Reflections:
I’m Retiring – But CANHR Continues to Thrive
By Pat McGinnis, JD

I’ve been the Executive Director of California Advocates for Nursing Home Reform (CANHR) for almost 40 years. Bay Area Advocates for Nursing Home Reform (BANHR) was incorporated in December 1983, approved as a Lawyer Referral Service in 1985 and went statewide to “CANHR” in 1990, establishing a statewide 800 toll-free hotline and becoming eligible by the State Bar as a legal services support center.

The goal of BANHR, as noted in the Articles of Incorporation, was simple: to improve the quality of care for nursing home and residential care residents through the provision of advocacy and educational services. Inspired by a Margaret Mead quote: “Never doubt that a small group of thoughtful committed individuals can change the world. In fact, it’s the only thing that ever has.” – we thought we could change the way long term care was provided; change the balance of power in Sacramento to allow consumers a voice; and change the quality of care. Indeed, we thought we could change the world of long-term care.

Corporate Chains

We didn’t change the world of long-term care, but the world of long-term care has changed radically. Most nursing homes are still primarily for-profit corporations and chains. Even today, few nursing homes in California offer decent care; too many are understaffed; and far too many still value profits over the care of the residents. In some ways, it was easier 30-40 years ago to keep track of the bad performers.

[continued on page 3]
Welcome New Staff

CANHR welcomes Alex Valdes, CANHR’s new Aging and Disability Advocate. Alex brings extensive experience in service coordination in the Bay Area, as well as long term care experience with the CARES system in Florida’s Area Agency on Aging. Welcome, Alex.

CANHR Factsheet for Medi-Cal Asset Limit Increases

California increased the asset limits for certain Medi-Cal programs. Beginning July 1, 2022, the state raised the Medi-Cal asset limit for a single individual to $130,000, $195,000 for a couple, and $65,000 for each additional family member. On January 1, 2024, the state is expected to eliminate the Medi-Cal asset limit completely. CANHR’s factsheet answers key questions about the effects of the new asset limits on current recipients and prospective applicants.

Leave a Legacy

Planned giving leaves a legacy to honor your memory 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 include gifts by will; gifts of life insurance or, by a revocable living trust or charitable remainder trust. If you would like more information on CANHR’s Planned Giving Program, please email maura@canhr.org to get more information and a free booklet on planned giving.

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.
Most of the big chains were public corporations whose corporate leaders, acquisitions, SEC filings and profit margins were public documents. Today, in efforts to garner even more profits and hide corporate liability, for profit chains create layers of limited liability corporations and are often funded by Real Estate Investment Trusts (REITs) that invest in income-producing properties. Today it’s more difficult to find out who truly owns individual nursing homes and who is in charge.

State Oversight

0 years ago, BANHR/CANHR was able to work with the leaders at the Department of Health Services and the Department of Social Services, often agreeing on legislation that would strengthen oversight and resident rights. The staff at Licensing & Certification and Community Care Licensing (CCL) saw their roles as guardians – as consumer protection agencies whose job was to enforce the federal (in the case of nursing homes) and state requirements pertaining to nursing homes and residential care facilities for the elderly (RCFEs) and to protect the residents. Over the past twenty years, numerous State Auditor reports have criticized the State’s failure to provide effective oversight of California’s nursing homes, to address substandard care issues and its failure to respond to complaints in a timely basis. One of several State Auditor’s reports on DSS, CCL’s monitoring of community care facilities noted that the continued weakness of CCL puts the health and safety of vulnerable residents at risk.

What has changed is that the Department of Public Health and the Department of Social Services have become provider-protection agencies – too often failing to investigate complaints; too often (75% -80% of the time) finding resident complaints “unsubstantiated;” and too often failing to fulfill their responsibilities as public oversight and consumer protection agencies.

Legislative Reform

Over the years, there have been multiple legislative hearings – at the state and federal level – on the problems with inadequate oversight of nursing homes and residential care facilities for the elderly (RCFEs). I’ve testified at many of them. In 1983, California’s Little Hoover Commission, under Chairperson Nathan Shapell, issued The Bureaucracy of Care, a detailed report on the problems in California’s nursing homes with recommendations for correction. Based on these recommendations, California’s then Lt. Governor Leo McCarthy, initiated the Nursing Home Patients Protection Act of 1984, which included a package of bills authored by Senator Henry Mello, and Assemblymembers Isenberg and Art Agnos – all of whom went on to author several more reform bills. We’ve had many heroes and heroines in the California legislature who’ve been willing to confront the powerful nursing home, residential care and financial services industries, and we need more.

Since 1984, CANHR has sponsored or co-sponsored most of the nursing home and residential care reform bills that have been signed into law – not to mention many Medi-Cal, elder abuse and elder financial abuse reform bills – at last count, there were over 100 new laws initiated by BANHR/ CANHR. Theft and loss laws, admission agreement protections for nursing home and residential care consumers, transfer and eviction protections, reverse mortgage requirements, family councils and Medi-Cal recovery reforms – to name a few. Indeed, because of these efforts, long term care residents and elders have more rights and the ability to assert these rights than ever before. We can be proud of this work, but clearly, there is more to do.

A Day Without CANHR

CANHR receives hundreds of email and phone requests for assistance every month. From illegal evictions and transfers from hospitals, nursing homes and RCFEs, to resident rights violations, to assistance with Medi-Cal denials because there is little training for the county Eligibility Workers, who aren’t familiar with current laws and policy.
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CANHR staff have had to become experts on multiple substantive areas. Many of the same and similar issues persist even with laws meant to prevent such violations. However, I take comfort in knowing that these consumers will get the assistance they need, and, without CANHR, they would be denied the services they so sorely need.

Laws are only worthwhile if they are enforced. We need to continue to hold the feet of DPH and DSS to the fire to do their jobs on oversight and enforcement. We need to continue to educate legislators, strengthen the rights of long-term care consumers, older adults and people with disabilities and give them the tools to self-advocate, since it is clear that the agencies established to protect them won’t do it.

