Don’t Sign That Mandatory Arbitration Agreement, Phase II:

CANHR Launches New Website and Jumps Into Federal Case to Protect Resident Rights

The Spring issue of The Advocate introduced the CANHR campaign to avoid mandatory pre-dispute arbitration agreements in nursing homes (and other long-term care facilities). We explained how arbitration agreements are often presented at the time of resident admission and signed unwittingly, waiving the right to seek justice in a court of law. We urged residents and their representatives to “don’t sign them!” because the agreements almost always favor the facility.

To further educate consumers on the harms of pre-dispute arbitration agreements, CANHR has launched a new website http://canhr.org/arbitration. The site includes basic information on arbitration agreements and the insidious role of such pre-dispute agreements in nursing home admissions. The relevant laws are available on the site as well as articles and helpful links.

The Don’t Sign It Campaign is more urgent than ever given that arbitration agreements may soon prevent residents from getting access to justice to enforce their own rights. On July 25, CANHR filed a petition to intervene in one of the most important California nursing home cases in history. The case was brought by the nursing home industry against the State of California in a federal court in Fresno. The industry is seeking to rescind a state law that guarantees nursing home residents’ access to the courts in cases where their rights have been violated. If the suit is successful, most nursing home residents will not be able to meaningfully enforce their rights.

In 1982, when state enforcement of nursing home resident rights was considered soft, the legislature armed residents with a private right of action in cases where their rights were being violated. In order to protect this right, the legislature added that “an agreement by a resident . . . to waive his or her rights to sue pursuant to this subdivision shall be void as contrary to public policy.” (California Health and Safety Code § 1430(b)) Thus, even if a resident has signed an arbitration agreement, she maintains the ability to file a lawsuit if it concerns her state or federal rights.

In 2013, when state enforcement of nursing home rules has become even more slack, the right to sue for rights violations has become a powerful tool for preventing abuse and neglect and guaranteeing decent quality of care. Rights violation lawsuits have led to multi-million dollar cases against nursing home chains that chronically understaff their facilities, groundbreaking cases to stop the misuse of chemical restraints, and simpler cases to protect residents’ privacy and dignity. In addition, the immunity of resident rights cases from compulsory arbitration has kept many important elder abuse and neglect cases in courts, where residents can gain fuller recoveries and get judge-signed orders to stop illegal nursing home practices.

You can find more information about the federal case on the new CANHR arbitration agreement website at http://canhr.org/arbitration/valley_view.html and view important case documents. CANHR hopes to thwart the lawsuit and protect resident rights, but if we are not successful, it will be more important than ever for consumers to refuse to sign mandatory pre-dispute arbitration agreements.

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Gov. Appoints CANHR Attorney to Advisory Committee

Governor Jerry Brown has appointed CANHR Senior Staff Attorney Prescott Cole to the California Professional Fiduciaries Advisory Committee. Mr. Cole’s training as an attorney and his interactions with countless seniors who have been financially abused has made him keenly aware of the need for strong safeguards, clear regulations, and vigorous oversight of those who control the assets of elder or disabled individuals. As an Advisory Committee member, Mr. Cole will have the opportunity to contribute to the continued development of the professional fiduciary system in California.

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 Mary Stern, a graduate student in Gerontology at San Francisco State University and Aidan O’Donnell, who will finish his college years in Oregon – thank you for your time and talent!

In Memory – Ellie Enriquez Peck

Ellie Enriquez Peck, a veteran Democratic activist who was influential in California as a mentor for Latino youths and an advocate for seniors, died Tuesday, July 30, in Sacramento. Ms. Peck was the principal consultant on aging and minority affairs for Lt. Gov. Leo McCarthy and was instrumental in passing California’s Nursing Home Patients Protection Act of 1984. Ms. Peck, or “Ellie” as she was known to many, was a member of CANHR’s Board of Directors for many years during the 90’s and helped develop legislation and public policy that enhanced the lives of thousands of California’s long term care consumers. An activist and advocate, Ellie Peck was a force of nature who will be missed.

Photo: Chicano Latino Leadership Project (CLYLP)
Life and Death in Assisted Living

In a major investigation with ProPublica, a new FRONTLINE documentary examined the operations of the nation's largest assisted living company, raising questions about the drive for profits and fatal lapses in care. The documentary is accompanied by a series of reports published on ProPublica. The documentary, “Life and Death in Assisted Living,” traces the rise of the assisted living sector and Emeritus in particular, which has grown into the country’s largest assisted living provider. Emeritus now operates over 500 facilities in 45 states.

The reporters, A.C. Thompson, Jonathan Jones and Carl Byker reviewed extensive Emeritus records, including more than 100 lawsuits filed against the company, and collected thousands of pages of state inspection records for the company’s facilities in California, Texas, Ohio, Iowa, Mississippi and Georgia over the last five years. They looked at every Securities and Exchange Commission filing since 1995, 911 call records and internal company documents such as emails and budgets. They spoke with facility directors and other Emeritus employees, workers at other assisted living companies, academics, ombudsman and regulators. They also attended the trial in the case of Joan Boice, who died while residing at an Emeritus facility in California. The company faces a $22.9 million judgment in that case – an amount that the jurors arrived at by adding together the 2011 compensation for Emeritus’s chairman and CEO.

Emeritus went into immediate defensive mode, calling on assisted living executives to form a “united front,” and asking Emeritus employees to post positive remarks about the company on Frontline and ProPublica’s Facebook and website accounts and noting that the Frontline piece focused on “…a few unfortunate and tragic resident incidents that happened several years ago.” The documentary, however, reveals a different story. You decide. To view the documentary and read the reports, visit PBS’s website.

CANHR Partner in Improving Dementia Care Wins National Ombudsman Award

Sylvia Taylor-Stein, the Executive Director of Long Term Care Services of Ventura County Inc., has been named the winner of the 2013 Howard Hines Memorial Award. The award, given by the National Consumer Voice for Quality Long-Term Care, goes to an individual who has effectively advocated for long-term care consumers at a local level. Sylvia has been an effective advocate and then some. In late 2010, when CANHR’s Campaign to End the Misuse of Psychotropic Drugs in Nursing Homes was new, Sylvia had an idea to educate the long-term care providers of Ventura County about chemical restraints and improved dementia care. Her organization and CANHR co-sponsored the first dementia care symposium in March 2011 and has since held two more full-day events featuring some of the nation’s top dementia care experts as well as presentations by progressive local providers. Use of antipsychotic drugs in Ventura County nursing homes is down 27% since the first symposium, garnering national attention. Congratulations to Sylvia and her Ombudsman staff for such excellent advocacy!

California Nursing Homes Get a “C” in Report Card

California nursing homes rank 28th in the United States according to Families for Better Care, a nursing home resident family advocacy group in Florida. The group recently released a nursing home care report card for all 50 states and Washington, DC where nursing home care was assessed using a formula of staffing levels, enforcement actions, and Ombudsman complaints. Alaska facilities were ranked first and Texas was ranked last. California rated a “C” - average score - with D’s in registered nursing hours, deficiencies, and inspections. The California report stated “rampant problems plague California nursing homes as 9 out of 10 facilities cited a deficiency.” To see the report cards, go to http://nursing-home-reportcards.com.

What is a Professional Fiduciary?

A Professional Fiduciary is an independent third-party managing your affairs during your lifetime and after your death. They can provide you with the personal service that you might want or need, because they usually accept accounts in areas close to where they reside and/or operate their business. An experienced, licensed Professional Fiduciary offers a variety of solutions, has received specific training, is objective in dealing with your beneficiaries and is duty bound to follow your wishes as closely as possible. It is their full time job to take care of you and your estate; an unpaid family member has to juggle all of this work with their job, family and normal life, and things may slip through the cracks. It is important to get to know the professional fiduciary you select to manage your trust or estate. This may be the person who helps you receive care in your home; who may also handle all your finances and who may communicate directly with your family members. Professional Fiduciaries may also be willing to act as attorney-in-fact for health care decisions whereas corporate fiduciaries are generally not allowed to take on this role for individuals. Not all professional Fiduciaries take on Conservatorship or Guardianship cases. For more information you can visit the Department of Consumer
Living in a Nursing Home and Want to Go Home?

If so, the California Community Transitions program might be right for you. This not-too-well-known program is run by the California Department of Health Care Services to help nursing home residents on Medi-Cal return home. This could be to your own home, an apartment, or a facility that is participating in California’s assisted living waiver program. The program serves people of any age or type of disability.

The goal of the program is to reduce the number of Medi-Cal recipients receiving care in long-term care facilities by arranging needed home and community based services. In 2012, more than 400 people returned home from California long-term care facilities through help from the California Community Transitions program.

To qualify, you must have continuously lived in a long-term care facility for 90 days or longer. Time spent receiving short-term rehabilitation services paid by Medicare does not count toward the 90-day requirement.

The program is aimed at providing the extra help a person needs to go back home after a lengthy stay in a nursing home. A transition coordinator works with each interested person to counsel them about options and, if they want to go home, helps them do so. The program can help nursing home residents locate and arrange affordable housing, pay moving costs, re-learn skills needed to live at home, apply and obtain In-Home Supportive Services, arrange needed care and medical services, and much more.

