Almost, Nearly, Practically Back to Normal

The State of Visitation Rights in California
Long Term Care Facilities

A whopping two-and-a-half-years after visitation in long term care facilities was shut down to protect residents from COVID-19, the rights of residents to see visitors have been almost fully restored to their pre-pandemic norms. With the rescission of an Omicron-fueled state public health order that had required visitors to demonstrate proof of vaccination or a negative COVID test, residents of nursing homes and assisted living facilities should be back to receiving visits when they want.

Robust Access Required

The end of California’s vaccination/testing requirement means that residents should have the broad access to visitors that has long been protected by law and regulations. Prior orders from the federal Centers for Medicare and Medicaid Services (CMS) and the state Department of Public Health (DPH) have:

- Restored residents’ rights to outdoor, indoor, and in-room visitation;
- Ended facilities’ ability to limit the length or duration of visits;
- Ended facilities’ ability to limit visitation to prescribed or pre-approved times beyond what the law provides;
- Clarified that residents’ rights to visitation include robust availability of virtual visitation options

Residents should now have access to visitors seven days a week - and when it comes to family members in nursing homes - 24 hours a day.

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**CANHR News**

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**Summer Intern**
We want to thank Jack Grimm, a rising 3rd year Hastings Law student, for his wonderful work over this summer at CANHR and to wish him well in his future endeavors.

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**Need Help or Information?**
CANHR offers free information and support to consumers across California by phone and email. If we are in a meeting or unavailable, you can always email us your questions at canhrmail@canhr.org. We always respond as soon as possible.

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**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.

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**Donate to CANHR**
CANHR answers thousands of consumer calls each year, and provides advocacy services for older adults and people with disabilities across the state. Our services are free, and all donations – however large or small - can make a huge impact.

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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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While facilities can ask visitors to schedule appointments, they may not require an appointment for visits. Facilities may not shut down visitation during a COVID-outbreak – which is often done even though it doesn’t protect residents from COVID – except that nursing homes may “pause” visitation temporarily for outbreak testing and cohorting of residents.

Reasonable Infection Prevention Safeguards During Visits

While residents have had their visitation rights restored, visitors can be required to comply with reasonable procedures to limit the spread of COVID. Visitors can be screened for symptoms of COVID and must continue to wear masks while visiting indoors. Outdoor visits are encouraged over indoor visits and indoor visits are encouraged in spaces that don’t include roommates if possible. Visitors should steer clear of residents other than the one they are visiting and wash their hands before and after their visit.

Report Problems to the State

While the federal, state, and local governments have pulled back on permissible visitation restrictions over the past two years, facilities continue to place illegal restrictions on visitation based on their own ad hoc policies. Some facilities are limiting visits to 60 minutes or less, some require appointments in advance, and others lock out visitors for 10-14 days whenever a resident or staff person tests positive for COVID. Some facilities will likely continue to require proof of vaccination or a negative COVID test before allowing visits. All of these limits on visitation are illegal and violate the rights of the residents. Victims of these violations should file complaints with DPH (for nursing homes) or the Department of Social Services (for assisted living facilities). If the appropriate state agencies are not helpful in enforcing residents’ visitation rights, please let CANHR know.
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 have been posting updates there. The website contains over 1300 pages.

See the guide below for an overview of the many resources you can find there.
Long Waitlists Persist Despite Expansion of Assisted Living Waiver (ALW) Program

The Assisted Living Waiver Program is a Medi-Cal program designed to help low-income older adults and individuals with disabilities remain in their community as an alternative to nursing home placement. A September 7, 2022 article by CalMatters reports that the recent expansion of the program is going slowly, with individuals and their caregivers still reporting long waitlists and confusing implementation policies. The ALW program is a vital lifeline helping low income seniors avoid institutionalization, while also providing necessary care and services at a lower cost than a nursing home. CANHR is actively working with other long term care advocates across California to improve access to the ALWP and to ensure new slots are distributed effectively.

New Consumer Voice Report Examines Impact of Poor Care in Nursing Homes with High Staff Turnover

Are nursing homes really facing a staffing crisis? Or have nursing home operators created a job quality crisis for their workers through longstanding neglect of them?

It is the latter according to a compelling new report by Consumer Voice, High Staff Turnover: A Job Quality Crisis in Nursing Homes. The report examines nursing homes with higher staff turnover, assesses the causes of high turnover and the impact on care, and offers solutions to this pervasive problem.

High turnover harms residents. In reviewing CMS data, Consumer Voice found that nursing homes with higher turnover have higher instances of resident abuse, lower Medicare five-star ratings, and greater numbers of substantiated resident complaints.

The average nursing home loses half of its direct care staff each year through turnover, a result of poor pay, lack of benefits, little training, and impossible working conditions.

Solutions are not a mystery, says Consumer Voice. Nursing home operators should increase pay and benefits, improve training and support, lower workloads and strengthen management. Doing so is a clear pathway to better jobs and better care.

CFPB Calls Out Illegal Nursing Home Debt Collection Practices

For decades, nursing homes have often defied federal and California laws prohibiting them from holding family members or friends personally liable for the cost of a resident’s care. On September 8, 2022, the Consumer Financial Protection Bureau (CFPB) held a virtual hearing on this subject and took a series of actions to help stop illegal debt collection practices. The hearing featured testimony from victims of outrageous lawsuits who were sued by nursing homes and debt collection companies for huge debts they did not owe.

“In nursing homes that participate in Medicare and Medicaid are prohibited from forcing a resident’s family or friends to assume responsibility for the cost of care as a condition of admission or continued stay in the facility,” said CFPB Director Rohit Chopra. “Debt collectors must take steps to ensure they are not violating the law by collecting on invalid nursing home debts.”

In addition to holding the hearing, the CFPB released an Issue Spotlight and a Consumer Financial Protection Circular on nursing home debt collection practices and, together with the Centers for Medicare & Medicaid Services (CMS), released a joint letter to nursing homes and debt collectors advising them on their legal responsibilities.

Unfair debt collection practices is also the subject of a July 28, 2022 report by Kaiser Health News and National Public Radio on nursing homes using lawsuits to target friends and relatives of residents in debt collection actions: Nursing Homes Are Suing the Friends and Family of Residents to Collect Debts.

Transfer and Discharge Pause and Medicare and Medi-Cal Payments Are Extended at Laguna Honda Until November 13, 2022

On August 15, 2022, city, county, state and federal officials announced that all transfers and discharges at Laguna Honda will remain paused and federal payments will continue until November 13, 2022.

[continued on next page]
The joint statement declares that “CMS, CDPH, and the City and County of San Francisco will work together as Laguna Honda continues to provide critical services for vulnerable residents in San Francisco.”

This welcome news came just days after San Francisco officials sued the federal government and held a press conference denouncing CMS for putting the lives of hundreds of Laguna Honda residents at risk by decertifying the facility and requiring its closure. At least nine former Laguna Honda residents died after transfers to dangerous nursing homes and homeless shelters. San Francisco City Attorney David Chiu described the City’s lawsuit as a last resort needed to save the lives of Laguna Honda residents and to prevent the closure of the vital safety net facility.

Laguna Honda is the nation’s largest nursing home and is owned and operated by the City and County of San Francisco. The tragic deaths of so many of the transferred residents demonstrates that most Laguna Honda residents have nowhere safe to go. The one-of-its-kind facility houses over one-third of all skilled nursing facility beds in San Francisco, with some of its residents having lived there for over 40 years. As of August 1, Laguna Honda reported it had transferred or discharged 57 residents and that 610 residents remained at the facility.

**Kingston got big fines alleging improper transfers, then left behind needles, meds**

That is the headline of an August 1, 2022 Bakersfield.com article about the closure of Kingston Healthcare Center, a Bakersfield nursing home with one of the worst performance histories in California. The article reports that the California Department of Public Health (CDPH) issued 54 citations and fined Kingston more than $200,000 this year for violating requirements aimed at protecting residents from transfer trauma during nursing home closures.

