the CANHR
Advocate

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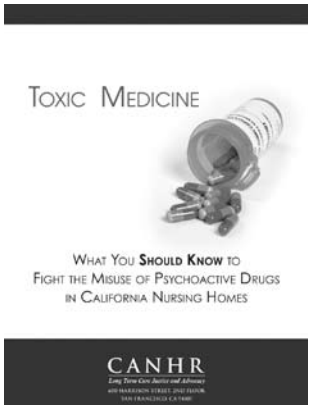
Northern & Southern California

The Newsletter of California Advocates for Nursing Home Reform

Join CANHR's 2010 Campaign to End Drugging of California Nursing Home Residents

In the last issue of the CANHR Advocate, we announced our 2010 Campaign to End the Inappropriate Drugging of California Nursing Home Residents. As the first stage of our campaign, we are pleased to announce the release of our consumer guide on taking a stand against the inappropriate use of psychoactive drugs in nursing homes. The guide is called "Toxic Medicine: What You Should Know to Fight the Misuse of Psychoactive Drugs in California Nursing Homes."



The guide is 17 pages long and covers all the basics regarding psychoactive drugs in nursing homes, describing their uses and side effects and examining the applicable laws. More importantly, the guide gives practical tips for nursing home residents or their family members to prevent misuse of psychoactive drugs.

Almost 60% of all California nursing home residents receive psychoactive drugs. Many of these drugs are antipsychotics, a powerful class of drugs designed to blunt the workings of the brain. Antipsychotic drugs come with Black Box warning labels, an FDA-required label to tell consumers that the drugs increase the risk of death for elderly people with dementia. Additionally, the antipsychotics are most often used "off-label," meaning they are not FDA approved for the conditions for which they are being prescribed. In other words, the drugs come with proven risks and unproven benefits.

There is rampant misuse of psychoactive drugs in California nursing homes. The overuse stems from many reasons. One reason is the massive marketing efforts of the pharmaceutical companies that reap incredible profits from the sale of these drugs. The marketing efforts are often illegal. Last year pharmaceutical giant Eli Lilly settled criminal and civil charges against it by agreeing to pay a record $1.4 billion in criminal and civil penalties for illegally marketing Zyprexa (an antipsychotic drug) for unapproved use by elders and children. (Also, please see the article in Long Term Care News regarding Johnson and Johnson's alleged illegal kickback scheme for prescriptions of Risperdal, a popular antipsychotic.)

A second reason why psychoactive drugs are overused in nursing homes is because they are perceived as much more cost-effective than personal care. Drug costs are often footed by the government as part of Medicare or Medi-Cal benefits; labor costs, however are paid directly out of a nursing home's revenue. Therefore, nursing homes profit when drugs are used as a substitute for care needed by residents. Drugged-up residents are far more sedate and less demanding of care than other residents.

Another major factor is the very poor enforcement of laws against drugging. The Department of Public

Campaign.....(continued on page 3)

Highlights This Issue:

CANHR News Spring 2010

United Way Campaign Gearing Up

Keep an eye out for this year's United Way Work Place Giving Campaign for 2010, coming soon to your work place. As a Certified Community Campaign Agency, California Advocates for Nursing Home Reform (CANHR) is participating in:

- The Bay Area Community Campaign (#151)
- The California State Employees Charitable Giving Campaign (#151)
- The Combined Federal Campaign (#6010)

Consider CANHR when making a charitable contribution through payroll deductions and support CANHR services. A full description of CANHR services is available at www.canhr.org.

Make a donation without writing a check!

Did you know you could make a secure online donation to CANHR with your credit card?

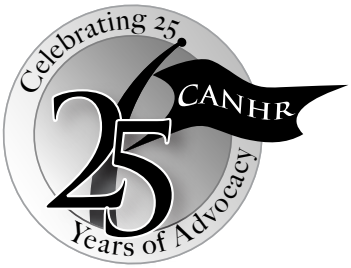
Simply by clicking on the yellow "Donate Now" button on CANHR's website at www.canhr.org, you can help us to continue to provide valuable services to resident's of long term care and their families. Even better, you can even make a recurring donation and help through out the year!