I am proud of the work that CANHR has done, and I have been honored and blessed to be able to spend my career working with the best - - the best staff, the best elder law attorneys, the best advocates, including the friends and families of long-term care residents, legal services staff and long-term care ombudsman staff. And particularly blessed to be able to consider many of you as my friends.

Being an advocate and community organizer is not something that is listed in college or law school curricula, but to be able to spend your career doing work that you are passionate about is a gift. I’ve had that opportunity for the past 40 years, and I thank all of you for the privilege of joining me in this work. I will always be an “advocate,” and I will be around to offer advice and counsel as needed. But I look forward to a less intensive life – to visit friends and family and to learn a language other than Medi-Cal and EADACPA.

Meanwhile, CANHR will continue to be the voice of long-term care consumers and continue to advocate for those whose voices are rarely heard.
North Coast Journal Examines Nursing Home Spending Bill

The North Coast Journal, a newspaper that has done a fair amount of in-depth coverage of nursing home ownership and finance concerns, has an illuminating story on AB 1537 (Wood), a bill that would require a direct care spending requirement in California nursing homes. The bill would require that a minimum of 85% of a facility’s non-Medicare revenue be spent on direct care for residents.

American College of Physicians Calls for Better Visitation Access During Pandemics

A position paper from the American College of Physicians (ACP) finds that restrictive visitation policies during the COVID-19 pandemic went overboard, perhaps causing more suffering than they saved. The authors of the paper wrote:

Despite ameliorating the public health factors that initially justified visitor restrictions, many institutions continue to restrict or prohibit loved ones at the bedside, raising questions of whether restrictive visitation policies were/are supported by ethical principles and best available medical evidence.

While visitor restrictions aimed to achieve the critical societal goal of protecting public health, this aim was often allowed to override considerations of individual patient welfare and clinicians’ ethical duties to patients, calling into question whether the appropriate balance of community versus individual interests was being struck. Meanwhile, evidence demonstrating that visitor restrictions were necessary to reduce nosocomial SARS-CoV-2 transmission was lacking.

This finding comes at a time when the state’s taskforce on facility access is meeting in preparation to advise the Legislature on essential caregiver and other visitor access to long term care facilities during public health emergencies.

Attorney General Bonta Issues New Guidance To Protect Elder and Dependent Adults from Abuse

California Attorney General Rob Bonta released new guidance on the role and responsibilities of mandated reporters in safeguarding elders and dependent adults. In California, any person who is involved in the care of elder or dependent adults is a mandated reporter, including employees of long-term care facilities, health practitioners, and law enforcement professionals. The California Department of Justice (DOJ) has launched a newly revised curriculum and resources to train mandated reporters on identifying and reporting abuse and neglect of those under their care. The curriculum also provides tips and information on reporting instances of suspected or known abuse. To file a report, contact the Attorney General’s Division of Medi-Cal Fraud & Elder Abuse at (800) 722-0432 or online: https://oag.ca.gov/dmfea/reporting

CMS Did Not Accurately Report on Care Compare Deficiencies related to Heath, Safety, and Emergencies of Nursing Homes

Office of the Inspector General (OIG) reports that The Centers for Medicare Medicaid Services (CMS), a federal agency that administers Medicare and Medicaid/Medi-Cal, did not accurately report on Care Compare nursing homes’ deficiencies as related to the nursing homes health, fire safety, and emergency preparedness. Care Compare is an online website run by CMS to provide to consumers the nursing home’s quality ratings, results of recent inspections, staffing levels, specific quality-of-care measures, and characteristics such as COVID-19 vaccination rates of residents and staff, ownership information, and the number of resident beds, among other issues. OIG has informed CMS of their findings, and CMS made corrections to some of the inspection results reported on Care Compare; however, CMS has not responded to the inquiry by OIG about some of the causes of their findings.
UC San Francisco Professor Charlene Harrington Honored

The 2022-2023 Constantine Panunzio Distinguished Emeriti Award honoring Emeriti Professors in the University of California system has been awarded to Professor Emerita of Nursing Charlene Harrington, a longtime CANHR supporter and advocate for improving the quality of care in California’s long term care facilities. Awardees of the award have especially long and notable records of research, teaching, and service to the University of California, their disciplines, and their communities.

Dr. Harrington has maintained an exceptional level of scholarly productivity and service in the field of nursing home care. Throughout her career, she has been an energetic and expert advocate for nursing and long-term care facilities whose problems came dramatically and tragically to everyone’s attention during the COVID pandemic. Her efforts have focused on measures that directly improve the lives of residents, including better training standards for nurses, public reporting of nursing home quality, and greater transparency for consumers about care expectations and price. Notably, her research and advocacy contributed to the President of the United States’ plan for “Protecting Seniors by Improving Safety and Quality of Care in the Nation’s Nursing Homes.”

Biden Executive Order Promises to Increase Access to High-Quality Long-Term Care Services

President Biden issued an executive order designed to increase access to high quality long-term care services, support family caregivers, and create better jobs for long-term care workers. The order acknowledges that the country must do more to support workers who provide long-term care services by increasing pay and benefits, providing additional training and educational opportunities, and offering other support to workers. The order also called for the U.S. Department of Health and Human Services (HHS) to explore innovative ways to support family members providing care to loved ones with dementia.

DPH Clarifies Nursing Home Complaint Substantiation

The California Department of Public Health (DPH) recently issued a District Office Memorandum (DOM) clarifying the criteria for substantiating complaints filed against nursing homes. When someone files a complaint about a nursing home, DPH conducts an investigation and gathers evidence from three sources outlined by federal and state guidance: on-site observations, interviews, and written records. CANHR was receiving reports that some DPH investigators were saying they could not substantiate a complaint or take enforcement action unless there was evidence from at least two of the three sources. The new DOM clarifies that there is no requirement to have evidence from at least two of the three sources; rather complaints are substantiated when it is more likely than not that a regulatory violation occurred, considering all of the evidence taken together. The DOM also states that long term care Ombudsmen are reliable sources of information and their observations should be considered evidence of regulatory compliance or noncompliance.