According to the CDPH citations, dozens of residents were endangered by Kingston’s failure to conduct required medical and psychosocial assessments before they were transferred and by transfers made without adequate notice.

In doing so, the citations allege that Kingston violated the terms of its own relocation plan submitted to CDPH. Kingston Healthcare Center is owned by David Silver, the CEO of Rockport Healthcare Services.

On average, California nursing homes receive less than one citation per year. The extraordinary number of citations to Kingston illustrates the grave dangers residents often face during nursing home closures. It also speaks to the folly of placing trust in unfit operators to protect residents’ rights and to transfer residents safely after their facilities have been decertified due to neglect or abuse.

**Waiving Patients’ Legal Rights is NOT a Health Care Decision: Logan v. Country Oaks**

A new Second Appellate District opinion has found that health care agents designated under an Advance Health Care Directive do not have the authority to bind principals to binding arbitration agreements. In making this finding, the Court expressly overturned the Garrison v. Superior Court decision, which ruled that health care agents could bind principals to arbitration agreements.

In Logan, the Court determined “the decision to waive a jury trial and instead engage in binding arbitration . . . is not a health care decision. Rather it is a decision about how disputes over health care decisions will be resolved.” The Court also found it important that both state and federal law require nursing homes to keep admission agreements (related to receiving health care) separate from arbitration agreements (not related to receiving health care) and prohibit arbitration agreements from being made a condition of receiving care.

Much of the Logan court’s reasoning resembles arguments made by CANHR in the Winter 2019 edition of its Legal Network News (page 11, “Garrison and Hogan Are Wrong: Why Health Care Agents Cannot Bind Principals to Pre-Dispute Arbitration Agreements”). The Logan decision brings long-needed common sense to California’s long term care facility arbitration jurisprudence and aligns it with several other states. Litigation, trials, and legal dispute resolution are not health care.
Public Health Emergency Extended

In response to the COVID-19 pandemic, a national Public Health Emergency (PHE) was declared in January 2020, by the Secretary of the United States Department of Health and Human Services (HHS) that has been extended until October 14, 2022. Protections during the PHE have included:

- Medi-Cal is not processing negative actions
- No increases in Share of Cost
- No retroactive negative actions after PHE ends
- Waiver of premium payments
- People will not lose their benefits due to an increase in assets

HHS has committed to providing all states a 60-day notice before the PHE expires or is terminated. Although the current national COVID-19 PHE is set to expire in October, a 60-day notice was not provided by HHS, and it is expected that the PHE will be extended beyond October. Medi-Cal has released new guidance to counties on processes for the end of the COVID Public Health Emergency, including ACWDL 22-18 (case processing actions post-PHE), and MEDIL 22-28 (post-PHE renewal flowcharts).

Inflation Reduction Act Signed into Law

The Inflation Reduction Act of 2022 (IRA), passed by Congress mid-August, included sweeping Medicare prescription drug reforms and changes to the Part D program to protect people with Medicare from high out-of-pocket costs. This legislation includes historic Medicare prescription drug reforms that will save older adults money, cap their out-of-pocket costs, and expand eligibility for the full Part D low-income subsidy. Justice In Aging’s new fact sheet provides a summary of the IRA’s health provisions that will bring cost savings to low-income older adults: How the Medicare Prescription Drug Reforms in the Inflation Reduction Act Help Low-Income Older Adults.

CANHR

Consumer Education Resources

CANHR publishes fact sheets on a wide range of topics important to long term care consumers. Below are some of the new fact sheets, including new translations.

California Medi-Cal Asset Limit Changes

English  Spanish

Nursing Home Discharge Rights

English  Spanish  Chinese  Korean

RCFEs: Eviction Protections for

English  Spanish  Vietnamese  Japanese  Korean

This fact sheet offers information on the rights of residents of RCFEs or Assisted Living facilities related to evictions or facility closures.

Please see CANHR’s website for additional fact sheets

http://canhr.org/factsheets/index.html
End of Life Options in California Long Term Care Facilities

California’s End of Life Options Act (“EOLA”; Health and Safety Code Section 443 et. seq.) allows terminally ill adult Californians to request and receive medication that assists them in dying. The Act includes a number of rules designed to ensure the adult/patient understands what they are doing and is not motivated to end their life because of depression or undue influence. The law is written in a way that requires the patient to have a fair amount of capacity - they must be able to engage with physicians, self-administer the medication, and account for obtaining and storing the medication. Terminally ill patients who wish to end their lives may not have sufficient capacity to end their own lives without some help from others.

Residents of long term care facilities who wish to utilize the EOLA face unique challenges and, in some cases, hostility from facility staff and facility policies. Residents rely on staff for at least some of their daily needs such as eating, grooming, toileting, and storing and taking medications. Terminally ill residents are likely to be even more dependent on staff assistance than other residents. So, what are residents’ rights regarding end of life options?

Like all adult Californians suffering a terminal illness (defined as an incurable and irreversible disease that will, within reasonable medical judgment, result in death within six months), residents of long term care facilities have the right to end their life if they can satisfy the procedural requirements of the EOLA. The 2021 EOLA data report shows that 61 (2.5%) of the 2,422 reported EOLA deaths since 2016 occurred in nursing homes and 106 (4.4%) occurred in assisted living facilities. Long term care facility residents are free to utilize whatever treatments they want, take whatever medications they want, or refuse treatments that are proposed. Facility staff may not interfere with a resident’s right to self-administer aid-in-dying medication obtained via the EOLA.

The EOLA permits care providers to refuse to “participate” in the EOLA, the definition of which includes obtaining, dispensing, or delivering the aid-in-dying medication and “being present” when the medication is ingested (patients are counseled to have another person present when they ingest). This means residents may have to rely on family or friends to obtain and deliver aid-in-dying medication or store it if the resident wants to wait. Nursing home residents have the right to store their own medications but the right is contingent on the nursing home staff determining that self storage is clinically appropriate (42 CFR Sec. 483.10(c) (7)). Assisted living residents also have a right to store their medications but facilities can require they be turned over to staff for central storage if the medications are determined to be a “safety hazard.” (22 Cal. Code Regs. Sec. 87465(h))

Health care providers (nursing homes, but not assisted living facilities) may not refuse to provide information about EOLA to residents, and those that refuse to participate in EOLA must inform residents that they do not participate in the End of Life Option Act.

The bottom line is that long term care facility residents have the right to participate in the EOLA process and facility staff may not interfere with the exercise of those rights. But while facility staff may not withhold information about the EOLA (at least in nursing homes because they are health care providers), they can refuse to facilitate the EOLA process by refusing to obtain, store, or deliver the aid-in-dying medication or by refusing to be present when the resident ingests the medication. Hopefully, residents who wish to use the EOLA will be supported by staff, but they may ultimately have to rely on the assistance of friends and family to fulfill their end-of-life wishes.

While long term care facilities may not prohibit residents from exercising their EOLA rights, they may refuse to provide any assistance with the exercise of those rights.
Dear Advocate:

My mom recently passed away in a nursing home, and she left an outstanding balance. She didn’t own a home and only had about $2,000 in her bank account when she passed, nothing else. The financial director of the nursing home insists that we must pay the balance on her behalf because we are her family. Are we responsible for her debt to the nursing home?

Sincerely,

Frustrated in Fresno

Dear Frustrated,

Only the resident is responsible for paying any nursing home bills, not their family or friends unless they are the resident’s court-appointed conservator or someone who has who has legal access to a resident’s available income or resources, e.g., an agent under their power of attorney who is responsible for paying the share of cost out of the resident’s income. In that case, they are responsible for the share of cost payments if the resident has the funds.. Even if you signed the admissions agreement as her responsible party or representative, the Standard Admissions Agreement states that a “Resident’s Representative does not, in and of itself, make the Resident’s Representative liable for the Resident’s debts...” In addition, Federal and state laws prohibit a nursing home from requiring a third party to guarantee payment as a condition of a resident’s admission, expedited admission, or continued stay in the facility. (See also the article on illegal nursing home debt collection practices in this issue’s Long Term Care News.)