If you select "I want to make a recurring donation", you will be registering to make a credit card donation every month, 3 months, or year. After you complete this initial donation, future donations will be made automatically. For example, if you choose to make a recurring monthly donation of $10.00, your next donation of $10.00 will be automatically charged to your account one month from the date of your initial donation.

You will receive an email receipt for each recurring donation. As soon as you complete this initial donation, you will receive a separate email containing a password and a link to a site where you can review and change your donation options (amount, frequency, billing information) at any time. Of course, you will also be able to cancel your recurring donation at any point in the future.

Request a Speaker for Your Next Meeting or Event

A reminder to our readers that CANHR staff members are available to speak to groups of 20 or more about CANHR services and long term care issues. Contact our office if you would like to discuss having a CANHR speaker at your next meeting or event. CANHR does request an honorarium from professional groups to cover costs.



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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.

CANHR

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Campaign.....(cont. from page 1)

Health is supposed to closely monitor the use of psychoactive drugs and ensure they are prescribed only when clinically indicated and as a last resort when other, less-harmful measures have been attempted and failed. Additionally, the Department should be verifying that all residents or their legal representatives are giving informed consent to psychoactive drugs. Despite its obligations, the Department has not seriously addressed the systemic overuse of these drugs. In the past decade, the Department has issued fewer than ten citations to nursing homes for violations of informed consent laws.

Our campaign will focus on raising awareness about the overdrugging of nursing home residents and what can be done to stop it. As part of the campaign, CANHR is preparing a new section of its website that will be devoted to this topic. Among other information, it will include facility-specific drugging information, a blog hosted by CANHR staff, and extensive resources on this problem.

You will be able to join the campaign by signing an online petition to the Governor urging a crackdown on those responsible for this problem. Look for an announcement from CANHR soon.

Join the campaign and spread the word. With your help, the drugging epidemic can be stopped.

For more information about the campaign, please contact CANHR staff members Mike Connors (Michael@canhr.org) or Tony Chicotel (Tony@canhr.org)

Long Term Care News

Johnson & Johnson Latest Drug Company Sued by U.S. for Illegally Promoting Antipsychotic Drugs for Nursing Home Residents

In January, Johnson & Johnson (J&J) joined a growing list of major drug companies to be sued by the U.S. Department of Justice for illegal actions to persuade nursing homes and doctors to use antipsychotics to drug elderly residents with dementia.

The misuse of antipsychotic drugs is a form of death sentence for many nursing home residents. The FDA has not approved their use for treatment of dementia. Rather, it has determined that antipsychotic drugs greatly increase the risk of death for persons with dementia.

J&J is accused of having paid tens of millions of dollars in kickbacks to Omnicare, the nation's largest long-term care pharmacy, to induce Omnicare and its pharmacists to recommend Risperdal (an antipsychotic drug produced by J&J) for nursing home residents who had dementia.

According to the Department of Justice, the kickbacks were extremely effective. The lawsuit states: "During the 1999 through 2004 period, Omnicare engaged in intensive efforts to convince physicians to prescribe J&J drugs, and Omnicare's annual purchases of J&J drugs increased from approximately $100 million to over $280 million, with annual purchases of Risperdal alone rising to over $100 million."

A "Risperdal Initiative" sought to generate as many Risperdal prescriptions as possible. As part of this initiative, Omnicare provided J&J with a list of "resistant prescribers" so that J&J's sales force could "increase the call frequency on these resistant prescribers and to eventually influence them to use more Risperdal in the Elderly demented patient." By July of 1999, Omnicare helped J&J identify more than 350 resistant physicians who were targeted for Risperdal promotions.

In November 2009, Omnicare, which dispenses drugs to approximately 1.4 million long- term care residents in 47 states, entered a $98 million False Claims Act

Long Term Care News .....(continued on page 4)

settlement with the United States for taking kickbacks from J&J.

