California has a growing problem of nursing homes being operated by unsuitable, unapproved, and unaccountable persons and entities. Chain operators are acquiring and operating facilities without first obtaining licenses from the California Department of Public Health (CDPH), yet CDPH allows them to continue operating facilities even after denying licenses due to findings that they are unfit. AB 1502 would bring overdue reforms that give CDPH strong authority to disqualify unfit applicants, set suitability standards for operators, require prior approval to operate a skilled nursing facility, close licensure loopholes, give the public an opportunity to comment on pending change-of-ownership applications and sanction non-compliant operators.

Building off an inspiring 2021 for nursing home reform, the attention of state legislators fortunately remains engaged on improving long term care quality and access. A number of bills have been introduced that further address nursing home care, resident rights, and Medi-Cal shortcomings. CANHR is grateful to the authors and supporters of these bills and will work hard to turn them into law. For up-to-date information about CANHR’s legislation, please check out https://canhrlegislation.com

**CANHR-Sponsored Bills:**

**AB 1502 (Muratsuchi and Wood)**  
Skilled Nursing Facility Ownership and Management Reform

2022 CANHR Legislation and Policy Update  
Lots of Action for Long Term Care Reform at the State Capitol!

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CANHR News

New Staff

CANHR welcomes several new staff members to the CANHR family. **Jaclyn Flores**, MSW, our new consumer and policy advocate, has extensive experience working as a long term care ombudsman and consumer advocate. **John Hafner**, a new CANHR staff attorney, will coordinate CANHR’s elder abuse unit and assist with the Homeless and HEPP projects. John has practiced as a civil litigator for over 15 years and has specialized in nursing home abuse litigation. CANHR also welcomes **Rebekah Nand**, our new receptionist/AA. Welcome to CANHR and to a new and successful year.

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

Leave a Legacy

Planned giving leaves a legacy to honor your memory or that of someone you love and helps to ensure the future of CANHR. With careful planning, it is possible to reduce or eliminate income and estate taxes while turning appreciated assets into income for yourself or others. Call the CANHR office or email maura@canhr.org to get more information and a free booklet on planned giving.

Donate to CANHR When You Shop on Amazon

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

Donate to CANHR

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

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About CANHR

Since 1983, California Advocates for Nursing Home Reform (CANHR), a statewide nonprofit 501(c)(3) advocacy organization, has been dedicated to improving the choices, care and quality of life for California’s long term care consumers.

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(800) 474-1116

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2022 CANHR Legislation and Policy Update

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**AB 1663 (Maienschein)**
The Probate Conservatorship Reform and Supported Decision-Making Act

The Britney Spears conservatorship case exposed deep flaws within California’s probate conservatorship system – demonstrating how easily people can become trapped in a conservatorship and how difficult it is to escape. AB 1663 introduces the valuable concept of supported decision-making (SDM) as an alternative to conservatorship. SDM, to varying extents, formalizes how every adult makes important decisions: using the advice of trusted family members, friends, and experts. AB 1663 also provides much-needed access to court review of unwanted conservatorships and ensures more inclusion of the conservatee’s voice in a conservator’s decisionmaking process. This bill is co-sponsored by CANHR, California Community Living Network, California State Council on Developmental Disabilities, Coalition for Elder & Disability Rights, Disability Rights California, Disability Rights Education and Defense Fund, Disability Voices United, and Free Britney L.A.

**AB 1809 (Aguiar-Curry)**
Nursing Facility Resident Informed Consent Protection Act of 2022

Despite dangerous side effects, condemnation by care providers, and a decade-long national and state campaign to reduce the inappropriate use of psychotropic drugs in nursing homes, over half of California nursing home residents are being given psychotropic drugs, typically without informed consent. AB 1809 would codify and expand existing informed consent rules to ensure nursing home residents are given important information about drugs that are prescribed for them and an opportunity to consent or withhold consent.

**AB 1900 (Arumbala)**
Increase Maintenance Need Income Levels

The Medi-Cal share of cost program extends coverage to low-income older adults and people with disabilities who are just above the free Medi-Cal income limit. The program is a critical pathway to health care coverage, but outdated income limits force people to spend more than half of their income on health care needs every month. The maintenance need income level, currently $600, has not been updated since 1989, although the cost of living has increased greatly in the past three decades. It is impossible for anyone to meet their basic needs on just $600 a month - especially in California’s high-cost cities. AB 1900 will raise the maintenance need income level to 138% of the federal poverty level, on par with the current income eligibility limit for free Medi-Cal. This bill is co-sponsored by CANHR, Justice In Aging, Western Center on Law & Poverty, Bet Tzedek, Disability Rights California, and Senior and Disability Action.

**AB 2823 (Levine)**
Increase Home Upkeep Allowance

Individuals on Medi-Cal living in a nursing home may qualify for a little-known Medi-Cal deduction called the Home Upkeep Allowance (HUA). Right now, the HUA allows a person to keep an additional $209 a month of their income to pay for the maintenance and upkeep of their home while they are temporarily residing in the nursing home. With today’s skyrocketing prices, it is nearly impossible to maintain the upkeep of the home with just $209. AB 2823 would increase the allowance to the actual cost of maintaining the home, including mortgage or rent, and prevent the Medi-Cal recipient from losing their home.

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2022 CANHR Legislation and Policy Update

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CANHR-Supported Bills:

AB 2079 (Wood)
Skilled Nursing Facility Direct Care Spending Requirement

This bill requires nursing homes to spend at least 85 percent of their revenues on the direct care of residents. This ensures the billions of dollars we pay to nursing homes as taxpayers is actually spent on the residents and not to pad the profits of already very rich owners.

AB 2546 (Nazarian)
Resident-Designated Support Persons Act

Nursing home residents suffered the most during the pandemic. COVID-19 took the lives of hundreds of thousands of residents, but another kind of sickness was a leading factor to the many loved ones lost. Strict visitation policies that prohibited essential visits from family caregivers severely contributed to the decline in the health of nursing home residents. AB 2546 would ensure that a resident has the right to in-person, onsite access of at least two designated support persons during any public health emergency.

SB 1323 (Archuleta)
Foreclosure Equity Sale

When a homeowner can’t pay back their mortgage loan, the lender often sells the property at an auction, takes back the loan’s remaining balance, and the homeowner receives any surplus funds from the sale. As properties at auction sell for far below value, the defaulted homeowner often loses tens or hundreds of thousands of dollars of accrued home equity. Meanwhile, wealthy cash investors benefit from these oppressive below-market value sales by acquiring properties at bargain rates. Foreclosed homeowners are low-income, often elderly, immigrant, or disabled members of California’s most vulnerable communities.

Their home is often their only asset, and home equity their only lifetime savings. SB 1323 requires lenders to sell foreclosed properties at market value using a real estate agent, and to sell the property at its appraised value, so that owners losing their home can receive their full savings in equity after the sale.

Family Councils: Making a Difference

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

http://canhr.org/familycouncils/video/
The evolving Coronavirus Crisis has had a worldwide impact that will take a long time to become fully understood. At the beginning of the crisis, in an effort to keep you all better informed, we created a website,

[https://canhrnews.com/](https://canhrnews.com/)

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

See the guide below for an overview of the many resources you can find there.
Long Term Care News

White House Announces Reform Plan to Crack Down on Nursing Home Bad Actors

On February 28, 2022, the White House announced plans for far-reaching reforms to improve the safety and quality of nursing home care, establish and enforce a federal minimum staffing requirement, fight inappropriate drugging of residents, reduce resident room crowding, strengthen emergency preparedness standards, integrate pandemic lessons into requirements, hold poor performing nursing homes and chains accountable, and improve public information on nursing home ownership and quality.

The bold statement took direct aim at the nursing home industry, acknowledging widespread failures by nursing homes to comply with federal standards and the need “to crack down on bad actors.” It described its actions as first steps to ensure taxpayer dollars go toward quality care, “not to the pockets of predatory owners and operators who seek to maximize their profits at the expense of vulnerable residents’ health and safety.”

Decisive action is needed now, it states, or unacceptable conditions may get worse.

The minimum staffing requirement is the centerpiece of the plan. The Centers for Medicare and Medicaid Services (CMS) will conduct a new research study to determine the level and type of staffing needed to ensure safe and quality care and will issue proposed rules within one year.

CANHR applauds the Biden Administration for standing up so strongly for nursing home residents and is excited to work with it to make a real difference in residents’ lives.

Consumer Voice Finds Badly Deteriorating Resident Outcomes During Pandemic

A new report from the National Consumer Voice for Long Term Care has found severe declines in the quality of care in nursing homes during the COVID-19 pandemic.

Using publicly available, self-reported nursing home data, Consumer Voice found alarming increases in the percentage of residents with pressure sores, significant weight loss, and feelings of depression and hopelessness.

The percentage of residents receiving antipsychotic drugs increased to their highest levels in nearly a decade, many of which may have been “justified” by phony schizophrenia diagnoses, which also suspiciously rose during the pandemic.

Consumer Voice concluded these deteriorating conditions in nursing homes were caused by the one-two punch of staffing shortages and the abrupt suspension of support and oversight in March, 2020 when family visitation was shut down and regular government inspections and Ombudsman visits were stopped. The combination of inadequate staffing and termination of outside support and oversight proved dangerous and deadly. The report ends on a hopeful note, citing the recent commitment from the Biden administration to a national minimum staffing standard which will likely come with more investment in training and wages for frontline staff.

Brookdale Senior Living to Pay $3.25 Million to Settle Allegations it Violated Transfer and Discharge Rights of California Nursing Home Residents

On March 11, 2022, the California Attorney General and a coalition of District and City Attorneys announced a settlement with Brookdale Senior Living resolving allegations that its California skilled nursing facilities endangered residents by failing to notify and safely prepare them for transfer and discharge and that they misrepresented quality of care by reporting false information to the government on staffing levels to fraudulently increase its star ratings. The judgment and injunction requires Brookdale to stop engaging in the illegal practices, appoint a monitor to oversee compliance at its Kern County facility, and pay $2.4 million in civil penalties, $550,000 in costs and $300,000 to the Kern County Long Term Care Ombudsman.

