policies and procedures when the cook removed a soiled knife from the dishwashing sink, used the knife to slice onions without first cleaning the knife or washing the onions. The cook also used a food processor to puree meat loaf and then only rinsed rather than clean and disinfect prior to using it to prepare rice. These failures had the potential to result in a food borne illness. Citation # 110008952.

B $1000 Dietary Services Patient Care 03/08/2012
The facility was cited for failing to meet the following standards for food supplies; a cook failed to check and document the final cooking temperature of a leftover meat loaf before serving, failed to monitor and document the cool down process of potentially hazardous foods, as well as failed to follow policy and procedures related to food temperatures. These failures had a potential to result in food borne illness. Citation # 110008874.

B $1000 Chemical Restraints Physical Restraints 03/08/2012
A resident was illegally physically restrained with bed and wheelchair waist belts and bed rails. A physician order was present for only some of the restraints and the orders that existed did not specify a duration for use. The facility used the order as an impermissible “standing” order to prevent the resident from moving. The resident was strapped down and unsupervised, with her door nearly closed and her bed behind a privacy curtain. The restraint was determined to be for staff convenience. The resident was also chemically restrained with Seroquel and around the clock Ativan because “even in bed she moves.” Citation # 110008866.

B $1000 Physical Restraints 03/08/2012
A resident was illegally physically restrained with soft tie waist restraints in bed along with full bed rails with a cover and a Geri-Chair. Some of the restraint orders were 28 months old, long after the “emergency” that precipitated the restraints. The bed restraints were implemented because the “resident tried to get out bed and one time he got really confused.” The facility was cited for failing to explore less restrictive behavioral interventions, failing to follow its own policies and procedures, and continuing restraints after their precipitating event had passed. Citation # 110008867.

B $1000 Dietary Services 03/08/2012
On 10/31/11, state investigators found extensive evidence that the facility was storing expired and potentially hazardous food. Investigators found six dented cans of soup, nine dented cans of juice, one dented can of puree tomatoes and one dented can of apple rings. There were three swollen and undated boxes of grape drink mix, five boxes of grapefruit juice that had expiration dates of 10/24/09, and one box of orange juice that expired on 10/24/09. The facility was cited for having expired food and swollen, rusted, and dented cans in their food storage room. These failures had the potential to result in food borne illness including upset stomach, abdominal cramps,
nausea, vomiting, diarrhea, fever and dehydration. Citation # 110008873.

B $1000 Physical Restraints 03/08/2012
On 10/25/11, a resident was observed strapped into a reclined Geri-Chair. An investigation revealed that there was no physician’s order for the physical restraint being used on this resident. The reclined Geri-Chair position leaves a resident with limited ability to self propel and may increase weakness, loss of muscular strength in lower extremities, decrease sense of independence, potential for depression, social isolation, increases in infections and the potential for development of pressure sores. A less restrictive restraint would have been an upright Geri-Chair position, wheelchair, cushions, wedges, or pillows. When interviewed, a CNA who had worked at the facility for 40 years states “all” of the facility residents, except one, had dementia and wore belts. When interviewed, the Facility Medical Director stated that he was “a rubber stamp” for the recommendations of facility staff on who to use physical restraints on. The facility was cited for an improper physical restraint of a resident. Citation # 110008872.

B $1000 Chemical Restraints Physical Restraints 03/08/2012
The facility was cited for failing to find a less restrictive way and a time limit for managing a resident’s dementia. The facility used physical restraints and psychotherapeutic medications (Avitan) for his behavior, however there was no care plan in place for the use of either. Citation # 110008870.

B $1000 Physical Restraints 03/08/2012
The facility was cited for failing to find a less restrictive way of managing a resident’s dementia when the facility used physical restraints. The belts were used when the resident was in a wheelchair and in bed. Although the resident was classified as a candidate for restraint reduction; the doctors orders were seven months old and had not been reviewed. Citation # 110008869.

B $1000 Administration Careplan Physical Restraints 03/08/2012
During an observation and interview on 10/31/11, it was found that the facility lacked the required food and water to provide residents adequate supplies in the event they needed to implement their written disaster and mass casualty program. The facility was cited for failure to maintain sufficient food and water supplies in the event of an emergency or disaster. Citation # 110008853.

B $1000 Physical Restraints 03/08/2012
During an interview on 10/25/11, staff stated that a resident was placed in a Geri-Chair in a reclined position because the resident was “moving too much...and trying to get out of the chair.” A Geri-Chair is a large padded wheelchair and is considered a restraint when in a reclined position as it limits the resident’s ability to move. There were no physician’s orders for the restraint and no plan of care was developed to eliminate the behavior for which the restraint was applied. The facility was cited for failure to obtain physician’s orders prior to restraining the resident and failure to develop a care plan to eliminate the need for the restraint. Citation # 110008871.

B $1000 Administration Careplan Physical Restraints 03/08/2012
The facility was cited for failing to obtain a physician’s order prior to restraining the resident in bed, failing to write physician’s orders for physical restraints designed to lead to a less restrictive way of managing the resident’s behavior, failing to develop a care plan for the use of physical restraints that specified the behavior to be eliminated and a time limit for the use of restraint, and failing to follow policies and procedures for the use of physical restraints. These failures put the resident’s psychological and physical health at risk. Citation # 110008868.

Country Villa Novato Healthcare Center
1565 Hill Road, Novato
B $1000 Patient Rights Verbal Abuse 03/01/2012
The facility was cited for violating the regulation by failing to protect a resident from an abuse when the facility’s business office staff verbally abused a resident in an effort to have the resident complete a Medi-Cal application. Citation # 110008780.

Modoc County

Modoc Medical Center D/P SNF
228 W. Mc Dowell St., Alturas
B $1000 04/04/2012
CitationWatch description will be published once citation is received. Citation # 230009021.

B $1000 Mandated Reporting Patient Rights Physical Abuse Supervision 04/04/2012
During an investigation of alleged abuse between Resident 1 and Resident 2, the surveyor noted a report describing another alleged abuse incident involving Resident 1. The report did not show evidence that the facility had reported the incident to the Department immediately or within 24 hours. Citation # 230009201.