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… Dogs may be allowed in nursing homes to help residents?

Under the Americans with Disabilities Act (ADA), nursing homes must allow service animals into the facility. Service animals may help people with various disabilities ranging from epilepsy to Post Traumatic Stress Disorder, and may offer support for people who are deaf or blind. When people become residents of nursing homes, they do not have to give up their service animal, as a service animal is not considered a pet. Service animals, such as dogs, are trained to provide aid directly related to the person’s disability.

Additionally, some nursing homes may also partner with local shelters for animal visits as a form of emotional support. These types of visits can often help to uplift residents’ moods and provide social interaction. They can also be beneficial to residents’ mental health which may, in turn, improve their physical health.

Nursing homes may have their own pet policies within the facility. If some nursing homes happen to allow residents to have pets or have animals visit the facility that are not emotional support animals, there may be liability risks. However, this is up to the discretion of the individual facility to decide if it is a risk they are willing to take.

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
Refusing to Go - Hospital Discharges as Health Care Decisions

For years, CANHR has received calls and emails from harried hospital patients or their loved ones, desperate for information about slowing down a rushed or irresponsible hospital discharge. While CANHR’s expertise relates to long term care facilities, not acute care hospitals, we have a fact sheet for challenging hospital decisions and we provide information to patients and their families about their rights related to discharges. Patients often have more leverage regarding discharges than they are led to believe by hospital staff, particularly when discharges are properly regarded as health care decisions requiring patient consent.

When hospitals contemplate a patient’s discharge, the patient is often far from recovered. They may need significant care that either must be provided in the hospital, a long term care facility, or at home with in-home care providers. The discharge plan is often incomplete or risky; e.g. sending a patient home with no care providers available or to a facility with a poor track record or one with an insufficient level of care. An unsound discharge plan leaves a patient at risk for setbacks, harm, or death.

Why Hospitals Rush Patient Discharges

Hospitals are often in a rush to discharge patients for one reason - money. Medicare and other health care insurers pay hospitals a predetermined amount based on the patient’s diagnosis, not the intensity or length of the actual service provided. This is known as the prospective payment system (PPS). Prior to PPS, hospitals were paid a per day rate for patient care. As one would expect, when hospitals no longer were paid by the day, the average length of stay for hospital patients plummeted. In the case of Medicare, the average length of stay has dropped from 17 days to 4 days since the installment of PPS in the 1980’s. This massive drop is at least partially attributable to the fact that patient discharge decisions are driven as much by payment as they are by patients’ health care needs.

If a Medicare-covered patient is admitted to a hospital, the hospital will be paid one lump-sum to provide care. The amount varies by condition. Each day that a patient remains in the hospital taking up a bed, the hospital is losing an opportunity to make more money by admitting a new patient. Rapid patient turnover is a primary way for hospitals to maximize revenue. Patient turnover requires discharges, lots of discharges.

Why Bad Discharges Are Such a Worry

Since hospitals provide such an intense level of care, moving from a hospital is almost always accompanied by elimination of important health care services - less nurse and physician monitoring and often less assistance with activities of daily living. Moving from a hospital, where highly trained staff are at your beck and call, to a lower staffed facility or to a home with few or no caregivers, is a radical shift. Moving to a lower level of care calls for planning, deliberation, and sensitivity from hospital staff but is often marked by impatience, pressure, and missed opportunities.

How Hospitals Push Patients Out

Hospitals use a number of tactics to force patients out before they are comfortable leaving or have a safe plan in place. Most of the tactics are successful because patients or their representatives erroneously feel the discharge decision is the hospital’s to make. Some of the more rotten pressure tactics include:

- Threatening to call Adult Protective Services (APS) and report the patient as having been abandoned. (The counter to this is easy: tell the hospital staff you will dial the APS number for them so you can report the hospital is trying to dump a patient with an insufficient plan for their safety.)

[continued on next page]
Discharging from a hospital is inarguably a health care decision because the patient is inevitably going to receive less care. Additionally, the patient is going to have a whole new set of caregivers or no caregivers at all. Not a single nurse or doctor from the hospital is going to follow the patient to their next setting. From a health care standpoint, leaving a hospital is a big deal and big deals require a patient’s consent. So, if a patient is uncomfortable with a proposed discharge, they are free to withhold consent and refuse to go.

Fighting Against a Bad Discharge

The best way to fight a bad hospital discharge is to tell the hospital staff, in writing, what the patient’s criteria are for a good discharge. Patients can be picky and be demanding. They may not get exactly what they want in terms of placement or services, but they have every right to insist the discharge is adequate and reasonably safe. By putting their criteria in writing, patients can re-frame the discharge as a health care decision and force the hospital to ensure the patient’s health is set to be protected even after they’ve left the building.

While patients cannot stay in hospitals indefinitely, there are laws meant to ensure discharges are safe and appropriate. Discharges are health care decisions and hospitals should be reminded that patients have the final say regarding health care decisions.

For further information on challenging hospital discharge decision please see the relevant CANHR Fact Sheet (pdf).
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 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:** Enrolled and presented to the Governor

**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:** Vetoed by the Governor

**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:** DEAD

**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:** DEAD

**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:** Enrolled and presented to the Governor

**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:** Enrolled and presented to the Governor

**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. Held under submission.
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: Enrolled and presented to the Governor

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: Chaptered by Secretary of State - Chapter 157, 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: Enrolled and presented to the Governor

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: Enrolled and presented to the Governor

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: Enrolled and presented to the Governor

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: DEAD

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: Enrolled and presented to the Governor

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: DEAD

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: Vetoed by Governor

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: Signed into Law

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: Chaptered by Secretary of State - Chapter 73, Statutes of 2022.

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: DEAD

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: Enrolled and presented to the Governor
Using the Board & Care Deduction to Reduce or Eliminate Share of Cost

Medi-Cal share of cost may be too high for many low to middle income residents of Assisted Living facilities. A special “Board and Care Deduction,” may help reduce or eliminate their share of cost.

Residential Care Facilities for the Elderly (RCFEs), sometimes called Assisted Living, or Board and Care, are not licensed as medical facilities, and are usually paid privately as they are not funded by Medicare or Medi-Cal. Many individuals who live in RCFEs could benefit from Medi-Cal to pay for doctors’ visits, copays, medical equipment, or medications, but they might be stuck with a large share of cost if they make more than the income limit for no cost Medi-Cal.

While persons on SSI/SSP or who make less than 138% of the federal poverty level are eligible for Medi-Cal benefits at no cost, an individual making more than the limit would normally have to pay a large share of cost, leaving them only about $600 for their living expenses. RCFE residents may be able to use the Board and Care Deduction to help them qualify for no or low share of cost Medi-Cal.

Typically, a person living at home who makes more than the income limit for Aged & Disabled Medi-Cal could be eligible, but with a large share of cost, leaving only $600 allocated as a “maintenance need” for their monthly living expenses. For example, a person who makes $2,000, may have a share of cost of $1,400. However, if the individual lives in an RCFE, any income above their monthly maintenance need is considered “unavailable” if the income is paid to the facility for care and support.\(^1\) The result is that resident might be able to reduce or eliminate their share of cost when all of their income is being used to meet RCFE living expenses.

For example, an RCFE resident with monthly income of $2,500 who pays the facility $2,500 per month would have no share of cost because any income above the $600 monthly maintenance need level would be considered unavailable. Since the facility charge is $2,500 per month, the resident’s income of $1,900 above the maintenance need level is considered unavailable. If the resident paid less than their income to the facility, they would likely have a share of cost.

Can the B&C Deduction be Used with the Assisted Living Waiver Program?

It may be possible for someone to use the B&C Deduction to eliminate their share of cost, and apply for the Assisted Living Waiver Program, which helps low-income Medi-Cal beneficiaries by paying for care and services in RCFEs. This small pilot program is only available for eligible beneficiaries without a share of cost in limited counties.