CMS Adds COVID-19 Booster Data and Staffing Data for Nursing Homes on Care Compare

The Centers for Medicare & Medicaid Services (CMS) is now posting booster information along with other vaccination data for residents and staff on each nursing home’s homepage on its Care Compare website.

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Long Term Care News

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The information separately reports facility, state and federal percentages for resident vaccinations, resident boosters, staff vaccinations and staff boosters.

CMS also announced that it has added staff turnover rates and weekend staffing levels for nursing homes under the staffing section for each facility on Care Compare.

CMS Advises Public Can File Complaints to it When States Fail to Inspect or Investigate Facilities

On February 9, 2022, the Centers for Medicare & Medicaid Services (CMS) notified state survey agencies that they could be subject to sanctions if they fail to inspect nursing homes and other health facilities in accordance with federal requirements. The memorandum appears to be a response to concerns that some state survey agencies have cut back or restricted their oversight of nursing homes despite contracts with the federal government to perform this role. That is the case in California, where concerns about failed oversight by the California Department of Public Health have never been greater.

Although the memo is directed to state survey agencies, it ends with a message to the public. “Individuals with a quality of care complaint related to a Medicare or Medicaid health and safety regulation that the state is not surveying for may contact the CMS location directly.” CMS gives email addresses for each of its regional offices. Complaints in California should be directed to its San Francisco office at ROSFOSO@cms.hhs.gov.

Assisted Living Waiver (ALW) Slot Expansion

The Centers for Medicare and Medicaid Services (CMS) approved California’s request to increase ALW capacity by approving 7,000 additional slots. This amendment is retroactive to July 1, 2021 and will be conditionally funded by the Federal Medical Assistance Percentage through the American Rescue Act Plan following implementation of California’s HCBS spending plan. The expansion will help keep eligible seniors and persons with disabilities in their communities and out of institutional care settings.
California Nursing Home Industry Seeks to Cash-In on Pandemic Tragedies

Raising the wages of nursing home caregivers is smart

Trusting nursing homes with even more hundreds of millions of taxpayer dollars is dumb

On March 2, 2022, the California Association of Health Facilities (CAHF) – a trade group representing nursing home operators – announced a legislative proposal for California to fund a living wage for certified nursing assistants (CNAs). Named “The Drive to $25,” the proposal would establish a CNA minimum wage that would grow to $25 in the next three years. The proposal calls for Medi-Cal to pay for two thirds of this wage increase via wage pass-throughs at an annual cost to Medi-Cal of about a half-billion dollars.

Two days earlier, the White House announced a crack-down on nursing home “bad actors.”

The uncommonly blunt statement called out nursing homes for widespread violations and substandard care that have harmed residents and caused tragic impacts before and during the pandemic. It points out that dangerously unsafe conditions exist in nursing homes despite tens of billions of federal taxpayer dollars flowing to nursing homes each year.

CAHF’s proposal ignores the White House announcement, the nursing home industry’s exceedingly troubled history, and chronic ownership scandals in California. It is fair to ask why California should put its financial trust in unscrupulous chain operators and send even more corporate welfare to facilities that so often jeopardize the lives of their residents.

There are many more serious questions about the CAHF proposal.

1. Who is responsible for low CNA wages?

It’s not the State. Nursing home chains and other owners set wages for their workers and are responsible for the abysmally low wages and benefits that exist today. CNAs have always deserved a living wage. But for decades operators have fought long and hard to avoid paying them one.

Operators ignore their existing commitments to pay decent wages. SNF Medi-Cal rates more than doubled under an industry-designed rate system enacted in 2004 known as AB 1629. Advancing decent wages is a stated purpose of that law, which funneled billions and billions of dollars to nursing home operators. Yet some California nursing home chains slashed staffing and wages after it took effect and used the new funds to increase profits.

Nursing home owners divert over a billion dollars to themselves rather than pay decent wages. California nursing home owners pay themselves over a billion dollars a year through related parties to hide and pad profits. Those funds should be un-diverted and used to increase staffing levels and to fund living wages now.

Nursing homes received tens of billions of dollars in government COVID-19 relief funds. The additional funds nursing homes received are so extensive they are difficult to catalog. The public does not know how this money was used.

2. Will this plan crowd out programs and caregivers that keep people out of nursing homes?

Sending more money to nursing homes while ignoring in-home and community-based options is not in keeping with Californians’ preferences on long term care. Most people who need long term care prefer to receive it at home. Government programs already pay California nursing home operators over $10 billion per year. In-home caregivers and staff members at assisted living facilities deserve living wages too. Singling out nursing home CNAs is certain to cause unintended consequences.

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California Nursing Home Industry Seeks to Cash-In on Pandemic Tragedies

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3. Why is the plan missing a minimum staffing requirement?

The plan calls instead for a study on staffing, a poorly disguised stalling tactic. California’s minimum staffing requirements are far below levels needed to meet the needs of residents from twenty years ago. CAHF’s plan would raise wages but would not prevent operators from slashing staffing and pocketing the savings. Nursing home care will not improve and residents will continue to suffer neglect until operators hire and maintain enough staff to meet residents’ needs. It is not “Real Reform” to skip the most important ingredient.

4. Who would want to work in an unsafe working environment?

Fair wages are critically important but they are not the only factor that matters to workers.

California’s overburdened nursing home workforce will not stabilize until the often-terrible working conditions improve in facilities.

5. What does CAHF mean that operators would use “facility funds” to cover about a third of the wage increase?

These are taxpayer funds, mostly from the Medicare program. As CAHF acknowledges, nursing homes rely almost completely on government funds. The proposal does not appear to include ownership investment in the wage increase.

6. Why are nursing homes completely dependent on government programs?

CAHF’s proposal acknowledges that “skilled nursing facilities (SNFs) in California are almost 100 percent government funded.” The fact that no one other than the government buys their product reflects the public’s fear of substandard nursing homes and strong desire to stay out of them. California’s nursing home population is shrinking despite the rapidly aging population.

7. Should California be “partners” with the nursing home industry?

CAHF describes nursing homes’ relationship with the government as a partnership, but should it be? Although nursing home owners are virtual wards of the state due to their financial dependence, profiteering operators do not act like partners. They hide behind extraordinarily complex ownership structures, engage in a tremendous churn in chain ownership that is harmful to residents, routinely put profits before care, blame the State for their own failures and sue the state constantly to defeat any efforts to hold them accountable. Californians are poorly served by this partnership.

California has been down this road before with the nursing home industry. The industry cries out for more money and promises better care. Well, the State’s expenditures to nursing homes are at an all-time high – and consumer complaints about nursing home care are too.

Funding wage increases for CNAs is a good idea but only if we:

- Ensure all additional spending goes to staff and does not further enrich owners;
- Increase the state’s minimum staffing standard to 4.1 hours of direct care per resident per day, eliminate all minimum staffing waivers, and hold nursing home operators accountable through strong enforcement of the staffing and wage requirements;
- Tie all future Medi-Cal nursing home rate increases directly to staffing and wage increases;
- Require a registered nurse in all nursing homes, 24 hours a day;
- Enhance working conditions and training and certification opportunities for CNAs.
- Raise wages for IHSS workers and provide greater financial support for home and community based services.
Dear Confused,

Great news! According to ACWDL 21-16, Medi-Cal recipients who received Medi-Cal in the community without a share of cost because of their participation in the Aged & Disabled Federal Poverty Level Program (A&D FPL) should not have received a share of cost if they moved into a nursing home and received Medi-Cal for Long Term Care. Medi-Cal recipients who participate in the A&D FPL Program fall under the Tier 1 coverage, “Beneficiaries…must remain in their same tier of eligibility through the end of the month in which the federal COVID-19 PHE ends.”

If your mom received an increase in her share of cost after she moved into the nursing home, contact the local county Medi-Cal office immediately and provide them with a copy of the all-county letter above.

Did You Know… Medi-Cal Discrimination & Room-to-Room Transfers

If a nursing home resident changes to Medi-Cal payment status, the nursing home is prohibited from transferring the resident to another room as a result of that payment change, with the exception of transferring the resident from a private room to a semi-private room. Although nursing homes have been prohibited from seeking to evict residents simply because of a change from private pay or Medicare to Medi-Cal, this provision also applies to those residents who have made a timely and good faith application for Medi-Cal benefits, but for whom an eligibility determination has not yet been made. (W&I Code §14124.7, 42 CFR §483.15(c)(1)(i)(E)). If a resident’s initial Medi-Cal application is denied but appealed, the resident is not considered to be in nonpayment status. Thus, an appeal suspends a finding of nonpayment. CMS State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities, at F622.

For more information, please read CANHR’s Transfer & Discharge Rights fact sheet or call the CANHR office directly at (800) 474-1116 to speak to an advocate.
Legislation Update, March 2022

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

SPONSOR / CO-SPONSOR

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

Status: In Senate, Read first time. To Com. on RLS. for assignment.

AB 1163 (Maienschein): Conservatorship
The Britney Spears conservatorship case exposed deep flaws within California’s probate conservatorship system – demonstrating how easily people can become trapped in a conservatorship and how difficult it is to escape. People with disabilities and older adults are often caught in the pipeline to conservatorship, a system that strips them of basic civil rights and their ability to advocate for themselves. The system offers little meaningful oversight and many opportunities for abuse.

Status: In Assembly Committee on Appropriations

AB 1809 (Aguiar-Curry): Informed Consent
Despite dangerous side effects, condemnation by care providers, and a decade-long national and state campaign to reduce the inappropriate use of psychotropic drugs in nursing homes, over half of California nursing home residents are being given psychotropic drugs, typically without informed consent. AB 1809 would codify and expand existing informed consent rules to ensure nursing home residents are given important information about drugs that are prescribed for them and an opportunity to consent or withhold consent.

Status: In Assembly Committee on Appropriations

AB 1900 (Arambula): The Share of Cost Reform
This bill would increase the maintenance need for community based Medi-Cal recipients from $600 to 138% of the Federal Poverty Level.