A $20000 Medication Neglect 06/19/2012
The facility was cited for failing to notify a resident’s physician about complications due to excessive use of Coumadin (blood thinner). Although the levels of blood thinning were flagged as high for over a month, the doses remained the same. The facility did not inform the physician that the resident vomited bloody fluid, or when her blood pressure dropped dramatically, was less responsive and eventually unconscious. The resident was taken to the emergency room on 3/6/11 at 9:40 pm and died on 3/8/11 of complications from too much Coumadin. Citation # 230008708.

Surprise Valley Community Hospital D/P SNF
741 N. Main Street, Cedarville
B $1000 Careplan Physical Abuse 04/05/2012
The facility was cited for failing to protect Resident 1 from physical abuse from Resident 2. Resident 2 hit Resident 1 on the head with a rolled up newspaper on 10/20/11, and pulled her hair on 10/21/11. Citation # 230009200.
Auburn Oaks Care Center  
3400 Bell Road, Auburn  
B $1000 Patient Care Physical Abuse 02/27/2012  
On 11/14/09, a CNA wrapped a resident’s hands together with a call light cord, yanked on it hard five times, then gritted her teeth, and said “Here is your call light.” The resident experienced pain and bruising. The facility was cited for failing to ensure the resident was free from physical abuse. Citation # 030009032.

Kindred Transitional Care & Rehabilitation - Siena  
11600 Education Street, Auburn  
B $1000 Patient Care 03/07/2012  
On 10/10/09, a 44 year old ventilator dependent adult with pneumonia and respiratory failure was admitted into the facility. On 10/11/09, the physician ordered her oxygen supply to be reduced from 15 Liters (L) of oxygen down to 3 L. In less than two minutes of reducing the oxygen, the resident became hypoxic (a condition in which the body is deprived of adequate oxygen). The resident experienced irregular and pounding heart palpitations, increased anxiety, and shortness of breath. The physician came back into the room and put the resident back up to 15 L. The resident was so distressed that she was transported to the hospital where she remained for 8 days. The facility was cited for failing to ensure that the resident’s special respirator needs were met. Citation # 030009085.

Sacramento County  
Applewood Care Center  
1090 Rio Lane, Sacramento  
B $1000 Mandated Reporting Physical Abuse 02/15/2012  
Two incidents of resident to resident abuse took place on 2/23/09 and 2/24/09. Neither incident was reported to the Department until 3/2/09. The facility was cited for failure to report incidents of abuse to the Department within 24 hours as required. Citation # 030009001.  
B $1000 Mandated Reporting Verbal Abuse 05/03/2012  
The facility was cited for failing to report alleged abuse to the Department within 24 hours. The alleged abuse happen on 5/21/09, 5/24/09 and 5/27/09. The first two cases were reported on 5/26/09 and the third case was reported on 5/29/09. Citation # 030009264.  
B $1000 Mandated Reporting Sexual Abuse 05/03/2012  
On 5/26/09, an employee was informed of an allegation of sexual abuse of a resident. The facility conducted an investigation but failed to notify the Department of the alleged abuse as required. The facility was cited for failure to notify the Department of an allegation of sexual abuse. Citation # 030009265.

Golden Living Center - Galt  
144 F Street, Galt  
B $1000 Mandated Reporting Patient Care Patient Rights Physical Abuse 04/12/2012  
On 6/5/09, a CNA reported that another CNA slapped a resident while repositioning her. However, the facility didn’t report the suspected abuse until four days later on 6/9/09. The facility was cited for failing to ensure that the resident was free from physical abuse, and for failing to report the abuse to the Department of Public Health within 24 hours. Citation # 030009221.

Norwood Pines Alzheimers Center  
500 Jessie Avenue, Sacramento  
B $1000 Careplan Physical Abuse 03/15/2012  
Nurse’s notes dated 4/13/09, indicated that a resident had an altercation with another resident with known aggressive behavior. The victim was struck repeatedly with a belt buckle resulting in lacerations, abrasions and bruises. The facility was cited for failure to protect the resident from physical abuse and failure to revise the care plan of the aggressive resident to prevent the assault. Citation # 030009124.
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Pioneer House
415 P Street, Sacramento

B $1000 Fall Neglect Patient Care 03/08/2012
A resident fell and hit her head at the facility on 6/11/09. The facility has a “Neurological Nursing Assessment” policy that was to be followed when a resident injures their head. The facility failed to follow policy when neurological checks were not completed every hour between, 1:05 pm and 5:05 pm. At 5:05 pm, the resident was vomiting; by 7:30 pm, the resident was unable to speak or understand verbal communication, but an ambulance was not called until 8:45 pm. The resident had a CT scan of the brain and it showed bleeding in the brain and required hospital care for eight days. The facility was cited for failing to conduct neurological assessment per their policy and for failing to transfer the resident immediately to the hospital. Citation # 030009086.

Sacramento Sub-Acute
5255 Hemlock Street, Sacramento

B $1000 02/01/2012
CitationWatch description will be published once citation is received. Citation # 030008960.

Windsor Elk Grove Care and Rehabilitation Center
9461 Batey Avenue, Elk Grove

B $1000 Physical Abuse 02/23/2012
A resident stated that on 2/25/09, a LVN tried to pull a pill out of her hand. “The nurse was pulling hard and this action hurt my shoulder.” The resident had a bruise on her wrist and was given pain medication for her shoulder. The facility was cited for failure to ensure the resident was not subjected to physical abuse. Citation # 030009035.

B $1000 Dignity Physical Abuse 03/28/2012
The facility was cited for failing to ensure that a resident was treated with dignity and respect. On 10/16/09, a resident was “tearful and had some confusion” after a CNA was “too rough” and “too quick” during her shower. Citation # 030009182.

B $1000 Mandated Reporting Sexual Abuse 03/28/2012
The facility was cited for failing to notify the Department of alleged abuse with 24 hours. On 10/14/09, a rehab aide brushed his arm against a resident’s breast and said “Oh baby let’s do that again.” The alleged abuse was not reported to the Department until 15 days later. Citation # 030009183.