If selected for the ALW, costs on the program could be significantly lower due to a fixed board and care rate, meaning people would have less excess board and care costs with which to reduce their share of cost. This may mean that they would end up once again with a share of cost, forcing them off of ALW. It would be important for individuals to take a look at their specific income and expenses before applying for ALW, as the numbers may not work for everyone.

While some people may be able to use the B&C Deduction to receive Medi-Cal without a share of cost, they may have income too high to be able to benefit from the ALW program. Medi-Cal can still be very helpful, paying for uncovered medical expenses, Medicare health and drug insurance premiums, and services that may prevent premature placement in a skilled nursing facility.

\(^1\)(California Code of Regulations, Title 22 Section 50515(a)(3))
• 6/21/2022: Senior Staff Attorney Tony Chicotel and Advocacy & Lawyer Referral Service Specialist Bea Layugan presented to Legal Assistance for Seniors on incapacity, surrogacy, decision-making, and health care directives.

• 06/30/2022: Director of Organizational Development Maura Gibney presented to Kaiser Social Workers on Medi-Cal Eligibility and Medi-Cal Recovery.

• 07/06/2022: Bea Layugan joined Tiffany Huyenh-Chu from Justice In Aging for a Zoom presentation to consumers and advocates about asset limit changes, Olmstead, and the Americans with Disabilities Act.

• 07/07/2022: Bea Layugan presented to a group of Social Workers from the Jewish Family Services of Oakland on Medi-Cal Eligibility and Spousal Impoverishment.

• 7/12/2022: Policy Advocate Jaclyn Flores and Staff Attorney John Hafner provided a presentation to the PG&E Legacy Group on Nursing Home Residents’ Rights.

• 7/12/2022: Executive Director Pat McGinnis spoke to the San Francisco Gray Panthers about the potential closing of Laguna Honda Hospital and residents’ rights.

• 7/13/2022: Tony Chicotel held a Zoom Consumer Town Hall with Disability Rights California, Bay Area Legal Aid, and Legal Assistance to the Elderly about eviction protection and the current state of Laguna Honda Hospital.

• 7/18/2022: Tony Chicotel participated in a panel discussion of the Laguna Honda closure on the radio program “KQED Forum.”

• 7/20/2022: Jaclyn Flores and John Hafner presented to the Santa Clara Office of Public Administrator Guardian & Conservator on RCFE, SNF, and hospital Residents’ Rights, including transfer/discharge & eviction protections.

• 7/20/2022: Deputy Director Pauline Shatara delivered a Zoom presentation to Kaiser Social Workers on Medi-Cal updates and Recovery issues.

• 7/25/2022: Program Coordinator/Long Term Care Advocate Efrain Gutierrez presented to consumers of the Davis Senior Center on CANHR services.

• 7/26/2022: John Hafner partnered with WellConnected to present a nationwide Zoom presentation regarding financial abuse, elder abuse, and patient rights.

• 7/28/2022: Bea Layugan partnered with Bay Area Healthcare Advocates to present on Medi-Cal eligibility, Spousal Impoverishment, and transfer discharge rights.

• 8/9/2022: Jaclyn Flores presented to Orange County’s FAST program on nursing home residents’ rights, transfer/discharge rights, and rights surrounding transitioning from Medicare to Medi-Cal coverage in nursing homes.

• 9/7/2022: Tony Chicotel was a featured guest on the “Your Legal Rights” program on KALW, speaking about important elements of long term care, from paying for care to ensuring good care is provided in facilities.

• 9/13/2022: John Hafner and Efrain Gutierrez participated in a statewide consumer Town Hall with Jennifer Pardini from Legal Assistance for Seniors on Protecting Senior Home Equity.

• 9/15/2022: Maura Gibney presented to Cedar Sinai Social Workers on HCBS programs, Spousal Impoverishment, and Medi-Cal Eligibility.

• 9/21/2022: Maura Gibney and Bea Layugan presented to CANHR’s Social Worker Advocacy Program members on home and community-based services, Spousal Impoverishment, and Medi-Cal Eligibility.
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 MEMORY OF

<table>
<thead>
<tr>
<th>My Mother</th>
<th>Yong Cha Pak</th>
<th>Amparo Garcia</th>
<th>Celia Christian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shizu Kawai</td>
<td>Sun Yong (“Sunny”) Pak</td>
<td>Paul Meyers</td>
<td>Lydia Gugich</td>
</tr>
<tr>
<td>Patti Medlin</td>
<td>Bill Taylor</td>
<td>Tim Millar</td>
<td>Kevin Kane</td>
</tr>
<tr>
<td>Michael Medlin</td>
<td>CANHR Staff</td>
<td>CANHR Staff</td>
<td>CANHR Staff</td>
</tr>
</tbody>
</table>

Tim Millar – our colleague, our friend and our brother, who died on October 28, 2016. A certified financial planner and owner of Millar Financial, Tim was a part of the CANHR family for over 25 years.
The following citation summaries are compiled from the citations issued by the California Department of Public Health to Northern California skilled nursing facilities and received by CANHR as of the publication of this issue of the Advocate. CANHR makes every effort to ensure that consumers are provided with accurate information. CANHR welcomes comments and suggestions or notice of errors. Please direct such comments to frontdesk@canhr.org or by calling the CANHR office at (800) 474-1116. Citations without summaries will be reprinted with summaries once received by the CANHR office. Citations from earlier months are included if a description was not printed in a previous issue. Appeals of citations and collection of fines can take up to three years.

Explanation of citation classifications: Class “AA” citations are issued for violations that are a substantial factor in the death of a resident and carry fines of up to $120,000. Class “A” citations are issued when violations present imminent danger to a resident or the substantial probability of death or serious harm, and carry fines of up to $25,000, except in cases involving the death of a resident, when the Class “A” penalty can be up to $60,000. Class “B” citations carry fines of up to $3,000 for violations that have a direct or immediate relationship to a resident’s health, safety, or security, but do not qualify as Class “A” or “AA” citations. “Willful material falsification” (WMF) and “willful material omission” (WMO) citations carry fines of up to $25,000. Fines are not always required to be paid. Citations can be appealed. Violations repeated within twelve months may be issued “trebled fines”—triple the normal amount.

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Colusa County

**COLUSA MEDICAL CENTER - SNF**
199 E Webster St, Colusa

**Careplan; Neglect; Patient Care; 10/5/21**
The facility was cited for deficient practices regarding the care for two residents who had urinary catheters, including failure to develop an adequate careplan or prevent urinary tract infections (UTIs). For one resident, the facility failed to document urinary output and inform the resident’s physician of a change in condition, leading to a six-day delay in treating the resident’s UTI.

Citation #020017184

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Santa Clara County

**THE VILLAS AT SARATOGA SKILLED NURSING AND ASSISTED LIVING**
20400 Saratoga Los Gatos Rd, Saratoga

**B $2000 Patient Rights; Physical Restraints 11/5/21**
The facility was cited for failure to implement a fall prevention plan for a resident with dementia and a history of falls. As a result, the resident fell from his bed to the floor, suffering a cut to his face and a broken hip.

Citation #070017078

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Contra Costa County

**STONEBROOK HEALTHCARE CENTER**
44367 Concord Boulevard, Concord

**B $2000 Careplan; Fall 12/13/21**
The facility was cited for failure to implement a fall prevention plan for a resident with dementia and a history of falls. As a result, the resident fell from his bed to the floor, suffering a cut to his face and a broken hip.

Citation #020017184

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**VASONA CREEK HEALTHCARE CENTER**
16412 Los Gatos Blvd, Los Gatos

**B $2000 Bed Hold; Evictions; Patient Rights 6/7/22**
On 3/23/22, the facility transferred a resident to a hospital under an involuntary psychiatric hold and refused to readmit the resident after the hold was lifted the following day. The resident’s representative asserted the resident’s right to readmission, filed an appeal and obtained a decision ordering the resident’s immediate readmission. On 4/23/22, a month after he was hospitalized, the resident was readmitted. The facility was cited for violating his readmission rights.