After you move home, the California Community Transitions program continues to work with you for at least a year to make sure your needs are met and that long-term services and supports are in place.

To get help from this program, contact the local care coordination agency in your area. The California Community Transitions program operates in most, but not all, areas of California. The California Department of Health Care Services (DHCS) contracts with local care coordinating agencies to offer these services.

To identify the agency serving your area and get contact information, go to the DHCS webpage on the California Community Transitions program at: [http://www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx](http://www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx)

The California Community Transitions program is one option for getting help to return home from a nursing home. If you or someone you know needs help getting out of a nursing home, you can call the DHCS Long-Term Care Division at 916-552-9105 for information and assistance even if you do not qualify for the California Community Transitions program. There may be other programs, services and agencies that can help you.

**CANHR on the Move...**

Past Speaking Engagements, Panel Discussions and Training Sessions

- **June 5**: Tony Chicotel traveled to El Centro to present on elder abuse. His topic was the rights of long-term care residents.
- **June 6**: Pat McGinnis presented a workshop to seniors at the WLCAC Theresa Lindsay Center in L.A.
- **June 28**: Tony Chicotel participated in Practicing Law Institute training on estate planning. The training was recorded and will be made available to legal services and pro bono attorneys.
- **July 9**: Tony Chicotel co-presented on a webinar for the Assisted Living Consumer Alliance. The topic was comfort-focused dementia care.
- **July 26**: Terry Donnelly presented on CANHR services and resources to LA County Social Workers from HealthCare Partners.
- **July 31**: Advocates Tony Chicotel and Mike Connors attended meetings of the statewide partnership to reduce antipsychotic use and improve dementia care in nursing homes.
- **August 7**: Terry Donnelly trained ombudsman staff and volunteers on Family Council organizing at the Region IV Lakewood Regional Office – LA County
- **August 7**: CANHR volunteer Claire Lomax attended the Twelfth Annual Healthy Aging Fair at Chabot College where she shared information about Medi-Cal, Veteran Affairs Aid and Attendance, and Planning for Incapacity.
- **August 10**: CANHR volunteer Clair Lomax represented CANHR at the Health Forum hosted by Ca. State Assembly member Kevin Mullin. The focus was providing information and free service promoting wellness and healthy activity.
- **August 14**: Tony Chicotel gave a webinar on incapacity and legal decision making for CANHR’s Social Worker Advocacy Program.
The September 13 deadline for passing bills out of the two houses, the Assembly and Senate, is fast approaching. Once the bills are on the Governor’s desk, he has until October 13, 2013 to sign or veto bills. Many of the bills that might have actually done some good died along the way, others will end up as two-year bills and be resurrected next year, and others will be reincarnated in future years.

**CANHR Sponsored**

**AB 140 (Dickinson): Undue Influence**

This bill would define undue influence as excessive persuasion that causes another person to act or refrain from acting in a manner that results in an unfair outcome. In determining whether the outcome was produced by undue influence, the vulnerability of the victim, the influencer’s apparent authority, the actions or tactics used by the influencer, and the equity of the result shall be considered. **Status:** On the 3rd reading in the Senate. This bill is likely to be enrolled and signed by the Governor.

**SB 272 (Corbett): Advertising: Military Endorsements**

This bill would make it illegal for any nongovernmental entity to use a seal or emblem to imply any connection or endorsement of any federal or state military, veteran or Veterans Service Organization (VSO), without approval, for the purpose of financial gain. This would apply to advertising or promotion of events or products, without permission. **Status:** On consent calendar in Assembly Appropriations; likely to pass and be signed.

**CANHR Support**

**AB 261 (Chesbro): RCFE Fees Payable on Death of Resident**

This bill would prohibit a residential care facility for the elderly from requiring advance notice for terminating an admission agreement upon the death of a resident, and would prohibit the facility from assessing any fees once all personal property of the deceased is removed from the facility. **Status:** Senate Appropriations and is likely to pass and be signed.

**AB 581 (Ammiano): Residential Care Facilities for the Elderly: Retaliation**

This bill would prohibit an adult residential facility licensee or a residential facility for the elderly licensee, or officer or employee of the licensee from discriminating or retaliating in any manner, including, but not limited to, eviction or threat of eviction, against any person receiving the services of the facility; or against any employee of the licensee’s facility, on the basis, or for the reason that, the person or employee or any other person has initiated or participated in the filing of a complaint, grievance, or a request for inspection with the department or the local or state ombudsman pursuant to prescribed provisions of law. **Status:** On consent in the Senate appropriations, and likely to be enrolled and signed.

**AB 663 (Gomez): Residential Care Facilities: Administrators: LGBT Cultural Competency**

This bill would require the administrator training to be a total of 40 hours and would require that the training include 5 hours of training in cultural competency and sensitivity in aging lesbian, gay, bisexual, and transgender minority issues. **Status:** In Senate Appropriations. Likely to pass and be signed into law.

**AB 1217 (Lowenthal): Home Care Services Consumer Protection Act of 2013**

This bill would enact the Home Care Services Consumer Protection Act of 2013, which would provide, on and after July 1, 2014, for the licensure and regulation of home care organizations, as defined, by the State Department of Social Services, and the certification of home care aides. **Status:** In Senate Appropriations suspense file, which means that it probably will die there – particularly after the ridiculous DSS/CCL estimate of one-time costs of $22.5 million, on going costs of $20 million, etc. It is unlikely that we will see any oversight of caregivers in our lifetimes.

**SB 609 (Wolk): Office of the State Long-Term Care Ombudsman**

Existing law requires the office to solicit and receive funds, gifts, and contributions to support the operations and program of the office. This bill would require the office to deposit those funds into the Long-Term Care Ombudsman Program Improvement Act Fund, and would continuously appropriate those funds for the purpose of supporting the operations and programs of the office. **Status:** Assembly Appropriations consent calendar, which is a good sign.

Please check the CANHR website for updated details on legislation.
Choosing RCFEs/Assisted Living Facilities

On July 30th 2013 ProPublica aired a special on PBS titled “Life and Death in Assisted Living” featuring CANHR’s Executive Director, Patricia McGinnis. The program shed light on the bleak reality concerning the lack of quality care provided to elders in Assisted Living Facilities. These facilities, also known as board and care and residential care facilities for the elderly, can cost up to $5,000 a month or more with no government assistance available. As McGinnis described in the interview, enforcement and regulation are lacking and, unfortunately, when it comes to filing complaints with licensing, “you might as well be filing them down a black hole.” Many of the viewers felt at a loss for a good solution. The question still remained, what is the best way to choose an assisted living facility?

There are over 7,400 residential care facilities for the elderly in California, with over 75% having 6 or fewer beds, and the rest ranging from 7 to 200+ beds. The size of the facility is important. Where would you or your relative feel most at home? The location of the facility is also important. The closer it is to your social network and family, and the more visitors, the better the quality of care is likely to be. And most important of all is the cost of care. It doesn’t do much good to research and find the best facility in the state if you can’t afford to live there. RCFE/Assisted living can be expensive and most of the residents are private pay, relying on monthly income and retirement funds to pay the monthly costs. Get a true picture of the costs, including a breakdown of any charges for additional services.

Elders with dementia have very specific needs that must be addressed when choosing a facility; environment, and philosophy of care can be just as important as other key factors like food and activities. Elders with dementia may have more difficulty expressing their needs, which makes finding the right fit crucial. Request a copy of the plan of operation from the facility or your local licensing and certification office. The plan should contain information about the philosophy of care, special services and staff training. Try to find a facility that meets the special needs of the resident.

Do your research before signing an admission agreement and moving in. Although little quality of care information is available on-line, records about facility inspection visits, citations or deficiencies can be found at your local Community Care Licensing office. CANHR has a listing with basic information of all the licensed residential care facilities in California. Some of the facilities have filled out the questionnaire providing information on the types of residents accepted, services offered, staffing information, costs, and ownership information. Download CANHR’s free fact sheet Evaluation Checklist for RCFEs and the Dementia Care Checklist. These tools can be useful when evaluating and choosing a facility.

In using the checklist, keep in mind the following general tips:

- Start the process early before there is a crisis.
- Involve the prospective resident as much as possible in the process.
- Use the checklist to get an overall feel for the facility and its practices.
- Narrow the options down to two or three facilities.
- Visit each facility several times.
- In making visits, walk through the whole facility and visit at different times and visit during a mealtime.
- Pay special attention to how residents are being treated by staff and the quality and responsiveness of the services. Don’t be sold only on the attractiveness of the facility.
- Obtain a copy of the admission agreement. Read it carefully. Understand the services, costs and conditions for transfer.

To obtain a complete copy of the Evaluation Checklist for RCFEs and the Dementia Care Checklist please visit our website at www.canhr.org. If you do not have access to the internet and would like a copy please call our toll free help line 1-800-474-1116 to request a copy.

