Generations of advocates, residents and workers have fought to set safe staffing standards because of the ever-present dangers to residents in understaffed nursing homes. Understaffing results in bedsores, falls, injuries, infections, dehydration, malnutrition, starvation, drugging, hospitalizations and preventable deaths. Beyond harm and death, understaffing routinely causes misery and humiliation to residents. This has especially been the case during the pandemic, when countless residents suffered and died alone in understaffed nursing homes.

Why are most nursing homes so understaffed? The White House statement rightly points a finger at “predatory owners and operators who seek to maximize their profits at the expense of vulnerable residents’ health and safety.” Our nation has entrusted many of its nursing homes to owners and operators who are wholly unworthy of that trust.

At the center of the Biden Administration’s remarkable nursing home reform proposal announced on February 28, 2022 is an ambitious plan to establish and enforce a federal minimum staffing requirement for the nation’s nursing homes. The President expressed an urgent commitment to ensure that every nursing home provides a sufficient number of staff who are adequately trained to provide high-quality care.

Within one year, the Administration pledged to issue proposed rules establishing a minimum staffing level following a new research study on the level and type of staffing needed to provide safe and quality care.

[continued on page 3]
**CANHR News**

**CANHR Plans in 2022**

CANHR staff has had an ambitious legislative agenda for the 2022 legislative session, sponsoring or co-sponsoring a number of bills, including efforts to included more transparency and enforcement for California’s nursing homes; establish suitability of ownership for persons and entities seeking to own, operate, or manage skilled nursing facilities in California; ease income standards for Medi-Cal aged and disabled; and establish protocols for informed consent prior to the administration of psychotherapeutic drugs, among others. See our Legislative Updates and register your support for these important bills.

**We’re All Still Here**

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. Planned giving can take a number of forms, including gifts by will, gifts of life insurance or annuities or gifts via a revocable living trust or charitable remainder trust. Call the CANHR office or email 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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Historic Biden Plan on Minimum Staffing Standards Gets Boost

[continued from page 1]

Decades of research show the critical need to set safe staffing standards. Twenty years ago, the federal government’s own research found conservatively that 4.1 hours per day of nursing care were necessary to avoid harm to nursing home residents. Yet the federal government has repeatedly rejected opportunities to set minimum staffing requirements despite the mountain of evidence supporting the need to do so. Until now.

The Biden Administration commitment to establish a federal minimum staffing requirement is one of the most important developments in the history of nursing home reform.

An important first step has already been taken. On April 15, 2022, the federal Centers for Medicare & Medicaid Services (CMS) published a Notice of Proposed Rule Making that included a Request for Information on establishing the minimum staffing requirement. CMS posed seventeen questions for public consideration. CANHR and many other advocacy organizations weighed in with comments by the June 10, 2022 deadline.

Recommendations from National Academies Committee Echo Biden Reform Plan

On April 6, 2022 – just weeks after the White House announcement of the Biden nursing home reform plan – the National Academies of Sciences, Engineering and Medicine’s Committee on the Quality of Care in Nursing Homes released a 605-page report that provides a strikingly similar blueprint for federal nursing home reform. Established in late 2020, the Committee had been charged with examining how the United States delivers, finances, measures, and regulates the quality of nursing home care.

Echoing the White House reform plan, it calls for the federal government to set new minimum staffing requirements that address the needs of today’s nursing home residents, while basing the standards on research that identifies specific minimum and optimum levels of direct care staff.

The voluminous report gives much attention to the nursing home workforce, calling for a complete transformation of workers’ training and stature. Describing workers as “often underappreciated, undercompensated and underprepared for their roles,” the Committee recommends increasing both the numbers and the qualifications of virtually all types of nursing home workers and providing them competitive wages and benefits. Transforming workers’ preparedness and working conditions are essential, it says, to attract needed staff and deliver high-quality care.

Fight Not Over Yet

As always, the well-connected, well-heeled nursing home industry stands in the way of these reforms. After decades of paying, treating and training its workers terribly, the industry is fighting the establishment of minimum staffing standards, claiming they are unreasonable due to a severe shortage of workers. What’s unreasonable is expecting people to work for operators who exploit and endanger them.

The nursing home industry is fond of calling its workers heroes. It is time for operators to begin treating them that way.

The Biden Administration reforms give the fading, failing nursing home industry a golden opportunity to transform and grow its workforce by training, supporting and paying its workers fairly and employing enough of them so they are able to provide humane care to residents. The industry will have only itself to blame if it kills this historic opportunity.

You can help support these reforms. Thank President Biden for proposing the nursing home reforms. Contact your Members of Congress and urge them to support the President’s proposals. And stay tuned for information on opportunities to support the establishment of minimum staffing standards when CMS issues proposed rules in the months ahead.
The evolving Coronavirus Crisis has had a worldwide impact that will take a long time to become fully understood. At the beginning of the crisis, in an effort to keep you all better informed, we created a website, 

https://canhrnews.com/

specifically for COVID-19 information, news and resources related to Long Term Care. For the duration of this crisis, we are posting frequent updates there. The website contains over 1300 pages, and is still growing.

See the guide below for an overview of the many resources you can find there.
Residents of Laguna Honda Have the Right to Stay Despite Decertification

The April 14, 2022 termination of Laguna Honda’s Medicare and Medi-Cal certification put funding for California’s largest nursing home in jeopardy and left its nearly 700 residents worried about their futures. Laguna Honda remains licensed and has announced its plans to obtain recertification and stay open.

At the same time, it has also prepared a plan to transfer residents and close the facility, which has allowed it to continue to receive federal funds to care for residents while it seeks recertification by Medicare and Medi-Cal.