Citation #070017692
Sonoma County

**Broadway Villa Post Acute**
1250 Broadway, Sonoma

**Careplan: Fall 10/18/21**
The facility failed to update the careplan or implement a fall prevention plan for a resident diagnosed with Parkinson’s Disease, legal blindness, who had a history of falling. The resident, who upon admission required very little assistance with ambulation, was observed by multiple staff as demonstrating a decline in balance and mobility. Although staff made notes in the resident’s clinical record about the change in status, which included a decline in balance and an increased risk of falls, the resident careplan was not revised to meet the resident’s need for fall prevention. As a result, the resident fell, and was found by staff on the floor in front of her bed, unconscious, with blood coming out from her head, requiring care in intensive care for an intracranial hemorrhage.

QCor Federal Deficiency

Tulare County

**Redwood Springs Healthcare Center**
1925 E Houston Ave, Visalia

**A $20000 Fall 12/13/21**
The facility failed to provide supervision for a resident diagnosed with dementia, who was allowed to go outside on a patio in his wheelchair without staff or an attendant. The resident fell, and was found lying on the floor, suffering from a head injury and facial trauma.

Citation # 120017103
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------------- Kern County -------------

KINGSTON HEALTHCARE CENTER, LLC
329 Real Rd, Bakersfield

B $3000 Patient Rights; Transfer 3/1/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility failed to conduct a required medical assessment prior to transferring a 64 year old resident who was diagnosed with multiple mental health disorders to another facility. Her physician did not make any recommendations on counseling or follow-up visits to prevent or minimize potential adverse health consequences. 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.” The facility issued the resident a notice of proposed transfer and discharge on 2/8/22, the same day of her transfer. The 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 # 120017385

B $3000 Patient Rights; Transfer 2/23/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, 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 to experience emotional trauma due to leaving her home and friends.

Citation # 120017380

B $3000 Patient Rights; Transfer 2/24/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility failed to conduct a required medical assessment prior to transferring an 80 year old resident who had dementia and multiple other health disorders 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 to experience emotional trauma due to leaving her home and friends.

Citation # 120017390
B $3000 Patient Rights; Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility failed to conduct a required medical assessment prior to transferring a 76 year old resident to another facility on 2/8/22. The resident’s diagnoses included fainting and collapse, kidney disease, history of heart attack, high blood sugar, high blood pressure, seizures, a history of falls and digestive disorder. 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 to experience emotional trauma due to leaving her home and friends. Citation # 120017404

B $3000 Patient Rights; Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility failed to conduct a required medical assessment prior to transferring an 81 year old resident to another facility on 2/9/22. The resident’s diagnoses included dementia, respiratory disease, seizures, high blood pressure and chronic pain. His physician did not make any recommendations on counseling or follow-up visits to reduce stress prior to his 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 to experience emotional trauma due to leaving his home and friends. Citation # 120017406

B $3000 Patient Rights; Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility failed to conduct a required medical assessment prior to transferring a 59 year old resident before he was transferred to another facility on 2/8/22. His diagnoses included dizziness, difficulty with walking, high blood pressure, heart disease, depression, history of alcoholism, joint pain and difficulty with breathing. 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. Her Social Service Coordinator orientation checklist was blank, but it had signatures of both the assistant and the administrator. 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 to experience emotional trauma due to leaving his home and friends. Citation # 120017418

B $3000 Patient Rights; Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility failed to conduct a required medical assessment prior to transferring a 93 year old resident to another facility on 2/3/22. The resident’s diagnoses included spinal injury, heart and kidney disease, anxiety and a history of falling. 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 to experience emotional trauma due to leaving her home and friends. Citation # 120017401

B $3000 Patient Rights; Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility failed to conduct a required medical assessment prior to transferring a 81 year old resident to another facility on 2/9/22. His diagnoses included fainting and collapse, kidney disease, history of heart attack, high blood sugar, high blood pressure, seizures, a history of falls and digestive disorder. 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 to experience emotional trauma due to leaving her home and friends. Citation # 120017430
B $3000 Patient Rights; Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility failed to conduct a required medical assessment prior to transferring a 76 year old resident to another facility. The resident’s diagnoses included diabetes, hypertension, major depressive disorder, generalized anxiety disorder, muscle weakness and acquired absence of left and right leg below knee. His physician did not make any recommendations on counseling or follow-up visits to reduce stress prior to his 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 to experience emotional trauma due to leaving his home and friends.
Citation # 120017445

B $3000 Patient Rights; Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility failed to conduct a required medical assessment prior to transferring a 73 year old resident to another facility on 2/7/22. The resident’s diagnoses included respiratory disease, muscle disease and weakness, chronic pain, high blood pressure and wound care. His physician did not make any recommendations on counseling or follow-up visits to reduce stress prior to his 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 to experience emotional trauma due to leaving his home and friends.
Citation # 120017405

B $3000 Patient Rights; Transfer 2/24/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility failed to conduct a required medical assessment prior to transferring an 80 year old resident who had dementia to another facility. His physician did not make any recommendations on counseling or follow-up visits to reduce stress prior to his 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 to experience emotional trauma due to leaving his home and friends.
Citation # 120017384

B $3000 Patient Rights; Transfer 2/24/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility transferred a 70 year old resident to another facility without providing her a written notice of her transfer rights. The resident said “no one from the facility talked to me about the transfer.” She learned of the transfer from the admission coordinator of the facility she was transferred to on 2/2/22. The facility failed to provide the resident written notice at least 60 days in advance of the transfer, failed to inform the resident of available alternative facilities that were adequate to meet resident needs and failed to provide notice on resident and family rights.
Citation # 120017378

B $3000 Patient Rights; Transfer 2/28/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, a licensed clinical social worker did not conduct a required psychosocial assessment of a 66 year old resident before he was transferred to another facility on 2/7/22. The resident had multiple health impairments and diagnoses of depression, bipolar disorder and schizophrenia. 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. Her Social Service Coordinator orientation checklist was blank, but it had signatures of both the assistant and the administrator. 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 to experience emotional trauma due to leaving his home and friends.
Citation # 120017409
B $3000 Patient Rights; Transfer 2/28/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, a licensed clinical social worker did not conduct a required psychosocial assessment of an 85 year old resident before she was transferred to another facility on 2/5/22. The resident was bedbound and had diagnoses of dementia, end-of-life care, wound care and joint pain. 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. Her Social Service Coordinator orientation checklist was blank, but it had signatures of both the assistant and the administrator. 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 to experience emotional trauma due to leaving her home and friends.
Citation # 120017414

B $3000 Patient Rights; Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, a licensed clinical social worker did not conduct a required psychosocial assessment of a 60 year old resident before he was transferred to another facility on 2/8/22. The resident required extensive personal care and his diagnoses included diabetes, morbid obesity, altered mental status, high blood pressure, sepsis and cellulitis. 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. Her Social Service Coordinator orientation checklist was blank, but it had signatures of both the assistant and the administrator. 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 to experience emotional trauma due to leaving her home and friends.
Citation # 120017413

A $25000 Patient Rights; Transfer 3/11/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility failed to comply with notice requirements before transferring a 78 year old resident who had dementia and Parkinson Disease to another facility on 2/7/22 without providing written notice to the resident’s responsible party at least 60 days in advance and without informing the resident’s representative of available alternative facilities that were adequate to meet resident needs and rights. An untrained social services assistant at the facility had the resident sign transfer paperwork despite the resident’s lack of capacity to do so due to severe cognitive impairment. The resident’s family was not notified before the transfer, did not give consent for it to take place, did not know of the transfer until after it had taken place and objected to the transfer. The resident was returned to the facility. This violation presented either imminent danger or a substantial probability that death or serious harm would result.
Citation # 120017441