To view the frontline program visit http://www.pbs.org/wgbh/pages/frontline/life-and-death-in-assisted-living/
Dear Advocate,

My wife is in a nursing home and we have submitted an application for Long Term Care Medical. I have been told by Medi-Cal that I am considered the community spouse and that California law allows me to retain a minimum monthly maintenance needs allowance (MMMNA) of $2,898. When determining the share of cost that she owes to the nursing home, can I count my Medicare premiums and other supplemental insurance premiums as a deduction?

Sincerely,

Befuddled in Berkley

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Dear Befuddled,

Unfortunately, once your wife is in in nursing home on Long Term Care Medi-Cal, you are considered as part of a separate Medi-Cal Family Budget Unit (MFBU). Therefore, health insurance premiums paid on behalf of the well/community spouse are not allowed as an income deduction from the LTC spouse’s financial budget. Only the institutionalized spouse’s premiums are deducted. If there is one joint payment for a health care or long term care insurance policy for both spouses, then the entire amount can be deducted from the institutionalized spouse’s income. Otherwise, they are in separate MFBUs and the community spouse is not a Medi-Cal applicant or beneficiary, so his/her premiums would not be deducted.
A 2006 study by the National Association of Social Workers (NASW) of Licensed Social Workers found that “social work retention was negatively affected when employers hired non social workers to social worker’s jobs.” Tracy Whitaker, Director of NASW’s Center for Workplace Studies, said “social workers become frustrated when they find they are working in similar jobs with people who do not have similar education or training. As a result, this hiring practice pushes many social workers, not only out of specific agencies, but out of the profession itself.”

As a former social worker and current CCRC resident, I am very frustrated by my experience with the California Department of Social Services Community Care Licensing Division (CCL) and their employment policy regarding the hiring of Licensing Program Analysts (LPA), which excludes the hiring of qualified social workers in favor of a policy of hiring people who have degrees in literature, merchandizing and real estate, as well as high school graduates with compensatory experience. This column is designed to educate social workers who specialize in working with seniors who have chosen to live in Residential Care Facilities for the Elderly (RCFEs).

On June 26, 2013, I wrote to the Deputy Director of Community Care Licensing to request a list of the number of social workers in that department working as Program Licensing Analysts. To date the Deputy Director has not given me the information I requested. My harrowing personal experience with CCL and the LPAs I have dealt with confirms my belief that this policy of excluding trained social workers represents a real danger to seniors.

On May 8, 2013, I was verbally attacked by another resident in the presence of the head of security in the facility where I live. When that employee did not get me out of harms way and deal with the resident intimidating me, I filed a Behavioral Incident Reporting Form on 5/10/2013. The follow-up report made by the LPA concluded that my fear for my safety was “unfounded because of the brief nature of the attack.” That LPA refused my request to see the report made because it was deemed “confidential.” The ombudsman who requested to see the report was told the same thing.

When I contacted Deputy Director of the Community Care Licensing Division and protested, the report was mailed to me. I subsequently learned that the LPA assigned to my case has no experience with elders, but was swept into the LPA position because two divisions of the Department of Social Services had merged and this LPA has been swept into the new position with no prior experience in dealing with RCFE residents. If I had accepted the LPA’s edict, I would have given up the right to see that report. That report did not reflect the reality of my position as a resident threatened in the lobby of the facility. The LPA spent three hours with the facility administrators and a very short time with me. Although this LPA said, “I have not made up my mind,” it was clear that the decision to do nothing had already been made.

On June 21, 2013 I received a letter from the Executive Director of my facility that stated “At the Resident Update meeting this morning we made clear that we do not tolerate conduct that threatens or otherwise interferes with any other resident.” I believe my actions and protests succeeded in altering a policy that for years had tolerated bullying of one resident by another. I shall continue to expose abuses in the flawed and broken regulatory system and RCFE administrators who do not protect the seniors in their care.

Ms. Hyatt is a resident of a CCRC and an AARP Policy Specialist on CCRCs.
Family Council At the Motion Picture & TV Fund Home - A Positive Force for Change

When you hear Motion Picture and TV Fund Home (MPTF), you might think of a retirement community for the stars, and you would be right. Some of the residents there were stars, but many worked behind the scenes as writers, sound technicians, costume designers, and film editors. The real stars, however, are the family members, friends of residents, and residents who stood up to stop the closure of their nursing home in January 2009. This closure directly affected the lives of 136 residents, and the lives of hundreds more who counted on the commitment of the industry to “take care of its own.”

A Family Council was formed by Nancy Biederman who brought together residents, family, friends, and supporters from the motion picture and TV industry to fight the closure. During this three-year crisis, one of the major efforts was to support residents and families and to maintain quality of care. The outcome of the struggle was a commitment to maintain a nursing home and special care unit providing dementia care. There were also major changes in leadership and administration. In reflecting on this experience, Ms. Biederman believes it is “more effective to form a family council to prevent problems rather than to wait for a crisis to do so.”

As Ms. Biederman explains, “this fight left some wounds on all sides that needed to be healed. It was important to find common ground and to drop labels and start talking to one another so we could rebuild trust and cooperation.” This healing and trust-building process took time; but out of the conflict and sense of betrayal has emerged a community rededicated to promoting the quality of care and life for residents.

The Family Council has an informal structure with Ms. Biederman acting as the Council’s Facilitator. It meets monthly and holds special meetings when necessary. The Family Council asks members to volunteer as ambassadors to greet and welcome family members and friends of new residents. The Family Council is promoted in a variety of other ways: information on the Family Council is included in the admissions packet for new residents; notices of Family Council meetings and events are featured in the facility newsletter; and Family Council activities and speakers are displayed in a case dedicated to the Family Council. They have also developed an email list and telephone tree to stay in touch with one another between meetings.

Another unique feature of the Family Council is to invite Resident Council members to all Family Council Meetings. The Resident Council also invites a member from the Family Council to attend its meetings and to make reports on Family Council activities. This hybrid approach, Ms. Biederman believes, adds to the vibrancy and relevancy of the Family Council.

In addition to inviting guest speakers, the Family Council sponsors a periodic “round table” where they invite persons from administration or key departments, e.g. nursing, dietary, etc. The focus of the round table is to have a frank sharing of what is and isn’t working from the viewpoints of family members, residents, administration and key staff with the goal of finding mutually acceptable solutions. This approach has helped shift family members’ and residents’ perceptions of administration and key staff as the adversary to a partner in creating positive change, and the administrations’ and staffs’ perceptions of the Family Council as troublemakers to collaborators.

Ms. Biederman believes that the different approaches described in this article have all helped make the Family Council “a legitimate, and positive force for change at the Motion Picture and TV Fund.”

Please share with CANHR how your Family Council is a “positive force for change” so we can continue to promote and support the development of Family Councils.

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 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**

- Dotty Opp
  James & Dorothy Opp
- Jean Levine
  Zita Bar
- Albert Moscow
  Alfreda Moscow
- Bette Stith Peters
  Kathie Zatkin
- Lee Sault
  Helen Drachkovitch
- Maxine and Ernie Gallo
  La Vonne Gallo
- Hennilue Albury
  Barbara Jones
- Thomas Spear Walther
  Anthony Moy
- Francis X. Kelly
  Colette Kelly
- Bob Floden
  Laural Reid
- Ina de Vries
  Dr. Darlene Yee-Melichar
- My Beloved wife, Rita, Joseph Twomey, husband
  Joseph Twomey
- Mary Yip
  Thomas Yip
- Ann Smith
  Geraldine Murphy
- Mary W. Ballantyne
  CANHR Staff
- Mary W. Ballantyne
  Robert Peterson
- Pearl Caldwell
  CANHR Staff
- Edith Delpeschio
  CANHR LRS Advisory Committee

**IN HONOR OF**

- The Development of Better Public Policy
  Anonymous Donor
- CANHR’s Work
  Harry & Julia Carpente
- Robert A. MacInnes
  Gail MacInnes

**CANHR Up Coming Events**

- **September 28**: City of San Mateo Health & Wellness Fair from 10 am – 2 pm located at the San Mateo Senior Center, 2645 Alameda de las Pulgas, San Mateo, CA 94403. For more information call 650-522-7499.

- **October 4**: City of Newark Senior Center 14th Annual Healthy Lifestyle & Fitness Fair 9 am – 12 pm at the Newark Community Center 35501 Cedar Blvd., Newark, CA. For more information call 510-578-4845.

- **October 23**: Marin County Senior Information Fair 9 am – 3 pm, Marin Exhibit Hall, 10 Avenue of the Flags, San Rafael, CA 94903. For more information visit [www.marinseniorinformationfair.org](http://www.marinseniorinformationfair.org).
Support CANHR...
If you appreciate our services and the information we bring to you, please help us by making a donation.
Make a secure donation online at www.canhr.org or fill out this section and return it with your donation to:

CANHR, 650 Harrison Street, 2nd Floor, San Francisco, CA 94107.