DHCS Receives Federal Approval on Asset Waiver

The California Department of Health Care Services received approval from CMS to allow the waiver of asset verification for current Medi-Cal participants who have renewals scheduled for 2023. This means that if someone is already on Medi-Cal, and increased their assets during the last 3 years, putting them over the current asset limit, their assets should not be considered during redetermination - helping already eligible beneficiaries to transition through to the elimination of the asset limit in January 2024.

DHCS issued MEDIL 23-19 on this issue instructing counties on how to conduct redeterminations. These flexibilities do not apply to people in the process of applying for Medi-Cal, the current asset limits will still apply.
U.S. Senate Aging Committee Denounces Nursing Home Oversight Failures

On May 18, the U.S. Senate Special Committee on Aging released a report, “Uninspected and Neglected, Nursing Home Inspection Agencies are Severely Understaffed, Putting Residents at Risk.” The report links significant delays in nursing home inspections and complaint investigations with poor care and resident rights violations. When shoddy practices are not discovered and remedied in a timely way, residents are endangered and needlessly suffer. While the need for timely inspections and complaint investigations has grown substantially in the past ten years, the resources dedicated to them has been stagnant, resulting in surveyor shortages, delayed data reporting to consumers, failed oversight, and resident abuse and neglect.

The report also examined states’ (including California’s) increased use of private contractors to perform nursing home surveys instead of state employee surveyors. The report questioned the quality of the contractors’ work and found contractors are much more expensive than state employees and often have conflicts of interest with the survey work as they sometimes provide paid consulting services to the same nursing homes they are surveying.

In addition to releasing its report, the Committee also hosted a hearing on nursing home oversight where the panel members unanimously advocated for improved state supervision.

In California, 609 nursing homes (more than half in the entire state) have not had a timely annual inspection while 168 nursing homes have not had an annual inspection since 2019.

RCFE Infection Control Regulations Become Permanent on July 1

The Department of Social Services’ emergency regulations regarding infection control standards for RCFEs become permanent on July 1, 2023. The regulations are at 22 California Code of Regulations Section 87470 and cover hand washing, disinfection, personal protective equipment (PPE), and the creation of infection control plans to deal with contagious diseases.

Nursing Homes Substantially Underreport Falls and Bedsores

A new study in the Journal of the American Medical Association found that nursing homes throughout the country substantially underreport resident falls and bedsores that lead to hospitalization. Forty percent of all major injury falls went unreported and over 33% of stage 3 or 4 bedsores were unreported. Falls and bedsores are required to be reported to the Centers for Medicare and Medicaid Services (CMS) and the reports are used as part of each nursing home’s federal 5-star rating. When facilities fail to report their data accurately, their ratings are artificially inflated, misleading the public and casting doubts about the efficacy of the rating system.
Protecting Them to Death - Looking Back on the COVID Visitation Lockouts

By Tony Chicotel, Esq.

Prior to COVID-19, the work of family and friends to provide direct care and other critical supports to nursing home residents was largely unnoticed and wholly unsung. These support persons quietly spent countless hours supplementing the work of the paid long term care facility staff and, in many cases, supplying basic care the staff was unable to deliver. A 2022 Health Affairs study found long term care facility residents are often supported by an “invisible workforce” with residential care facility residents receiving about 65 hours per month of informal care from outside support persons and nursing home residents receiving about 37 hours. Support persons are indispensable to overall resident well-being, keeping residents happy and alive.

When COVID devastated long term care facilities, resident well-being became a leading topic of national discussion. Policy leaders and public health officials sought to minimize residents’ exposure to COVID by limiting their in-person interactions to facility staff only. These leaders and officials determined that facility staff members provide greater marginal benefit to resident well-being than outside support persons. They literally ordered outside support persons be locked out of long term care facilities.

The lockout lasted, more or less, for a year and a half and proved to be a colossal mistake that led to substantial and unnecessary misery and an untold number of deaths in long term care facilities. It deprived residents of the support that many relied on to survive. And it came at a time when paid staff members were straining to the breaking point. Frontline staff members fled their jobs, leaving those who remained caring for more residents than they could manage. Residents had less care from staff than before and no support persons to make up the difference.

The result was profound social isolation, severely diminished quality of life, and dramatic physical deterioration and death.

There is perhaps no more obvious benefit of visitation in long term care facilities than reducing the social isolation of the residents. Despite efforts to keep facilities homelike, life there is often characterized by loss: lost connections to friends and family and lost connections to the community. Social isolation and loneliness are known to cause poor health outcomes, including death, and deterioration in cognitive functioning. Virtual visitation through phones and tablets proved to be an imperfect substitute for in-person interaction, especially for people with cognitive impairment, who often found virtual visitation to be more distressing than comforting.

In addition to isolation, the COVID lockouts created other intense loss in resident quality of life. Group activities were shut down in facilities and families were prevented from filling the void. Residents were left unengaged, with nothing to do. In addition, the little things that support persons attend to went unattended. Lost clothing, glasses, dentures, and hearing aids went unreplaced. Nails went unclipped and teeth and hair went unbrushed. Residents did not spend time outdoors.

Worst of all, the lockouts caused the health devastation that they were supposed to prevent. While the lockouts likely prevented COVID cases among residents, many more suffered from extreme deterioration due to the loss of their support persons. Studies show that long term care facilities saw a dramatic increase in falls, pressure ulcers, and cognitive decline among residents.

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Data reported to CMS demonstrate that the use of antipsychotic drugs jumped during the lockouts, most likely to chemically restrain residents who were expressing their pandemic-related stress through behavior.