This lawsuit is the most recent reminder that drug companies, pharmacies, doctors, and nursing homes are putting many residents' lives at risk while conspiring to profit from the widespread misuse of antipsychotic drugs.

The lawsuit and exhibits are available at: http://www.justice.gov/usao/ma/J&J.html. The U.S. Department of Justice news release can be found at: http://www.justice.gov/opa/pr/2010/January/10-civ-042.html

Inspectors Tell GAO Why Abuse and Neglect Aren't Cited

In January, the U.S. Government Accountability Office (GAO) issued the latest in a long series of highly critical reports on the government's failure to enforce federal nursing home standards: Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment.

The new report is a follow-up to the GAO's findings in 2008 that many state inspection agencies understate deficiencies, meaning they fail to cite serious deficiencies or citing violations at too low a level. These failures can lead to more abuse and neglect and have a corrupting influence on the inspection system.

To gain insight on this problem, the GOA asked inspectors and directors of state inspection agencies throughout the nation for their views. They told the GAO that the predictable timing of inspections allows nursing homes to conceal problems. Other factors they cited include shortages of inspectors, inadequate staff and time to complete inspections, insufficient training, complex and confusing inspection procedures, and reliance on inexperienced inspectors.

They also reported that supervisory reviews usually focus on high-level deficiencies rather than on lower-level deficiencies, those most likely to be understated. Some inspectors reported that their supervisors often removed or changed deficiencies they cited. Inspectors also criticized unfair dispute resolution systems that allow nursing home operators to get deficiencies and citations wiped off their record. These practices encourage inspectors to ignore violations.

Outside pressures are also a problem. Some state agency directors complained about pressures from nursing homes, the nursing home industry or politicians acting on their behalf.

A copy of the report is posted on CANHR's website.

Jack Easterday Goes to Prison

After years of appeals, Jack Easterday entered federal prison on January 15, 2010 when he reported to Herlong Federal Correctional Insitution in Herlong, CA. Mr. Easterday owns eight skilled nursing facilities in Northern California.

In March 2007, Mr. Easterday was convicted of failing to pay about $9.6 million in payroll taxes owed by his nursing homes. The court sentenced him to 30 months in prison and ordered him to pay $8.7 million in restitution but delayed the prison sentence pending the appeal.

Shortly after an earlier conviction in 2006, Senator Norm Coleman (R-Minn) described Mr. Easterday as a prime example of federal contractors who cheat on their taxes while maintaining a luxurious lifestyle. At a Senate hearing, he stated that Mr. Easterday "was living like Louis XIV, compliments of the American taxpayer." The March 14, 2006 hearing was titled "GSA Contractors Who Cheat on Their Taxes and What Should Be Done About It."

Notwithstanding his criminal status, the California Department of Public Health (DPH) has allowed Mr. Easterday to continue operating several nursing homes, which receive tens of millions of dollars annually from the Medi-Cal and Medicare programs. Mr. Easterday owns the Alameda Care Center, Brookvue Care Center, Eden West Convalescent, Homewood Care Center, Oakland Care Center, Pleasant View Convalescent, Rounseville Rehab Center, and Sunrise Healthcare Center.

Following his surrender to federal prison, CANHR

Long Term Care News .....(continued on page 5)

contacted DPH to determine whether it has forced Mr. Easterday to transfer his nursing homes to a qualified operator. At press time, DPH had not responded.

RCFEs Cannot Evict Residents Who Become Eligible for SSI

Confirming what CANHR and other advocates have long contended, the California Department of Social Services (DSS) issued a December 30, 2009 letter firmly stating that residential care facilities for the elderly (RCFEs) cannot evict residents for non-payment when they become eligible for Supplemental Security Income (SSI) and start paying the SSI rate set by state law.