Enclosed is my check for: □ $500 □ $100 □ $50 □ $30 □ Other ____________________________

This gift is in memory of: _____________________________________________________________
(or in honor of: _____________________________________________________________

☐ Contact me about legislation and other advocacy opportunities.
☐ Save paper, send me The Advocate via e-mail. E-mail: ________________________________

Name: ________________________________________________________________
Address: __________________________________________________________________
City/State: ___________________________ Zip: _____________________________
Telephone: ___________________________ E-mail: ____________________________
Facility Name: __________________________________________________________________

CANHR prohibits the use of its name for the purpose of advertisement by attorneys, financial planners or any other organization or entity.
Citation Watch - Consumer Report

The following citation summaries are compiled from the citations issued by the California Department of Public Health to Northern California skilled nursing facilities and received by CANHR as of the publication of this 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.

Butte County

Cypress Healthcare Center
1633 Cypress Lane, Paradise
A $10000 Fall 02/20/2013
On 9/9/11, a 76 year old resident who was assessed as unstable while walking and being a risk for falling, fell while attempting to use her bedside commode. The fall opened a gash in her head and caused bleeding in her brain. The resident was transported via helicopter to a medical facility where she received aggressive treatments for her brain injury. The injury left her substantially diminished, without the ability to perform many of the functions she was capable of doing for herself prior to the fall. The facility was cited for failure to ensure the safety of the resident by not providing assistance with toileting. Citation # 230009708.

Contra Costa County

Lafayette Care Center
1010 First Street, Lafayette
B $850  6/8/2013
CitationWatch description will be published once citation is received. Citation # 020008296.

Windsor Rosewood Care Center
1911 Oak Park Blvd., Pleasant Hill
B $2000 Transfer 04/25/2013
On 8/22/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's Unit for more than 2 years and suffered from a severe cognitive impairment. The resident’s responsible party reported the facility staff stated the Alzheimer's unit was closing and "told me that I had 30 days, not even that, to find a new placement." Citation # 020009798.
B $2000 Transfer 04/25/2013
On 11/4/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for more than a year and suffered from advanced dementia. After being informed that the facility planned to close the Alzheimer's unit, the resident's responsible party reported feeling quite upset when she learned that the facility was planning to replace the Alzheimer's unit "with a more profitable population." Additionally, the responsible party said it was difficult to find a new placement because the resident suffered from severe sundowner syndrome. Citation # 020009854.

B $2000 Transfer 04/25/2013
On 9/11/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for about 6 months and suffered from dementia and other impairments. After the facility stated it was closing the Alzheimer's unit and discharging the residents, the resident's responsible party reported "I sorta freaked out when I read the letter. (The) resident was happy at the facility. I was scared and worried about what to do." Citation # 020009800.
B $2000 Transfer 04/25/2013
On 8/12/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for about 19 months and suffered from advanced dementia. After receiving a letter from the facility on 8/18/11 about plans to close the Alzheimer's unit, the resident's responsible party reported "they sorta put pressure on me. I started to panic, trying to find a good place." Citation # 020009802.

B $2000 Transfer 04/25/2013
On 10/11/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for about 3 years and suffered from advanced dementia. The resident's responsible party stated that it was shocking to get notice from the facility in August that the Alzheimer's unit was closing and that the resident had to move by December. Citation # 020009811.
B $2000 Transfer 04/25/2013
On 10/7/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for about a year and suffered from advanced dementia. Upon learning of the facility's plan to close the Alzheimer's unit and discharge the residents, the resident's responsible party reported that she did not want the resident moved because the resident had a familiar routine and environment. Citation # 020009812.
B $2000 Transfer 04/25/2013
On 10/21/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for about three years and suffered from dementia and Parkinson's Disease. Upon learning of the facility's plan to close the Alzheimer's unit and discharge the residents, the resident's conservator reported feeling dismayed because the family had made a tremendous effort to settle the resident into the secured unit. Citation # 020009813.

B $2000 Transfer 04/25/2013
On 10/06/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for more than six years and suffered from advanced dementia. Upon learning that the facility was closing the Alzheimer's unit and wanted the resident out, the resident's responsible party and a family member reported they felt shocked and powerless because the resident was comfortable at the facility and did not respond well to change. Citation # 020009814.

B $2000 Transfer 04/25/2013
On 9/26/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for about three years and suffered from advanced dementia. The resident's conservator reported she was surprised when she learned the facility was closing the Alzheimer's unit and that the resident was really mad and upset about the move. Citation # 020009815.

B $2000 Transfer 04/25/2013
On 8/09/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for more than a year and suffered from dementia. The resident's responsible party reported she felt surprised when she learned that the facility planned to close the Alzheimer's unit and discharge the resident and was concerned because the resident did not adjust well to change. Citation # 020009816.

B $2000 Transfer 04/25/2013
On 8/2/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for more than seven years and suffered from advanced dementia. Upon learning that the facility planned to close the Alzheimer's unit and discharge the residents, the resident's responsible party reported the family was shocked and did not want the resident to be moved because it would be very traumatic. The resident was shaking while leaving on the day of discharge. Citation # 020009817.

B $2000 Transfer 04/25/2013
On 10/10/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for about a year and suffered from advanced dementia. The facility discharged the resident while closing the Alzheimer's unit, exposing the resident to increased risk of confusion, fear and distressful behaviors. Citation # 020009818.

B $2000 Transfer 04/25/2013
On 10/5/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for almost a year and suffered from advanced dementia. Upon learning that the facility planned to close the Alzheimer's unit and discharge the residents, the resident's responsible party reported the resident was upset and unable to understand why discharge was necessary. The responsible party was told that the facility would move the resident to a facility in Sacramento if she did not move the resident. Citation # 020009819.

B $2000 Transfer 04/25/2013
On 10/6/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for more than a year and suffered from advanced dementia. The resident's responsible person reported she was stressed by the facility's plan to close the Alzheimer's unit and discharge the residents. After subjecting the resident to confusion and distress by moving her, the facility sent a letter one month later inviting the resident to return. Citation # 020009820.

B $2000 Transfer 04/25/2013
On 10/8/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for more than 30 months and suffered from advanced dementia. After learning that the facility planned to close the Alzheimer's unit and discharge the residents, the resident's responsible party reported, "We were given no choice" about moving, and that the resident did not like being moved. Citation # 020009821.

B $2000 Transfer 04/25/2013
On 10/18/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had recently been admitted to the facility's secured Alzheimer's unit and suffered from advanced dementia. After being notified that the facility planned to close the Alzheimer's unit, the resident's responsible party reported feeling troubled by the discharge decision, the process of finding a new facility and the facility's plan to discharge the resident to an unsecured facility. Citation # 020009822.

B $2000 Transfer 04/25/2013
On 9/28/11, Windsor Rosewood involuntarily discharged a resident without a legal reason, putting the resident at risk of serious harm. The resident had resided on the facility's secured Alzheimer's unit for more than 30 months and suffered from advanced dementia. After learning that the facility planned to close the Alzheimer's unit, the resident's responsible party reported feeling troubled by the discharge decision, the process of finding a new facility and the facility's plan to discharge the resident to an unsecured facility. Citation # 020009823.

Lake County

Evergreen Lakeport Healthcare
1291 Craig Avenue, Lakeport

AA $100000 Medication 5/16/2013
On 8/8/11, a female resident was given methadone that was not ordered by a physician. The licensed nurse confused the resident for a different resident. The nurse discovered her error about 15 minutes later. Despite the resident's declining functioning, the staff did not call 911 until eight hours later and she died shortly after. The staff had decided to monitor vital signs instead of sending the resident to the hospital or seeking treatment with a reversal agent. The facility was cited for giving the resident the wrong medication and failing to transfer the resident to the hospital after the error was discovered. The violations were a direct proximate cause of the resident's death. Citation # 110008617.

Marin County

Novato Healthcare Center
1565 Hill Road, Novato

B $1000 Dietary Services Neglect Patient Care 12/07/2012
On 3/19/10, a resident who required supervision while eating was found sitting in front of the nurses station looking pale and weak due to choking on a large piece of orange. When staff tried to feed her, she spat at them. 911 was called and the paramedics removed a large piece of orange from her mouth that was causing the choking and low oxygen in her blood. They took her to the acute care emergency room. Upon reviewing the physician's orders, the resident was put on a mechanical soft diet 2 days prior to the choking incident. The dietary supervisor stated that the menu served reflected the same diets served during that week, which did not address the physician's order two days prior. The staff failed to follow up and monitor the resident when her diet order was changed and that a speech language pathologist evaluation was not completed within 24 hours of the physician's order. The facility violated this regulation, which had a direct relationship on the health safety and security of the resident. Citation # 110009322.

Monterey County

George L. Mee Memorial Hospital D/P SNF
300 Canal Street, King City

B $800 Fall Injury 8/10/2013
On 7/12/10, a resident fell from his bed and sustained a hip fracture. The resident had previously requested that his bed be inspected as it tilted to one side when in the lowered position. A CNA had lowered the resident's bed when he slid from the bed and fell. The facility was cited for failure to ensure continuing assessment of the resident's needs when they failed to inspect his malfunctioning bed. Citation # 070007442.