Status: In Assembly Committee on Appropriations

AB 2546 (Nazarian): Resident-Designated Support Persons Act
The COVID-19 pandemic has had a devastating impact on residents of long-term care facilities. In addition to virus-caused sickness and death, residents have suffered severe loss from government-imposed visitation lockouts that separated residents from their families, friends, and other essential support persons. AB 2546 gives every resident of a nursing home or assisted living facility the right to in-person, onsite, and unscheduled access to a minimum of two resident-designated support persons during any public health emergency in which residents’ normal visitation rights are curtailed. AB 2546 also guarantees residents have the right to leave the facility on outings, so long as reasonable infection control precautions are taken.

Status: In Assembly Aging and Long Term Care

AB 2823 (Levine): Home Upkeep Allowance
This bill would increase the Home Upkeep Allowance (HUA) from $209 to the actual costs of maintaining a home.

Status: In Assembly Committee on Appropriations
Legislation Update, March 2022

SUPPORT

AB 895 (Holden): Skilled Nursing and Intermediate Care Facilities
This bill would require a skilled nursing facility or intermediate care facility to provide a prospective resident of a skilled nursing facility or intermediate care facility, or their representative, prior to or at the time of admission, a written notice that includes specified contact information for the local long-term care ombudsman.
Status: In Senate. Read first time. To Com. on RLS. for assignment.

AB 1995 (Arambula): Eliminating Medi-Cal Premiums
This bill will ensure pregnant individuals, children, and people with disabilities can access the health care services that they need to stay healthy and thrive by eliminating their monthly Medi-Cal premiums.
Status: In Assembly Committee on Appropriations

AB 2077 (Calderon): Medi-Cal
This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $50, and would specify that the cost of this benefit would be supplemented by federal funds, to the extent they are available.
Status: In Assembly Committee on Appropriations

AB 2079 (Wood): Skilled Nursing Facilities
This bill would require, no later than July 1, 2023, the establishment of a direct care spending, reporting, and rebate requirement for skilled nursing facilities, with exceptions. Under the direct care spending requirement, the bill would require that a minimum of 85% of a facility’s total health and nonhealth revenues from each and all payer sources in each fiscal year be expended on residents’ direct care, as defined.
Status: Assembly Health. From Committee: Amend, and do pass as amended and re-refer to Com. on APPR. Read second time and amended.

AB 2145 (Davies): Skilled Nursing Facilities: Dental Services
This bill would provide that a registered dental hygienist in alternative practice may render dental services to a patient in a skilled nursing facility or an intermediate care facility/developmentally disabled. The bill would also authorize a registered dental hygienist in alternative practice to provide oral health inservice training to staff in a skilled nursing facility or an intermediate care facility/developmentally disabled.
Status: In Assembly Committee on Appropriations

AB 2262 (Calderon): IHSS: Needs Assessment
This bill will allow clients with stable needs to perform physical, in-person reassessments every 3 years instead of every 12-months. To satisfy the 12-month reassessment federal requirement, clients with stable needs can opt for virtual or telephonic reassessments.
Status: In Assembly Committee on Appropriations

AB 2511 (Irwin): SNF Backup Power Source
This bill would state the intent of the Legislature to require a skilled nursing facility to have an alternative source of power in case of an electrical power shut off or an emergency.
Status: Assembly Committee on Health

SB 1093 (Hurtado): Criminal Background Checks in RCFEs
This bill will focus on procedures for transferring criminal background checks for people who wish to operate community care facilities residential care facilities for persons with chronic, life-threatening illness, residential care facilities for the elderly, childcare centers, and home care services.
Status: In Senate. Re-referred to Com. on APPR.
**SUPPORT (Continued)**

**SB 1323 (Archuleta): Foreclosure: Equity Sale**
This bill would recast provisions to require that an equity sale, as defined, of property under a power of sale of a mortgage or deed of trust be made by a licensed realtor and by publicly listing the property for sale on the California Multiple Listing Service with an initial listing price at the property’s appraised value, as specified.
*Status: Senate Judiciary*

**HR6698 (Schakowsky): Eliminate Medicaid Recovery**
To amend title XIX of the Social Security Act to repeal the requirement that States establish a Medicaid Estate Recovery Program and to limit the circumstances in which a State may place a lien on a Medicaid beneficiary’s property.
*Status: Referred to the House Committee on Energy and Commerce.*

**OPPOSE**

**AB 499 (Rubio): Referral Source for Residential Care Facilities for the Elderly**
This bill would require an RCFE referral agency to provide certain disclosures to seniors, and to maintain a minimum amount of liability coverage, but does not provide oversight or sufficient enforcement mechanisms.
*Status: Ordered to inactive file*

**AB 2619 (Patterson): RCFEs**
Addressing capacity for 6 bed facilities. By expanding the types of facilities subject to the act, the bill would expand the definition of a crime, thereby imposing a state-mandated local program.
*Status: Assembly Human Services Committee*

**SB 1320 (Jones): Life Insurance: Nonpayment Premium Notice**
This bill would clarify requirements that apply to a life insurance policy issued or delivered in this state on or after January 1, 2013. The bill would specify that the 60-day grace period begins the first day after the due date if the premium is unpaid.
*Status: DEAD*

**WATCH**

**AB 1093 (Jones-Sawyer): Notaries**
The bill would authorize an online notary public to perform notarial acts and online notarizations by means of audio-video communication.
*Status: In Senate Rules Committee - Read first time*

**AB 1907 (Bauer-Kahan): Improving Inspections for Nursing Homes**
This bill streamlines the process for inspection by allowing a state inspector to do one inspection that fulfills the requirement for the state and the federal government at the same time.
*Status: In Assembly Committee on Appropriations*

**AB 2175 (Rubio): Wandering Prevention Task Force**
This bill would establish the California Wandering Prevention Task Force, under the jurisdiction of the Department of Justice, to address, on a statewide basis, the issue of wandering by individuals with cognitive impairment.
*Status: Assembly Committee on Aging & LTC*
AB 2288 (Choi): Advance Health Care Directives
This bill would clarify that health care decisions under those provisions include mental health treatment. The bill would revise the statutory advance health care directive form to clarify that a person may include instructions relating to mental health treatment.
Status: Assembly Health

AB 2338 (Gipson): Health Care Surrogates
This bill would specify individuals, in an order of priority, who may be chosen as a surrogate if a patient lacks the capacity to make a health care decision or to designate a surrogate.
Status: Assembly Committee on Health

AB 2604 (Calderon): Long Term Care Insurance
Assembly Bill 2604 seeks to help make policies sold through the California Partnership for Long Term Care more affordable and attainable by authorizing policies to include a 3% compound inflation rider, in addition to the policies with the minimum 5% compound inflation rider currently required.
Status: Assembly Committee on Insurance

AB 2616 (Low and Laird): Conservatorship and Guardianship
This bill would require a guardian or conservator to avoid actual conflicts of interest and the appearance of conflicts of interest and would require a conservator to avoid any person, business, or professional interest or relationship that is, or reasonably could be perceived as being, self-serving or adverse to the best interest of the conservatee.
Status: Assembly Judiciary Committee

AB 2813 (Santiago): Long Term Services and Supports Benefits Program
The bill would establish the Long-Term Services and Supports Benefit Program Fund and would require the department and the board to administer the program using proceeds from the fund.
Status: Assembly Aging & LTC Committee

SB 602 (Laird): Conservatorship: Care Plans
This bill would require a conservator, within 30 days of appointment and within 30 days before a hearing to determine the continuation or termination of an existing conservatorship, to submit a care plan to specified persons regarding the care, custody, and control of the conservatee.
Status: In Assembly. Read first time. Held at Desk.

SB 861 (Limón): Dementia Care
This bill would establish the Dementia Care Navigator Grant Program, to be administered by the California Department of Aging, in partnership with organizations with expertise using community health workers, promotores, and health navigators.
Status: Senate Appropriations

SB 965 (Eggman): Conservatorship
Existing law, the Lanterman-Petris-Short Act, authorizes a conservator of the person, of the estate, or of the person and the estate to be appointed for a person who is gravely disabled as a result of a mental health disorder or impairment by chronic alcoholism. This bill would make technical, non substantive changes to that provision.
Status: Senate Judiciary Committee
What’s Wrong with CCRCs in California - Continuing Care Retirement Communities?

Let me count the ways:

1. The laws governing CCRC’s in California, Health & Safety Code, chapter 10 of Division 2, §§1700 et seq. were largely written by and for the CCRC industry. Most – if not all – of the recommendations from consumer advocates were rejected in 1990, when these CCRC laws were enacted. Over the years, organizations like CALCRA were able to insert a few consumer-protection provisions, but overall, the statutes are geared toward protection of the providers, despite the legislative intent of the law.

2. Want to contest a level of care change ordered by the provider? An increase in monthly fees? A reduction in services? Good luck with that. While the CCRC Branch does issue some provider information notices, including the resident’s complaint process and the level of care transfer dispute process, complaints are rarely substantiated, the process is confusing due to the multiple agencies involved and there are no regulations regarding due process rights for residents. DSS, CCRC Branch website: https://www.cdss.ca.gov/inforesources/community-care/continuing-care

3. Want to participate in or form a Resident Council? While the CCRC statutes (Health & Safety Code § 1771.8) do include provisions that suggest CCRCs “encourage” Resident Associations – again, these laws were written for and by the CCRC industry. Most of these “Resident Associations” are controlled by the providers with little autonomy for the residents. The providers can choose or reject the Associations’ recommendations for the provider Governing Board, withhold information regarding litigation, personnel, etc. and generally fail to provide whatever information the provider chooses. They can also exclude residents from meetings of the Residents Association. Despite a provision under Health & Safety Code 1771.7 that specifies “Meetings shall be open for all residents to attend…”, another provision states that executive sessions of the governing body of the Resident Association shall be limited to the governing body itself. So, a “Resident Association” whose members are approved by the providers can prohibit other residents from attending. Clearly these should be called “Provider Associations,” since there are so few rights for residents to raise concerns.