There was perhaps no more telling impact of the lockouts on residents than skyrocketing rates of malnutrition. Support persons very often assist residents with eating, from bringing in outside food that is more appetizing, calorie rich, and culturally appropriate, to taking the time to help residents eat their meals and snacks. The lockouts precipitated an unprecedented nutrition crisis in long term care facilities. Data reported to CMS by the nursing homes themselves showed the rate of resident malnutrition went from 5.38% in 2019 to 11.68% in 2020 to 16.57% in 2021 to 19.99% in 2022. Resident malnutrition rose nearly four-fold during the lockouts!

The tragic result of all the resident deterioration was increased death. A number of studies found significant numbers of “excess” deaths in nursing homes and among people with dementia during the first two years of the pandemic. These were deaths that were not due to COVID but due to the loss of support suffered in response to COVID.

Among all of the public policy responses to COVID, there may have been no greater mistake than the long term care facility lockouts. In March of 2020, the lockouts made a modest amount of sense, provided they were temporary and narrowly tailored. They proved to be neither. The lockouts lingered month after interminable month and the most obvious adjustments, such as permitting outdoor visitation, were made at a glacial pace.

At the heart of the lockouts was a fatal underappreciation for the extensive assistance that support persons routinely provide to long term care facility residents. Policymakers simply did not know how much the long term care facility system relies on the contributions of outside support persons to keep residents safe and healthy. They did not know that locking out support persons would hurt more than it would save. They had better know now.

* The Department of Aging has a Long Term Care Facility Access Workgroup that is meeting periodically to discuss support person access during public health emergencies. If you would like to be part of this discussion, please [click here](#).
Dear Advocate:

My father is a resident at a nursing home, his Medicare coverage will soon run out, but he has Medi-Cal and he needs to remain because his condition has not improved. The facility recently informed me that my father would be transferred to a Medi-Cal bed in a different part of the facility. Is this legal?

Sincerely,

Confounded in Contra Costa

Dear Confounded,

If a facility is certified for Medi-Cal, all of the beds—except for the Medicare distinct part—are Medi-Cal certified, and facilities cannot discriminate by “weeding out” Medi-Cal residents.

“Transfers” usually refer to moving a resident from one room or bed to another within the same nursing home. Nursing homes give one of three reasons for intra-facility transfers. Basic rights regarding transfers include a written notice stating the reasons for the transfer and the right to appeal the decision. By voluntarily agreeing to move, residents can lose some of their rights.

1. Medicare Coverage Runs Out: In California, facilities can choose to certify a separate wing or section of the facility as a Medicare distinct part. Under federal law and regulations (42 U.S.C., Section 1395i-3(c)(1)(A)(x) and 42 C.F.R., Section 483.10(e)(7)), a resident has the right to refuse a transfer out of the Medicare Distinct Part to another part of the facility when Medicare coverage stops. However, if the resident refuses to transfer and Medicare does not continue to pay for the care, the resident must either pay privately for the care or arrange for Medi-Cal payment, if eligible.

2. Conversion to Medi-Cal: Facilities cannot move a resident to another room (except from a private room to a semi-private room) because of a change in payment status from private pay or long-term care insurance to Medi-Cal. (Welfare & Institutions Code, Section 14124.7)

3. Room or Roommate Changes: Changes in rooms or roommates require “reasonable notice in writing and transfer and discharge planning” (Health & Safety Code, Section 1599.78). Federal law also requires notice (42 CFR 483.15(e)(2)).

Transfers are often upsetting and even traumatic for residents. Know and exercise your rights to refuse and appeal intra-facility transfers. To learn more, refer to CANHR’s fact sheet, Transfer and Discharge Rights in Nursing Homes, available at http://www.canhr.org/factsheets/nh_fs/html/fs_transfer.htm
In an effort to provide continuous coverage until the implementation of the asset elimination on January 1, 2024, the Department of Health Care Services (DHCS) is allowing current Medi-Cal beneficiaries to keep their benefits even if they report having assets over the limit of $130,000 ($195,000 for a couple). In fact, during the annual renewal process, the County Eligibility Worker (CEW) must determine eligibility with information already in the case file or from the most recent redetermination, without requesting additional property or asset verification. This also applies to current beneficiaries who report any change of assets. Down below is a scenario to explain the effects of this temporary waiver:

Example: Ms. A, single, applied and was approved for Medi-Cal in January 2023 with reported assets of $50,000. She sold her home in April 2023 to live in a skilled nursing facility. She received about $400,000 from the sale and reported the new assets to Medi-Cal.

Outcome: Because Ms. A’s previously reported assets were within the current asset limit, the CEW cannot take any further action on the newly reported assets. Ms. A’s benefits will not change.

For more information, see MEDIL I23-19.

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
Who Runs the Nursing Home Care Plan?

Care plans are designed to be the lifeblood of nursing home care. The care plan is the written guidance for what care will be provided to a resident and how it will be delivered and audited. Most of the care plan rules are in Title 42 of the Code of Federal Regulations, Section 483.21. These rules require a base care plan be created for each resident within 48 hours of their admission, that it be replaced by a comprehensive plan shortly thereafter, and the care plan be revised and implemented throughout the resident’s stay. The care plan is integral to each resident’s care. A question that sometimes arises is who controls the care plan drafting process - the resident or the nursing home staff?

Nursing homes often assume control of care plan meetings, setting the date, time, and place and “inviting” the resident, the resident’s representative, and perhaps some family members to participate. Occasionally, the facility staff may reject potential participants, such as a resident advocate, claiming that the facility controls the care plan meeting. As the average facility hosts dozens of care plan meetings and drafts the care plan, there may be a sense that facilities do control care plans and care plan meetings.