Placer County

Auburn Oaks Care Center
3400 Bell Road, Auburn

B $1000 7/8/2013
CitationWatch description will be published once citation is received. Citation # 030009992.

Lincoln Meadows Care Center
1550 Third Street, Lincoln

AA $100000 3/21/2013
CitationWatch description will be published once citation is received. Citation # 030009792.

Rock Creek Care Center
260 Racetrack Street, Auburn

B $1000 Verbal Abuse 5/9/2013
On 5/8/10, while a LVN and another staff member were assisting a 75 year old non-ambulatory resident who had short and long term memory impairment, another LVN came in and shouted at the resident, scolding him saying that he should have a Norco patch (narcotic pain medication). The LVN who had been assisting the resident noted that the resident was terribly confused and near tears because he didn't know what he did that was wrong. The facility was cited for failing to ensure that the resident was free from mental abuse. Citation # 030009884.

Sacramento County

Applewood Care Center
1090 Rio Lane, Sacramento

B $1000 Patient Rights 5/3/2013
On 5/27/09, a 29 year old resident reported to the facility that she had been left naked and exposed on her bed following a shower, and that in the past she had to resort to calling the facility on her cell phone after no one coming to her room after waiting 45 minutes for assistance for her incontinence. In a 5/29/09 letter to the Department, the Administrator stated that their investigation had been completed and the allegations of neglect were substantiated. The facility was cited for failure to keep the resident free from humiliation and deprivation when she was left naked and exposed on her bed for an extended period of time. Citation # 030009263.

B $1000 Patient Care Careplan Injury 5/17/2013
On 6/12/11, the facility failed to assess and consult with appropriate health professionals to determine whether a quadriplegic resident could be safely transferred using a sit to stand lift. The facility also failed to update the resident's careplan in regards to safe transfer from one surface to another after she was diagnosed with paraplegia. This led to a dismal fracture of the resident's femur, as well as moderate soft tissue swelling in her knee, which was first noticed on 8/9/11. Citation # 030009910.

Asian Community Nursing Home
7801 Rush River Drive, Sacramento

AA $80000 Dietary Services 7/3/2013
On 1/9/12, the facility failed to ensure a resident consumed food in a form that she could safely swallow during a facility sponsored outing, which caused her die from choking on a large piece of meat. On 6/7/11, the resident was evaluated to have moderate impairment with the oral phase of swallowing and recommended to have intermittent meal supervision with a diet of soft chopped solids. A careplan for this diet was initiated on 6/13/11. The resident became unconscious from choking on her food and died of asphyxiation in a hospital on 1/10/12. Citation # 030009946.

Carmichael Care & Rehabilitation Center
8336 Fair Oaks Blvd., Carmichael

B $500 Mandated Reporting 3/8/2013
On 7/30/11, the facility failed to report the observed abuse of a resident within 24 hours of the observation. As the resident struggled to breathe and tried to get up, two facility aides pushed her back onto her bed. One of them held or sat on her legs, while the other pushed her down on the bed. A quarter-sized bruise developed on the resident's cheek. The Director of Nurses claimed to not be familiar with the incident, and the Social Services Assistant said that the Administrator handles the reports and that she was "only asked to get a statement from the witness." The administrator did not file a report to the Department of Public Health until the Department told him he had to on 8/5/11. Citation # 030009775.

A $20000 5/16/2013
CitationWatch description will be published once citation is received. Citation # 030009885.

B $1000 5/16/2013
CitationWatch description will be published once citation is received. Citation # 030009887.

Eskaton Care Center Greenhaven
455 Florin Road, Sacramento

B $1000 Careplan Dietary Services Hydration Neglect Patient Care 3/12/2013
A resident at risk for dehydration and nutritional status was admitted to the facility on 3/12/10, and lost 17 pounds in two months. During an interview with the DON on 3/30/11, she confirmed she was unable to locate documentation that the resident was assessed for dietary intake and hydration status. On 5/13/10, the resident was showing a decreased level of consciousness and transferred to the hospital. The emergency department report showed that the resident had multidrug resistant urinary tract infection, dehydration, elevated sodium levels and kidney failure. The resident died on 5/15/10 from cardiopulmonary arrest and
septic shock. The facility was cited for failure to assess and provide necessary food and fluids and follow procedures on documenting intake and output. Citation # 030009780.

Whitney Oaks Care Center
3529 Walnut Avenue, Carmichael
B $1000 Sexual Abuse 6/10/2013
The facility failed to prevent a resident from being sexually abused by another resident. The abusive resident's most recent assessment, dated 4/28/2010, indicated he was moderately impaired with decision making and required supervision. On 5/25/2010, a CNA found the abusive resident with his hands in the abused resident's underpants. Citation # 030009931.

Windsor Care Center of Sacramento
501 Jessie Avenue, Sacramento
B $1000 5/31/2013
CitationWatch description will be published once citation is received. Citation # 030009893.

Windsor Elk Grove Care and Rehabilitation Center
9461 Batey Avenue, Elk Grove
B $1000 5/29/2013
CitationWatch description will be published once citation is received. Citation # 030009920.

San Joaquin County
Delta Rehabilitation & Care Center
1334 South Ham Lane, Lodi
B $1000 Mandated Reporting 05/20/2013
On 4/28/10, the facility received a Grievance Complaint Report from a family member about a CNA who was mean to a resident on 4/26/10. The report stated that the CNA told the resident she didn't have time to take her to the bathroom and left the resident sitting in diarrhea. Also, when the CNA came to change the resident she talked mean to her and was very rough. The Department did not receive the complaint until 5/18/10. The facility was cited for failing to notify the Department of an allegation of neglect of a resident within 24 hours as required by law. Citation # 030009898.

Golden Living Center - Portside
2740 N. alifornia Street, Stockton
B $1000 4/25/2013
CitationWatch description will be published once citation is received. Citation # 030009836.

Windsor Hampton Care Center
442 Hampton Street, Stockton
B $800 Injury Physical Abuse 5/31/2013
On 2/1/11, the facility failed to ensure a resident was safe from physical abuse, which led to bruising on his left wrist. A CNA roughly pulled on the resident's arm while helping him transfer from his bed to the toilet. Citation # 030009917.

Shasta County
Marquis Care at Shasta
3550 Churn Creek Road, Redding
B $2000 Injury Neglect Patient Care 10/12/2012
On 8/8/12, a female resident who required total assistance with transfers was transferred with a Medicare Stand. However, the resident's care plan stated that transfers should use total lift with two staff members. During this transfer, the resident suffered a skin tear and bruising as well as a right shoulder fracture that went undiscovered until 8/11/12. A total lift is done with a Medicare Lift, not a Medicare Stand. The CNA stated that she always used the Medicare Stand alone and did not look at the resident's care plan. On 8/10/13, the records showed that the physician had not been notified of the resident's complaints of severe pain and change in condition. The physician was not informed until the resident requested to go to the hospital. The facility failed to ensure that complaints of pain were assessed by a registered nurse and reported to a physician in a timely manner. Citation # 230009575.

Siskiyou County
Shasta View Nursing Center
445 Park Street, Weed
B $1000 Notification Patient Care Physical Abuse 04/29/2013
On 10/26/12 and 10/28/12, a resident was reported to have hit another resident on the arm with a closed fist. The facility had a policy to inform the California Department of Public Health within 24 hours of an incident as required by State and Federal regulations as well as the facility's abuse policy. However the incident that occurred on 10/26/12 was not reported until 10/29/12. This failure to report the incident endangered the health and safety of the resident. Citation # 230009590.

Solano County
Fairfield Post-Acute Rehab
1255 Travis Blvd., Fairfield
A $18000 04/10/2013
CitationWatch description will be published once citation is received. Citation # 110009374.

Windsor Vallejo Nursing & Rehabilitation Center
2200 Tuolumne, Vallejo
B $1000 Administration 12/19/2012
On 11/26/12 and 11/27/12, inspectors found that the facility failed to post its Five Star rating in all of the required places, and that the information it did post was incomplete. Nursing homes are periodically rated by the federal government. The facility was cited because its failure to post the rating compromised the ability of residents and others to access this information. Citation # 110009677.

Sonoma County
Apple Valley Post-Acute Rehab
1035 Gravenstein Ave., Sebastopol
B $1000 Physical Environment 5/30/2013
The facility was cited for installing a software system for tracking resident care and failing to notify the Department of the changes, and failing to ensure that changes to the facility were in compliance with Title 24 Chapter 1, Division 17, Part 6, of the
California Administrative Code of the State Fire Marshall. These failures had the potential for unsafe installation of equipment. Citation # 110009220.

Cloverdale Healthcare Center
300 Cherry Creek Rd., Cloverdale
B $1000 Mandated Reporting 02/15/2013
The facility staff failed to report an alleged incident of sexual abuse within 24 hours of the incident. This lack of warning put other residents at risk of abuse. An anonymous complaint said that facility staff witnessed a resident being sexually inappropriate with another resident on multiple occasions. An unlicensed staff member said that she saw the accused resident masturbating in the presence of the abused resident on 11/24/11, and told two official staff that day and the day after. The California Department of Public Health received no report of sexual abuse. Citation # 110009477.