B $1000 Mandated Reporting Physical Abuse 06/07/2012
The facility was cited for failing to report alleged abuse within 24 hours to the Department. On 7/13/09, a staff member witnessed a CNA “manhandle” a resident by trying to push the resident’s head and arm into a hospital gown, while the resident resisted. The alleged abuse was reported on 7/15/09 to the Department, and the CNA was terminated on 7/17/09. Citation # 030009350.

B $1000 Physical Abuse 06/07/2012
On 7/13/09, a staff member witnessed a CNA pushing an 82 year old female resident’s head and right arm into a hospital gown while the patient resisted, causing the resident’s arms to become reddened. The staff member intervened and directed the CNA to leave the room. She also completed an Incident Investigation/Statement form. Because the facility did not immediately remove the CNA from the care and vicinity of the resident, the facility was cited for failing to ensure the resident was free from abuse by staff and for failure to implement facility policies related to patient abuse and abuse reporting. Citation # 030009346.

San Benito County

Hazel Hawkins Memorial Hospital D/P SNF
911 Sunset Drive, Hollister

B $600 Patient Records 07/20/2012
The facility was cited for failure to ensure that the records of two of six sampled residents were accurate. One of the two residents was to have had his behavior monitored and recorded in medication administration records (MARs). Upon investigation, it was discovered that his March, April, and May MARs couldn’t have been accurate because there were no behavior monitors on the MARs during those months. Also, Nurse A who supposedly made the entries stated that she never monitored the resident for behaviors, that the entries were not made by her, and the signature on the bottom of one of the MARs was not written by her. During a confidential telephone interview on 6/22/12, Nurse B stated that initials on a resident’s vitamin D administration was inaccurate and the initials were not hers. Citation # 070009407.

San Joaquin County

Golden Living Center - Chateau
1221 Rose Marie Lane, Stockton

B $1000 Careplan Patient Care Supervision 03/08/2012
The facility was cited for failing to ensure that a resident’s elopement detection system was functioning properly to provide supervision to prevent elopement or an accident. The facility failed to develop a written plan of care. This resulted in the resident eloping from the facility and being found in the parking lot twice in one day. Citation # 030009090.

Santa Clara County

White Blossom Care Center
1990 Fruiteidae Avenue, San Jose

B $1400 Mandated Reporting Theft & Loss 06/04/2012
A resident was admitted on 1/28/12. On 2/1/12, his family discovered his wedding ring was missing from his finger. Despite filing a police report on 2/3/12, the facility never notified the Department of Public Health of the suspected theft/abuse as required by law. Citation # 070009349.
Santa Cruz County

Country Villa Watsonville East Nursing Center
535 Auto Center Drive, Watsonville

**B $1400 Sexual Abuse 07/20/2012**

On 7/6/12, an employee exhibited sexually inappropriate behavior while providing therapy on a resident who suffered from advanced Parkinson’s disease. The male employee exposed himself and performed sexual acts while providing therapy that included stretching and massage. The resident reported that the employee had acted improperly on several occasions and she had been afraid of saying anything for fear of retaliation, but final came forward because of her worries that the employee might be violating other women. The facility was cited for failing to ensure that the resident was free from sexual abuse. Citation # 070009408.

Shasta County

Golden Living Center - Redding
1836 Gold Street, Redding

**B $1000 Dignity Patient Care Patient Rights Verbal Abuse 05/17/2012**

The resident asked one of the kitchen staff if he could have some tomato slices. However, the kitchen staff person told the resident in a disrespectful manner that he would not give him the tomato slices and to go take a shower. The kitchen staff person was suspended and then discharged from employment. The facility was cited for failing to ensure the resident was treated with dignity and respect. Citation # 230008963.

**B $2000 Dignity Verbal Abuse 07/05/2012**

The facility was cited for failing to ensure residents were treated with dignity and respect by the Occupational Therapist (OT). On 3/12/12, when a resident returned from church services, the OT told the resident that therapy was more important and therapy was paying the bill for her stay at the facility. The resident’s roommate was present, and both residents were horrified and the roommate felt verbally assaulted. The OT was terminated on 3/26/12. Citation # 230009382.

Marquis Care at Shasta
3550 Churn Creek Road, Redding

**B $2000 Fall 04/25/2012**

On 2/8/11, a resident who had had a recent stroke and had impaired balance stood up from her wheelchair without staff assistance and fell. The resident’s care plan was not updated with a higher level of interventions after the fall. On 2/12/11 the resident had a second fall which resulted in her fracturing her hip. The facility was cited for failure to properly assess and implement interventions to reduce the resident’s risk of falls. Citation # 230009133.

Northern California Rehabilitation Hosp. D/P Snf
2801 Eureka Way, Redding

**B $2000 Fall Patient Care Physical Environment Supervision 05/17/2012**

On 3/22/12, the resident (Resident A) was being assisted to the bathroom by the CNA. While the CNA was waiting outside the bathroom for Resident A to finish, another resident (Resident B) yelled for help. The CNA then left to help Resident B. While Resident B was being attended to, Resident A fell and sustained a skin tear on her elbow and was complaining of pain in her right leg. The facility was cited for failing to ensure that Resident A’s environment remained free of incident hazards, and failing to ensure that Resident A received adequate supervision and assistance. Citation # 230009273.

Solano County

Fairfield Post-Acute Rehab
1255 Travis Blvd., Fairfield

**B $1000 04/27/2012**

CitationWatch description will be published once citation is received. Citation # 110008977.

Sonoma County

Creekside Rehabilitation & Behavioral Health
850 Sonoma Ave, Santa Rosa

**B $1000 05/16/2012**

The facility was cited for violating the Health & Safety code when the facility staff failed to post the facility overall rating in an employee break room and a community room used by residents. This failure resulted in the potential residents and staff not being informed of the facility’s overall rating. Citation # 110009252.