4. Resident Councils and Family Councils as prescribed under Health & Safety Code §§1569.157 & 1569.158 provide more autonomy for the residents, allow them to meet in private without provider interference, and include penalties for willful interference with the formation of such Councils. CANHR’s fact sheet on Family Councils and Resident Councils in RCFEs explain the laws and resident rights, and copies can be downloaded for free from our website at www.canhr.org. These rights apply equally to CCRCs, and the CCRC Branch actually issued a Provider Information Notice on these rights (PIN 17-11.1). See the CCRC Branch website above for a copy.

5. Many current CCRC residents entered their units under the impression that their provider was a not-for-profit, often religious-affiliated, entity and that their fees would pay for their care, not realizing that they are actually paying for real estate expansions in other communities. Also not realizing that the provider they thought was governing their community is now a management company whose mission is to cut costs. Thus, in a number of CCRC communities, food service, staff, health services and other amenities are slowly reduced.

6. Despite having contracts approved by the Department of Social Services, Continuing Care Contracts Branch, these communities are now remarketing themselves as “Life Plan Communities” hoping to distant themselves from anything having to do with “retirement”, elders or any word that might connotate getting older or withdrawal from active work. Targeting younger and “vibrant” elders who have the means to invest $200,000 to $1.5 million and more, plus $4,000-$8,000 per month, these communities often offer multiple amenities for the “active” senior. Nothing wrong with that at all, of course, but to pretend that this is anything more than an actuarial decision to pull in more funding is disingenuous. Let’s face it. Most CCRC didn’t count on their residents living so long or needing nursing home care. With the turnover in units greatly reduced, building more communities, targeting younger elders and remarketing is key to regaining profits.

These are only a few of the concerns with CCRCs in California. We’ll continue in the next issue and include recommendations for change.
Community Care Licensing Strikes a Blow for Resident Rights

Late last year, the Department of Social Services’ Community Care Licensing Division (CCLD) released a new Provider Information Notice (PIN 21-48-ASC) to reiterate the rights of residents to make their own decisions about their care and other personal aspects of their lives while living in an assisted living facility. The PIN explains that all residents, even those with a cognitive impairment or diagnosis of a disease that affects their thinking, have the full array of rights available to all residents unless the resident waives those rights or has had their ability to exercise them taken away by a court of law. Some of the information in the PIN used to exist in the old Residential Care Facility for the Elderly (RCFE) Evaluator Manual but it was not widely known by providers or residents. Releasing this information in a PIN will hopefully ensure it circulates more widely.

The PIN supports resident rights in two ways. The first way is by clarifying that every resident, regardless of their diagnosis or condition, has important rights as an RCFE resident including:

- the right to receive visits from friends, family, ombudspersons, advocacy representatives, and others; to visit privately during reasonable hours and without prior notice, provided that the rights of other residents are not infringed upon;
- to both make and receive confidential calls; and to send and receive unopened correspondence as specified in California Code of Regulations (CCR), Title 22, section 87468.1 Personal Rights of Residents In all Facilities.

The second way the PIN supports resident rights is by stating that residents often retain control over exercising their rights, even if they have a surrogate decisionmaker. Surrogate decisionmakers, ranging from a formal surrogate such as an agent under a Power of Attorney form to an informal surrogate who makes decisions based on their relationship status to the resident (such as a spouse or adult child), cannot override decisions made by the resident. These surrogates enjoy a shared decisionmaking authority, meaning the resident can defer to the surrogate for decisions or they can overrule the surrogate. All residents retain their full extent of rights, including the right to dismiss or overrule their surrogates, unless they have been court-adjudicated as incapable of doing so.

The only RCFE residents who may have their decisions overruled are those that have been court-adjudicated as incapable of making decisions, usually through a conservatorship process. However, even for residents who are conserved, they retain many of their personal rights, such as control over visitation, telephone calls, and private correspondence, unless the court specifically takes them away.

The last page of the PIN has an excellent table showing the extent and limits of surrogate decisionmakers’ authority to control some particularly sensitive decisions for an RCFE resident. The table makes it clear that only court-appointed surrogates can consent to secured placements, wearable egress alert devices, or visitation limitations for residents who have not provided or are unable to provide consent.

We applaud CCLD for issuing the PIN to better ensure adherence to resident rights. Locking residents up and controlling their calls, mail, and visitation are major infringements of their personal rights and should only be done with the appropriate legal authority.
CANHR On The Move

• 01/13/2022: Bea Layugan and Maura Gibney presented to a team of Social Workers for Kaiser about Medi-Cal Updates.

• 02/15/2022: Tony Chicotel and the Essential Caregivers Coalition hosted a town hall on the state of visitation in California long term care facilities for consumers, family members and advocates.

• 02/15/2022: Bea Layugan and Jaclyn Flores presented to the Medicare to the Center for Healthcare Rights on Medicare to Medi-Cal Transition & Medi-Cal Recovery.

• 02/17/2022: Maura Gibney presented to caregiver group, East Bay Daughtehood Circle, on Medi-Cal Eligibility & HCBS

• 3/1/2022: Pat McGinnis was a guest speaker for the UC Hastings College of the Law on Medi-Cal and Long Term Care.

• 3/22/22: Tony Chicotel testified at the State Capitol in support of AB 1809 would codify and expand existing informed consent rules to ensure nursing home residents are given important information about drugs that are prescribed for them and an opportunity to consent or withhold consent.

• 3/22/22: Bea Layugan testified at the State Capitol in support of AB 1900 which would increase the maintenance need level for Medi-Cal recipients and AB 2823 which would increase the home upkeep allowance for nursing home residents.

CANHR Senior Attorney Tony Chicotel and CANHR Advocate Bea Layugan after testifying in support of AB-1809 (Aguiar-Curry), AB-1900 (Arambula) and AB-2823 (Levine) at the California State Assembly Health Committee hearing on March 22, 2022.
CANHR welcomes memorial and honorary gifts. This is a great way to honor a special person or a loved one, while helping those who are long term care residents. Recent gifts have been made in the names of the following persons:

**In Honor Of**

<table>
<thead>
<tr>
<th>Vondina Thomson</th>
<th>Wayola B. Larson</th>
<th>Miriam and Morris Rothschild</th>
<th>Sabita</th>
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<tr>
<td>Lance Thomson</td>
<td>Paul Larson</td>
<td>Jeffrey Rothschild</td>
<td>Subrata Goswami</td>
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<td>Pat McGinnis</td>
<td>Pat McGinnis</td>
<td>Sharon Lipschultz</td>
<td>Florence Templeman</td>
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<tr>
<td>Joan Brownstein</td>
<td>Rosemarie E. Dittrich</td>
<td>Bruce Preston</td>
<td>Steve Templeman</td>
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**In Memory Of**

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<tr>
<th>Leslie A. Bard, MD</th>
<th>Joseph Wong (my father)</th>
<th>Ethel &amp; Stanley Marks</th>
<th>Carmen Clingo</th>
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<tr>
<td>Penny Bard</td>
<td>Timothy D. Wong Esq.</td>
<td>John L. Everts</td>
<td>Rosemary Nigro</td>
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<tr>
<td>Alice &amp; Tom Riley</td>
<td>Joseph W. McDonough</td>
<td>Jack Anderson</td>
<td>Gerald Forrest</td>
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<tr>
<td>Barbara B. Riley</td>
<td>Gwen M. McDonough</td>
<td>Joanne Anderson</td>
<td>Luette Forrest</td>
</tr>
<tr>
<td>Christopher Kroll</td>
<td>Daniel Colomba</td>
<td>Michael Philips</td>
<td>Catherine G. Lynch, RN</td>
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<tr>
<td>Kuritis Lemke</td>
<td>Julius Schnall</td>
<td>Darcy Philips</td>
<td>Judith Lynch-Kenney</td>
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<td>Jan Vyeda</td>
<td>Jean Schnall</td>
<td>Sheila Lillian Krieger</td>
<td>Dora B. Remson</td>
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<tr>
<td>Margaret Mizner Glidden</td>
<td>Eunice Stuart</td>
<td>Larry Mong</td>
<td>George J. Gomez</td>
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<tr>
<td>Nancie Glidden</td>
<td>Kathleen Stuart</td>
<td>Robert C Mong</td>
<td>Nora Ghamari Esq.</td>
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<tr>
<td>Faye Jewell Nearing</td>
<td>Georgia Mongelluzzo</td>
<td>Georgia Mongelluzzo</td>
<td>Beryl Dubois</td>
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<tr>
<td>Karen Wong</td>
<td>Donna Campagna</td>
<td>Coleen Nelson</td>
<td>Candie Brady</td>
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<td>Bob Bilheimer</td>
<td>Steve Levine</td>
<td>Kevin Kane</td>
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<tr>
<td>Geraldine Murphy</td>
<td>Eileen Harrington</td>
<td>Marta Kane</td>
<td>CANHR Staff</td>
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<td>Bill Taylor</td>
<td>Tim Millar</td>
<td>Walter Rosen</td>
<td>Sherry Mcllwian</td>
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<td>Patrick Nobis</td>
<td>Hellen Muller Drachkovitch</td>
<td>CANHR Staff</td>
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---------- Alameda County ----------

ALAMEDA COUNTY MEDICAL CENTER D/P SNF
15400 Foothill Boulevard, San Leandro

B $2000 Mental Abuse; Neglect; Patient Care
10/29/21
The facility failed to keep a resident free from neglect when the call light was not left within his reach for an hour, preventing the resident from alerting staff when he needed suctioning to remove excess saliva when he felt like he was choking. The resident, who was diagnosed with multiple sclerosis and was unable to move his extremities, stated that after calling staff to request suction, a CNA entered his room, turned off the call light, moved his air blow call light (a handsfree method used to activate a call light by blowing through a tube) out of reach, but did not help with suction before leaving the room. As a result, the resident experienced both physical and emotional distress and was subsequently transferred to the hospital for treatment of pneumonia.