In direct violation of California law, many RCFEs evict residents in these situations. In fact, an attorney representing RCFE providers acknowledged that illegal evictions are common in an e-mail letter that triggered the DSS response. On November 6, 2009, Joel Goldman of Hanson Bridgett LLP wrote DSS stating that "We (the provider community) have always presumed that if someone comes in as a private pay resident and their admission agreement requires that they pay a stated rate, we have the right to evict them if they are unable to pay the stated rate."

Not if the person is eligible for SSI, says DSS. Its letter concludes by stating, "when a RCFE resident becomes a SSI/SSP recipient, the facility must continue to provide basic services to the resident at the SSI/SSP basic rate."

A copy of the DSS letter is available upon request. See CANHR's website for more information on SSI payments to RCFE residents and the eviction rights of RCFE residents.

Legislature Orders Audit of DPH Citation Accounts

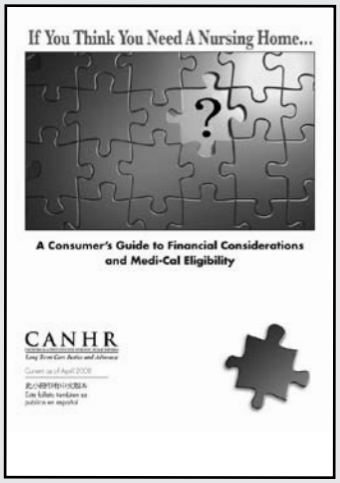
On February 17, 2010, the Joint Legislative Audit Committee approved an audit that will investigate the Department of Public Health's notorious failure to collect fines imposed against nursing homes and the near-bankrupt status of its citation penalty accounts. The audit was requested by Assembly Member Mike Feuer and nine other legislators. The CANHR-supported audit will be conducted by the California Bureau of State Audits.

The DPH manages two citation penalty accounts that hold state and federal fines imposed against nursing homes for neglect and abuse. The state citation penalty account is running out of money because DPH only collects a small fraction (less than a third) of the nursing home fines it issues. Its failure to collect the fines is greatly compromising California's nursing home enforcement system.

Making matters worse, DPH recently notified legislative officials that the federal citation penalty account is running out of money after it removed $2.6 million from the account. DPH has not explained where the money went.

DPH mismanagement of the citation penalty accounts is threatening the future of long term care ombudsman services in California. The citation penalty accounts are serving as stopgap funding sources for these programs following severe budget cuts the Governor made last year.

The layperson's guide to Medi-Cal Eligibility



Current Community Spouse income and assets standards

Share of Cost calculations and deductions

Saving the Family Home

Medi-Cal Estate Recovery

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or visit www.canhr.org to order copies today!

Did You Know?

Leaves of Absence from Nursing Homes

Residents of skilled nursing facilities, whose care is being paid for by Medicare, can leave their facility for short leaves of absence without losing their Medicare coverage. The Medicare Benefit Policy Manual states that residents may leave their facilities for short periods of time to attend a special religious service, holiday meal, family occasion, or for a trial visit home. Such a leave of absence does not prove that the resident no longer needs nursing home care and cannot be used as the basis for terminating nursing home benefits. If the resident returns to the facility by midnight, Medicare will pay for the day's care. For residents who are gone overnight, they may be liable for paying for that day's care but Medicare coverage will resume on the day they return.

If the resident is on Medi-Cal, California Welfare and Institutions Code §14108.2 provides for up to 18 days per year for leaves of absences (LOAs) for overnight (or longer) visits to the home of relatives or friends or participation by developmentally disabled recipients in an organized summer camp, not including days of bed hold for acute hospitalization. Up to 12 additional days of leave may also be approved on an individual basis in increments of no more than two consecutive days, if certain other criteria are met. Many nursing home residents and their relatives are told that the resident will "lose" their bed or their Medi-Cal if they leave the facility for any brief period of time. This is not the case, and a Leave of Absence may be granted in accordance with the resident's care plan. If you are planning leaves of absence for you or your relative, make sure to include LOA's in the plan of care.