Park View Gardens at Montgomery
3751 Montgomery Drive, Santa Rosa

**B $1000 03/14/2012**

At 1:40 pm on 12/18/10, the facility’s Physical Therapist (PT) found a 93 years old resident slumped in a reclining chair with an adjustable cervical collar covering his mouth. The PT noted that the resident’s oxygen saturation was in the “80’s”. The PT returned the resident to his bed and reported his findings to the nurse. At 2:30 pm, oxygen was administered and the resident’s level rose above 90%. At 3:30, the resident’s levels had dropped to 83%. Oxygen was given and his level rose to 90%. The resident’s records contained an order to notify the physician if the oxygen level fell below 90%. Oxygen saturation under 90% is considered too low to provide adequate oxygen to all parts of the body, including the brain. At 5:30 pm, the resident’s family found him unresponsive. He was sent to the hospital where he died the next day. The facility was cited for failure to follow physician’s orders which resulted in a delay of treatment which contributed to his death. Citation # 110009098.
Summerfield Healthcare Center
1280 Summerfield Rd., Santa Rosa

B $2000 Patient Care Supervision 06/04/2012
On 2/15/11 at about 6:45 pm, the facility was notified that one of their residents who has senile dementia was found sitting on the sidewalk, in the rain, in front of the facility. She was complaining of ankle pain and had an injury to the back of her head. She was transferred to a local hospital for treatment to her injuries. The resident had a history of cutting off her wander guard and attempting to leave the facility. The facility was cited for failing to adequately supervise the resident. Citation # 110009311.

Stanislaus County

Acacia Park Nursing & Rehabilitation Center
1611 Scenic Drive, Modesto
B $1000 Mandated Reporting Physical Abuse
Verbal Abuse 05/25/2012
A “Report of Suspected Dependent Adult/Elder Abuse” dated 12/12/08, revealed that a resident reported that a CNA was rough with him when taking vital signs and then cursed at the resident repeatedly when he complained. The facility reported the allegation on 1/22/09, 41 days after the incident occurred. The facility was cited for failure to report an allegation of abuse to the Department within 24 hours as required. Citation # 030009323.

B $1000 Physical Abuse Verbal Abuse 05/25/2012
A “Report of Suspected Dependent Adult/Elder Abuse” dated 12/12/08, revealed that a resident reported that a CNA was rough with him when taking vital signs and then cursed at the resident repeatedly when he complained. The facility was cited for failure to ensure the resident was not subjected to rough handling and verbal abuse. Citation # 030009324.

Hy-Lond Health Care Center - Modesto
1900 Coffee Road, Modesto
A $20000 Fall 03/16/2012
On 5/23/09, a 69 year old resident fell from a shower chair onto the bathroom floor, injuring his elbow and breaking his hip. The incident occurred when a CNA pulled him out of the shower stall then let go of the shower chair, causing it to roll down the sloped floor and tip over. The facility was cited for failure to prevent a fall which resulted in a fractured hip requiring open surgical repair. Citation # 030009138.

Sutter County

Yuba Skilled Nursing Center
521 Lorel Way, Yuba City
B $1000 Mandated Reporting Sexual Abuse 05/24/2012
The facility was cited for failing to report two incidents of alleged abuse to the Department within 24 hours. On 3/16/12, a resident reported to the director of nurses that a male resident wheeled himself into her room and put his hands under her blanket and touched her private parts. Citation # 230009276.

B $1000 Patient Care Physical Abuse 05/24/2012
On 5/28/11, a resident complained that a CNA “wiped too hard” during care. She claimed she told the CNA to stop but the CNA continued rubbing making the resident angry. The incident of alleged abuse was not reported to the Department within 24 hours as required. The facility was cited for failure to report an incident of alleged abuse to the Department. Citation # 230009241.

Yolo County

Davis Healthcare Center
715 Pole Line Road, Davis
B $1000 Bed Hold 04/10/2012
The resident was admitted to the general acute care hospital on 7/11/09, and returned to the nursing home facility four days later on 7/15/09. However, upon his return, he was notified that he had been moved from his room. The facility was cited for failing to provide notification to the resident prior to moving him out of his room. Citation # 030009213.
Citation Watch - Consumer Report

The following citation summaries are compiled from the citations issued by the California Department of Public Health to Southern California skilled nursing facilities and received by CANHR as of the publication of this Advocate. CANHR makes every effort to insure 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 Advocate. Appeals of citations and collection of fines can take up to three years. For up-to-date information on any citation or facility, visit the Nursing Home Guide through CANHR's web site: www.canhr.org, or call the CANHR office.

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 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.

Kern County

Evergreen Arvin Healthcare
323 Campus Drive, Arvin

B $1000 Mandated Reporting Physical Abuse
06/13/2012
On 9/24/11 at 10:40 am, a resident shoved another resident. They were separated, but managed to get free and began hitting each other. They were separated again and taken to separate rooms. The California Department of Public Health (CDPH) was not notified of the incident until 9/29/11 at 5:38 pm, five days later. The facility was cited for failing to report the abuse to the CDPH within 24 hours of the incident. Citation # 120009141.

B $1000 Mandated Reporting Physical Abuse
06/13/2012
On 9/18/11 at 7:30 pm, a resident (A) slapped another resident’s (B) hand when Resident B attempted to take a pen from a CNA. The incident was not documented and the California Department of Public Health (CDPH) was not notified until 9/26/11 at 7:59 am, eight days later. The facility was cited for failing to report the abuse to the CDPH within 24 hours of the incident. Citation # 120009142.

Los Angeles County

Arcadia Health Care Center
1601 S Baldwin Ave., Arcadia

A $10000 Fall 06/04/2012
On 8/3/2011, a 96 year old female resident fell to the floor when the sling on the mechanical lift being used to transfer her from the shower to her wheelchair broke. The resident suffered a laceration to her right elbow that required 21 stitches. The facility was cited for failure to maintain the mechanical lift sling as recommended by the manufacturer to prevent accidents during transfers. Citation # 950009303.

Bel Tooren Villa Convalescent Hospital
16910 Woodruff Ave., Bellflower

B $2000 Fall 05/09/2012
On 2/23/11, a resident who was on mind altering psychotropic medication was refusing to be transferred from a Geri-chair to her bed and was holding her right hand inside an opening below the armrest. A CNA attempted to lift the resident and remove her hand from the armrest without assistance from other staff members. While transferring the resident the CNA repeatedly told her to “Let it go”, then removed the resident’s hand from gripping the armrest. The resident ended up on the floor with a fractured wrist. The facility was cited for failing to have two staff assisting the resident during the transfer and for not waiting until the resident was calmer and less combative before attempting the transfer. Citation # 940009289.
A   $20000   05/02/2012
CitationWatch description will be published once citation is received. Citation # 910008601.