Upon reviewing the several laws and regulations regarding care plans, it is clear the care plan process is meant to be collaborative, co-authored by both facility staff and the resident. Section 483.21 requires nursing homes to include staff or professionals on the care planning team as requested by the resident and of course the resident and resident representatives must be included to the extent practicable. Similarly, the facility must engage residents in the care planning process (42 CFR Sec. 483.10(c)(3)(i)) and hold care plan meetings when the resident is functioning best, planning enough time for discussion and decision making, encouraging representatives to participate in the care planning meetings and holding the meetings at a time that accommodates the resident’s and the resident’s representative’s schedule.

These rules make it clear the resident is the centerpiece of the care plan and the care plan meetings. As the centerpiece, their preferences and requests should be accommodated.

If a facility is not willing to accommodate a resident’s wishes when writing a care plan or holding a care plan meeting, the resident or their representative should make their requests in writing and force the facility to respond directly, preferably in writing. If the facility persists in its failure to accommodate, the resident or their representative can file a complaint with the Department of Public Health.

For more information about care planning, check out CANHR’s fact sheet.
CANHR has supported, opposed, and/or closely followed the below pieces of legislation this session. Please check [www.canhrlegislation.com](http://www.canhrlegislation.com) for updated details on legislation, and [www.leginfo.ca.gov](http://www.leginfo.ca.gov) for information on specific bills.

### SPONSOR / CO-SPONSOR

**AB 48 (Aguiar-Curry): Informed Consent**  
This bill would codify and expand existing informed consent rules to ensure nursing home residents are given important information about drugs that are prescribed for them and an opportunity to consent or withhold consent.  
**Status:** In Senate Judiciary on Consent Calendar. Hearing date 6/27/23.

**AB 979 (Alvarez): Family Councils**  
This bill would modernize existing family council laws, so that members can continue to meet, communicate, and operate during a public health emergency; ensure facilities are more responsive to concerns; discourage operators from undermining family council activities; and clarify that control of the family council membership and participation in meetings lies with the family council itself.  
**Status:** In Senate Committee on Human Services. On Consent Calendar. Hearing date 7/3/23.

**AB 1309 (Reyes): Nursing Home Eviction Protection**  
Would require nursing homes to include the same level of detail on written notices to justify a resident eviction that is required of Residential Care Facilities for the Elderly (RCFEs), allowing residents to better defend against inappropriate and unsafe evictions on appeal.  
**Status:** In Senate Committee on Appropriations. On Consent Calendar.

### SUPPORT

**AB 486 (Kalra): Long-Term Health Facilities: Citation Appeals**  
This bill would provide a more consistent framework for the appeals process across regulatory citations for long-term care facilities in California. This would reduce the burden on our superior court system and save judicial resources and taxpayer money. Furthermore, it would streamline and improve a process that is designed to hold negligent facilities (i.e., nursing homes) accountable.  
**Status:** In Senate Committees on Health and Judiciary. Hearing date 6/28/23.

**AB 751 (Schiavo): Elder Abuse**  
The bill would codify existing law requiring most local law enforcement agencies to adopt a detailed, specific policy providing much better protection to the 8.5 million older adult Californians and to the 9 million California children and adults with disabilities.  
**Status:** In Assembly. Ordered to Engrossing and Enrolling.

**AB 1085 (Maienschein): Medi-Cal: Housing Support Services**  
This bill would require the Department of Health Care Services (DHCS) to seek federal approval to make housing support services a Medi-Cal benefit.  
**Status:** Re-referred to Committee on Appropriations
SUPPORT (CONTINUED)

AB 1417 (Wood): Elder and Dependent Adult Abuse: Mandated Reporting
Will require mandated reporters to follow a single, simplified reporting process, and also require reports of abuse or neglect to be reported sooner than under the current system (e.g., 24 hours vs. 2 working days). Would ensure that criminal acts are reported to law enforcement first. This bill will ensure that residents of long-term care facilities have the same protections against elder abuse as persons who reside in their own homes.
Status: In Senate Committee on Human Services.

AB 1537 (Wood): Skilled Nursing Facilities: Direct Care Spending Requirements
This bill would require by July 1, 2024, the establishment of a direct patient-related services spending, reporting, and rebate requirement for skilled nursing facilities, with exceptions. Would require that a minimum of 85% of a facility’s total non-Medicare health revenues from all payer sources in each fiscal year be expended on residents’ direct patient-related services, as defined.
Status: In Senate. Referred to Committee on Health. Hearing date 7/12/23.

SB 525 (Durazo): Minimum Wage: Health Care Workers
SB 525 will raise to $25 the minimum wage for the lowest paid healthcare workers including those who provide services in nursing, caregiving, housekeeping, security, clerical, food services, laundry, and other patient-care related services.
Status: In Assembly Committees on Labor and Employment.

SB 278 (Dodd): Elder Abuse
Would strengthen California’s elder financial abuse protections by clarifying current language in statutes governing elder financial abuse under Welfare & Institutions Code §15610.30.
Status: In Assembly Committees on Banking and Finance. Hearing date 7/10/23.

SB 299 (Eggman): Medi-Cal Eligibility: Redetermination
This bill would delete the requirement that county eligibility workers automatically terminate an individual’s Medi-Cal coverage when mail is returned to the county as undeliverable.
Status: In Assembly Committee on Health.

SB 311 (Eggman): Medi-Cal Part A Buy-In
Would require the Department of Health Care Services to submit a State Plan Amendment for California to become a Part A Buy-In State. Would benefit low-income older Californians and persons with disabilities, who rely on Medicare and Medi-Cal but struggle to pay costly Medicare Part A premiums, by simplifying the enrollment process for financial assistance.
Status: In Assembly. On Consent Calendar. Re-referred to Committee on Appropriations.
AB 839 (Addis): Residential Care Facilities for the Elderly: Financing
This bill would expand the California Health Facilities Financing Authority Act and California Health Facility Construction Loan Insurance Law to include RCFEs by adding an RCFE to the definition of “health facility” under those programs. By expanding the purpose for which the two continuously appropriated funds may be used, with regard to RCFE projects, the bill would make an appropriation from each of those funds.
Status: In Senate. Re-referred to Committee on Human Services.