For now, Laguna Honda residents have the right to stay at the facility because there is no legal basis for transferring or discharging them. The facility continues to be paid for residents’ care and is not ceasing to operate. Importantly, residents have strong appeal rights and should exercise them if needed. Click here to read more about the rights of residents at Laguna Honda to stay at the facility.

LAist Reports on Medical Parole Patients Shipped to Decertified Nursing Home

A recent story from LAist reports how the California Department of Corrections and Rehabilitation (CDCR) consolidated nearly every one of its medical parole patients into Golden Legacy, a Sylmar nursing home with a very troubled history of bad care. Medical parole patients are incarcerated individuals who are moved from prison, often into nursing homes, because they are “medically incapacitated” and need assistance with activities of daily living that would qualify them for placement in a health care facility. For years, medical parole patients have lived in nursing homes throughout the state.

Recently, the federal Centers for Medicare and Medicaid Services (CMS) has found that the conditions imposed on medical parole patients (such as physical restraints and limitations on privacy) are at odds with the rights of nursing home residents. All nursing home residents, including justice-involved residents, have the full array of federal resident rights to protect them. As a result of the CMS crackdown on rights violations, CDCR has sent its medical parole patients to Golden Legacy, which has been stripped of its federal certification due to a number of serious problems and a long history of regulatory noncompliance. The medical parole patients have been dumped into a potentially dangerous facility where the care is reportedly often poor and neglectful and residents are perceived to have fewer protective rights.

Hopefully, CDCR, CMS, and the state Department of Public Health will find a way to restore the medical parole program so residents can be placed in better facilities while balancing residents’ rights with public safety concerns.

Newsom Administration Releases Last-Minute Plan to Extend and Expand Failed Payment System for Skilled Nursing Facilities

On May 17, 2022, the Newsom Administration released a budget proposal that would give nursing home operators hundreds of millions of additional dollars annually through a Medi-Cal rate increase with no strings attached. The proposal would expand and extend the current payment system – known as AB 1629 – for another four years without including any of the badly needed reforms CANHR and other advocacy organizations have recommended.

Designed by the nursing home industry with promises to improve staffing and care, the AB 1629 rate system has instead produced billionaire owners and epidemic levels of elder abuse in California nursing homes. The new proposal will produce more of the same. Read CANHR’s opposition letters to the Assembly and Senate Budget Committees.
CONSUMER ALERT

California Medi-Cal Asset Limit Increasing for Seniors and People with Disabilities

California will increase the asset limits for certain Medi-Cal programs, and is expected to eventually remove asset limit requirements altogether. Beginning July 1, 2022, the state will raise the Medi-Cal asset limit for a single individual to $130,000, $195,000 for a couple, and $65,000 for each additional family member. On January 1, 2024, the state is expected to eliminate the Medi-Cal asset limit completely.

What is the current asset limit?

Medi-Cal is a combined federal and California state program designed to help pay for medical care for public assistance recipients and other low-income persons. Currently, seniors and people with disabilities who apply for Medi-Cal must show that they are beneath the asset limit of $2,000 for a single individual and $3,000 for couples. If an individual has more than $2,000, they will not be eligible. This limit, which has not been updated since 1989, counts money from savings, checking, and any excess cash surrender value of life insurance among other assets.

Are there other changes to Medi-Cal?

Medi-Cal income guidelines and share of cost calculations will remain the same. The rules for exempt and non-exempt assets will also remain the same. For information on exempt and non-exempt resources under Medi-Cal, read CANHR’s Resource Limits fact sheet: http://canhr.org/factsheets/medi-cal_fs/html/fs_medcal_limits.htm

The asset limit changes only apply to California’s Medi-Cal program. Individuals who receive SSI benefits, or other public benefit support programs, will still need to comply with asset limit rules under those programs.

Medi-Cal Recovery rules will not change. If a beneficiary used certain services under Medi-Cal, it is possible that the State may make a claim against their estate when they die, if the estate is subject to probate under California law. There are simple steps people can take to protect their home, or other assets, from Medi-Cal Recovery. Read CANHR’s guide on Medi-Cal Recovery for additional information: http://canhr.org/medcal/medcal_recoveryinfo.htm

Visit CANHR’s Fact Sheet on Asset Limit Changes for additional details.
Dear Peeved,

You do not have to tell the nursing home staff who you are or why you are calling. Both federal and state regulations guarantee nursing home residents access to confidential private telephone calls and other forms of communication.* Confidentiality guarantees that the identity of a caller and the nature of the call need not be revealed to staff members. The only time a staff member may question a caller is when the resident has consented to an inquiry in advance. If the nursing home is reluctant to forward your calls to your mother unless you reveal personal information, file a written grievance with the Administrator. If the problem persists, call CANHR and file a complaint with the California Department of Public Health.

* The applicable federal regulation is 42 C.F.R. Section 483.10(h) and the state regulation is 22 California Administrative Code Section 72527(a)(21).

Sincerely,

Peeved in Petaluma

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**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/
Did You Know… Spousal Impoverishment Protections

When a person who is married or have a registered domestic partner enters a nursing home or participates in a Home and Community Based Services (HCBS) program, the couple will benefit from Spousal Impoverishment protections that allows the spouse that is not on Medi-Cal to keep additional assets and income to prevent them from running out of money. The spouse that is not on Medi-Cal is known as the community spouse. These protections allow the community spouse to pay for food, rent, mortgage, or other bills necessary to continue living at home. If the community spouse also needs Medi-Cal, they may lose some, or all, of the income and asset protections offered under spousal impoverishment.

When the second spouse (community spouse) applies for Medi-Cal, their application is processed as if they are in their own household, subjecting them to the asset limit for a single individual ($130,000 effective July 1, 2022). The other spouse that already receives Medi-Cal will continue to receive their benefits, but some Spousal Impoverishment protections no longer apply. For example, the community spouse cannot keep the Community Spouse Resource Allowance (CSRA) and must maintain the asset limit for a single individual. Income allocation may also be removed if the community spouse receives certain services under Medi-Cal.