B   $2000   Careplan Patient Care   05/09/2012
Resident 1, who was diagnosed with bladder cancer, was transferred to an acute care facility for an x-ray to confirm the placement of a G-tube. The x-ray showed the resident’s bladder to be over full, which required flushing of 1,150 ml of urinary output. Normal bladder capacity is 300-500 ml. In another incident on 12/8/10 at 4:15 pm, Resident 2 was observed with 900 ml of urine in her urine drainage bag. The facility was cited for failing to identify that Resident 1 didn’t urinate for over 12.5 hours, irrigate Resident 1’s catheter to avoid blockage as ordered by the physician, monitoring Resident 2’s urinary output, and implement care plans for monitoring urinary output for Resident 1 and 2. Citation # 940009393.

Berkley East Convalescent Hospital
2021 Arizona Ave., Santa Monica

A   $20000   05/02/2012
CitationWatch description will be published once citation is received. Citation # 910008601.

B   $2000   Careplan Patient Care   05/09/2012
Resident 1, who was diagnosed with bladder cancer, was transferred to an acute care facility for an x-ray to confirm the placement of a G-tube. The x-ray showed the resident’s bladder to be over full, which required flushing of 1,150 ml of urinary output. Normal bladder capacity is 300-500 ml. In another incident on 12/8/10 at 4:15 pm, Resident 2 was observed with 900 ml of urine in her urine drainage bag. The facility was cited for failing to identify that Resident 1 didn’t urinate for over 12.5 hours, irrigate Resident 1’s catheter to avoid blockage as ordered by the physician, monitoring Resident 2’s urinary output, and implement care plans for monitoring urinary output for Resident 1 and 2. Citation # 940009393.

Burbank Healthcare And Rehabilitation Center
1041 S Main St, Burbank

A   $20000   Careplan Dietary Services Hydration Patient Care   06/01/2012
The facility was cited for failing to accurately assess the resident’s bowel habits as indicated in the care plan, provide adequate fluids, provide interventions to increase activity and incorporate specific dietary needs and failed to implement and monitor the effectiveness of the physician’s order to administer stool softeners, laxatives, or enemas to prevent fecal impaction. This resulted in complications and death for the resident. Citation # 920009039.

Century Skilled Nursing Care
301 N Centinela Ave, Inglewood

B   $1800   Deterioration   05/16/2012
The facility was cited for failure to ensure that an 82 year old female resident and an 88 year old female resident received exercises and positioning devices as ordered by their physician on 6/24/10. As a result, both patients suffered diminished shoulder joint range of motion. Citation # 910007645.

WMF   $2000   Patient Records   05/16/2012
On 6/22/10 at 9 am, an unannounced visit was made to the facility to conduct an annual standard health survey. The survey found that the RNAs made willful material falsification entries in the patients’ Restorative Charting Record by signing off on them to reflect that three patients received range of motion exercises as ordered by the physician. However the patients didn’t receive the exercises. Citation # 910007644.

Chatsworth Park Care Center
10610 Owensmouth Ave., Chatsworth

A   $19000   Fall Injury Patient Care   04/03/2012
The facility was cited for failing to identify resident care needs when transferring the resident from her bed to a shower chair. The resident was assessed to require two persons and an assistant device to lift the resident for transfers. This failure resulted in the resident fracturing her spinal column. Citation # 920009123.

Country Villa Belmont Heights Healthcare Center
1730 Grand Ave, Long Beach

B   $2000   Physical Environment   07/10/2012
On 6/12/12, during the general environmental inspection of the facility, the hot water temperature was found to be unsafe in eight restrooms and one shower room. A total of 17 residents used the affected rooms. The facility failed to ensure the resident environment remained as free from hazards as possible. Citation # 940009393.

Country Villa Maple Cvlt Center
2526 S. Maple Avenue, Los Angeles

A   $15000   Fall   02/10/2012
On 10/31/09, a 69 year old resident died after he fell and struck his head on the wall while running in the facility during the middle of the night, with a nursing assistant in pursuit. The impact dented the wall and the resident suffered a fatal neck fracture. The LVN on duty did not immediately call 911, but instead placed him in a chair without immobilizing his head or neck. When paramedics arrived, he was sitting in the chair but his vital signs were zero. An autopsy report by the coroner stated in part: “When a person suffers a suspected neck fracture, the best treatment is not to move them... One thing you certainly don’t want to do is to sit the person up; that is highly likely to exacerbate the fracture.” There was no documentation that the LVN had been trained on handling emergency situations and there was no RN on duty when the resident died. The facility was cited for failing to provide appropriate assessment, interventions and emergency care after the resident fell. Citation # 940008692.

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

A   $19000   Careplan Deterioration Neglect Patient Care Patient Rights   04/27/2012
The facility was cited for failing to implement a resident’s care plan, investigate an unwitnessed fall, failing to call 911, and document progress notes. After a fall, there was no monitoring for possible injuries and no neurological status for 72 hours after the fall per facility’s policy. On 12/18/08, a resident was found unresponsive 36 hours after an unwitnessed fall. The facility did not call 911, instead called an ambulance, and the resident was not transferred to the hospital for approximately two hours after he was found. The resident’s care plan stated the his oxygen levels were to be greater than 92%, however there was no documentation that this was monitored. When he was found unresponsive his O2 level was 60% and a rectal temperature of 86.9 degrees F. In the emergency room, the resident required a ventilator, a warming blanket and warm IV fluids. Citation # 910009207.

Four Seasons Healthcare & Wellness
5335 Laurel Canyon Blvd., Valley Village

B   $500   03/16/2012
CitationWatch description will be published once citation is received. Citation # 920009122.
Harbor View Center
490 W 14th Street, Long Beach

B $2000   05/09/2012
CitationWatch description will be published once citation is received. Citation # 940009293.

B $1200   Patient Care   05/16/2012
On 10/21/09, a 17 year old resident sustained a fractured collar bone following attempts by facility staff to subdue and restrain her. The resident suffered from mood and psychotic disorder and had a history of poly-substance abuse. The fracture occurred a staff person jumped on the resident’s back and grabbed and twisted her left arm. This action caused the resident to fall on her right side and snap her collar bone. The facility was cited for failure to ensure that restraints be used in a such a way as not to cause physical injury to the resident and for failure to restrain the resident in a safe manner. Citation # 940009309.