SB 43 (Eggman): Behavioral Health
This bill expands the definition of “gravely disabled” to also include a condition that will result in substantial risk of serious harm to the physical or mental health of a person due to a mental health disorder or a substance use disorder.

SB 263 (Dodd): Insurance: Annuity Recommendations
Would require insurance producers and insurance companies to strengthen suitability standards for the sale of annuities and life insurance policies. The bill would ensure California meets federal and national model standards, while providing additional consumer protections.
Status: In Assembly. Re-referred to Committees on Insurance.
Why The CCRC Laws Need to be Reformed

The Statutes governing Continuing Care Retirement Communities in California are at California Health & Safety Code, Chapter 10 of Division 2, §§ 1770 et seq. A copy of the current statutes can be found on the CCRC Bureau website – look at Quick Links: https://www.cdss.ca.gov/inforesources/community-care/continuing-care.

These laws were written primarily by the CCRC industry and their lobbyists. No regulations have ever been promulgated by the Department of Social Services (DSS), although the statutory language has been amended numerous times over the years since 1990. The most significant changes came in 2000, with statutory recommendations made by the “CCRC Statute Revision Task Force” - a group made up primarily of industry, including a representative from DSS.

These statutes not only limit information available to residents, but limit their rights to appeal complaints; limit their ability to contest increases in monthly care fees; limit their ability to participate in the Residents Association; allow litigation expenses to be passed on to the residents, even when the provider has clearly breached the law; and, even for not-for-profit providers, allow unlimited “profits” to be retained without any accountability.

Some of the more onerous provisions and missing links:

**Duty of good faith and fair dealing:** There is no duty of good faith, fair dealing and honesty – a common covenant implied in most contracts, but missing in CCRC contracts. CCRC contracts are complicated, lengthy and written by the CCRC’s legal counsels.

**Resident Associations:** Although Resident Associations are “encouraged” to elect a governing body, and meetings are open to all residents, the statute allows executive sessions of the Residents Association’s governing body to exclude other residents. This, of course, is to ensure that, in those communities where the provider controls the Resident Association’s governing body, that the residents are prevented from really knowing what’s going on. CANHR suggests either forgoing the Resident Associations or, in addition, starting a Resident Council as authorized under Health & Safety Code 1569.157. More rights, better response time and more responsibilities on the provider.

**Monthly Care Fee Increases:** Although residents can certainly complain about the increase in care fees, don’t expect any relief from the DSS CCRC Bureau. They will delay any response and eventually uphold any increase regardless of the amount of increase, profits, amount of reserves, promises made at admission, or pass-through of capital costs associated with other communities. CCRC providers, in short, have an open door at DSS to increase rates however much they choose.

**Complaints:** Residents can, of course, file complaints with the DSS CCRC Bureau, which is required to “respond” within 15 days. They are not, however, required to actually investigate the complaint in a timely manner and residents can wait months to hear about the final outcome of a complaint. (This author has had one complaint outstanding since January 3, 2023). Under past leadership at the CCRC Branch, the legal counsel simply dumped complaints and never responded in writing. Under current leadership, which seems to take direction from the CCRC providers’ legal counsel, not much has changed. The complaint and the DSS response are given to the provider first, and, after going over the complaint with the DSS representatives, the complainant may receive a response. The determination of the CCRC Bureau is final! The complainants have no appeal rights with DSS. However, they do have the right to file judicial appeals, if they can find an attorney and/or afford attorney fees.

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**Enforcement:** CANHR has been working on CCRC issues for over 30 years. While enforcement of the limited statutory rights of CCRC residents has always been spotty, it’s never been as dismal as today’s system. Despite the clear provision in §1775(e) that “This chapter shall be liberally construed for the protections of persons attempting to obtain or receiving continuing care,” the provisions are usually construed to protect the interests of the provider. This needs to change.

The CCRC statutes need to be amended to protect the rights of CCRC consumers; to provide them with the information necessary to make informed choices at admission and on-going; and to provide consumers and the State with the tools and willingness necessary to overturn illegal actions on the part of providers.

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**Family Councils: Making a Difference**

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

http://canhr.org/familycouncils/video/
HCBS Corner

CANHR’s New Home and Community Based Services Quick Guide

Home and Community-Based Services (HCBS) are programs offered as alternatives to nursing homes that allow participants to remain in their homes and community safely by receiving the care and support they need. These programs vary by county and may have other requirements for eligibility such as age, medical need and income limits. Although many people prefer to age in place and remain in their homes, our current system is a patchwork of services and difficult to navigate. The burden is on the consumer to learn about what is available and to find out where and when to apply.

CANHR created a new guide to give consumers a quick overview of the Home and Community-Based Services programs paid for by the Medi-Cal program in California. Please use it to inform yourself about the existing programs and to determine which ones may be the best fit. If you would like more information about a specific program use the provided links in the “Other Resources” section of the guide or contact the program directly. Contact information for each program is linked in the guide.

Medi-Cal eligibility is often the first step to accessing these programs. For information about community based Medi-Cal, please see our factsheet. If you need assistance completing the Medi-Cal application (SAWS 2 PLUS), contact the Health Consumer Alliance at 1-888-804-3536.

There are extra financial protections for spouses and registered domestic partners called Spousal Impoverishment. These protections are intended to keep the spouse who does not need Medi-Cal and HCBS from becoming impoverished. The spouse who does not need these services is called the community spouse and is eligible to keep more assets and income. For more information about Spousal Impoverishment see our factsheet.

When you apply for Medi-Cal you may receive a notice about the Medi-Cal Recovery program. Medi-Cal seeks to recover payments made for certain services from the Medi-Cal recipient’s estate after they die. Medi-Cal recovery does apply to certain HCBS programs however there is usually a way to prevent recovery if you take action during the recipient’s lifetime. For more information about Medi-Cal Recovery and how to avoid it read our Medi-Cal Recovery Guide.