If the community spouse participates in a HCBS program or enters a nursing home, Medi-Cal deems them as “institutionalized,” and they will no longer be considered a community spouse. The newly institutionalized spouse cannot receive income allocations in this scenario and may be subject to a share of cost depending on their monthly income and whether they enter a nursing home.

On the other hand, if the community spouse uses their benefits for services unrelated to HCBS or does not enter a nursing home, Medi-Cal will allow only income allocations to continue, but the recipient must consider how this may affect their share of cost because the income allocation will be added to the community spouse’s countable monthly income.

For the guidance on this rule, please refer to ACWDL 18-19, page 13, number 6.

A Consumer’s Guide to Financial Considerations and Medi-Cal Eligibility

This booklet outlines Medi-Cal eligibility requirements and discusses the protection of assets, such as the home and other items, when a spouse enters a nursing home.

http://canhr.org/publications/Consumer_Pubs.html
CANHR has supported, opposed, and/or closely followed the below pieces of legislation this session. Please check [www.canhrlegislation.com](http://www.canhrlegislation.com) for updated details on legislation, and [www.leginfo.ca.gov](http://www.leginfo.ca.gov) for information on specific bills.

**SPONSOR / CO-SPONSOR**

**AB 1663 (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 Senate. Re-referred to Com. 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 Senate. Re-referred to Com. 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 Senate. In Committee on Appropriations: Referred to suspense file

**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 Senate. In Committee on Appropriations: Referred to suspense file

**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. Re-referred to Com. on Appropriations

**AB 1855 (Nazarian): Long-Term Care Ombudsman Program: Facility Access**  
This bill, notwithstanding any other law, would prohibit a skilled nursing facility or residential care facility from denying entry to a representative of the office acting in their official capacity, under any circumstances. The bill would make related findings and declarations.  
**Status:** In Senate. Read second time, amended, and re-referred to Com. on Health

**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 Senate. In Committee on Appropriations: Referred to suspense file
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 Senate. In Committee on Appropriations: Referred to suspense file

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 Senate. Read second time. Ordered to Consent Calendar

AB 2511 (Irwin): SNF Backup Power Source
This bill would require skilled nursing facilities to have an alternative source of power to protect resident health and safety for no fewer than 96 hours during any type of power outage.
Status: In Senate. In Committee on Appropriations: Referred to suspense file

AB 2673 (Irwin and Allen): Hospice Licensure: Moratorium and New Licenses
This bill would extend the existing moratorium on issuing new licenses to hospices and enact some of the recommendations made by the California State Auditor in his March 29, 2022 report, which found that the California Department of Public Health’s weak oversight of hospice agencies has enabled large-scale fraud and abuse.
Status: In Senate. From Committee: Do pass and re-refer to Committee on Appropriations

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. Do pass and re-refer to Com. on Appropriations

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 Assembly. Do pass and re-refer to Committee on Appropriations

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: In Assembly. Do pass as amended and re-refer to Committee on Appropriations

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 1502 (Muratsuchi and Wood): Skilled Nursing Facilities
CANHR was the bill’s sponsor and worked diligently to secure its passage. Unfortunately the recent extensive amendments eviscerated the bill and will harm nursing home residents. Please see our legislation website for further updates on this.
Status: In Senate. Re-referred to Committee on Appropriations

AB 2724 (Arambula): Medi-Cal: Alternate Health Care Service Plan
This bill would authorize the department to enter into one or more comprehensive risk contracts with an alternate health care service plan (AHCSP), as defined, to serve as a primary Medi-Cal managed care plan for specified eligible beneficiaries in geographic regions designated by the department.
Status: In Senate. Senate amendments concurred in. To Engrossing and Enrolling

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: In Assembly

SB 1338 (Umberg and Eggman): Community Assistance, Recovery, and Empowerment (CARE) Court Program
This bill would enact the Community Assistance, Recovery, and Empowerment (CARE) Act, which would authorize specified people to petition a civil court to create a CARE plan and implement services, to be provided by county behavioral health agencies, to provide behavioral health care, stabilization medication, and housing support to adults who are suffering from schizophrenia spectrum and psychotic disorders and who lack medical decision making capacity.
Status: In Assembly. Do pass as amended and re-refer to Committee on Appropriations

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. In Committee on Judiciary. Hearing canceled at the request of author

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 Senate. Ordered to third reading

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: In Senate. Read second time, amended, and re-referred to Committee on Health
WATCH (CONTINUED)

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: In Secretary of State. Chaptered by Secretary of State - Chapter 21, Statutes of 2022

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: In Senate. In Com on Judiciary: Do pass. (Ayes 10. Noes 0) (June 28)

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: In Senate. Do pass and re-refer to Committee on Health with recommendation: To Consent Calendar

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: In Assembly. Re-referred to Committee on Appropriations
New Provider Information Notices

**PIN 22-15-ASC**
This PIN removes the recommendation that residents who received the COVID-19 booster or have completed their primary series, but are not yet eligible for the booster, and residents who have recovered from COVID-19 in the past 90 days be routinely quarantined after an exposure. This PIN also updates the duration of quarantine for residents who are unvaccinated or completed their primary series and are booster eligible, but have not been boosted, from 14 days to 7-10 days. Read [PIN 22-15-ASC](#) for full details.

**PIN 22-16-ASC**
This PIN provides information regarding testing of residents with recent exposure to COVID-19. Residents who are fully vaccinated, but have been recently exposed to COVID-19 and are asymptomatic are not required to be quarantined and should be tested two days after exposure. If negative, test again 5-7 days after exposure. Unvaccinated residents and residents who are booster eligible, but have not yet received it should be quarantined and tested two days after exposure and within 48 hours of planned discontinuation of quarantine. Read [PIN 22-16-ASC](#) for full details and further information.