Hollywood Presbyterian Medical Center D/P Snf
4636 Fountain Avenue, Los Angeles

B $1000   Dignity   Physical Abuse   04/19/2012
The facility was cited for failing to ensure that a resident was treated with dignity and respect and free from physical abuse. A CNA transferred the resident from the day room to the bedroom using a Geri-chair in a rough manner. The resident’s foot hit the wall, door, linen cart and medication cart, causing a cut on his right big toe. Citation # 930009022.

Joyce Eisenberg Keefer Medical Center D/P SNF
7150 Tampa Ave., Reseda

A $15000   Careplan Fall Injury Patient Care Transfer   07/03/2012
The resident’s care plan dated 1/26/11, indicated the resident was a risk for falls/injuries related to impaired mobility and non ambulatory status post amputation of her right leg. The resident’s Minimum Data Set indicated the resident required extensive assistance in transfers with a two person assist, and was totally dependent on staff for toilet use. On 9/11/11, the resident slid down on the floor while a CNA was assisting her from the toilet seat. The fall resulted in an angulated displaced fracture, a spiral fracture, and a left femoral shaft fracture. The CNA was suspended for three days pending an investigation. The facility was cited for failing to ensure the resident’s environment was free of accident hazards, received adequate supervision and assistance devices to prevent accidents, and provide a two person assist as indicated in the care plan. Citation # 930009078.

Lakewood Park Health Center
12023 S. Lakewood Blvd, Downey

B $600   Physical Abuse   05/22/2012
On 3/14/12, a resident sustained scratches and bruises from an altercation with another resident in the activity room. The aggressor had a history of physically abusive behaviors and was recorded as striking out and pushing others. The facility was cited for failing to properly supervise a resident who had been assessed as having aggressive behaviors towards others. Citation # 940009325.

Las Flores Convalescent Hospital
14165 Purche Avenue, Gardena

A $20000   Administration   Patient Records
03/29/2012
On 05/16/09, the resident was observed by a LVN breathing abnormally and was unresponsive to her questions. The LVN stated that she took the resident’s vital signs, but didn’t document them. The LVN then called the physician in order to obtain a transfer order, but didn’t call 911 until 4 hours after she initially observed the resident. The facility was cited for failing to ensure their policy and procedure for “Emergency Transfer to Acute Care Hospital” was implemented, failing to document pertinent information for the resident, and for failing to obtain and document the resident’s vital signs when he was observed with difficulty breathing and as his condition changed. Citation # 910009196.

B $1000   Careplan Decubiti (Bedsores) Deterioration Patient Care   05/23/2012
On 7/27/09, the resident was readmitted to the facility from the general acute care hospital (GACH) with diagnosis of decubitus ulcers on her right and left heels, sacral, and left buttocks. However physician’s orders to treat the ulcers were not obtained until two days later on 7/29/09, and the orders did not indicate treatment was to be done to the left buttocks. On 7/13/09, the resident’s condition worsened and had a temperature of 102.4 degrees Fahrenheit and developed a sore on her right ear. She was transferred back to the GACH. The facility was cited for failing to ensure the resident had physician’s treatment orders for each decubitus ulcer, and failing to ensure the resident’s skin was assessed in accordance with facility policy to prevent development of the ulcer on the right ear. Citation # 910009321.

Longwood Manor Convalescent Hospital
4853 W. Washington Blvd., Los Angeles

B $500   Administration   Physical Environment
02/28/2012
On 2/15/12, an unannounced visit was made to the facility to investigate a complaint that there were ongoing alterations being made to the facility without permits and/or approvals from the Office of Statewide Health Planning and Development. It was found that the facility was in violation of twelve alterations. These violations put the residents’ health and safety at risk. Citation # 910009048.

B $500   03/08/2012
CitationWatch description will be published once citation is received. Citation # 910009049.

Mirada Hills Rehabilitation And Convalescent Hosp
12200 S. La Mirada Blvd, La Mirada

B $2000   Mandated Reporting   Physical Abuse
04/27/2012
The facility was cited for failing to carry out a physician’s order for a psychiatric consultation after a resident choked and threatened to kill three other residents. The
facility also failed to administer an increase in Risperdal as ordered by the physician. These failures resulted in the resident becoming agitated and physically assaultive to three residents from 12/1/11 to 1/22/12. Citation # 940009244.

B $2000 Mandated Reporting  Physical Abuse
Verbal Abuse  04/27/2012
The facility was cited for failing to report two incidences of alleged abuse of two residents in the facility to the Department within 24 hours. A resident choked a resident on 1/21/11 and threatened to kill another resident on 12/17/11. Citation # 940009245.

B $2000 Careplan  Patient Care  Supervision
07/02/2012
The facility was cited for failing to follow the resident’s care plan by supervising the resident while smoking and not providing the resident with a protective apron while she was smoking. This resulted in the resident sustaining a 1.2 centimeter in length by 1.2 centimeter in width superficial burn on the mid-chest area. Citation # 940009384.

Paramount Meadows Nursing Center, Llc
7039 Alondra Blvd, Paramount
B $1000  03/27/2012
CitationWatch description will be published once citation is received. Citation # 940009192.

Studio City Rehabilitation Center
11429 Ventura Blvd., Studio City
B $750 Patient Records  04/11/2012
The facility was cited for failing to maintain a resident’s medical record in accordance with the facility’s policy and procedure and ensure that the closed medical record was filed and kept in a safe place, or was filed in an accessible manner and was readily available to the Department for review. Citation # 920009222.

The Californian - Pasadena Convalescent Hospital
120 Bellefontaine, Pasadena
B $2000 Physical Abuse  05/18/2012
On 6/6/08 at 12:50 pm, the resident sustained a bruise on her left forearm when an employee forcefully grabbed her arm while trying to change her clothes. The employee was immediately suspended on 6/6/08, and subsequently terminated on 6/12/08. The facility was cited for failing to ensure that the resident was free from physical abuse. Citation # 940009266.