Dear Advocate,

I am the responsible party for an elderly friend. There is an amount on her bill this month for "Medications not covered by Medi-Cal." I am reluctant to pay the bill without knowing what it's for. Do I have the right to an itemized billing? I have asked both in person and in writing for this, but the facility will not give me one.

Sincerely,
Hesitant to Pay

Dear Hesitant:

Yes, California Health and Safety Code § 14134.6 requires that the facility provide an itemized billing:

14134.6. Long-term health care facilities may charge a resident only the actual price paid by the facility for goods and services actually supplied to the resident and may not charge for hospital gowns. Facilities in the original contract shall inform residents of charges for personal laundry and dry cleaning, haircuts, beautician services, manicures, pedicures, phone calls, television rental, and any other services payable by the resident. The facility shall also inform residents of any changes in those charges, and shall indicate on a resident's bill every good, product, service, and medication for which the resident is being charged, including, if the patient is a senior citizen, whether or not a senior discount was obtained on the medication.

If the medication is not covered by Medi-Cal, you can purchase it, deduct the amount from the share of cost that month, and provide a copy of the prescription and the bill to the nursing home under the Johnson v. Rank deduction. Make sure the item is ordered by the doctor and included in the care plan. The nursing home doesn't lose any money, because Medi-Cal simply makes up the difference in the share of cost.

CANHR will be sponsoring or co-sponsoring some limited legislation over 2010. Although we will likely be supporting or opposing other bills, it is too early in the legislative session to know what bills will be introduced. However, following is a list of some of CANHR's priorities for 2010.

SB 1329 (Leno) The RCFE Residents Foreclosure Protection Act

This bill will add requirements for Residential Care for the Elderly licensees to notify Community Care Licensing of certain events that indicate fiscal distress and potential foreclosure; to notify all residents or their representatives of those events; provide certain protections to RCFE residents; and require licensees to take reasonable steps to transfer residents safely to avoid transfer trauma.

SB 660 (Wolk): Suitability Standards for Reverse Mortgages

This bill would create suitability standards for lenders, brokers, or persons or entities who recommend the purchase of a reverse mortgage and to have objective and reasonable grounds for believing that the reverse mortgage is appropriate for the prospective borrower. Those engaged in the sale of the reverse mortgage loan would be required to make reasonable inquiries to determine its suitability. This bill also creates a private right of action for those borrowers who are injured lenders who breach their fiduciary duties.

AB 2555: Restoring Long Term Care Ombudsman Funding

This bill would use penalties paid by substandard nursing homes to help restore oversight and advocacy by local long-term care ombudsman programs. It would appropriate $1.6 million to help restore some of the $3.8 million in funds for these programs cut by Governor Schwarzenegger in 2008. The bill has numerous co-sponsors.

Stop the Budget Cuts to California's Aged and Disabled

CANHR will work closely with other consumer and advocacy organizations to stop further budget cuts to California's aged and disabled and low-income citizens. Any further cuts to IHSS, aging services, Healthy Families, services for the Developmentally Disabled and other health and human services will result in irreparable harm from which California may never recover.

Nursing Home Reimbursement

California's Medi-Cal reimbursement system for skilled nursing facilities is rewarding nursing homes that give poor care. Unless it is extended, the rate system will sunset next year. CANHR strongly supports reforming the system by adding accountability measures to the reimbursement system and ending subsidies to nursing homes that neglect and abuse residents.

CANHR 2010 Campaign: End Inappropriate Drugging of California Nursing Home Residents

In 2010, CANHR will initiate a major community outreach and education campaign to end the inappropriate use of psychoactive and other mind-altering drugs in California's nursing homes. Tens of thousands of California nursing home residents are given dangerous antipsychotic drugs, often without their knowledge and consent. As a first step in its campaign, CANHR released a new guidebook, "Toxic Medicine: What You Should Know to Fight the Misuse of Psychoactive Drugs in Nursing Homes. For a free copy of the consumer's guidebook, see www.canhr.org. Additional campaign activities will be announced on CANHR's website throughout the year.