Citation # 020017045

---------- Fresno County ----------

---------- Humboldt County ----------

EUREKA REHAB & WELLNESS CENTER, LP
2353 23rd St, Eureka

B $2000 Discharge 2/7/22
On 8/28/19, the facility discharged a resident at noon. Hours later, the facility notified the long term care ombudsman of the discharge. The facility was cited for failing to send timely notice of the discharge to the ombudsman, which had the potential for the resident being inappropriately discharged and not being provided an advocate who could inform him of his discharge rights and options. Citation # 110017083
Marin County

SAN RAFAEL HEALTHCARE & WELLNESS CENTER, LP  
1601 5th Ave, San Rafael

B $2000 Patient Care 2/25/22
The facility failed to assess a resident’s medical emergency in a timely manner when he was found face down on the floor with his torso lying over a trash can. Staff also failed to provide CPR or any other life sustaining interventions against accepted professional guidelines and the facility’s policy and procedure for CPR. As a result, the resident died from his medical emergency.  Citation # 110016434

San Joaquin County

LINCOLN SQUARE POST ACUTE CARE  
1032 N. Lincoln Street, Stockton

WMF $5000 Careplan; Decubiti (Bedsores); Infection; Patient Care; Patient Records; Death 12/15/21
On 6/2/21, an unannounced visit was done at the facility to investigate an allegation of the resident’s responsible party not being notified of the development of pressure sores. It was determined that the facility did not maintain accurate documentation in the resident’s medical records. The resident was admitted on 3/30/21. A skin assessment dated 4/8/21 indicated “blanchable redness to the sacrococcyx” (tailbone and lower back). The resident’s careplan indicated that staff should monitor every shift and notify a physician of significant changes. Licensed staff members documented that they checked the resident’s sacrococcyx on 4/20/21, 4/21/21, 4/22/21, and 4/23/21, even though they had not been completed by licensed staff. The resident developed an unstageable pressure sore, which had been identified in the facility on 4/24/21. The development of the pressure sore lead to hospitalization of the resident on 5/5/21 and ultimately their death on 5/9/21. The resident’s death certificate listed sepsis, severe pressure sores, and caretaker neglect as the cause of death.  Citation # 030017173

San Mateo County

SAN MATEO MEDICAL CENTER D/P SNF  
222 W 39th Ave, San Mateo

B $2000 Evictions; Patient Rights; Retaliation Against Resident; Transfer; Discharge 1/7/22
On 10/26/21, the facility failed to readmit a resident after hospitalization to treat a urinary tract infection. The resident lived in the facility for a year until the hospitalization. The facility lied and claimed they did not have any beds available to accommodate the resident’s large size, but it was discovered on 11/2/21 that the resident’s bed was still empty, and their belongings were still in the room. A refusal to readmit hearing was held on 12/1/21, affirming that the facility was required to take the resident back, but the facility failed to follow the order. On 11/1/21, when the hospital discharge planner was working on transferring the resident back, the facility notified the hospital that the resident’s bed had been filled by a new admission.  Citation # 220017257

Santa Clara County

VALLEY HOUSE REHABILITATION CENTER  
991 Clyde Ave, Santa Clara

B $2000 Patient Rights; Physical Abuse; Sexual Abuse 11/23/21
Adult Protective Services (APS) reported to the California Department of Public Health (CDPH) that APS received a complaint that during a resident’s stay at the facility, the resident alleged that a CNA bathed her, and “...soaped her down, including rubbing her upper private area, lower private area, and buttocks,” and “...repeatedly put lotion on her upper private area.” APS reported the resident stated, “...he also cleansed inside her lower private area and buttocks in a way that made her feel uncomfortable.” The staff heard the resident screaming, “help me”; crying. In a separate incident regarding another resident, facility staff observed a male resident touching her lower private area, including penetration with fingers. The facility failed to implement its abuse policy and procedure and was cited because their failure to immediately report the allegation to appropriate authorities and conduct a thorough investigation put the health, safety and security of other residents at risk.  Citation # 070017124
Shasta County

Veterans Home of California - Redding
3400 Knighton Rd, Redding

AA $80000 Feeding; Neglect; Death 12/28/21
A 69 year old resident died of aspiration on 12/31/19 after choking while being fed his lunch in bed by a CNA. Nine out of nine facility staff members failed to respond as trained with the basic emergency life support intervention. The staff failed to implement the Heimlich Maneuver in a timely fashion while the resident was alert and responsive. This failure worsened the outcome of the choking episode and contributed to the death of the resident. Emergency medical services were summoned and declared the resident’s death two minutes after arrival. The facility was cited for failing to follow basic life support training for removal of an airway obstruction during the resident’s choking episode, resulting in inadequate oxygenation to the brain and heart, ultimately leading to respiratory arrest followed by a heart attack.

Citation # 170016433

Tulare County

Alameda County Medical Center D/P SNF
15401 Foothill Boulevard, San Leandro

B $2000 Mental Abuse; Neglect; Patient Care 10/29/21
The facility failed to keep a resident free from neglect when the call light was not left within his reach for an hour, preventing the resident from alerting staff when he needed suctioning to remove excess saliva when he felt like he was choking. The resident, who was diagnosed with multiple sclerosis and was unable to move his extremities, stated that after calling staff to request suction, a CNA entered his room, turned off the call light, moved his air blow call light (a handsfree method used to activate a call light by blowing through a tube) out of reach, but did not help with suction before leaving the room. As a result, the resident experienced both physical and emotional distress and was subsequently transferred to the hospital for treatment of pneumonia.

Citation # 020017045

Eureka Rehab & Wellness Center, LP
2354 23rd St, Eureka

B $2000 Discharge 2/7/22
On 8/28/19, the facility discharged a resident at noon. Hours later, the facility notified the long term care ombudsman of the discharge. The facility was cited for failing to send timely notice of the discharge to the ombudsman, which had the potential for the resident being inappropriately discharged and not being provided an advocate who could inform him of his discharge rights and options.

Citation # 110017083

Willow Creek Healthcare Center
651 W Alluvial Ave, Clovis

A $18000 Fall; Injury; Patient Care; Supervision 11/23/21
On 12/22/20, the facility failed to implement its fall risk careplan for the resident, a 79 year old female, by leaving the pressure pad disconnected to the alarm pad box and not turned on. A pressure pad is a device placed on the surface of the bed that beeps when the resident tries to get up. This resulted in the resident falling when she tried to get up unassisted and caused a broken bone in her hip. The resident was hospitalized for six days from 12/22/20-12/28/20.

Citation # 040017121

Tuolumne County

San Rafael Healthcare & Wellness Center, LP
1602 5th Ave, San Rafael

B $2000 Patient Care 2/25/22
The facility failed to assess a resident’s medical emergency in a timely manner when he was found face down on the floor with his torso lying over a trash can. Staff also failed to provide CPR or any other life sustaining interventions against accepted professional guidelines and the facility’s policy and procedure for CPR. As a result, the resident died from his medical emergency.

Citation # 110016434
On 6/2/21, an unannounced visit was done at the facility to investigate an allegation of the resident’s responsible party not being notified of the development of pressure sores. It was determined that the facility did not maintain accurate documentation in the resident’s medical records. The resident was admitted on 3/30/21. A skin assessment dated 4/8/21 indicated “blanchable redness to the sacrococcyx” (tailbone and lower back). The resident’s careplan indicated that staff should monitor every shift and notify a physician of significant changes. Licensed staff members documented that they checked the resident’s sacroccocyx on 4/20/21, 4/21/21, 4/22/21, and 4/23/21, even though they had not been completed by licensed staff. The resident developed an unstageable pressure sore, which had been identified in the facility on 4/24/21. The development of the pressure sore lead to hospitalization of the resident on 5/5/21 and ultimately their death on 5/9/21. The resident’s death certificate listed sepsis, severe pressure sores, and caretaker neglect as the cause of death.

Citation # 030017173
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Kern County

KERN VALLEY HEALTHCARE DISTRICT D/P SNF
6412 Laurel Ave, Lake Isabella

**B $2000 Mandated Reporting; Physical Abuse; Sexual Abuse 2/4/22**
A resident reported to facility staff that another staff member “cupped” her vagina while changing her bed linens in her room. The resident stated, “to me, that was considered rape. . .”. Health & Safety Code §1418.91 provides that (a) a long-term health care facility shall report all incidents of alleged abuse or suspected abuse of a resident of the facility to the department immediately or within 24 hours. In violation of this code, the facility failed to ensure staff reported an abuse allegation in a timely manner, resulting in a delay in the investigation.

Citation # 120017297

**B $3000 Transfer 2/25/22**
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, the facility failed to conduct a required medical assessment prior to transferring a 67 year old resident to another facility. Her physician did not make any recommendations on counseling or follow-up visits to reduce stress prior to her transfer. During an interview, the facility’s Medical Director stated, “Why the assessment? The residents are going to be discharged anyway because the facility is closing.” This failure had the potential to result in the resident not receiving continuity of care and experiencing emotional trauma due to leaving her home and friends.

Citation # 120017387

**B $3000 Transfer 2/25/22**
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, the facility failed to conduct a required medical assessment prior to transferring an 80 year old resident to another facility. During an interview, the facility’s Medical Director stated, “Why the assessment? The residents are going to be discharged anyway because the facility is closing.” This failure had the potential to result in the resident not receiving continuity of care and experiencing emotional trauma due to leaving his home and friends.

Citation # 120017425
**B $3000 Transfer 3/1/22**
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, a licensed clinical social worker did not conduct a required psychosocial assessment of an 86 year old resident before she was transferred to another facility on 2/8/22. The resident was bed-bound, completely dependent on staff for daily life functions, and had severely impaired cognition and multiple other health impairments. Yet, an assessment completed by a social services assistant indicated “no psychosocial concerns.” The assistant stated she had not been trained on transfer and discharging of residents, and her personnel records indicated no orientation on over 35 orientation topics on social services. A facility representative stated the facility did not have a full-time social worker. The facility’s failure to conduct the required psychosocial assessment had the potential to result in the resident not receiving continuity of care and experiencing emotional trauma due to leaving her home and friends.