B $3000 Patient Rights; Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, a licensed clinical social worker did not conduct a required psychosocial assessment of a 90 year old resident before she was transferred to another facility on 2/2/22. Her diagnoses included chronic kidney disease, depression and chronic pain. 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. Her Social Service Coordinator orientation checklist was blank, but it had signatures of both the assistant and the administrator. The facility’s failure to conduct the required psychosocial assessment by a licensed clinical social worker 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 # 120017443
B $3000 Patient Rights; Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, a licensed clinical social worker did not conduct a required psychosocial assessment of a 93 year old resident before she was transferred to another facility on 2/3/22. The resident’s diagnoses included spinal injury, heart and kidney disease, anxiety and a history of falling. She required anti-anxiety medication routinely every day. 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. Her Social Service Coordinator orientation checklist was blank, but it had signatures of both the assistant and the administrator. 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 to experience emotional trauma due to leaving her home and friends. 
Citation # 120017416

B $3000 Patient Rights; Transfer 2/28/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, a licensed clinical social worker did not conduct a required psychosocial assessment of a 73 year old resident before he was transferred to another facility on 2/7/22. The resident’s diagnoses included respiratory disease, muscle disease and weakness, chronic pain, and high blood pressure. 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. Her Social Service Coordinator orientation checklist was blank, but it had signatures of both the assistant and the administrator. 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 to experience emotional trauma due to leaving his home and friends.
Citation # 120017412

B $3000 Patient Rights; Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility failed to conduct a required medical assessment prior to transferring an 86 year old resident to another facility on 2/8/22. The bed bound resident was oxygen dependent, had severely impaired cognition and a medical history of bone disease, muscle weakness, and a history of infections. 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 to experience emotional trauma due to leaving her home and friends.
Citation # 120017402

B $3000 Patient Rights; Transfer 2/28/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility failed to conduct a required medical assessment prior to transferring a 78 year old resident who had dementia and other health disorders to another facility. His physician did not make any recommendations on counseling or follow-up visits to reduce stress prior to his 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 to experience emotional trauma due to leaving his home and friends.
Citation # 120017391

B $3000 Patient Rights; Transfer 2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility failed to conduct a required medical assessment prior to transferring an 80 year old resident to another facility on 2/7/22. The resident had severely impaired cognition and diagnoses including kidney disease, digestive disorder and schizophrenia. 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 to experience emotional trauma due to leaving her home and friends.
Citation # 120017407
A $25000 Patient Rights; Transfer; Discharge 3/15/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility failed to comply with notice and other requirements before transferring a 64 year old resident who had multiple health and mental health disorders to another facility on 2/8/22. An untrained social services assistant at the facility had the resident sign transfer paperwork despite the resident’s severe cognitive impairment. The resident did not have a representative to manage health affairs, however, the facility failed to submit an application for a public guardianship on her behalf in accordance with California requirements. The receiving facility expressed concern that the resident “was not what the facility expected;” it held an ethics committee meeting, determined the resident needed conservatorship and began the process of obtaining it. The facility’s notice to residents regarding its closure did not inform them the residents had the right to remain in the facility for 60 days following the notice. The facility was cited for failing to comply with notice requirements before transferring the resident, failing to timely apply for a public guardianship for her, and not inviting a resident advocate to the Interdisciplinary Team meeting to discuss the resident’s pending discharge. This violation presented either imminent danger or a substantial probability that death or serious harm would result from an unsafe transfer.

Citation # 120017467

B $3000 Patient Rights; Transfer 2/23/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, a licensed clinical social worker did not conduct a required psychosocial assessment of a 68 year old resident before she was transferred to another facility on 2/4/22. The resident had diagnoses of depressed mood, heart failure and high blood pressure. 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. Her Social Service Coordinator orientation checklist was blank, but it had signatures of both the assistant and the administrator. 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 to experience emotional trauma due to leaving her home and friends.

Citation # 120017374

B $3000 Patient Rights; Transfer 3/15/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility transferred a 95 year old resident who had dementia and a history of hip fracture to another facility on 2/3/22 without providing her a written notice of her transfer rights. The resident’s son stated he did not receive any call or letter from the facility before his mother was moved to a facility in Tulare that was 60 miles from Bakersfield. He said he was only called by the admitting facility, which pressured him by telling him the facility (Kingston) was closing and he would have no choice. The son added that his mother “is not a piece of luggage.” The facility failed to provide the resident written notice at least 60 days in advance of the transfer, failed to inform the resident of available alternative facilities that were adequate to meet resident needs and failed to provide notice on resident and family rights.

Citation # 120017379

B $3000 Patient Rights; Transfer 2/24/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility transferred an 87 year old resident to another facility. No physician assessment was conducted to assess and prevent adverse health consequences. 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 # 120017398

B $3000 Patient Rights; Transfer 3/1/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, a licensed clinical social worker did not conduct a required psychosocial assessment of a 76 year old resident before she was transferred to another facility on 2/3/22 without providing her a written notice of her transfer rights. The resident who had dementia and a history of hip fracture to another facility on 2/4/22. Her diagnoses included left-side paralysis and weakness following stroke, malnutrition and generalized muscle weakness. The facility’s failure to conduct the required psychosocial assessment 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 # 120017444
B  $3000  Patient Rights; Transfer;  2/28/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, a licensed clinical social worker did not conduct a required psychosocial assessment of a 52 year old resident before he was transferred to another facility on 2/9/22. The resident had diagnoses of heart disease, high blood pressure, respiratory disease, seizures, shortness of breath, digestive disorder, depression and serious mental disorders. 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. Her Social Service Coordinator orientation checklist was blank, but it had signatures of both the assistant and the administrator. 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 to experience emotional trauma due to leaving his home and friends.

Citation # 120017415

B  $3000  Patient Rights; Transfer;  2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, a licensed clinical social worker did not conduct a required psychosocial assessment of a 76 year old resident before she was transferred to another facility on 2/8/22. The resident had diagnoses of falls and digestive disorder. 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. Her Social Service Coordinator orientation checklist was blank, but it had signatures of both the assistant and the administrator. 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 to experience emotional trauma due to leaving her home and friends.

Citation # 120017410

B  $3000  Patient Rights; Transfer;  2/24/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, the facility failed to conduct a required medical assessment prior to transferring a 57 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 to experience emotional trauma due to leaving her home and friends.

Citation # 120017388

B  $3000  Patient Rights; Transfer;  2/25/22
During the pending closure of the facility due to the termination of its Medicare and Medi-Cal certification in February 2022, a licensed clinical social worker did not conduct a required psychosocial assessment of an 80 year old resident before she was transferred to another facility on 2/7/22. The resident had severely impaired cognition and diagnoses including kidney disease, digestive disorder and schizophrenia. 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. Her Social Service Coordinator orientation checklist was blank, but it had signatures of both the assistant and the administrator. 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 to experience emotional trauma due to leaving her home and friends.

Citation # 120017408
A S$25000 Elopement; Injury; Physical Environment
8/12/22
The facility failed to provide a safe environment for a resident by failing to ensure the resident’s window crank was in good working order. This failure resulted in the resident’s elopement (departing from health care facility unsupervised and undetected) through the bedroom window which caused facial bruising and a forehead laceration. This violation presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result.

Citation # 120017666

Los Angeles County

BEARCREST NURSING CENTER
5648 Gotham St, Bell Gardens

A S$25000 Dignity; Injuries; Patient Care; Patient Rights; Physical Restraints 8/2/22
A resident’s arm was entrapped between bed side rails and the bed frame, sustaining an upper arm fracture. It was determined that the following violations by the facility presented either imminent danger that death or serious harm would result: 1. The facility failed to implement its policy on the use of side rails by failing to assess the resident for risk of entrapment (an occurrence involving a resident who is caught, trapped or entangled in the hospital bed system), for proper use of side rails prior to applying the use of the side rails; 2. The facility failed to obtain a physician order, create a careplan and obtain consent from the resident prior to use of side rails, as required by the regulations and policies and procedures. 3. The facility failed to ensure side rail entrapment zones (any open space where an individual can become caught by their body part in the tight spaces around the bed rail or bedside mobility aid) were measured prior to installation and use.