Oppose:

SB 105 (Harman) Donative Transfers Restrictions: Care Custodians

Proposed by the California Law Revision Commission, this bill attempts to address the problem of fraud and undue influence in elder abuse cases. Unfortunately, the bill would water down the current protections in Probate Code 21350 by reducing the burden of proof to overcome the presumption of undue influence from "clear and convincing evidence" to "a preponderance of the evidence." SB 105 would also limit the definition of "care custodian" to those who provide services for remuneration. The changes proposed by SB 105 could result in seniors being at greater risk for undue influence and exploitation.

Citation Watch Consumer Report

Below are CANHR summaries of citations received by Northern California skilled and intermediate care facilities as of the print date of this issue of *The Advocate*. Citations printed without summaries will be reprinted with summaries once received by the CANHR office. Citations from earlier months are included if a description was not printed in a previous *Advocate*. Appeals of citations and collection of fines can take up to three years; for that reason the amount collected at time of publication is often zero. For up-to-date information on any citation or facility, visit the nursing home guide on CANHR´s web site: **www.canhr.org**. or call the CANHR office.

Explanation of citation classifications: "AA" citations are issued when a resident death has occurred due to nursing home regulation violations, and carry fines of up to $100,000. A class "A" citation is issued when violations present imminent danger to resident or the substantial probability of death or serious harm, and carry a fine of up to $20,000. Class "B" citations are fined up to $1,000 and are issued for violations which have a direct or immediate relationship to health, safety, or security, but do not qualify as "A" or "AA" citations. "Willful material falsification" (WMF) violations also result in a fine. Fines are not always required to be paid. Citations can be appealed, requiring the Department of Health Services to substantiate the violation. Violations repeated within twelve months may be issued "trebled fines"— triple the normal amount. Call CANHR for information on the outcome of citation appeals.

Butte County

Riverside Convalescent Hospital

375 Cohasset Road, Chico

B $1000 Patient Care 10/15/2009

The facility did not treat a 79-year-old resident's urinary tract infection, causing her increased confusion and agitation. The resident, who has Alzheimer's disease, was increasingly agitated and resisting care on 5/22/09, 5/24/09, 5/25/09. A LVN requested a physician to order a urinalysis on 5/25/09, and the facility obtained an order for the antipsychotic drug, Haldol IM. After receiving both a urinalysis report and culture and sensitivity report indicating a urinary tract infection on 5/31/09, staff documented faxing them to the resident's physician but there was no record of the physician's reply or following up with physician. Citation # 230006619.

B $750 Staffing 10/28/2009

During a review of staff hours from 9/3/09, through 9/14/09, the hours of staff per patient per day of 3.2, were not met on three occasions. The facility was cited for failure to ensure the required minimum of 3.2 nursing hours per patient per day. Citation # 230006660.

Sunbridge Care Center For Paradise

8777 Skyway, Paradise

B $1000 Supervision Physical Environment 10/15/2009

A resident with dementia wandered outside the facility on 8/29/09, and 8/31/09, despite wearing a Wanderguard alarm device on her ankle, that was supposed to alert the staff if she exited the facility. On the first occasion, the resident was discovered sitting by the curb next to the parking lot with direct access to the main high traffic road. The facility was cited because it exposed the resident to an accident hazard, through its failure to maintain the Wanderguard alarm equipment per the manufacturer's guidelines. Citation # 230006610.

Windsor Chico Creek Care and Rehabilitation Center

587 Rio Lindo Ave., Chico

B $1000 Verbal Abuse Dignity 10/30/2009

On 10/13/09, after finishing playing bingo, a resident stated that a staff member wanted to take the bingo supplies from her. The resident stated she was responsible for the supplies and would keep them. The staff member began pacing back and forth and called the resident a "bitch" when he left the room. The resident also said she felt frightened as there was no one else in the room at the time. The facility was cited for failure to keep the resident free from abuse and treat her with dignity and respect. Citation # 230006670.