Citation # 120017417

**B $3000 Transfer 2/25/22**
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, the facility failed to conduct a required medical assessment prior to transferring a 78 year old resident to another facility. During an interview, the facility’s Medical Director stated, “Why the assessment? The residents are going to be discharged anyway because the facility is closing.” This failure had the potential to result in the resident not receiving continuity of care and experiencing emotional trauma due to leaving her home and friends.

Citation # 120017433

**B $3000 Transfer 2/25/22**
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, the facility failed to conduct a required medical assessment prior to transferring a 67 year old resident to another facility. During an interview, the facility’s Medical Director stated, “Why the assessment? The residents are going to be discharged anyway because the facility is closing.” This failure had the potential to result in the resident not receiving continuity of care and experiencing emotional trauma due to leaving his home and friends.

Citation # 120017438

**B $3000 Transfer 2/25/22**
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, the facility failed to conduct a required medical assessment prior to transferring an 88 year old resident to another facility. During an interview, the facility’s Medical Director stated, “Why the assessment? The residents are going to be discharged anyway because the facility is closing.” This failure had the potential to result in the resident not receiving continuity of care and experiencing emotional trauma due to leaving her home and friends.

Citation # 120017437

**B $3000 Transfer 2/25/22**
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, the facility failed to conduct a required medical assessment prior to transferring a 68 year old resident to another facility. During an interview, the facility’s Medical Director stated, “Why the assessment? The residents are going to be discharged anyway because the facility is closing.” This failure had the potential to result in the resident not receiving continuity of care and experiencing emotional trauma due to leaving his home and friends.

Citation # 120017428

**B $3000 Transfer 2/25/22**
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, the facility failed to conduct a required medical assessment prior to transferring a 73 year old resident to another facility. During an interview, the facility’s Medical Director stated, “Why the assessment? The residents are going to be discharged anyway because the facility is closing.” This failure had the potential to result in the resident not receiving continuity of care and experiencing emotional trauma due to leaving her home and friends.

Citation # 120017429

**B $3000 Transfer 2/25/22**
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, the facility failed to conduct a required medical assessment prior to transferring a 73 year old resident to another facility. During an interview, the facility’s Medical Director stated, “Why the assessment? The residents are going to be discharged anyway because the facility is closing.” This failure had the potential to result in the resident not receiving continuity of care and experiencing emotional trauma due to leaving his home and friends.

Citation # 120017437
B $3000  Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, the facility failed to conduct a required medical assessment prior to transferring a 106 year old resident to another facility. During an interview, the facility’s Medical Director stated, “Why the assessment? The residents are going to be discharged anyway because the facility is closing.” This failure had the potential to result in the resident not receiving continuity of care and experiencing emotional trauma due to leaving his home and friends.
Citation # 120017431

B $3000  Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, the facility failed to conduct a required medical assessment prior to transferring an 82 year old resident to another facility. Her physician did not make any recommendations on counseling or follow-up visits to reduce stress prior to her transfer. During an interview, the facility’s Medical Director stated, “Why the assessment? The residents are going to be discharged anyway because the facility is closing.” This failure had the potential to result in the resident not receiving continuity of care and experiencing emotional trauma due to leaving her home and friends.
Citation # 120017389

B $3000  Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, the facility failed to conduct a required medical assessment prior to transferring an 85 year old resident to another facility. During an interview, the facility’s Medical Director stated, “Why the assessment? The residents are going to be discharged anyway because the facility is closing.” This failure had the potential to result in the resident not receiving continuity of care and experiencing emotional trauma due to leaving her home and friends.
Citation # 120017373

B $3000  Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, the facility failed to conduct a required medical assessment prior to transferring an 65 year old resident to another facility. Her physician did not make any recommendations on counseling or follow-up visits to reduce stress prior to her transfer. During an interview, the facility’s Medical Director stated, “Why the assessment? The residents are going to be discharged anyway because the facility is closing.” This failure had the potential to result in the resident not receiving continuity of care and experiencing emotional trauma due to leaving her home and friends.
Citation # 120017435

B $3000  Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, the facility failed to conduct a required medical assessment prior to transferring a 78 year old resident to another facility. During an interview, the facility’s Medical Director stated, “Why the assessment? The residents are going to be discharged anyway because the facility is closing.” This failure had the potential to result in the resident not receiving continuity of care and experiencing emotional trauma due to leaving her home and friends.
Citation # 120017427
B $3000  Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, the facility failed to conduct a required medical assessment prior to transferring a 78 year old resident to another facility. During an interview, the facility’s Medical Director stated, “Why the assessment? The residents are going to be discharged anyway because the facility is closing.” This failure had the potential to result in the resident not receiving continuity of care and to experience emotional trauma due to leaving her home and friends.

Citation # 120017432

B $3000  Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, the facility failed to conduct a required medical assessment prior to transferring a 99 year old resident to another facility. During an interview, the facility’s Medical Director stated, “Why the assessment? The residents are going to be discharged anyway because the facility is closing.” This failure had the potential to result in the resident not receiving continuity of care and experiencing emotional trauma due to leaving her home and friends.

Citation # 120017434

B $3000  Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in 02/22, the facility failed to conduct a required medical assessment prior to transferring an 85 year old resident to another facility. Her physician did not make any recommendations on counseling or follow-up visits to reduce stress prior to her transfer. During an interview, the facility’s Medical Director stated, “Why the assessment? The residents are going to be discharged anyway because the facility is closing.” This failure had the potential to result in the resident not receiving continuity of care and experiencing emotional trauma due to leaving her home and friends.

Citation # 120017386

Los Angeles County

AVAlon VILLA CARE CENTER
12029 Avalon Blvd, Los Angeles

B $2000  Feeding; Neglect; Patient Care  1/7/22
A resident with difficulty swallowing and unable to feed themselves or communicate on their own was fed by a CNA who did not follow procedures to feed a resident with a swallowing disorder safely. The resident was fed while lying nearly flat instead of upright, and CNA did not follow swallowing procedures to assist the resident to properly clear mouth and airway. A resident of a neighboring room heard the resident choking and coughing and took a photograph of the CNA feeding the resident. After the airway was cleared, staff administered oxygen to the resident. The resident developed aspiration pneumonia and sepsis and was transferred to an acute hospital. The choking incident that required oxygen administration was not reported to the resident’s family or physician.

Citation # 910017254

BERKELEY EAST CONVALESCENT HOSPITAL
2021 Arizona Ave, Santa Monica

B $2000  Dignity; Mental Abuse; Patient Rights; Verbal Abuse  1/28/22
On 11/4/21, a facility staff member yelled at a resident for having a dirty diaper and told the resident she was a “horrible being, a liar and came off as sweet and nice, but it was a façade, and they were “happy you had cancer and deserve to die.” The Director of Admissions for the facility was notified about the staff member’s rude behavior that same day. Further, it was alleged that the same facility staff member took the resident’s phone away and placed it on her bedside table out of reach. The resident also stated the same staff member took her call light and put it away because she kept pressing the call light. The facility failed to report to the SSA an allegation of employee-to-resident verbal abuse no later than two hours after the allegation was made. The facility was made aware of the verbal abuse allegation on 11/4/21. However, the facility did not report the abuse to the SSA until 11/7/21, delaying the SSA investigation and placing the resident at risk for further abuse.

Citation # 920017299
**Berkley Post-Acute**  
6600 Sepulveda Blvd, Van Nuys

**B $20000 Patient Rights; Physical Abuse 12/30/21**  
A resident, who is severely cognitively impaired, reported to a family member that a staff person had pulled the resident’s necklace when the resident wanted to go back to bed. The family member immediately reported the incident to the facility administrator, who did not report it to the State Survey Agency, the Ombudsman or law enforcement, as required. By the time a complaint was filed and an investigator visited the facility, details of the incident could not be determined, including what staff was involved or exactly when it occurred (sometime between the resident’s readmission on 9/8/21 and the initial visit on 10/07/21), so the facility was cited for failing to report the incident in a timely manner.

Citation # 920017237

**Burlington Convalescent Hospital**  
845 S Burlington Ave, Los Angeles

**A $20000 Fall; Injury; Neglect; Supervision 12/8/21**  
The facility failed to take necessary fall precautions and failed to have staff frequently observe a resident who was diagnosed with a history of falls. As a result, on 8/9/21, the resident fell to the floor, requiring transfer to an acute hospital where the resident was diagnosed with a displaced fracture of the thigh bone, requiring surgery. The facility staff stated that the resident did not have a floor mat because she had never fallen before and was not a high risk for falls. However, the resident had fallen before and was a fall risk. A review of the resident’s Fall Risk Assessment indicated that the resident had intermittent confusion, poor safety awareness and was unable to stand without assistance due to unsteady gait, making her at risk for falls.

Citation # 910017187

**Claremont Care Center**  
219 E Foothill Blvd, Pomona

**B $2000 Patient Care 6/27/21**  
The facility failed to try the use of less restrictive appropriate alternatives before installing bed rails to the beds of three residents, which placed them at risk for entrapment and injury from the rails.

Citation # 950016862

**Clear View Convalescent Center**  
15823 S Western Ave, Gardena

**B $2000 Patient Care 12/13/21**  
The resident was a known fall risk. However, the use of a clip alarm intended to notify staff if the resident attempted to get out of bed without assistance had been discontinued. The resident apparently attempted to get out of bed and fell and broke a hip requiring surgery. An incident report was completed but was not reported to DPH because the administrator stated that an unwitnessed fall with injury was not an unusual occurrence requiring a report to DPH.

Citation # 910017187
CLEAR VIEW CONVALESCENT CENTER
15823 S Western Ave, Gardena

B $2000 Patient Care 12/13/21
The resident was a known fall risk. However, the use of a clip alarm intended to notify staff if the resident attempted to get out of bed without assistance had been discontinued. The resident apparently attempted to get out of bed and fell and broke a hip requiring surgery. An incident report was completed but was not reported to DPH because the administrator stated that an unwitnessed fall with injury was not an unusual occurrence requiring a report to DPH.