B $1000 Patient Rights Sexual Abuse 02/15/2013
On 11/24/11, a male resident with a history of masturbating in front of other residents was seen masturbating under his pants while holding the hand of the other resident in his room. He was removed to another room with a resident who was alert and able to voice concerns. No report had been made to the Ombudsman. After the incident, checks every 15 minutes were started and discontinued on 12/9/11. The nursing plan of care and the facility policy and procedure for "Abuse Prevention" did not ensure how the facility staff would protect all residents from this resident's inappropriate sexual behaviors. The failure to continuously monitor, ensure protection and prevent resident abuse put the other resident and others at risk for further abuse. The violation of this regulation had a direct relationship to the health, safety, and security of the residents. Citation # 110009476.

EmpRes Post Acute Rehabilitation
300 Douglas Street, Petaluma
B $1000 Mandated Reporting Sexual Abuse 02/21/2013
On 2/9/11, licensed staff saw two residents in bed fully clothed. The staff pulled the curtains for privacy, checked the residents every 15 minutes for safety, and both residents ended up naked. The department was notified on 2/18/11, nine days after the event. The facility was cited for failure to report an incident of sexual abuse as required by federal or state statute. Citation # 110009717.

B $1000 Mandated Reporting Sexual Abuse 02/21/2013
On 2/9/11, two residents were observed in the same bed and licensed staff pulled the privacy curtain. This caused one of the residents, who suffers from dementia, to become agitated and punch in the code for the dining room alarm. The resident showed increased anxiety and was irritated requiring one to one supervision. The facility was cited for failure to protect the resident from sexual abuse. Citation # 110009718.

Stanislaus County

Evergreen Nursing & Rehabilitation Care Center
2030 Evergreen Avenue, Modesto
AA $100000 Medication 05/20/2013
On 10/26/12, a resident on hospice care was mistakenly given twenty times his prescribed dose of morphine sulfate and overdosed and died. The resident had an order for five mg of morphine every six hours. At noon, a nurse gave the resident 100 mg. The nurse realized her error about an hour later when doing documentation. The facility did not have a policy for signing drug accountability records before giving a narcotic medication nor did it have a policy for nurses to have a high alert medication double-checked by another nurse. At 3:00 pm, a hospice nurse administered Narcan to counter the morphine. By 6:00 pm, the resident was unresponsive. He was briefly hospitalized, returned to the facility, and died at 12:55 am on 10/27/12. His cause of death was morphine intoxication. Citation # 040009912.

Trinity County

Trinity Hospital D/P SNF
410 N. Taylor St., P. O. Box 1229, Weaverville
B $1000 Verbal Abuse 5/7/2013
The facility was cited for failure to ensure that a resident diagnosed with Alzheimer's was not subjected to physical and verbal abuse. On 7/30/12, a CNA grabbed the resident by both wrists and shouted at her in her face after the resident became combative with another staff member. The CNA did not follow the facility's written procedures for dealing with residents who have dementia in a calm and soothing manner. Citation # 230009534.

Yolo County

Cottonwood Healthcare Center
625 Cottonwood Street, Woodland
B $500 Physical Abuse 03/07/2013
On 11/2/10 a facility CNA put both of her hands over a resident's mouth, telling him to stop screaming. The facility failed to ensure the resident was free from physical abuse. Citation # 030009770.

Courtyard Health Care Center
1850 East 8th Street, Davis
B $1000 Mandated Reporting 10/12/2012
The facility failed to report an observed incident of resident abuse within 24 hours of the observation. On 1/4/09, a facility staff member witnessed a resident's wife punching him in the stomach. A facility Social Services Designee's (SSD's) notes on the incident said the SSD felt no need to send a report to the Department of Public Health, but they would "continue to monitor." Citation # 030009544.

B $1000 Physical Abuse 10/12/2012
On 3/25/09, and again on 4/11/09, CNAs observed the wife of an 87 year old, wheelchair bound resident slapping his legs and forcing his chin up with a closed fist. The wife stated that she did these things not to harm him, but to move his legs and to keep him from slouching in his chair. An investigation of the incidents revealed that one CNA who had observed the wife slapping the resident's legs heard the resident moaning. The facility was cited for failing to protect the resident from harm when they knew he was at risk of being struck by his wife due to her behavior on previous occasions and not taking steps to prevent further occurrences. Citation # 030009545.

Woodland Skilled Nursing Facility
678 Third Street, Woodland
B $1000 02/11/2013
CitationWatch description will be published once citation is received. Citation # 030009721.

B $1000 Physical Abuse Verbal Abuse 6/25/2013
On 5/3/10, the facility failed to ensure that a resident was safe from verbal or physical abuse from a staff member. In an interview on 7/2/10, two residents said a CNA had "spoken rudely" to them and physically handled them "roughly." Citation # 030009944.
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 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.

Los Angeles County

Allen Care Center, Inc.
201 Allen Ave., Glendale

A $20000 4/12/2013
CitationWatch description will be published once citation is received. Citation # 920007870.

Avalon Villa Care Center
12029 S Avalon Blvd, Los Angeles

B $1000 11/30/2012
On 2/3/12, a resident who had a history of falling was identified with swelling and pain on the right ankle. The facility was cited for failing to implement written patient care policies and procedures on investigating the patient's right fractured ankle and reporting to the Department an injury of unknown source. This resulted in a lack of plan of action to prevent further injuries. The above violation had direct or immediate relationship to the health, safety or security of the resident. Citation # 940009634.

Bay Crest Care Center
3750 Garnet Avenue, Torrance

B $2000 Fall 05/15/2013
On 9/10/2009, an 82 year-old wheelchair bound resident was found on the ground floor still strapped into his wheelchair. The facility was cited for failing to implement written patient care policies and procedures on investigating the patient's right fractured ankle and reporting to the Department an injury of unknown source. This resulted in a lack of plan of action to prevent further injuries. The above violation had direct or immediate relationship to the health, safety or security of the resident. Citation # 910009904.

B $2000 05/15/2013
On 6/3/09, a severely impaired resident fell from his bed after a CNA left the side rail down. The fall resulted in the resident being sent to the emergency hospital with a large hematoma on the right side of his head above the eye and knee injuries. The resident's care plan called for his bed rails to be up and secure while the resident was in bed. The facility was cited for failure to implement the resident's care plan to keep the rails up and secure. Citation # 910009897.

Bloomfield East
3615 Imperial Hwy, Lynwood

B $2000 12/26/2012
CitationWatch description will be published once citation is received. Citation # 950009689.

B $2000 2/8/2013
CitationWatch description will be published once citation is received. Citation # 950009735.

B $2000 Fall 05/15/2013
On 6/3/09, a severely impaired resident fell from his bed after a CNA left the side rail down. The fall resulted in the resident being sent to the emergency hospital with a large hematoma on the right side of his head above the eye and knee injuries. The resident's care plan called for his bed rails to be up and secure while the resident was in bed. The facility was cited for failure to implement the resident's care plan to keep the rails up and secure. Citation # 910009897.

Driftwood Healthcare Center
4109 Emerald Avenue, Torrance

B $2000 10/15/2013
On 10/15/2013, a 78 year-old resident fell from his bed in the hallway. The resident was in a wheelchair and had the side rails down. The facility was cited for failure to implement the resident's care plan to keep the rails up and secure. Citation # 910009897.

Coast Care Convalescent Center
14518 E. Los Angeles, Baldwin Park

B $2000 11/25/2013
CitationWatch description will be published once citation is received. Citation # 950009735.

Country Villa Bay Vista Healthcare Center
5901 Downey Ave., Long Beach

B $1000 Feeding Notification 9/12/2012
The facility's staff failed to prevent a resident with a feeding tube from experiencing aspiration pneumonia and vomiting on 3/12/12. This could have been avoided if the staff had properly placed the tube in the resident's stomach, rather than her esophagus; informed the physician of the improper tube placement; followed her care plan by keeping her head elevated while in bed; and postponed feeding until the tube was properly placed. Citation # 940009484.

Driftwood Healthcare Center
4109 Emerald Avenue, Torrance

B $2000 05/15/2013
On 6/3/09, a severely impaired resident fell from his bed after a CNA left the side rail down. The fall resulted in the resident being sent to the emergency hospital with a large hematoma on the right side of his head above the eye and knee injuries. The resident's care plan called for his bed rails to be up and secure while the resident was in bed. The facility was cited for failure to implement the resident's care plan to keep the rails up and secure. Citation # 910009897.
heart rate for fibrillation of the heart's atrium). This could have been avoided if the resident's physician and facility staff followed the pharmacy's recommended careplan, and if the staff notified the physician of the resident's change of condition. Citation # 910009863.

**El Monte Convalescent Hospital**
4096 Easy Street, El Monte

B $2000  4/18/2013
CitationWatch description will be published once citation is received. Citation # 950009844.