How to file a complaint about an RCFE

Residents of RCFEs, friends, family members, or any person may file complaints against facilities (HSC 1569.35(a)). Complaints may be filed about abuse, neglect, inadequate staffing, poor care, mistreatment of residents, eviction issues, and other matters protected by law. There are two agencies where people may file complaints against an RCFE: Community Care Licensing (CCL) of the Department of Social Services and their local Long Term Care Ombudsman Program (LTCOP).

CCL is the regulatory agency responsible for investigating complaints, issuing licenses, conducting inspections, and enforcing the laws and regulations by issuing civil penalties and administrative sanctions. CCL also has the authority to suspend or revoke a facility’s license in instances where the health or safety of residents are in danger. Ombudsmen are resident advocates and conduct investigations within facilities. The LTCOP is a consent-based program and will investigate complaints per the consent of the resident or their representative, if appropriate.

To file a complaint with CCL, contact their complaint hotline at 1-844-LET-US-NO (1-844-538-8766) or email your complaint at letusno@dss.ca.gov. To file a complaint with the LTCOP, find your county’s LTCOP through the California Department of Aging [https://aging.ca.gov/Find_Services_in_My_County/](https://aging.ca.gov/Find_Services_in_My_County/). You may also call the Statewide CRISISline number 1-800-231-4024. All RCFEs are required to post their local Ombudsman office phone number and CRISISline in a visible location.
RCFE Corner

Theft and Loss in RCFEs

Residents have a right to a safe environment where their personal property is not lost or stolen (HSC 1569.269(a)(28); CCR 87468.2(a)(25)). Every RCFE must have a written policy on theft and loss, which must be posted within the facility, in the admission agreement, and must be provided to the residents. It is the facility’s responsibility to maintain an inventory of residents’ personal belongings and residents and family members should update the facility of any changes to keep the inventory current (HSC 1569.153(d),(h)). The facility is required to provide a secured storage area for residents and install locks on cabinets or drawers, at the resident’s request and expense (HSC 1569.153(j)).

The facility must report lost or stolen items to the resident or their representative if the item is valued at $25 or more and make a police report if the item is $100 or more (HSC 1569.153(c),(i)). To hold the facility accountable for lost or stolen items, residents/representatives may write a demand letter to the facility for reimbursement, file complaints with Community Care Licensing (CCL) and/or their local ombudsman, or sue in Small Claims Court for up to $10,000. To read further details on Theft and Loss in RCFEs, please refer to CANHR’s fact sheet.

CANHR On The Move

- 3/30/2022: Maura Gibney presented to Coast Caregiver Resource Center on Medi-Cal Eligibility, Recovery, and Medi-Cal Updates.

- 4/20/22 Jaclyn Flores participated in a transfer discharge hearing as a representative for a Laguna Honda resident who was discharged illegally from the facility.

- 4/21/2022: CANHR staff Maura Gibney and Bea Layugan hosted a statewide virtual meeting for consumers and advocates on Medi-Cal Updates and Asset Limit Changes.


- 05/24/2022: Maura Gibney presented to Social Workers from Kaiser San Leandro on Home and Community Base Services and Spousal Impoverishment.

- 05/25/2022: Staff Attorney Tony Chicotel participated in a national meeting for Advocates regarding staffing in nursing homes hosted by Consumer Voice.

- 05/27/2022: Staff attorneys Tony Chicotel and John Hafner presented to Inland County Legal Services on Elder Abuse, Elder Financial Abuse, and Remedies.

- 6/1/22 Jaclyn Flores accompanied a resident to Laguna Honda to ensure their readmission following a successful discharge hearing with the Department of Health Care Services (DHCS).


- 06/08/2022: Maura Gibney and Bea Layugan held a virtual presentation for consumers on Medi-Cal Eligibility and Home and Community Based Services (HCBS) Programs.
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**

Yvonne Troya  
Jack and Valerie Cumming

**In Memory Of**

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<tr>
<th>In Honor Of</th>
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<td>Kurtis Lemke</td>
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<td>Jennifer Bing’s</td>
<td>Celia Christian</td>
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<td>Mother</td>
<td>Lydia Gugich</td>
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<td>Janie Lanning</td>
<td>LaVerne Schwacher</td>
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<td>Art Gharibian Esq.</td>
<td>Debra Vogler</td>
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<td>Yong Cha Pak</td>
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<td>Beverly Fogle</td>
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<td>Geraldine Murphy</td>
<td>Patricia C. Hassakis, MD MPH</td>
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<td>Greta A. Hassakis</td>
<td>Yong Cha Pak</td>
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Yong Cha Pak: January 8, 1938 - December 28, 2020

Yong Cha Pak was born in Incheon, South Korea, on January 8, 1938. The beaches of Incheon are known for their beauty and Yong Cha loved to swim in them as a young girl. She attended Incheon Girl’s High School and worked for the U.S. Military in South Korea as a supervisor for the data processing department for many years. After immigrating to the United States, Yong Cha worked as an insurance processor for Allstate in Northern and Southern California and continued her career for nearly 30 years. She was a hard working, devoted employee who loved her job. Yong Cha was a survivor of World War II and the Korean War and came from a bygone generation where hard work and uncomfortable sacrifices were expected to provide for her family, but that she did happily to offer more comfortable lives for her two children.