CLICK HERE to download CANHR’s new Home and Community-Based Services Quick Guide.
3/22/2023: Director of Organizational Development Maura Gibney, Deputy Director Pauline Shatara, and Bet Tzedek Policy Specialist Kim Selfon presented at a Town Hall Zoom meeting for consumers on Medi-Cal and Community Based Services.


4/12/2023: Senior Staff Attorney Tony Chicotel and Staff Attorney Arabelle Malinis hosted a statewide Zoom meeting regarding capacity issues to legal services programs across California.

4/17/2023: Maura Gibney and Pauline Shatara collaborated with Jewish Children & Family Services on an educational Zoom meeting for consumers regarding long term care options.

4/17/2023: Tony Chicotel and Staff Attorney John Hafner hosted a statewide meeting for California Ombudsmen called Improving Resident Care: From the Courtroom to the Nursing Home Room.

4/18/2023: Tony Chicotel hosted a webinar called The Doctor Is In - Medical Practice and Standards of Care in Long Term Care Facilities for California litigators.

4/19/2023: Patricia McGinnis and Bea Layugan presented a webinar for legal services in California on Medi-Cal Updates, Eligibility & Recovery.

4/26/2023: Maura Gibney and Pauline Shatara hosted a statewide presentation on Home & Community Based Services for legal services programs.

5/2/2023: CANHR staff members hosted a virtual meeting for residents, family members and advocates on the current status of Laguna Honda and residents’ rights.

5/3/2023: Tony Chicotel hosted training for legal services programs on long term care residents’ rights.

5/3/2023: Long-Term Care Advocate Efrain Gutierrez and Maura Gibney hosted an outreach table at the Long Beach Senior Center Wellness Expo.


5/10/2023: Attorneys Peter Stern and Carlos A. Arcos volunteered their time to present a webinar called Medi-Cal Basics Part 1.

5/16/2023: Patricia McGinnis and Bea Layugan joined the Gray Panthers in a Town Hall meeting on Laguna Honda resident rights.


5/19/2023: Tony Chicotel presented a training called Mindful Conservatorship Practice for SF Bar Association.

5/19/2023: Office Manager Armando Rafailan was invited to host an outreach table at the Cupertino Senior Center - Live Well, Age Well Health Expo along with other Senior Services in Bay Area.

5/24/2023: Maura Gibney and Pauline Shatara presented a training called Accessing HCBS Services through Medi-Cal for California attorneys.

5/31/2023: Attorneys Peter Stern and Kevin Urbatsch volunteered their time to present on Trusts and Special Needs Trusts After Asset Limit Changes to attorneys and legal services in California.

6/5/2023: CANHR staff members hosted a quarterly roundtable for legal services program staff regarding incapacity issues and residents’ rights.
Armando Rafailan hosting an outreach table at the Cupertino Senior Center Live Well, Age Well Health Expo.

Efrain Gutiérrez and Maura Gibney hosting an outreach table at the Long Beach Senior Center Wellness Expo.

Medi-Cal Eligibility and Updates in 2023

- Learn about Medi-Cal eligibility for older adults and people with disabilities
- Hear updates on current and upcoming changes to Medi-Cal eligibility rules, managed care plans, and services

https://tinyurl.com/canhrmedical2023
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>In Memory Of</th>
<th>Memorial or Honorary Gift Details</th>
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<tbody>
<tr>
<td>John Lanning</td>
<td>Aunt Jan</td>
</tr>
<tr>
<td>Debra Vogler</td>
<td>LaVerne Schwacher</td>
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<tr>
<td>Robert Boileau, Former CANHR Board Member</td>
<td>Robert Boileau, Former CANHR Board Member</td>
</tr>
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**Home & Community Based Services Available Through Medi-Cal**

Learn about different Medi-Cal covered programs that help people receive care and support in their home or in the community including:

- In Home Supportive Services
- Assisted Living Waiver
- PACE, MSSP and more!

[https://tinyurl.com/canhrhcbs2023](https://tinyurl.com/canhrhcbs2023)
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.

For the foreseeable future, due to an overwhelming number of citations and staff time constraints, CANHR will be publishing only Class “A” or “AA” citations in the Advocate.

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.

Lake County

LAKEPORT POST ACUTE
1291 Craig Ave, Lakeport

A $20,000 Death 7/26/22

The facility failed to notify the attending physician of a significant change in a resident’s health conditions including low blood pressure and decreased urine output. The resident was improperly administered medication which may have contributed to critically low blood pressure. Staff documented the resident’s decline in health over several days including decreased urine output, low blood pressure, nausea and vomiting, however, facility staff did not communicate the change in status to the physician. The resident was eventually found unresponsive, and was transferred to the ER, where she was diagnosed with septic and hypotensive shock, and died shortly after admission.

Citation # 110015203

Kern County

PARKVIEW JULIAN HEALTHCARE CENTER
1801 Julian Ave, Bakersfield

A $20,000 Feeding; Nutrition; Patient Care 9/2/22

The facility failed to properly review the health status and respond to a resident’s changing health condition over time related to his tube feeding of a formula that caused him to gain 47 pounds in 15 months. This change led to the resident developing elevated blood sugar, multiple trips to a local acute care hospital for constipation, rectal bleeding, dehydration, high sodium and a change in mental status. The resident remained in the hospital for eight days with diagnoses of a blood infection, a urinary tract infection, morbid obesity and diabetes.

Citation # 120017740

Santa Clara County

CUPERTINO HEALTHCARE & WELLNESS CENTER
22590 Voss Ave, Cupertino

A $25,000 Careplan; Deterioration; Medication; Patient Care 3/13/23

The CDPH determined the facility failed to ensure finger stick blood sugar levels were checked for a resident two times a day as ordered. This failure resulted in the resident experiencing severe low blood sugar which led to his admission to an intensive care unit for treatment.