**Emeritus at San Dimas**
1740 San Dimas Avenue, San Dimas

B $2000  11/29/2012
CitationWatch description will be published once citation is received. Citation # 950009632.

B $2000  11/29/2012
CitationWatch description will be published once citation is received. Citation # 950009633.

**Glendora Grand, Inc.**
805 West Arrow Highway, Glendora

B $2000  Physical Abuse  05/01/2013
On 12/17/11, an 89 year old resident who suffers from dementia was discovered with a skin tear to the face, a swollen nose, and discoloration on the jaw, right upper thigh, and right upper arm. The resident was transferred to the hospital, but the facility failed to notify the Department about the resident's injuries. It was not determined how the resident received her injuries. The facility was cited for failure to immediately report the incident to the Department. Citation # 950009868.

**Hancock Park Rehabilitation Center**
505 N. La Brea Ave, Los Angeles

B $2000  Patient Care  1/30/2013
At 9:10 am on 7/12/12, during a physical therapy session, a resident became short of breath. She was checked for her oxygen saturation level. Oxygen saturation levels of lower than 95% indicate impaired cardiopulmonary function or abnormal gas exchange. Her level was 77%. The resident was back in her room where an attempt to take her blood pressure and oxygen saturation failed. The resident went to the ER in full cardiac arrest and was pronounced dead at 10:43 am. The facility was cited for failure to provide the resident with the necessary care. Citation # 940009724.

B $500  Physical Environment  1/30/2013
The facility was cited for failing to provide supervision and maintain an environment free of hazards when the licensed nurses failed to lock the medication cart and secure a set of keys that provided access to the medicine cart, the medication room, the medical supply room, the fire alarm box, and two exits. As a result, a resident obtained seven medication packs, keeping them for two weeks. The resident also took the set of keys while they were left unattended, posing a risk for other unauthorized individuals to gain access to medications and the inability of staff to access the fire alarm. Citation # 940009723.

B $6000  2/12/2013
CitationWatch description will be published once citation is received. Citation # 940009743.

**Hancock Park Rehabilitation Center**
4096 Easy Street, El Monte

B $2000  Patient Care  2/12/2013
On 10/11/12, during the midday medication pass, an LVN failed to check residents' blood sugar levels. The LVN also failed to administer insulin doses until after lunch started. This resulted in hyperglycemia for three residents and placed them at risk for hypoglycemia. A review of the LVN's assignment indicated that she had thirty-five residents under her care. Sixteen of the 35 residents were diabetic and required blood sugar checks by finger stick and insulin administration. Six of the 16 diabetic residents had G-Tubes and ten received oral diets. The facility was cited for failure to provide residents with the necessary diabetic care. Citation # 940009741.

B $6000  Patient Care  2/12/2013
On 10/11/12, an LVN who had 35 residents under her care failed to provide seven diabetic residents who received oral diets with the proper diabetic care. The LVN's failure placed these residents at risk of serious hypoglycemia. During an interview with the LVN she stated that a week prior to the incident she spoke with the director of nursing about her heavy workload. An interview with the LVN's supervising RN indicated that the RN did not recall any conversation about the LVN's workload. The facility was cited for failing to provide seven residents who received oral diets with the necessary diabetic care. Citation # 940009742.

**B $6000  02/12/2013**
CitationWatch description will be published once citation is received. Citation # 940009744.

**Intercommunity Care Center**
2626 Grand Avenue, Long Beach

B $750  Administration Mandated Reporting Supervision  2/27/2013
On 12/24/12, a male resident with dementia went missing from the facility where he resided. The police department was notified and a missing person report was filed. On 2/7/13, the resident had yet to be found. The facility had a policy to report within 24 hours an unusual occurrence to the local health officer and Department of Health Services. However the administrator and the director of nursing were unable to provide evidence the Department was notified of the missing resident. Citation # 940009760.

**Ivy Creek Healthcare & Wellness Centre**
115 Bridge Street, San Gabriel

The facility failed to prevent a resident from developing pressure sores by not developing a proper careplan after she was assessed as being at risk of developing pressure sores on 9/14/12. The facility also failed to conduct weekly body checks for pressure sores, implement the Activities of Daily Living plan of care to turn and reposition the resident every two hours, and document the healing of previous sores. This caused the resident to develop two stage II pressure sores on her left and right buttocks, which were found on 12/12/12. Citation # 950009850.

**Kindred Transitional Care and Rehabilitation-Foothill**
401 W. Ada Ave., Glendora

B $2000  01/24/2013
CitationWatch description will be published once citation is received. Citation # 950009714.
Lakewood Healthcare Center
12023 S. Lakewood Blvd, Downey

B $6000 10/02/2012
citationwatch description will be published once citation is received. Citation # 940009535.

Long Beach Care Center
2615 Grand Avenue, Long Beach

A $18000 Injury Physical Environment 2/11/2013
On 9/13/12, a resident fell from her broken shower chair with a non-fitting safety bar, fracturing both of her knees. Her Care Area Assessment notes from 6/30/12 indicated she was at risk for falls/injuries due to lack of mobility, cardiac medication use, and incontinence. The facility failed to provide safety from injury for the resident by not providing her with a shower chair large enough for the safety bar to fit around her, strong enough to support her weight, and able to support her lower extremities with a foot rest. Citation # 940009696.

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

WMF $2000 06/27/2013
citationwatch description will be published once citation is received. Citation # 910009979.

Lotus Care Center
6011 West Blvd, Los Angeles

A $20000 Injury Supervision 6/18/2013
On 8/9/2010, a 67 year old resident with mild mental retardation suffered fractures to his hip and wrist and a head injury when he fell outside of the facility. He was not supervised at the time and lacked a cane or other supportive device, contrary to his care plan. Due to his injuries, he was hospitalized for 14 days, admitted into intensive care, required orthopedic surgery, and suffered pain daily. The facility was cited because it failed to provide needed supervision to keep the resident safe and failed to update his assessment and care plan after an earlier fall. Citation # 910009911.

Mayflower Gardens Convalescent Hospital
6705 W Avenue M, Lancaster

B $700 Physical Environment 2/4/2013
The facility's maintenance staff made several alterations to the building without the approval of the Office of Statewide Health Planning and Development (OSHPD). Citation # 920009726.

Olive Vista A Center For Problems Of Living
2335 S. Towne Avenue, Pomona

B $2000 9/20/2012
citationwatch description will be published once citation is received. Citation # 950009514.

B $2000 4/3/2013
citationwatch description will be published once citation is received. Citation # 950009828.

Park Avenue Healthcare & Wellness Center
1550 N. Park Ave., POMONA

B $2000 11/06/2012
citationwatch description will be published once citation is received. Citation # 950009584.

A $10000 Patient Care 04/19/2013
On 3/14/11, a resident at risk for strokes was noticed to have slurred speech, one of the warning signs of a stroke. The physician was notified and the staff waited for a response before calling emergency services. Later that morning the resident's daughter called emergency medical services herself after noticing the slurred speech. The resident suffered an acute stroke and was hospitalized for 17 days. She did not return to the same facility at the family's request. The facility was cited for failure to recognize the impending stroke and immediately call emergency services. Citation # 950009804.

Rehabilitation Center of Santa Monica, The
1338 20th Street, Santa Monica

B $2000 Notification Patient Care 06/20/2013
The facility was cited for failing to provide appropriate care to an 88 year-old resident when the resident's gastrostomy feeding tube was pulled out by the resident twice on 5/28/12 and 6/10/12. The facility did not follow policy in obtaining a physician's order for re-insertion of the gastrostomy tube, which resulted in bleeding from the resident's gastrostomy tube site and the resident being hospitalized twice within 14 days. Citation # 910009958.

Royal Crest Health Care
519 W Badillo St., Covina

A $10000 11/05/2012
citationwatch description will be published once citation is received. Citation # 950009552.

Santa Anita Convalescent Hospital
5522 Gracewood Avenue, Temple City

A $10000 Careplan Medication Neglect Patient Care 4/26/2013
On 01/17/13, a female resident was admitted to general acute care hospital because her heart muscle was damaged due to a heart attack. During the hospital admission, her physician changed her anticoagulant medication from Plavix to Xarelto. The resident was readmitted from 01/2013 to 01/27/13, and again from 01/28/13 to 02/12/13. However when the resident was readmitted on 01/28/13, the resident's medical administration records showed no evidence that she received Xarelto to prevent further heart incidences. The physician's progress note indicated the resident was taking an anticoagulant medication due to an irregular and rapid heart rhythm. The resident was not given Xarelto until the physician was notified on 02/12/13. The facility failed to ensure that the resident was provided an anticoagulant to prevent further blood clots from forming for a total of 24 days. Citation # 950009824.