Yong Cha enjoyed fashion and was always the most stylish in the room at any occasion. She loved to work, sing, swim, laugh, travel, spend time with her children—and, because she was her family’s best cook—make the most delicious, resplendent Korean meals her family went crazy for. Yong Cha was married to Charles M. Pak for over 40 years. She was a loving, compassionate, devoted mother to her two children. Yong Cha is deeply adored and loved by her children, family, and friends, who all know her to be the embodiment of grace.
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Amador County

KIT CARSON NURSING & REHABILITATION CENTER
811 Court Street, Jackson

B $2000 Physical Abuse; 3/17/22
On 11/10/21, a resident was hospitalized for a broken hip that resulted from an altercation with a resident in an adjoining room, who reportedly hit and pushed her. The facility allowed the residents to room next to each other with a shared bathroom despite a history of abusive behaviors. The facility was cited for failing to protect the injured resident from physical abuse.
Citation # 030017487

B $2000 Physical Abuse; 3/17/22
On 11/10/21, a resident was hospitalized with a broken hip that resulted from an altercation with a resident in an adjoining room who reportedly hit and pushed her. The facility was cited for failing to report the alleged abuse immediately or within 24 hours, as required.
Citation # 030017488

Madera County

OAKHURST HEALTHCARE CENTER
40131 Highway 49, Oakhurst

B $2000 Bed Hold; Evictions; Patient Rights; Transfer 4/6/22
On 3/9/22, a resident with dementia was denied readmission to the facility after being sent to the hospital on a 5150 hold. The resident was cleared by the hospital’s emergency department physician and psychiatrist to return to the facility on the same day after they found she was stable and wanted to return to the facility. She remained in the hospital emergency department for 27 days and, at the time the citation was issued, had not been readmitted. The facility’s refusal to readmit the resident back to her home caused avoidable and undue stress and anguish.
Citation # 040017547
**Marin County**

**Northgate Post Acute Care**
40 Professional Center Pkwy, San Rafael

**B $2000 Evictions; Notification; Patient Rights; Retaliation Against Resident; Transfer; Discharge 3/23/22**

The facility failed to notify the Long Term Care Ombudsman of a resident’s discharge as soon as possible. This failure resulted in the Ombudsman’s inability to advocate for the facility-initiated discharge of the resident. On 10/25/21, the resident suffered a fall and was transferred to the hospital. The facility did not readmit the resident because the staff alleged they did not feel safe with this resident after he was verbally upset with them for not attending to him when he fell.

A note written by the Social Services Director dated 10/25/21 indicates that the “resident was transferred to the hospital on 10/25/21 and not coming back transferred to another facility.” Yet, the facility did not provide a Notice of Transfer/Discharge to the Ombudsman until 10/27/21. Because of this failure, the facility denied the resident the opportunity to appeal his discharge and left him sitting in the ER until another facility admitted him.

Citation # 110017509

**Santa Clara County**

**Valley House Rehabilitation Center**
991 Clyde Ave, Santa Clara

**B $2000 Medication 5/23/22**

From 4/19-4/26/22, the facility administered insulin injections past the medication’s expiration date, a significant medication error, to a resident 26 times. This deficient practice had the potential for ineffective use of the insulin, resulting in uncontrolled high blood sugar for the resident.

Citation # 070017656

**B $2000 Medication 5/23/22**

On 4/25/22, inspectors observed that the facility’s medication error rate was over 20% during medication passes, with seven medication errors out of thirty-four opportunities involving five residents. The facility was cited for not giving medications in accordance with the prescriber’s orders and/or manufacturer’s specifications.

Citation # 070017654

**Solano County**

**Greenfield Care Center of Fairfield**
1260 Travis Blvd, Fairfield

**B $2000 Mandated Reporting; Mental Abuse; Patient Rights; Verbal Abuse 5/23/22**

The facility failed to prevent the abuse of three residents. Two residents with dementia were subjected to humiliation when the admissions coordinator posted pictures of them to a social media site in 11/21 with vulgar text at the bottom of one of the images. A CNA reported the abuse to the administrator, who initially denied receiving the report and later acknowledged receiving the report, photos and screenshots from the CNA on 12/4/21. The administrator confirmed he did not suspend the admissions coordinator, did not investigate the alleged abuse, did not document the investigation and did not report the results of the findings of the investigation to any state agency. In a separate case on 4/10/22, the facility failed to suspend an LVN and failed to thoroughly investigate allegations he verbally abused and cursed at a resident during medication administration. The facility also failed to follow up on a background check on the LVN, who had a court record and six cases on file at the Superior Court, including an elder or dependent abuse restraining order.

Citation # 070017657

**Windsor Vallejo Nursing & Rehabilitation Center**
2200 Tuolumne St, Vallejo

**B $2000 Patient Rights; Sexual Abuse 5/9/22**

The facility failed to provide a safe environment and protect a resident from sexual abuse when the Central Supply Manager (CSM) kissed a resident’s cheek and placed his hand on her leg without her consent. This failure resulted in an unconsented sexual abuse by the CSM of the resident, causing her to feel angry, helpless, fearful, anxious and disrespected.

Citation # 110017609
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Kern County

**Windsor Post-Acute Center of Bakersfield**

6212 Tudor Way, Bakersfield

**B** $2000 8/20/21

A 77 year old resident who had been diagnosed with dementia, Alzheimer’s, feeding difficulties and generalized muscle weakness was not allowed to return to the facility after a four-day hospital stay, as is required by State law and regulations. This failure resulted in the resident having to stay in the hospital for an additional two days and violated their right to return to the facility. Citation # 120016809

**Brookdale Riverwalk SNF (CA)**

350 Calloway Dr, Bakersfield

**A** $20000 Patient Care 4/7/22

During an investigation of a complaint, a 95 year old resident diagnosed with dementia and osteoarthritis was observed to have a broken leg. The facility failed to notify a physician about the resident’s change in condition or to monitor the resident when a nurse discovered a bruise extending from her knee to her ankle. These failures resulted in a delay in treating the resident’s broken leg. Citation # 120017501