Citation # 910017187

COMMUNITY CARE CENTER (DUARTE)
2335 Mountain Ave, Duarte

A $20000 Dignity; Mandated Reporting; Patient Rights; Sexual Abuse 2/1/22
A resident alleged that she was sexually assaulted while she was sleeping, and on another occasion, another resident had raped her. The allegations were reported to the DON and the facility administrator as required, but the administrator considered the allegations to be a “delusion.” The resident has a diagnosis of schizoaffective disorder and reportedly has a history of delusions. A counselor determined that the allegations were not true because the resident claimed she had been assaulted by another resident with whom she had been seen holding hands with “like boyfriend and girlfriend and then [the resident] accused him of sexual abuse.” The facility was cited for failing to investigate the allegations and failing to follow required procedures to investigate and report allegations of abuse to CDPH, the Ombudsman, and local law enforcement within two hours, and failing to report the results of the investigation to CDPH within five days.

Citation # 950017258

COUNTRY VILLA BAY VISTA HEALTHCARE CENTER
5901 Downey Ave, Long Beach

B $2000 Retaliation Against Resident; Retaliation Against Staff; Sexual Abuse 1/7/22
The facility failed to prohibit and prevent retaliation against a resident and a certified nursing assistant (CNA) after they reported allegations of sexual abuse. After a resident alleged she was sexually assaulted on 9/25/21 and talked to the Department of Public Health (DPH) about it, the facility took away the resident’s shopping privileges. The administrator suspended the CNA after she notified the DPH of three allegations of sexual abuse at the facility, claiming the CNA had not notified her of the allegations. However, the administrator was aware of the resident’s allegation on 9/25/21.

Citation # 950017250

COUNTRY VILLA BELMONT HEIGHTS HEALTHCARE CENTER
1730 Grand Ave, Long Beach

B $6000 Patient Care 5/19/21
The facility failed to implement preventative measures for a resident with a history of trying to leave the facility who told staff they wanted to leave. Staff did not monitor exit doors or ensure the wander guard system was working properly on all exit doors and failed to provide adequate supervision for the resident with cognitive delays and multiple diagnoses, including schizophrenia. As a result, the resident left the facility unsupervised and went missing for 13 days.

Citation # 910016519
B $2000  Medication; Patient Records; Supervision  
9/10/21
The state inspector observed multiple errors in recording the administration of controlled narcotic medications, none of which could be explained by the facility staff, director of nursing, or the facility administrator. Discontinued medications were not disposed of, records of when the residents received controlled medications, and current pain levels were inaccurate or not recorded. This puts the residents at risk that they may receive medications that have been discontinued or on an inaccurate schedule, or that controlled medications could be lost or stolen.
Citation # 950016914

COUNTRY VILLA CLAREMONT HEALTHCARE CENTER  
590 S Indian Hill Blvd, Claremont

FOOTHILL HEIGHTS CARE CENTER  
1515 N Fair Oaks Ave, Pasadena

B $2000  Fall; Injury; Notification 10/15/21
On 3/28/21 at 7:30 pm, a 93 year old resident had an unwitnessed fall from her bed. Her physician ordered x-rays, and the results dated 3/29/21 at 10:41 am showed a fracture of the resident’s left hip. The resident’s physician was not notified of the x-ray results until 3/30/21 at 7:23 am (31 hours and 53 minutes after her fall), and she was transferred to the hospital at that time. The facility was cited for the delay in the care and treatment of the left hip fracture.
Citation # 950017021

HUNTINGTON PARK NURSING CENTER  
6425 Miles Ave, Huntington Park

B $2000  Dignity; Patient Care; Verbal Abuse  
12/10/21
The resident filed a complaint stating that a CNA used profanity and was rough while transferring the resident from a wheelchair to bed, resulting in physical pain and emotional distress for the resident. The CNA confirmed that profanity was used but claimed that the rough treatment was because the resident was going to fall and that the profanity was a “natural response” to the resident throwing a remote control at the CNA. The investigator found the treatment received by the resident to be a violation of the facility’s abuse prevention policy.
Citation # 910017179

LAKEVIEW TERRACE  
831 S Lake Street, Los Angeles

B $2000  Patient Care; Physical Abuse 1/10/22
The facility failed to ensure a resident was free from abuse and failed to provide recommended follow-up treatment and care when a staff member, allegedly under the influence of alcohol, repeatedly punched a resident in his face. The resident, diagnosed with an intellectual disability, had sustained a cut to his lip and was bleeding. Still, the staff did not immediately conduct a neurological status check or place an order for x-rays, as outlined in facility protocol.
Citation # 920017279

GRIFFITH PARK HEALTHCARE CENTER  
201 Allen Ave, Glendale

B $2000  Careplan; Elopement; Neglect; Staffing  
9/3/21
Three residents left the building unobserved and unattended on various days in 2020 and 2021. The residents’ whereabouts were unknown for some time in each case due to inadequate supervision, poor careplanning and a malfunctioning wander guard alert system. A fourth resident with a high risk of leaving while unattended and unobserved also had poor careplanning. The facility was cited for failing to provide appropriate nursing services and failing to maintain the wander guard alert system properly.
Citation # 950016890

B $2000  Injury; Mandated Reporting; Patient Rights; Physical Abuse 12/16/21
The facility failed to timely report an allegation of staff-to-resident abuse to the SAA within two hours after the allegation was made and failed to conduct a thorough investigation of the incident of abuse as per facility policy. On 9/22/21, a Licensed Vocational Nurse (LVN) allegedly physically abused a resident. The facility staff witnessed the LVN grab and hold down the resident by both arms against a wall because the resident had taken his soda. The resident sustained and was treated for minor injuries. The facility failed to timely report the incident, as the alleged abuse was not reported to SSA until 17 hours later.
Citation # 920017196
B $2000 Mandated Reporting 12/15/21
The facility failed to properly investigate and report an injury of an unknown source after a resident complained of severe pain in their hip and was diagnosed with a hip fracture upon transfer to the emergency room. The resident was diagnosed with schizophrenia and Alzheimer’s disease and needed extensive help getting out of bed and walking. Staff did not have any record of the resident getting out of bed prior to her report of severe pain and did not investigate the cause of the injury, resulting in a delayed investigation of the resident’s injury to rule out abuse.

Citation # 920017190

LANDMARK MEDICAL CENTER
2030 N Garey Ave, Pomona

A $20000 Sexual Abuse 8/12/21
A 30 year old resident was repeatedly sexually abused by another resident in 06/21. On 6/16/21, two nursing staff members found another female resident having sex with her in her room. The facility did not protect the resident from further abuse at that time by failing to report it to the authorities or to determine whether it was consensual. On 6/21/21, the abused resident subsequently reported that the same resident went inside her room several times on the weekend of 6/19/21 and 6/20/21 and forced herself on her. The resident waited until after the weekend to report the sexual assaults because she was afraid of angering the abusive resident. The facility was cited for failing to protect the resident from sexual abuse and failing to report the sexual abuse to the Department of Public Health in a timely manner. Citation # 950017198

MAYFLOWER CARE CENTER
5043 Peck Rd, El Monte

B $2000 Mandated Reporting; Patient Rights; Physical Abuse 12/16/21
A resident was assaulted by another resident and complained to a staff person. The accused resident was known to enter other residents’ rooms, and their careplan included strategies to address this. An LVN saw the accused resident enter the victim’s room but stated that at the time, they were busy with another resident and did not intervene. After the LVN heard a loud noise and entered the room, the victim stated that he had been physically assaulted and was afraid of the other resident. The LVN claimed to have texted the report of the incident to the DON, but the text did not mention physical assault. The assault only came to light when a family member of the victim made a report to the police. The facility’s policies did not reflect the requirement that an assault be reported to DPH, the Ombudsman and police within two hours, although the DON claimed that report would have been made within two hours if they had been made aware of the physical assault allegation.

Citation # 950017198

LONGWOOD MANOR CONVALESCENT HOSPITAL
4853 W Washington Blvd, Los Angeles

A $20000 Careplan; Patient Care 6/4/21
The facility failed to provide continuing assessment of a resident’s vital signs or notify the physician for over four hours after a resident experienced confusion, respiratory distress, had an elevated body temperature of 101 degrees, resulting in a delay in diagnosis and care provided to the resident. The resident eventually demonstrated an altered mental state and became unresponsive. The resident was transferred to the emergency room and diagnosed with severe sepsis, open bedsores, an abdominal bacterial infection, pneumonia in both lungs and required multiple intravenous antibiotics. The resident was hospitalized and died 47 days later.

Citation # 950016804

MAYFLOWER GARDENS CONVALESCENT HOSPITAL
6705 Columbia Way, Lancaster

B $2000 Staffing 12/23/21
During multiple visits to the facility, it was observed that the facility had failed to post nursing staff hours in a prominent location, resulting in the residents and the public not having easy access to the information.

Citation # 920017216

MISSION CARE CENTER
4800 Delta Ave, Rosemead

B $2000 Patient Care 12/2/21
The facility staff failed to properly safeguard oxycodone and hydrocodone medications for two residents, leaving keys to a locked medication storage cart unsupervised. An unauthorized staff person took the keys and took 12 tablets of controlled medications prescribed to manage the residents’ pain.

Citation # 950017148
**MESA GLEN CARE CENTER**
638 E Colorado Ave, Glendora

**B** $2000 Careplan; Elopement; Transfer 7/29/21

“On 5/27/21, a 75 year old resident with a diagnosis of dementia eloped (wandered) and was found on a major street a quarter-mile away from the facility. The resident’s careplan states the resident is at risk of injuries due to elopement and also wore a wander guard (monitoring bracelet) and required frequent checks. The facility failed to provide adequate supervision for this resident, which resulted in his elopement, and also failed to report the resident’s elopement to DPH. Because of the elopement, this resident was also inappropriately transferred to another facility on 5/27/21, going against the resident’s careplan.