Citation # 070018409
The following citation summaries are compiled from the citations issued by the California Department of Public Health to Southern California skilled nursing facilities and received by CANHR as of the publication of this 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.

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| Los Angeles County | Antelope Valley Health Center
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<tbody>
<tr>
<td>Desert Canyon Post Acute, LLC</td>
<td>44567 15th St W, Lancaster</td>
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<tr>
<td>1642 W Avenue J, Lancaster</td>
<td></td>
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<tr>
<td><strong>A $25 000</strong> Careplan; Fall; Injury; Patient Care; Physical Environment 5/11/23</td>
<td><strong>AA $120 000</strong> Patient Care; Death 4/27/23</td>
</tr>
<tr>
<td>The facility failed to ensure a resident’s environment was free from accident hazards and that the resident received services that met professional standards of nursing of practice by failing to ensure that a CNA used the correct size of sling to transfer the resident using a lift machine on 3/1/23, failing to accurately report that the resident fell out of the sling during said transfer, failing to do a complete assessment of the resident to rule out any injury and failing to further monitor condition and start an investigation to determine the circumstances of the incident. As a result, on 3/3/23, the resident had a change in condition requiring emergent transfer to a hospital which determined that the resident had a right hip fracture. On 3/5/23, the resident underwent surgery to repair the fracture.</td>
<td>The facility failed to provide a resident, who had COPD, shortness of breath and COVID-19, with immediate CPR upon a sudden and substantial change in condition on 3/5/23 when the resident was discovered with no breath or heart rate, and immediately call paramedics when the resident was found with no evidence of life and before checking the resident’s code status per facility’s policy and procedure. As a result, the resident did not receive the necessary emergency life-saving services immediately. The paramedics pronounced the resident’s death at the facility shortly upon arrival.</td>
</tr>
<tr>
<td>Citation # 920018747</td>
<td>Citation # 920018700</td>
</tr>
<tr>
<td><strong>A $15 000</strong> Fall; Injury 4/15/22</td>
<td><strong>A $15 000</strong> Fall; Injury 4/15/22</td>
</tr>
<tr>
<td>The facility failed to ensure that a resident who was identified as a fall risk was provided with appropriate supervision and assistance. The resident called for staff assistance to use the toilet but staff did not respond. As a result, the resident went to the restroom by himself and fell, sustaining a fracture to his tibia which required surgery to repair.</td>
<td>The facility failed to ensure that a resident who was identified as a fall risk was provided with appropriate supervision and assistance. The resident called for staff assistance to use the toilet but staff did not respond. As a result, the resident went to the restroom by himself and fell, sustaining a fracture to his tibia which required surgery to repair.</td>
</tr>
<tr>
<td>Citation # 920018700</td>
<td>Citation # 920017579</td>
</tr>
</tbody>
</table>
SHARON HEALTH CENTER
8167 W 3rd St, Los Angeles

A $15 000  Fall; Injury; Patient Care 4/15/22

A resident who was unable to move from the neck down and was totally dependent on staff for showering, was not provided with appropriate care and safety during showers to prevent injury. After the resident slid out of a shower chair that did not have a safety belt, she complained of leg and knee pain, but this pain was not reported to the physician, nor was the resident provided with any pain management. The resident unnecessarily suffered without pain medication or medical attention for five days, finally receiving X-rays which identified that she had suffered a spiral fracture of her femur which required surgery to repair.

Citation # 920017576

WESTERN CONVALESCENT HOSPITAL
2190 W Adams Blvd, Los Angeles

A $25 000  Fall; Injury; Patient Care; Physical Environment 5/2/23

An 80 year old resident, who was a fall risk and diagnosed with muscle spasms, fell during the positioning and re-positioning done by one CNA instead of two per the resident’s careplan. The resident was hospitalized and sustained a bump and cut, which required two staples to close. As a result, the facility was cited for failing to follow the resident’s care plan titled “At Risk for Falling from Low Air Loss Mattress (LAL),” a mattress designed to prevent and treat pressure wounds, which indicated the resident required a two-person assist with transfers, repositioning and daily care, and failing to follow its policy and procedures titled “Positioning/Repositioning Residents,” which indicated staff will turn the resident onto the side and place the side rail up on one side as needed.

Citation # 910018650

CALIFORNIA HEALTHCARE AND REHABILITATION CENTER
6700 Sepulveda Blvd, Van Nuys

AA $100 000  Careplan; Fall; Injury; Patient Care; Physical Environment; Death 5/16/23

The facility failed to accurately assess a resident’s fall risk by not considering the resident’s history of seizures, upon readmission to the facility on 1/28/23 in accordance with the facility’s policies and procedures and the resident’s careplan, and identified the resident as a low fall risk when the resident should have been identified as a high fall risk. The facility also failed to conduct a Fall Risk Interdisciplinary Team meeting for the resident who was a high risk for fall, and failed to ensure the resident’s careplan included interventions to address safety concerns. As a result, the resident fell on the floor and sustained a cut to the back of their head on 3/9/23. The facility staff found the resident unresponsive and called 911. Paramedics pronounced the resident’s death at the facility shortly thereafter.

Citation # 950018140
Give To CANHR

How Your Gift Helps

Your contributions help CANHR grow and thrive, so we can extend our services and support to ever more long term care consumers and their family members.

Why Donate?

CANHR is not a government agency. We are funded by membership donations, foundation grants, and publication sales. To continue our work, we need the support of people like you who are unwilling to ignore the abuse and loss that the elderly and disabled in this state suffer in long term care facilities.

What You Get

• Join a statewide network of informed and concerned consumers, caregivers, and advocates.
• Receive periodic updates on important legislation.
• Receive our quarterly newsletter, The Advocate, which includes important long term care information and a detailed report of citations issued against individual nursing homes.

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www.canhr.org/LRS/GetALawyerReferral/ContactCANHRLRS.htm

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