Sunnyside Nursing Center
22617 S Vermont Ave, Torrance

B $2000 Physical Abuse 5/1/2013
On 4/18/10, a resident alleged that when she requested assistance to go to the bathroom a CNA told her no. The CNA then closed and locked the bathroom door, and came back and struck the resident in the face cutting her bottom lip. The facility was cited for failure to ensure the resident was free from abuse of any kind. Citation # 910009864.
The Earlwood
20820 Earl Street, Torrance

A $60000 Careplan Fall Injury 1/7/2013
The facility was cited for failing to ensure that a resident's environment was free from hazards and providing supervision to prevent accidents. On 8/8/09, the resident slipped from her bed during a transfer to her shower chair without the use of two persons plus a mechanical lift. The fall resulted in the resident sustaining a right lower leg fracture and cut to her second toe. Citation # 910009565.

B $2000 Injury 06/19/2013
On 2/9/09, a 92 year old resident suffered a deep laceration down to the bone on her foot after facility staff failed to transfer her according to her care plan, which required two-person assistance during transfers. The facility was cited for failure to provide adequate supervision and assistance, and for not providing an environment free from accident hazards. Citation # 910009957.

The Rowland
330 W. Rowland Ave., Covina

B $1000 Injury 1/13/2013
On 12/19/11, a 90 year old resident eloped from the facility and was found one half mile from the facility. On 12/29/11, during a tour of the facility by the Department, this same resident was observed with a large bump on her forehead, a bruise on her right eye, and bruising on the whole side of the right face down to the neck. A review of her records indicated that she was assessed as a high risk for falls. The records also indicated that the resident had periods of confusion and episodes of wandering around trying to leave the facility. The facility was cited for failing to report the resident’s wandering out of the facility and being injured to the Department. Citation # 950009759.

Torrance Care Center East
4315 Torrance Blvd., Torrance

B $2000 07/02/2013
CitationWatch description will be published once citation is received. Citation # 910009990.

Two Palms Nursing Center, Inc.
2637 E. Washington, Pasadena

B $2000 4/22/2013
CitationWatch description will be published once citation is received. Citation # 950009852.

Country Villa University Park Healthcare Center
230 E Adams Blvd, Los Angeles

A $16000 Feeding 11/19/2012
On 11/5/11, without a physician's order, an RN pulled out a surgically inserted GT feeding tube and reinserted another tube to deliver feeding formula into the stomach of a resident. The RN inserted the tube incorrectly. The tube's tip was outside the stomach. This caused an intra-abdominal abscess and sepsis. The resident died on 11/23/11 from sepsis and pneumonia. The facility was cited for failure to ensure that the resident receive appropriate treatment and services. Citation # 940009529.

View Heights Convalescent Hospital
12619 S. Avalon Blvd., Los Angeles

B $1800 Injury Physical Abuse Supervision 11/28/2012

The facility was cited for failing to implement the care plan to ensure that a resident was not subjected to physical abuse. The care plan requiring frequent monitoring and close supervision was not followed. As a result, two residents who experience delusions and disorganized thought processes entered into a physical altercation. Resident 1 spit on resident 2, and in return resident 1 hit resident 2 in the face, resulting in a fractured nose. Citation # 940009627.

Villa Maria Care Center
723 E 9th Street, Long Beach

A $17000 Careplan 02/11/2013
The facility's staff failed to follow the resident's careplan after hospital treatment on 11/28/12 for fecal impaction (large mass of hard stool in rectum due to chronic constipation), thus putting the resident at risk of further fecal impaction. Citation # 940009709.

Vista Cove Care Center at San Gabriel
909 W Santa Anita, San Gabriel

B $2000 02/28/2013
Between 10/17/12 and 10/19/12, four residents were treated for scabies. The unusual incident was not reported by telephone within 24 hours as required but instead notification was sent by regular mail. The facility was cited for failure to report the incident by telephone within 24 hours. Citation # 950009759.

Madera County

Oakhurst Healthcare & Wellness Centre
40131 Hwy 49, Box 2349, Oakhurst

B $2000 7/25/2013
CitationWatch description will be published once citation is received. Citation # 040010032.

Orange County

Emeritus at Yorba Linda
17803 Imperial Highway, Yorba Linda

B $1000 Patient Records 12/10/2012
On 9/19/12, three licensed nursing staff willfully falsified a resident's medication administration record concerning a test that was ordered to be administered every shift to assess the adequacy of the oxygen in the resident's blood. An inspector found the resident's record blank on 9/19/12, then the next day reviewed it again and found that all three shifts from 9/1/12 through 9/20/12 were documented. The director of nursing initially denied knowing what happened, then later admitted she and other nurses filled in the record after being asked about the test during the inspection. Citation # 06009663.

Parkview Healthcare Center
1514 E. Lincoln Avenue, Anaheim

B $1500 Chemical Restraints Medication Patient Records 03/08/2013
On 1/16/13, records of the Physicians Orders List showed the facility had 20 of 29 residents on psychotherapeutic drugs. Of ten sampled residents, the facility failed to present any behavior data of seven residents to the prescriber of psychoactive medications. The facility failed to produce...
clinical records of monitoring of any behaviors associated with the need for antipsychotic medications, antidepressant medications and antianxiety medications or documentation showing an attempt for gradual dose reductions. Citation # 060009777.

Riverside County

Manorcare Health Services-Palm Desert
74-350 Country Club Dr, Palm Desert

B $1000 Physical Abuse 5/7/2013
The facility was cited for failure to implement the facility Abuse Policy and Procedure to conduct a timely, thorough and objective investigation of all allegations of abuse, neglect and mistreatment. The facility failed to immediately investigate an allegation of a staff member throwing the resident on the bed. Citation # 250009834.

Vista Cove Care Center at Corona
2600 S. Main Street, Corona

B $1000 Patient Rights Physical Abuse 11/14/2012
A 99 year old female resident with dementia suffered an ankle injury when she was roughly handled during a shower that she did not want. The facility was cited for failing to ensure the resident was free from physical abuse. Citation # 250009586.

San Bernardino County

Braswell's Yucaipa Valley Convalescent Hospital
35253 Avenue H, Yucaipa

B $1000 Verbal Abuse 09/20/2012
According to a LVN's progress notes from 4/16/11, a resident became agitated when a CNA tried to redirect her from the facility's entrance/exit door. The CNA ignored the LVN's advice to walk away when the resident started yelling and swearing. The resident threw an accucheck machine at the CNA, hitting her shoulder. The CNA shouted insults and threats at the resident, despite the LVN's continued advice to walk away. The CNA failed to follow the facility's "Walk-Away Policy and Procedure," and the LVN failed to intervene when the CNA ignored her advice. Citation # 240009505.

Community Convalescent Center of San Bernardino
1676 Medical Center, San Bernardino

B $2000 Supervision Careplan 10/18/2012
According to the facility's records, a 17 month old patient removed her own tracheotomy tube from the ventilator six times between 11/7/11 and 12/2/11. During the most recent incident, the patient was non-responsive to CPR, and reviews from an acute hospital showed she had "moderately abnormal" brain function, only responded to pain, and didn't open her eyes. The patient's careplan included close supervision to prevent such an incident, and there was no evidence of updates to improve the careplan since the original incident. The facility failed to properly monitor the patient and update her careplan to prevent such incidents. Citation # 240009556.

Heritage Park Nursing Center
275 Garnet Way, Upland

B $2000 Careplan Fall Injury 10/18/2012
Nurse's notes dated 3/31/12 indicate that a resident at risk for falls was left alone in her wheelchair while the CNA went get assistance to transfer the resident to the toilet. The resident fell while unsupervised sustaining a fracture to her left ankle. The facility was cited for failure to ensure that policies and procedures were implemented to prevent the resident's fall and injury. Citation # 240009558.

Sierra Vista
3455 E. Highland Avenue, Highland

B $1000 Verbal Abuse Mental Abuse 10/24/2012
On 7/25/07, three residents reported to have witnessed several episodes of verbal abuse by a CNA towards a resident since 6/29/05, including threats and slurs. One resident also reported seeing the CNA put the abused resident on time out as soon as her shift began. Another resident reported the CNA woke up several patients by yelling and down the hallway. During her interview on 7/25/07, the abused resident showed signs of anxiety and humiliation. The facility was cited for failing to ensure the abused resident was safe from mental abuse from the CNA. Citation # 240009569.

San Diego County

Escondido Post Acute Rehab
421 E. Mission Ave., Escondido

B $2000 Careplan Supervision 4/17/2013
On 1/20/13, a resident with a history of wandering was found by the police 1.3 miles from the facility confused, and also had no identification. The facility was cited for failure to provide adequate supervision, ensure the residents wore identification bands, and ensure the wanderguards were working. Citation # 080009842.

Tulare County

Sierra Valley Rehabilitation Center
301 West Putnam, Porterville

A $20000 Neglect 7/18/2013
On 6/11/11, after suffering a stroke, a 119 pound woman was sent to the facility for rehab. The resident died on 9/2/11 weighing less than 103 pounds. An investigation was conducted to determine if the resident's weight loss was due to inadequate care. The records indicated that in July her average meal consumption was between 40-50% and that in August that dropped down to 24% with 0% consumption for at least one meal per day. There was no documented evidence that the physician was notified when the resident's average meal consumption dropped to 25%. The facility was cited for failing to ensure that the resident maintained acceptable nutritional parameters. Citation # 120009044.