B $500 Mandated Reporting Verbal Abuse 10/30/2009
On 10/13/09, during an interview a resident stated that a staff member called her a "bitch." The incident was not reported to the Department until 10/16/09. The facility was cited for failure to report an incident of alleged abuse within 24 hours as required. Citation # 230006669.

Contra Costa County

Lafayette Care Center
1010 First Street, Lafayette

B $1000 Decubiti (Bedsores) 11/18/2009
On 10/22/09, a state surveyor observed a number of bedsores on the body of a resident. The resident was a quadriplegic who was at risk for developing bedsores due to stationary confinement and incontinence. The surveyor noted nine open areas on the resident's right buttock, and seven on the left buttock and posterior thigh. A review of records indicated that there were improper assessments. The physician's progress notes and the nurses' notes showed no evidence that the resident's physician was made aware of the wounds' deterioration. The facility was cited for failure to ensure that the resident received the necessary level of care. Citation # 020006720.

El Dorado County

Placerville Pines Care Center
1040 Marshall Way, Placerville

B $1000 Security 10/01/2009
A loaded gun was discovered in the Administrator's desk drawer by a staff member. When investigated, it was revealed that the gun had belonged to a resident who had entered the facility four and a half years ago. The administrator had kept it loaded and unsecured for that period of time. The facility was cited for placing the residents, staff and visitors of the facility at risk for potential harm. Citation # 030006589.

Humboldt County

Pacific Healthcare And Rehabilitation Center
2211 Harrison Avenue, Eureka

A $18000 Physical Environment Fall 09/01/2009
The facility was cited for failing to prevent a resident from falling and sustaining a laceration to her head which required suturing. The resident was at high risk for falling, and the facility failed to ensure that the resident's mattress pad alarm was maintained properly. The alarm did not go off when the resident got out of bed and resident was ambulating without staff knowledge and fell. Citation # 110005332.

B $1000 Careplan Fall Injury 11/23/2009
A resident fell on 7/27/08, 4/30/09, and 5/5/09, a total of three falls. On 7/27/08, a resident slid out of her recliner while sitting upright, waiting for a meal. The subsequent Interdisciplinary Team plan to teach CNAs that a resident must be monitored in an upright Geri-chair was not implemented when the resident fell on 4/30/09, while seated upright in a shower chair. The resident sustained abrasions above her left eye and was sent to the hospital. The plan was not implemented on 5/5/09, when the resident fell out of her Geri-chair in her room. The resident sustained lacerations to her right brow. The resident still has skin discoloration and scars from injuries. Citation # 110006248.

St. Luke Healthcare and Rehabilitation Center
2321 Newburg Road, Fortuna

A $18000 Fall Physical Restraints 10/19/2009
The facility was cited for failing to keep an 86-year-old resident free from physical restraints used for the convenience of staff. The resident fell out of bed with full side rails in place and broke her hip on 7/19/08, and caused a leg entrapment previously on 4/3/08. The facility failed to develop a plan and interventions to prevent falls. Citation # 110005291.

Lake County

Evergreen Lakeport Healthcare Center
1291 Craig Avenue, Lakeport

B $1000 Medication Patient Care 12/18/2009
The facility failed to follow a resident's bowel regimen according to a nursing care plan for constipation on 9/25/08, which set a goal of a bowel movement every three days. The resident did not have a bowel movement from 10/2/08, to 10/7/08, a total of five days. The resident complained of constipation with very small, hard bowel movements, and licensed nurses had to perform digital extraction of fecal matter. Citation # 110006437.

Lakeport Skilled Nursing Center, Inc.
625 16th. Street, Lakeport

B $1000 Patient Rights Dignity 12/18/2009
A 52-year-old resident attempted to choke an unlicensed member of the staff. The staff obtained an order to transfer the resident to the acute hospital emergency department for a 5150 evaluation. The facility failed to provide a seven day bed hold notice to the resident, to readmit the resident when he was ready to be discharged back to the facility. The facility did not provide an appropriate transfer/discharge notice to the resident's responsible party notifying them of their rights to request a hearing following the discharge, and the location to where the resident would be discharged. Citation # 110006341.