B $2000 Theft & Loss  05/18/2012
On 6/6/08 at 12:50 pm, the resident claimed the employee stole her wedding ring. The employee was terminated on 6/12/08. The facility was cited for failing to ensure that the employee didn’t misappropriate the resident’s wedding ring. Citation # 950009317.

B $2000 Administration  Physical Abuse  Theft & Loss  05/18/2012
On 6/6/08 at 12:50 pm, a resident sustained a bruise to her left forearm while an employee was trying to change her clothes. The resident claimed the employee also stole her wedding ring. The employee was terminated on 6/12/08. A review of the employee’s Record of Arrest and Prosecution Sheet found that the employee had a long history of criminal activity dating back to 1986 which included burglary, battery, and theft. The facility was cited for failing to implement policies and procedures to protect the resident from physical abuse and the theft of her wedding ring by failing to perform a criminal background check of the employee before being considered for employment. Citation # 950009267.

The Earlwood
20820 Earl Street, Torrance
A $20000 Injury  Physical Environment  Supervision
07/10/2012
During an inspection on 2/2/12, a diabetic resident told an inspector that he was in extreme pain from an untreated infection to his right great toe. When the resident removed his shoe, the inspector observed that his toe was red, swollen and covered with thick yellow pus. The resident stated he had been in pain for about two months and asked the nurses to see a podiatrist, but nothing was done. Due to his diabetic condition, his doctor had ordered monthly podiatry care, but he had not been seen since 10/27/11. The resident was hospitalized, treated for cellulitis, and returned to the facility. The facility was cited because the neglect created a risk of death or serious harm to the resident. Citation # 940009093.

View Heights Convalescent Hospital
12619 S. Avalon Blvd., Los Angeles
A $20000 Infection  04/03/2012
During an inspection on 2/2/12, a diabetic resident told an inspector that he was in extreme pain from an untreated infection to his right great toe. When the resident removed his shoe, the inspector observed that his toe was red, swollen and covered with thick yellow pus. The resident stated he had been in pain for about two months and asked the nurses to see a podiatrist, but nothing was done. Due to his diabetic condition, his doctor had ordered monthly podiatry care, but he had not been seen since 10/27/11. The resident was hospitalized, treated for cellulitis, and returned to the facility. The facility was cited because the neglect created a risk of death or serious harm to the resident. Citation # 940009093.
Woodruff Convalescent Center
17836 S Woodruff Ave, Bellflower
B $2000 Fall Injury Patient Care Staff (Inservice) Training 07/02/2012
The facility failed to ensure that the resident received adequate supervision and assistance devices to prevent accidents and injuries by failing to train the staff in the operating use of the mobility device. The resident fell on the floor when the harness became loose and went over the resident's head. The resident sustained a laceration to the back of the head requiring four staples. Citation # 940009383.

Riverside County
Manorcare Health Services-Hemet
1717 West Stetson Avenue, Hemet
B $2000 Medication Patient Rights Physical Abuse 03/29/2012
On 5/1/06, a licensed nurse forced a 95 year old resident to take medications by mouth after she refused. The abuse was witnessed by three staff members. One of them reported that the nurse “just forced the spoon in the pt (resident’s) mouth” after she refused the medications and “the meds went all over the pt.” The nurse then scraped up the medications and forcibly shoved them back into the resident’s mouth, making a noise when the spoon hit the resident’s teeth. Witnesses reported that the nurse had a history of being mean to residents, and threatened to give the resident “calm down medicine” if she didn’t shut up. The abusive nurse said “I have a 16 hour shift and I’m not putting up with her today.” In refusing the medications, the resident had expressed concern that they were poison. The facility was cited because it did not protect the resident from physical and verbal abuse. Citation # 250009184.

San Bernardino County
Apple Valley Care Center
11959 Apple Valley Road, Apple Valley
B $1000 Dignity Mental Abuse Patient Care 05/04/2012
From 1/3/99 to 1/7/11, a CNA had seven allegations of abuse filed against her. In 2001, the CNA was terminated for substantiated complaints of abuse, but was allowed to work in the facility again shortly after. The facility was cited for failing to protect the residents from abuse. Citation # 240009279.

Braswell's Hampton Manor
11970 Fourth Street, Yucaipa
A $20000 Careplan Fall Neglect Patient Care Supervision 01/17/2012
The facility was cited for failing to ensure that the staff followed the plan of care by not responding to a pressure pad alarm (a device used to alert the staff of a patient’s movement) on 1/29/11. This resulted in a resident falling and sustaining fractures to the right elbow and right hip which were not identified in a timely manner and resulted in delayed in diagnoses, surgical interventions and hospitalization. Citation # 240008915.

Desert Knolls Convalescent Hospital
14973 Hesperia Road, Victorville
B $1000 Careplan Fall Patient Care 04/19/2012
The facility was cited for failing to implement the resident’s care plan by failing to ensure the resident’s bed side rails were consistently in the up position while the resident was in bed. This resulted in the resident falling out of bed on 6/8/10. X-rays taken on 6/10/10 revealed displacement of the right femur and a fracture, requiring surgical interventions. Citation # 240009228.

Desert Manor
8515 Cholla Avenue, Yucca Valley
B $1000 Dignity Verbal Abuse 04/12/2012
The facility was cited for failing to ensure that a resident was treated with dignity and respect and not subjected to verbal abuse. On 12/12/10, two CNA's were observed verbally abusing a resident, one was overheard saying: “Since you are a pig, we will roast you on the barbecue grill and have a pig roast.” Citation # 240009227.

Highland Palms Healthcare Center
7534 Palm Avenue, Highland
B $1000 Careplan Injury Patient Care Staff (Inservice) Training 05/15/2012
The facility was cited for failing to develop and implement a care plan following a resident’s lumbar laminotomy surgery. As a result, the resident sustained another injury and needed an additional surgery to repair the damage. Citation # 240009306.

Sierra Vista
3455 E. Highland Avenue, Highland
B $1000 Injury Medication Physical Abuse 03/23/2012
The facility is cited for failing to inform a resident’s physician that he refused to take his medication for two days, which resulted in increased agitation that led to a physical altercation with another resident. On 11/4/10, the resident held the other in a head lock, hitting him with a closed fist in the face repeatedly, then slamming him into the bed frame and then slamming his face into the floor. The injured resident was sent to the emergency room. He suffered a fractured nose. Citation # 240009177.