Citation # 950016778

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**MONTE VISTA HEALTHCARE CENTER**
802 Buena Vista St, Duarte

**B** $2000 Infection; Neglect; Patient Care 12/29/21

An inspection initiated on 11/10/21 found that the facility failed to implement interventions to prevent and control the spread of COVID-19 and influenza. Fourteen residents had symptoms of coughs, with some of them repeatedly coughing, producing mucus and complaining of difficulty breathing. Yet the facility had not quarantined the residents into a “Yellow Zone” as required by both facility and state policies. It also failed to test the residents for COVID-19 and influenza and failed to ensure staff who had close contact with the residents donned full personal protective equipment (PPE).

Citation # 950017232

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**MONTROSE HEALTHCARE CENTER**
2123 Verdugo Blvd, Montrose

**B** $2000 Patient Care; Physical Abuse; Verbal Abuse 1/4/22

The facility failed to ensure a resident was free from abuse when a staff member displayed verbally and physically abusive behavior towards a resident during a bingo game. The staff member allegedly yelled and used derogatory words toward a resident, abruptly shook the resident’s wheelchair hard and then pushed the resident’s wheelchair out of the facility’s recreation room.

Citation # 950017248

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**OSAGE HEALTHCARE & WELLNESS CENTRE**
1001 S Osage Ave, Inglewood

**A** $20000 Careplan; Patient Care 5/13/21

The facility did not take steps to prevent the decline of residents diagnosed with COVID-19 and, for one specific resident, failed to follow physician orders and COVID-19 careplans to monitor vital signs regularly. The staff further failed to notify a doctor when the resident’s oxygen levels declined and failed to initiate CPR or call 911 when the resident was found unresponsive. This was against the resident’s wishes outlined on a Physician Order for Life Sustaining Treatment (POLST) form, which indicated they wanted life sustaining treatments. These failures resulted in a delay in care and treatment due to a lack of requested resuscitation measures after the resident was found unresponsive and were a direct proximate cause of death.

Citation # 910016498

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**PALAZZO POST ACUTE**
5400 Fountain Ave, Los Angeles

**A** $20000 Fall; Injury; Patient Care 5/13/21

On 10/16/21, the facility failed to provide supervision and an environment free of accident hazards for a resident, a 63 year old female, who was a high fall risk and had a history of falls with fractures, which was documented in her careplan. On 10/16/21 at 9 am, a CNA assisted the resident to the activity room where she remained unsupervised, and at 9:20 am was found on the floor next to her wheelchair complaining of pain in her left hip and thigh. On 10/17/21, the resident was diagnosed with a left hip fracture, which required her to be transferred to General Acute Care Hospital (GACH) on 10/18/21. While at GACH, the resident was transferred to the Intensive Care Unit (ICU) on 10/25/21 due to a heart attack. The resident was intubated and sedated, and Neurology was consulted due to seizure-like activity. The resident did not have a history of seizures.

Citation # 920017146
On 7/5/21, a resident called 911 after another resident hit her on the back of her head with a brick at 2 pm, causing her pain, dizziness and fear. The activities director witnessed the abuse. The facility was cited for failing to protect the resident from physical abuse and failing to send a written report to the Department of Public Health until 7/6/21 at 2:03 pm, 24 hours after the incident.

Citation # 950016968

The facility failed to provide residents with a safe and sanitary environment by not maintaining the roof. As a result, rainwater leaked from the ceiling in multiple locations. During a visit to the facility, wet towels were observed on the floor in multiple locations; buckets, trash cans and carts placed throughout the facility to collect rainwater; plastic tarps attached to ceilings to catch leaking water and exposed insulation material and other loose debris hanging from the ceiling throughout the facility. As a result of the leaks, four residents were transferred to different rooms.

Citation # 920017353

A review of the Inspection Report, dated 12/7/21, indicated there were five to six live cockroaches and two dead cockroaches in the facility’s kitchen, including one live German cockroach (known to carry disease). As a result, the facility placed the residents at risk of vector-borne diseases (illnesses that result from infections transmitted to humans by insects, such as cockroaches) from ingesting contaminated food and unsanitary food preparation.

Citation # 950017272

A CNA reported seeing one resident put his hand under the shirt of another resident and touch the woman’s breast. The resident who was abused has significant cognitive impairment. The abuser also has dementia. When the CNA’s report was delivered to the DON, the DON stated that the facility administrator had stated that because both residents have dementia, no report needed to be made to the police or the State Survey Agency, despite protocols requiring reporting within two hours of the incident. Instead, the residents were separated and monitored, and reportedly neither remembered the incident. This dismissal of the rights of a resident who has been abused because of dementia was found to be a violation of protocol and a failure to follow the federally mandated policy.

Citation # 910017314

The facility failed to implement infection control measures to prevent and control the spread of COVID-19. During a visit to the facility as a follow-up to a complaint investigation, the staff was observed not properly following infection control policies related to proper use of face masks and hand washing hygiene. One staff person changed soiled adult diapers, then touched an intravenous fluid bag without changing gloves, moved soiled laundry with bare hands and did not change gloves after touching one resident and then helping a second resident change their clothes. As a result, all residents and staff were placed at increased risk of becoming infected with COVID-19.

Citation # 950017167
**Solheim Senior Community**  
2236 Merton Ave, Los Angeles

A  $20000  Fall; Injury; Patient Care 12/4/20  
On 8/31/20, the facility failed to have two CNAs transfer an 86 year-old resident with functional quadriplegia and wheelchair dependence from wheelchair to bed using a mechanical lift, resulting in the resident falling and sustaining a broken right hip, right hip pain, left knee pain and a nose bleed. The resident’s careplan and facility policy require two or more people to assist with transferring the resident to and from surfaces, including their bed, chair and wheelchair. This failure resulted in the fall requiring the resident to have hip surgery.  
Citation # 950016174

**St. Andrews Healthcare**  
2300 W Washington Blvd, Los Angeles

AA  $100000  Elopement; Supervision; Death 10/18/21  
On 8/18/21, a resident left the facility unsupervised at 8:08 pm and wandered into a busy street, resulting in her being hit by a car and dying at 8:38 pm. Video surveillance showed that the resident wandered out the unlocked, unalarmed front doors of the facility. An RN stated it was his responsibility to lock the front doors and set the alarms at 8 pm, but he forgot to do so. The resident had previously wandered from the facility less than a month earlier on 7/26/21, but the facility failed to conduct an assessment or develop a wandering careplan. These failures and the failure to adequately monitor the resident were determined to be a direct proximate cause of her death.  
Citation # 920017143

**The Rowland**  
330 W Rowland St, Covina

B  $2000  Careplan; Decubiti (Bedsores); Patient Care 11/12/21  
During an unannounced visit on 9/4/20, it was revealed that the facility failed to ensure there was a nurse assigned to provide skin care treatments and assessments to prevent pressure sores, as per facility policy and physician’s orders outlined in three residents’ careplans. This resulted in three residents developing Stage II pressure sores.  
Citation # 950016152

**Stoney Point Healthcare Center**  
21820 Craggy View St., Chatsworth

B  $2000  Theft & Loss 12/2/21  
The facility failed to ensure a resident had the right to be free from misappropriation of property when their cellphone was stolen/missing on 6/27/20 and a second (replacement) cellphone was stolen/missing on 7/27/20, the same day it was given to the resident. It was the facility’s policy to report to the police department any item worth over $100, but a report was not made for either missing cellphones. The facility failed to comply with its own policies on Theft and Loss by not investigating and reporting allegations of misappropriation of residents’ property to law enforcement and the State Survey Agency (SSA). As a result, the resident’s representative had to spend money twice to replace the missing cell phones.  
Citation # 920017175

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

A  $16000  Careplan; Fall; Injury; Neglect; Supervision 12/9/21  
The facility failed to provide adequate supervision for a resident who had a history of falls and who was assessed as a moderate fall risk. As a result, the resident had another fall after walking unsupervised on 10/7/20 without a standby assist, as necessitated. Due to the fall, the resident suffered blood under the skin in the head and a broken nose requiring a transfer to an acute hospital and close monitoring in the intensive care unit. The facility failed to implement the recommendation of the physical therapist for the resident to have more supervision due to a new onset of a decrease in functional mobility after a previous fall on 9/20/20. These violations presented either imminent danger of death or serious harm or a substantial probability that death or serious harm would result to the resident.  
Citation # 910017022

Citation # 910017175
AA $100000 Careplan; Dietary Services; Feeding; Patient Care 12/3/21
A resident had a history of grabbing food from other residents and quickly trying to swallow it, despite having no teeth and a diagnosed inability to swallow. On two prior occasions, the resident had choked and been revived by the facility staff. On 10/12/21, a CNA gave the resident the permitted snack that was allowed on the resident’s diet but then left the resident on the patio. The resident subsequently choked and was not able to be revived. The facility was found to have failed to supervise when the resident was eating, failed to include in the resident’s careplan the need to supervise and failed to address in the careplan the resident’s difficulty swallowing and lack of teeth, which was found to be a direct proximate cause of the resident’s death.

B $2000 Mandated Reporting; Patient Care; Sexual Abuse 6/11/21
The facility failed to immediately report a sexual abuse allegation on 3/10/21 to the Department of Public Health, the Ombudsman and law enforcement. As stated in the facility’s Abuse Prohibition policy, with suspected abuse not resulting in serious bodily harm, the facility must make a telephone report within two hours to law enforcement and provide a written report within two hours to the Ombudsman and licensing agency. The facility failed to do so and reported 24 hours after the report of alleged sexual abuse, which had the potential to cause harm to the reporting resident as well as other residents.

B $2000 Patient Care 2/3/22
The facility failed to ensure the IV site of a resident was maintained and assessed as per the facility’s policy and procedure. A resident had a peripheral IV inserted on the left foot, which was left for seven days without a physician’s order to leave the IV catheter longer than 72 hours. In addition, the facility failed to ensure the IV site was assessed for complications and patency. This failure resulted in the resident developing an unstageable pressure sore at the IV site on the left foot.
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