Los Angeles County

**Alhambra Healthcare & Wellness Centre, LP**

415 S Garfield Ave, Alhambra

**B** $2000 Mandated Reporting; Medication; Patient Care 5/6/22

In 01/22, the facility failed to report missing narcotics for a resident under hospice care to the California Department of Public Health within 24 hours. The resident’s physician ordered morphine sulfate to be administered three times a day for pain management. However, on 1/27/22, a nurse at the facility discovered that the morphine bubble pack for the resident was not in the medication cart, and the narcotic count sheet was also missing. The DON contacted the hospice agency about the missing narcotics, but did not report the incident to the Department of Public Health. These failures created the risk of narcotic drug diversion. Citation # 950017628

**Beachwood Post-Acute & Rehab**

1340 15th Street, Santa Monica

**B** $2000 Mandated Reporting; Notification; Verbal Abuse 4/22/22

The facility failed to report an allegation of employee-to-resident verbal abuse to the California Department of Public Health no later than two hours after the resident made the allegation. Citation # 920017591
BROADWAY HEALTHCARE CENTER  
112 E Broadway, San Gabriel

**B $3000 Infection; Patient Care 5/5/22**
The facility failed to implement protocol for five staff members who were required to wear Personal Protective Equipment when entering the Yellow Zone rooms (isolation rooms for patients exposed to COVID-19).

Citation # 950017580

BURBANK HEALTHCARE AND REHABILITATION CENTER  
1041 S Main St, Burbank

**A $20 000 Fall; Injury; Neglect; Supervision; Death 2/24/22**
A 92 year old resident died on 12/7/21, eight days after a falling at the facility and suffering head trauma and bleeding of the brain. The resident, who had poor judgment due to confusion and was at high risk for falls, was not assisted when he was observed walking using a walker. The facility was cited for failing to provide the resident with supervision, assistance and a safe environment to prevent accidents and injuries.

Citation # 920017423

CHANDLER CONVALESCENT HOSPITAL  
1041 S Main St, Burbank

**A $20 000 Medication; Patient Care 1/28/22**
The facility failed to administer prescribed medication for at least three days, including medication to treat a condition of seizures. The failure to administer the medication resulted in the resident having a seizure and being transferred to a hospital.

Citation # 950017289

FIRESIDE HEALTH CARE CENTER  
947 3rd St, Santa Monica

**B $2000 3/25/22**
The facility failed to properly report an injury of unknown origin to the police and the Ombudsman when a resident was found to have a bruise on their forehead. The facility also failed to properly investigate the cause of the injury per their policy.

Citation # 920017530

CLARA BALDWIN STOCKER HOME  
527 S Valinda Ave, West Covina

**B $3000 Patient Rights 4/8/22**
In 01/22, the facility violated the visitation rights of five residents between the ages of 81 and 93 years old by imposing conditions that were unacceptable to their families. The facility charged family visitors $5 or $25 per visit, depending on the resident’s length of stay, for rapid antigen COVID-19 tests before visits. One family member reported she paid over $200 during the holiday season to visit her family member at the facility. This family member stated she had three daughters who wanted to visit their grandmother at the facility but could not afford to pay $25. The facility also charged residents’ hospice workers for testing them before letting them in the facility. The facility was cited for failing to ensure all visitors received full and equal visitation privileges consistent with resident preferences.

Citation # 950017558

FIDELITY HEALTH CARE  
11210 Lower Azusa Rd, El Monte

**A $20 000 Decubiti (Bedsores); Infection; Neglect; Patient Care 2/11/22**
An 85 year old resident was hospitalized for ten days from 11/6-11/16/21 for sepsis and a Stage IV pressure sore on her tailbone that required surgery. Hospital records stated the facility did not mention the resident’s pressure sore or treatment. The DON said that she did not know about the pressure sore until the resident was transferred to the hospital and acknowledged that it could have been prevented. After the resident was discharged back to the facility, an investigator observed the resident lying in bed on her back on several occasions. The resident stated she was “always” lying on her back on all shifts. The facility was cited for failing to provide necessary wound care services, failing to ensure the resident was not lying on her back directly on her pressure sore site, failing to detect and report the changes in her skin condition, failing to revise her care plan and failing to follow its policy to avoid the use of plastic-backed chux pads and thick linen on the low air loss mattress they used for the resident.

Citation # 950017344
A $20 000 Decubiti (Bedsores) 6/9/21
The facility failed to develop a careplan or properly care for a resident’s pressure sores. The resident had been determined to be at risk for developing pressure sores and had doctors’ orders that included preventative cleaning procedures, medication and frequent changing of position. The resident was not provided with regular wound prevention care and, as a result, developed more serious open wounds to his lower back and buttocks.
Citation # 950016581

B $2000 Physical Abuse 6/11/21
On 3/4/21, the facility failed to notify the Department of Public Health of an allegation of abuse within two hours of the allegation. A female resident, who had diagnoses of paranoid schizophrenia and osteoarthritis, alleged that on 2/9/21, the nurse supervisor covered her mouth when she indicated that she did not want to talk. The facility reported her allegations to the local Ombudsman on 3/4/21 but failed to notify the Department of Public Health until 3/8/21.
Citation # 920016592

A $20 000 Administration; Fall; Injury; Neglect; Patient Care; Physical Environment 5/12/22
The facility failed to provide a safe environment and necessary supervision for a resident who had been assessed as a high fall risk. On 11/13/21, a CNA, the resident’s assigned sitter, left the resident’s side to assist another resident. As a result, the resident fell off the wheelchair onto the floor, requiring transfer to a hospital where the resident was diagnosed with a broken thigh bone, which required surgery to repair. The above violations presented either an imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result to the resident.
Citation # 920017630