Veterans Home Of California - Barstow
100 E. Veterans Parkway, Barstow
A $16000 Administration Medication Patient Care 07/19/2012
From 5/1/11 to 6/16/11, when the resident was administered Insulin, the spaces to indicate that Insulin was verified by another licensed nursing staff were left blank. In between that time, 43 doses of Insulin were administered without documented verification that two nurses checked that the correct dosage was given. The facility was cited for failing to follow its Insulin Administration policy which resulted in a significant medication error. Citation # 170008822.
Waterman Convalescent Hospital
1850 N. Waterman Avenue, San Bernardino

B $1000 Patient Care Theft & Loss 05/23/2012
A female resident recovering from hip replacement surgery was prescribed a leg brace that was delivered on 6/7/11. By 6/8/11, the brace was missing and was not found. The resident was therefore unable to achieve her therapy goals but was nonetheless discharged on 6/16/11. As of 7/18/11, the resident, now back at home, did not have her brace and was unable to walk. The facility was cited for failing to provide the services necessary for the resident to achieve and maintain her highest level of functioning. Citation # 240009308.

San Diego County

The Dorothy And Joseph Goldberg Healthcare Center
211 Saxony Road, Encinitas

B $2000 Mandated Reporting Physical Abuse Sexual Abuse 06/21/2012
The facility was cited for failing to keep two resident free from abuse. A CNA sprayed and poured a air refresher on a resident’s genital stating “it smells in here.” Another CNA was in bed with another resident force feeding her, causing the resident pain, a bruise and an abrasion to the resident’s lower lip. The facility should have reported the alleged abuse within 24 hours, instead of over 60 days. Citation # 080009370.

Villa Rancho Bernardo Care Center
15720 Bernardo Center Drive, San Diego

B $1000 Fiduciary 05/16/2012
The facility was cited for failing to protect a resident from elder financial abuse. A resident gave a CNA her debit card to purchase two packs of cigarettes for her and one for himself. When the CNA returned, he told the resident that in addition to the cigarettes, he had put $10 worth of gas in his car. The resident checked with the bank, and it was actually $20. The CNA said that he would pay her back on payday. The resident told a physical therapist assistant who did not report the abuse to the supervisor. The CNA failed to pay back the money. Citation # 080009310.

San Luis Obispo County

Bella Vista Transitional Care Center
3033 Augusta Street, San Luis Obispo

A $10000 Patient Care 07/24/2012
On 5/4/09, a family member went to visit an 85 year old resident and found her moaning and complaining of pain in her back and abdomen. The family member notified staff that she suspected the resident might have a urinary tract infection (UTI) and requested a urinalysis. No urinalysis was performed and on 5/7/09, the resident arrived at the ER shaking and unable to talk. At the ER her temperature was 105.4. The facility was cited for failing to assess the resident promptly and not notifying the physician when a family member reported that the resident was in pain with a possible UTI. Citation # 050009334.

Santa Barbara County

Lompoc Skilled & Rehabilitation Center
1428 W. North Avenue, Lompoc

A $10000 Decubiti (Bedsores) Notification 07/25/2012
On 7/29/08, a resident developed a bedsore on his coccyx. The physician was notified and orders for treatment received. A weekly assessment of the bedsore on 8/5/08, demonstrated that the wound had progressed in size and developed drainage and an odor. Despite indications that the current treatment was not effective, the physician was not notified. The sore was evaluated again on 8/7/08 and a fax sent to the physician. However there was no response and no follow up by nursing. The facility was cited for failing to ensure the physician was notified when treatment of the bedsore was not effective. Citation # 050005373.

Marian Medical Center D/P SNF
1530 Cypress Way, Santa Maria

A $4000 Careplan Fall Patient Care Physical Environment Supervision 08/08/2012
On 10/19/11, the resident fell from her bed after the CNA turned her onto her left side. The side rail lowered, and the CNA left the resident unattended. The facility was cited for failing to leave the side rail up or provide adequate supervision. Citation # 050009380.

Tulare County

Westgate Gardens Care Center
4525 W. Tulare Avenue, Visalia

B $1000 Mental Abuse Neglect Patient Care Patient Rights Retaliation Against Resident Verbal Abuse 06/11/2012
On 7/20/11, an unannounced visit was made to the facility to investigate a report of alleged staff to resident abuse. The resident stated that she was either verbally abused, mentally abused, and/or neglected by multiple CNAs on several occasions. The facility was cited for failing to protect a resident from verbal and mental abuse, as well as neglect by multiple CNAs, which caused the resident to have anxiety and emotional trauma. Citation # 120009134.

Ventura County

Maywood Acres Healthcare
2641 South C Street, Oxnard

A $10000 Patient Care 07/20/2012
On 12/14/11, the sister of a 50 year old resident noticed that the resident seemed disoriented and unsteady. Between 12/14/11 and 12/17/11, the staff documented that the resident was sleeping more than usual and was refusing meals and medication. Despite these adverse changes, a physician was not notified until the afternoon of 12/17/11. Following notification the physician ordered the resident be transferred to the ER where she
was diagnosed with a urinary tract infection and a subarachnoid hemorrhage. The facility was cited for failing to properly assess the resident and promptly notify her physician when the resident exhibited a change in mental status and refusal to take meals and medications. Citation # 120009100.

**Vista Cove Care Center At Santa Paula**

250 March Street, Santa Paula

**A $10000 Fall Supervision 07/19/2012**

On 4/22/09, a resident had an unwitnessed fall and was found sitting on the bathroom floor. The resident was admitted to the facility for treatment of a subdural hematoma (a form of traumatic brain injury) related to a fall at home and his care plan indicated he was at risk for falls. The day before the fall, a nurse witnessed the resident attempting to get out of bed unassisted. Despite the observation, there was no evidence that fall interventions, such as a bed alarm, or a plan to monitor and supervise the resident were implemented despite the high risk for falls. The facility was cited for failure to provide adequate supervision and assistance devices to prevent accidents. Citation # 050007262.