Citation # 910017869

CLARA BALDWIN STOCKER HOME
527 S Valinda Ave, West Covina

B S$3000 Careplan; Medication; Death 6/9/22
A resident died after the facility failed to provide appropriate care and treatment for their diagnosis of hypertension. Staff did not properly follow up with the physician after the resident complained of burning during urination, or monitor and document blood pressure and pulse before administering a medication, as instructed by the physician. The resident was not properly assessed or monitored after their blood pressure dropped and they demonstrated an altered level of consciousness. The careplan was not revised to address the resident’s hypertension, hypotension and use of new medications. The resident was eventually transferred to the emergency room with severe sepsis and acute respiratory failure, and died of a heart attack with an identified underlying cause of sepsis caused by infection of the urinary tract.

Citation # 950017696

COMMUNITY CARE CENTER (DUARTE)
2335 Mountain Ave, Duarte

B S$2000 Sexual Abuse 1/7/22
A female resident reported on 4/12/21 that she had been raped by a male resident. The police investigated and allegedly determined that the sex between the residents was consensual. The male resident had a history of sexually inappropriate behavior in the facility. The facility was cited for failing to protect the resident from sexual abuse and failing to follow its policies to prohibit, prevent, and investigate allegations of sexual abuse.

Citation # 950017256
Covina Rehabilitation Center  
261 W Badillo St, Covina

B $3000  Mandated Reporting; Physical Abuse  
6/2/22
On 3/3/22 at about 1 am, a resident alleged that she was hit by a certified nursing assistant (CNA) and her right arm was broken. The facility was cited for failing to report the alleged abuse to the Department of Public Health within two hours as required and failing to protect the resident from the perpetrator by allowing the CNA to provide care to the resident after the resident made the physical abuse allegation against the CNA.

Citation # 950017690

Glendale Post Acute Center  
250 N Verdugo Rd, Glendale

B $2000  Medication; Patient Care 6/30/22
The facility failed to ensure that a resident with HIV was administered medications as ordered by the physician and appropriately documented in the medical record. As a result, the resident became at risk for developing life-threatening infections and complications.

Citation # 950017754

A $20000  Careplan; Medication; Patient Care  
6/30/22
Facility failed to ensure that a resident, with a diagnosis of HIV, received treatment and care in accordance with physician’s orders by failing to provide an infection disease physician and to administer proscribed HIV medications. As a result, the resident’s HIV treatment and care were delayed, affecting the residents wellbeing. These violations presented either imminent danger that death or serious physical harm would result.

Citation # 950017744

Griffith Park Healthcare Center  
201 Allen Ave, Glendale

B Careplan; Supervision 9/3/21
At least four different residents left the facility without supervision during a time period covering September 2020 to June 2021. At least one resident was found and had to be hospitalized while at least one other was never found. The facility was cited for failing to make and implement careplans to prevent residents from leaving unsupervised.

Citation # 950016890

Hawthorne Health & Wellness Centre, LP  
11630 Grevillea Ave, Hawthorne

B $3000  Mandated Reporting; Physical Abuse  
6/29/22
A 76 year old female resident reported that someone entered her room on 5/6/22 and punched her in the stomach. The resident told a family member of the abuse and the family member reported it to the facility. The facility was cited for failing to report the allegation of abuse to the state licensing agency within two hours as required.

Citation # 910017746

Huntington Drive Health and Rehabilitation Center  
400 W Huntington Dr, Arcadia

B $2500  Medication; Neglect; Patient Care; Staffing 3/24/22
The facility neglected 69 of 75 residents by failing to give them their scheduled medications during the months of January and February 2022. During the same period, nine of the residents were subjected to significant medication errors that put them at risk of adverse reactions, hospitalizations and death. A resident on hospice care who died at the facility on 2/1/22 did not receive numerous prescribed medications in January 2022, including opioid pain medications on some days before he died. On 1/31/22 and 2/7/22, 28 residents did not receive medications during the morning shift. Similar failures happened on other dates. Nurses stated the facility was understaffed, it sometimes did not have a licensed nurse for a nursing station and the facility’s Red Zone had not been staffed consistently since a Covid-19 outbreak on 1/22/22. One nurse stated the facility wrote her name in the staffing schedule on days she did not work. The Director of Nursing resigned on 1/23/22. The Medical Director stated he was not made aware that medications were not being provided or administered to multiple residents due to insufficient staff.

Citation # 950017521

A $20000  Infection; Neglect; Patient Care; Death 2/10/22
The facility failed to follow its own Covid-19 Mitigation Plan to protect the patients, staff and others. Also, the facility failed to implement its own procedures for testing and failed to conduct ongoing surveillance for compliance in infection control. As a result of these deficient practices, the facility yielded a total of 56 positive COVID-19 Patients, 26 positive COVID-19 facility staff and 10 Patient deaths (7 COVID-19 positive patients and 3 COVID-19 negative patients) during the facility’s COVID-19 outbreak from 11/30/20 to 1/28/21.

Citation # 950017330
INLAND VALLEY CARE AND REHABILITATION CENTER
250 W Artesia St, Pomona

A $20000 Careplan; Death 9/24/21
Facility staff failed to identify, address, or implement a prevention careplan for a resident with a tracheostomy and a history of pulling out their tracheostomy tube, and failed to prevent accidental extubation in accordance with the careplan. As a result, the resident was found lying on the floor unresponsive, with no pulse and no respiration and the resident’s tracheostomy tube was not in place. After transfer to the emergency room, and attempts at resuscitation, the resident died due to respiratory failure and anoxic encephalopathy.

Citation # 950016960

LONG BEACH CARE CENTER
2615 Grand Ave, Long Beach

B $2000 Patient Records; Transfer 7/1/22
As a result of the facility’s staff not documenting or addressing a resident’s sexual inappropriate behavior in the clinical records and discharge information, the receiving assisted living facility was not made aware of the resident’s behavior prior to accepting the resident. This non-compliance had the potential for the resident to perform inappropriate sexual acts and behaviors on residents in the facility and also resulting in the resident not receiving the appropriate care and services.

Citation # 910017760

MAYFLOWER GARDENS CONVALESCENT HOSPITAL
6705 Columbia Way, Lancaster

B $2000 Notification 12/23/21
During an unannounced recertification visit an investigator found that the facility failed to post its most recent Five-Star Quality Rating system in accordance with Centers of Medicare and Medicaid Services, as required.

Citation # 920017215

B $2000 Patient Care 12/23/21
The facility failed to provide physician-ordered range of motion exercises to multiple residents with limited mobility. Residents were not supported with walking, use of pedal bikes, or sit to stand exercises, usually prescribed to maintain or improve mobility, placing them at risk for further physical decline and joint pain.

Citation # 920017221

MOUNTAIN VIEW CONVALESCENT HOSPITAL
13333 Fenton Ave, Sylmar

B $3000 Mandated Reporting; Notification; Sexual Abuse 6/10/22
On 2/13/22, facility staff witnessed a resident inserting his finger in another resident’s vagina. The facility failed to implement its abuse reporting policy by: 1. Failing to complete a thorough investigation including submitting a written report of the investigative findings within five working days for an incident of alleged sexual abuse to the SSA for the abused resident and 2. Failing to report a sexual abuse allegation to the SSA, Ombudsman and local law enforcement agency for the abused resident. As a result, the abused resident was placed at risk for further abuse and feeling unprotected from the facility’s inaction of not conducting an immediate investigation and resulted in a delay of notifying the necessary agencies.