B $2000 Careplan; Elopement 8/13/21
On 6/17/21, the facility failed to prevent a 52 year old resident from eloping from the facility when she used a chair to reach the branches of an overhead tree and climbed over the fence of the facility. The facility failed to implement measures to prevent the resident from leaving the facility despite multiple assessments that she was a high risk for elopement.
Citation # 910016819

B $2000 Notification; Verbal Abuse 5/4/22
The facility failed to follow notification requirements after an LVN heard a CNA verbally abuse a male resident with racist remarks on 8/2/21. The LVN failed to notify the DON and administrator of the facility within two hours of the incident. Instead, she notified the Director of Staff Development (DSD) via text message. The DSD waited until the next day to notify the Department of Public Health, violating facility policy to notify the Department two hours after an incident. Additionally, the CNA was able to complete their shift that day, violating the facility’s policy to immediately suspend any staff members accused of abusing a resident. These failures caused a delay in performing a thorough investigation of the alleged verbal abuse and put the resident at risk of further abuse by allowing the CNA to continue working.
Citation # 920017617

AA $100 000 Careplan; Dietary Services; Feeding; Injury; Patient Care; Physical Environment; Staffing; Death 6/18/22
The facility failed to ensure a resident was provided with a specialized swallowing test to ensure a safe oral diet, that the resident was free from accidents and hazards and that the nursing staff had the appropriate competencies and skill sets to perform emergency basic life support techniques. As a result, on 2/26/22, during dinner (around 5:30 pm), the resident experienced a choking episode and died soon after.
Citation # 920017645
B $1500  Mandated Reporting; Sexual Abuse  
4/29/22  
The facility failed to report an allegation of sexual abuse of a resident within two hours following the incident on 1/28/21. The facility also failed to protect the resident from the alleged perpetrator during the investigation process for the allegation of sexual abuse.  
  Citation # 950017607

MAYFLOWER CARE CENTER  
5043 Peck Rd, El Monte

NORTH VALLEY NURSING CENTER  
7660 Wyngate St, Tujunga

A $20 000 Careplan; Medication; Patient Care  
2/24/22  
The facility failed to ensure a resident who had diagnoses of left hip replacement, lupus and fibromyalgia received pain management and was free from significant medication errors in a manner consistent with professional standards of practice, the facility’s policies, and the resident’s comprehensive plan of care. The resident was hospitalized for severe left hip pain on 10/2/21 and returned to the facility the same day. The facility failed to perform an assessment of the resident’s pain from 08/23-08/31/21 and from 10/1-10/31/21, and failed to document it in the Pain Assessment Flow Sheet every shift as per her careplan and facility policy. Further, the facility failed to re-evaluate the pain medication regimen for lack of effectiveness when the resident complained of continued pain and asked for her usual daily pain medication between 08/24-10/27/21. As a result, the resident suffered severe pain from the time of admission to the facility on 8/22/21 until 10/27/21, when the pain medication regimen was adjusted. These violations presented either an imminent danger or substantial probability that death or serious harm would result to the resident.  
  Citation # 920017422

MONTE VISTA HEALTHCARE CENTER  
802 Buena Vista St, Duarte

PACIFIC VILLA, INC.  
3501 Cedar Ave, Long Beach

PARK AVENUE HEALTHCARE & WELLNES CENTER  
1550 N Park Ave, Pomona

A $120 000 Neglect; Patient Care; Staff (Inservice) Training; Death 3/30/22  
A 79 year old resident died on 1/19/22 after the facility staff failed to provide basic life support, perform CPR or call 911 when he was found unresponsive, not breathing and without a heart rate at 5:30 am. A nurse called his doctor at 6 am. At 6:30 am, the doctor called back and pronounced the resident dead. The resident did not have an advanced directive or POLST (Physician’s Order for Life Sustaining Treatment) and the DON stated that the LVN who found the resident unresponsive should have performed CPR. The facility did not have an RN on-site when the resident was found unresponsive and did not require all staff to have basic life support (BLS) certifications. As a result of these failings, the resident did not receive CPR or 911 emergency services and died at the facility on 1/19/2022 at 6:30 am.  
  Citation # 950017535

B $3000 Physical Environment 3/10/22  
On 2/2/22, a county health inspector closed the facility’s kitchen due to a cockroach infestation after observing 26 live cockroaches. The facility’s dietary supervisor stated that there were cockroaches in the kitchen when she started working at the facility in 10/21. As a result of the infestation, the 192 residents of the facility were at risk of vector-borne diseases and infections that could lead to life-threatening complications and death.  
  Citation # 950017483

A $20 000 Careplan; Notification; Patient Care  
2/24/22  
The facility failed to intervene for over 22 hours after a resident had a change of condition and did not implement the care plan. The resident, who was on a blood thinner medication and at risk for gastrointestinal bleeding, was throwing up black colored vomitus, which contained blood. The facility failed to Immediately notify the physician as required by policy and procedures. As a result, the resident was admitted to the Intensive Care Unit (ICU) on 12/19/2021 due to hypotension (low blood pressure) and Gastrointestinal (GI) bleed.  
  Citation # 910017440
B $2000  Mandated Reporting; Physical Abuse 5/6/22
On 2/8/22, a 38 year old resident of the facility reported that a CNA had hit him in the eye a few days earlier and that his life was in danger. The resident told the facility he did not report the abuse right away because he was afraid. The facility had observed discoloration of the resident’s left eye on 2/6/22, but did not report it to the Department of Public Health until three days later, on 2/9/22. The facility was cited for failing to report an allegation of abuse in a timely manner.

Citation # 950017627

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

B $1500  Decubiti (Bedsores); Patient Care 3/1/22
The facility was cited for failure to provide proper assessment and care for an 83 year old resident’s Stage I pressure sore located on her lower back. The facility staff failed to properly assess, monitor and provide preventative care for the resident, who was completely immobile and dependent on staff for all activities. As a result, the resident’s wound progressed to a Stage III pressure sore, when skin breaks open and expands into deeper layers of the skin, requiring debridement procedures to remove damaged skin tissues.

Citation # 910017452

San Marino Manor
6812 N Oak Ave, San Gabriel

B $2000  Mandated Reporting; Notification; Physical Abuse 5/5/22
The facility failed to report an allegation of abuse in a timely manner when a resident bit the forearm of another resident. Allegations of abuse that result in serious bodily injury are to be reported immediately and no later than two hours after the allegation; or if the allegations do not involve serious bodily injury, no later than twenty-four hours after the allegation.

Citation # 950017625

Pasadena Grove Health Center
1470 N Fair Oaks Ave, Pasadena

The Rehabilitation Centre of Beverly Hills
580 S San Vicente Blvd, Los Angeles

A $15 000 Elopement; Fall; Injury 5/27/22
On 2/28/22, a 71 year old resident jumped out of the window of his room on the facility’s second floor. The facility failed to provide the resident with additional supervision despite knowing his risk for elopement. As a result, the resident sustained multiple fractures, broken teeth, skin cuts and brain bleeding. He required emergency hospitalization and underwent multiple surgeries.

Citation # 920017675

University Park Healthcare Center
230 E Adams Blvd, Los Angeles

B $2000  Mandated Reporting; Notification; Physical Abuse 3/30/22
The facility failed to ensure the reporting and thorough investigation of an abuse allegation. A family member of a resident informed the facility that the resident alleged that a CNA got in a fight with the resident after the resident scratched CNA. The facility did not report the abuse allegation to the Social Security Administration, the Ombudsman Program, or law enforcement.

Citation # 920017534

Vista Del Sol Care Center
11620 W Washington Blvd, Los Angeles

B $2000  Injury; Notification 3/18/22
A resident was found with a small cut on the left side of his forehead. The doctor was notified and ordered the resident to be sent to the emergency room for evaluation due to increased confusion and a left forehead cut. The facility failed to report the resident’s injury of unknown origin to the Social Security Administration, the police and the Ombudsman Program, as indicated in the facility’s Abuse Reporting policy. The facility also failed to implement its abuse policy and procedure by failing to investigate the resident’s injury.

Citation # 920017513
**West Gardena Care Center**  
16530 S Broadway, Gardena

**B $3000 3/3/22**  
The facility failed to implement infection control practices to prevent the spread and transmission of COVID-19, resulting in multiple residents becoming infected, putting staff, visitors and the community at high risk for infection. The facility failed to ensure staff wore gowns and gloves while attending to the care of residents designated as possibly infected and infected, and failed to ensure that staff designated to work with infected patients did not go to other areas of the facility to care for residents who were not infected.

Citation # 910017463

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**Whittier Hills Health Care Center**  
10426 Bogardus Ave, Whittier

**B $2000 Infection 12/4/20**  
The facility failed to take steps to prevent and control the spread of COVID-19, placing multiple residents at risk for infection that could lead to severe illness and/or death. A surveyor observed the facility not properly screening outside visitors for COVID-19, failing to separate residents who had tested positive from residents who had not yet tested positive, not ensuring staff change out PPE when providing direct care to residents and failing to ensure staff washed their hands after touching contaminated items.

Citation # 950016183

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**York Healthcare & Wellness Centre**  
6071 York Blvd, Los Angeles

**B $2500 Patient Care; Retaliation Against Resident; Verbal Abuse 4/22/22**  
On 3/10/22, an 83 year old resident who was blind and Spanish speaking reported that he felt like he was in “jail” because of the way he was treated. He stated that a CNA yelled at him, called him derogatory names and retaliated against him when he reported the ongoing abuse to the social worker months earlier. Another resident had similar complaints about the same CNA, reporting that she was mean, called him derogatory names and did not assist him with care in a timely manner. The facility had not verified that the CNA was competent before she began providing care to residents. The facility was cited for failing to keep the residents free from abuse.

Citation # 950017590

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**Seal Beach Health and Rehabilitation Center**  
3000 N Gate Rd, Seal Beach

**B $3000 Careplan; Sexual Abuse; Supervision 5/24/22**  
On 3/1/22, the facility failed to protect a female resident from sexual aggression caused by a male resident who had tendencies of inappropriate sexual behaviors around other female residents. To address the issues, the facility held careplan meetings to provide solutions, like redirection of the resident and close monitoring by staff. However, the facility failed to implement procedures to ensure that the staff in different shifts were aware of the need to monitor the resident closely. During a shift change, screams were heard from the female resident’s room, and she was found on her bed with the male resident on top of her. The LVN who responded to the screams claimed that she did not know to keep an eye on the male resident because there was no report from the previous shift indicating that he required close monitoring. Due to the facility’s failures, the male resident was able to enter the female resident’s room and engage in inappropriate sexual behaviors.

Citation # 060017647

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**Spring Valley Post Acute LLC**  
14973 Hesperia Rd, Victorville

**AA $25000 Elopement; Neglect; Supervision; Death 4/5/22**  
On 6/26/21, a 69 year old resident with dementia eloped undetected from the facility, was struck by a car in a roadway about four and a half miles from the facility and died instantaneously at 9:53 pm. A CNA assigned to his care stated he believed the resident went out the front door because the door in the front lobby did not have an alarm. An investigator observed on 7/2/21 that not all door alarms were activated. The resident had previously eloped from the facility on 2/1/21 without the staff’s knowledge and the resident’s brother had to inform the facility. The resident’s doctor ordered 1:1 monitoring and supervision of his care, but the facility failed to provide it. The facility also failed to monitor and supervise the resident on 6/26/21 and to ensure all door alarms were working to maintain an operable alarm system per the facility’s policy and procedure. These violations were a direct proximate cause of the resident’s death.

Citation # 240017545
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