Citation # 920017701

B $3000 Neglect; Sexual Abuse 6/10/22
The facility failed to ensure a resident, who lacked the capacity to consent to sexual activities, was free from continued sexual abuse inflicted by another resident and was free from neglect by staff who did not protect her from further sexual abuse. On 2/13/22, facility staff found a resident inside the resident’s room inserting his fingers into her vagina and reported the abuse to additional staff. After the reported incident, facility staff continued to allow the resident to violate the resident. As a result, the resident was subjected to non-consensual sexual assault by another resident while under the care of the facility.

Citation # 920017703
**Montrose Healthcare Center**  
2123 Verdugo Blvd, Montrose

**B $2000 Neglect 3/2/22**
On 9/6/21, a 74 year old male resident with cirrhosis of the liver and other abdominal problems had to be sent to the emergency room to treat deep, bleeding lacerations on his forehead and the back of his head. He was sent back to the facility the same day with written instructions to the staff to report any new bleeding that lasted more than a few minutes. At 12 am on 9/7/21, the resident’s head bandages were found to be saturated with blood. Rather than report this change of condition to a physician, a nurse replaced the head bandages and did not call for help until over two hours later when the resident’s blood pressure dropped. The resident was again sent to the emergency room, received a blood transfusion and was admitted to the ICU. The resident died on 9/17/21. The facility was cited for failing to notify a physician of a resident’s change of condition.

Citation # 950017283

**Olive Vista Behavioral Healthcare Center**  
2335 S Towne Ave, Pomona

**A $25000 Careplan; Deterioration; Neglect; Notification; Patient Care; Patient Records; Staff (Inservice) Training; Death 5/6/22**
The facility failed to provide the necessary nursing services to a resident by failing to contact 911 and notify their primary care provider timely when the resident experienced shortness of breath, lethargy, refusal to eat four consecutive meals and refusal to get out of bed from 2/6/22 to 2/7/22. As a result, there was a delay in the delivery of the necessary care and services resulting in the immediate deterioration and subsequent death of the resident. These violations presented either 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 # 950017629

**Pacific Palms Healthcare**  
1020 Termino Ave, Long Beach

**A $16000 Careplan; Fall 12/3/21**
The facility failed to follow physician’s orders for a sitter to be bedside to prevent falls and injuries for a resident diagnosed with dementia and schizophrenia. The resident was not provided with adequate supervision and, as a result, fell out of bed, suffering a broken wrist which required surgery and a four-day hospital stay.

Citation # 910017149

**Riviera Healthcare Center**  
8203 Telegraph Rd, Pico Rivera

**B $2000 Mental Abuse; Patient Rights; Privacy 12/13/21**
A resident was sent to her dialysis treatment on 10/14/22 without any pants. She was crying upon her arrival to the dialysis center due to embarrassment. Upon investigation, it was learned the CNA who was assisting the resident could not find her pants, was in a hurry, and decided to send the resident to dialysis wearing only her blouse, incontinence brief and a blanket covering her legs. The resident was very upset about the incident and experienced anxiety and inability to sleep. The facility was cited for violating the resident’s right to be treated with dignity and respect.

Citation # 910017186

**Studio City Rehabilitation Center**  
11429 Ventura Blvd, Studio City

**B $2000 Mandated Reporting; Verbal Abuse 1/5/22**
During a facility survey, a resident explained that she had been verbally abused periodically by her roommate for four months. The resident’s roommate yelled at and called the resident bad names. The resident had complained of the verbal abuse but the staff did not report the abuse to the State or the long term care Ombudsman program as required by regulations. The facility was cited for failing to make a timely abuse report.

Citation # 920017249

**Sylmar Health and Rehabilitation Center**  
12220 Foothill Blvd, Sylmar

**B $2000 Physical Environment 12/7/21**
The facility installed water heaters and made alterations to the building’s plumbing system without being in substantial compliance from the Department of Healthcare Access and Information, the State agency that reviews and approves plans for construction and repairs, made to healthcare facilities. In addition, the facility failed to notify the Department of Public Health, within five days of the commencement of any construction or repairs, as required by law. These violations had a direct relationship to the health, safety, and security of all the residents living in the facility.

Citation # 920017160
**Sunnyside Nursing Center**  
22617 S Vermont Ave, Torrance

**Citation #** 910017776

**A $25000** Infection; Neglect; Patient Care 7/8/22  
The facility neglected a resident by failing to change a dressing on her left hip for over 30 days after admission from a hospital on 12/30/21 following hip surgery. Without ever having changed the dressing, the facility discharged her to an assisted living facility on 2/2/22, where the neglect was detected and documented. The administrator of the assisted living facility stated that Sunnyside Nursing Center sent the resident with a filthy, soiled, and saturated dressing on her left hip with an extremely foul odor. A home health nurse was summoned on the same date to assess the wound. The home health nurse thought she was going to vomit when she removed the dressing, stating the wound smelled like a “dead body.” She described the dressing as black in color on the inside and that it looked like there was an abscess around the wound. The facility did not report the sexual abuse allegation to CDPH and the Ombudsman until 4/20/22 and the incident was not reported to local law enforcement. As a result, the resident was placed at risk of further abuse and was not protected from abuse.

**Citation #** 920017750

**Citation #** 910017767

**West Covina Healthcare Center**  
850 S Sunkist Ave, West Covina

**B $2000** Medication 7/1/22  
The facility was cited for failing to implement interventions to prevent significant medication errors by failing to ensure a resident did not receive more than three grams of Acetaminophen per 24 hours, per her physician’s order. Medication records indicated that the facility exceeded the maximum dose prescribed by her physician on 27 days from November 2021 to May 2022. As a result, the resident was placed in increased risk of discomfort and adverse effects of high dose of Acetaminophen, such as liver damage.

**Citation #** 950017756

**Windsor Gardens Convalescent Center of Long Beach**  
3232 E Artesia Blvd, Long Beach

**B $2000** Physical Environment 12/3/21  
The facility had cockroaches and evidence of mice activity in its kitchen and food storage areas. Cockroaches were also noted in a resident’s bathroom. The facility was cited for failing to prevent and remedy cockroach infestation and failing to follow its pest control policies.

**Citation #** 910017150

**Windsor Terrace Healthcare Center**  
7447 Sepulveda Blvd, Van Nuys

**B $3000** Mandated Reporting; Notification; Sexual Abuse 7/1/22  
The facility failed to report to the California Department of Public Health, the local LTC Ombudsman Program, and the local law enforcement an allegation of abuse upon a resident perpetrated by another resident. The resident alleged on 4/17/22 (around 4 am) that when she was in bed sleeping, she woke up to find a male resident had entered her room and was touching her legs. The resident reported the incident to facility staff and attending physician. The facility did not report the sexual abuse allegation to CDPH and the Ombudsman until 4/20/22 and the incident was not reported to local law enforcement. As a result, the resident was placed at risk of further abuse and was not protected from abuse.

**Citation #** 920017750

**Citation #** 910017767

**Heathbridge Children’s Hospital**  
Orange D/P SNF  
393 S Tustin St, Orange

**B $2000** Patient Care 1/8/21  
From 8/8/20 through 11/13/20, the facility failed to ensure a careplan for a resident that needed assistance with their right hand. The residents nails would dig into the palm and cause an injury. The facility did not have a process and procedure for nail care and relied on the family members to cut the resident’s nails. These failures contributed to the resident’s right-hand wounds worsening, requiring surgical intervention at the acute care hospital. A CNA stated that something smelled as she walked into the room. When she tried to open the hand, it was wrinkly and the skin was coming off. When she washed her hand, she didn’t know if skin or dirt was coming off.

**Citation #** 060016229

**Citation #** 910017767

**Blythe Post Acute LLC**  
285 W Chanslor Way, Blythe

**A $10000** Careplan; Fall; Patient Care 7/5/22  
The facility failed to ensure the careplan was reviewed and revised to address the episodes of four falls by a resident. In addition, the facility failed to conduct post fall risk assessment after each fall, in accordance with facility policy and procedure. These failures resulted in the resident suffering a fifth fall causing fractures of the leg and back. These failures had a direct or immediate relation to the resident’s health, safety or security.

**Citation #** 250016302
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