Marin County

Country Villa Novato Healthcare Center
1565 Hill Road, Novato

B $1000 Supervision 10/13/2009
On 12/15/08, a 70-year-old male resident diagnosed with dementia, seizure disorder, and difficulty walking, left the facility with another resident without notifying any staff. The resident had previously refused a wander guard, and there was no documentation that any other interventions had been tried. The residents went to a supermarket and were caught shoplifting wine. It was only upon receiving a phone call from the police that the staff discovered that the residents were missing. Citation # 110005862.

B $1000 Administration Mental Abuse Neglect Mandated Reporting 12/16/2009
Three staff-dependent residents sharing a room, were unable to use their call lights on 4/29/09, and 5/6/09, when someone taped down the reset button on both days. This created the potential for injury if the residents tried to get up themselves for assistance. The facility failed to report first incident on 4/29/09, to the Department within 24 hours, potentially contributing to the second incident on 5/6/09. Citation # 110006760.

B $1000 Mental Abuse Neglect Administration 12/16/2009
three staff-dependent residents sharing a room were unable to use their call lights on 4/29/09, and 5/6/09, when someone taped down the reset button on both days. This created the potential for injury if the residents tried to get up to look for assistance. The facility violated its own policy by failing to suspend suspected staff pending an investigation, allowing staff to work after both incidents. Citation # 110006326.

B $1000 Mandated Reporting Mental Abuse 12/16/2009
A resident's call light was disabled after repeated use, and the facility failed to report within 24 hours to the Department. In a confidential interview, a nursing assistant said that the resident's call light had been disabled when staff placed a table in front of the reset button of the call light during the night shift of 6/4/09, to 6/5/09. The facility placed two staff members on administrative leave pending the investigation, but the Administrator and DON were unable to give a reason why this was not reported to the Department. Citation # 110006310.

Redwoods, The
40 Camino Alto, Mill Valley

B $1000 Fall 10/07/2009
A resident at high risk for falls with impaired decision making capability, fell and sustained a pelvic fracture while attempting to transfer herself from the wheelchair to her bed. She had a pattern of repeatedly attempting to stand up on her own. The facility put personal clip-on alarm monitors on the resident which she repeatedly removed. The facility was cited for failing to address the resident's individual needs in her careplan, thus resulting in repeated attempts to self transfer and resulting in an injury. Citation # 110006224.

Mendocino County

Valley View Skilled Nursing Center
1162 S. Dora Street, Ukiah

B $1000 Dignity Sexual Abuse 10/08/2009
The facility was cited for failing to develop an effective careplan to prevent a male resident from touching a female resident's chest and putting his hand between the her legs. The male resident had a history of sexually inappropriate behaviors, from touching female residents to making sexual hand gestures. Staff were to monitor the male resident every half hour for 72 hours, but monitoring him did not prevent future incidents. A psychiatric social worker made twelve recommendations for interventions but nothing was done. Citation # 110006602.

Monterey County

Carmel Hills Care Center
23795 W. R. Holman Highway, Monterey

B $1000 Dietary Services 07/08/2009
On 6/23/09, an inspector found that the facility was using inappropriate cooking equipment in a makeshift kitchen, while its regular kitchen was being repaired. The facility was using electric hot plates, a sandwich griddle and electric roasting pans that were not suitable to maintain sanitary dietary conditions. Citation # 070006374.

B $1000 Dietary Services Nutrition Patient Care 07/08/2009
The facility failed to ensure sanitary food preparation as evidenced by the vegetables being washed in the sink, which was also used for cleaning soiled food equipment and hand washing. The federal Department of Agriculture food code indicates that this could pose an "imminent health hazard" as older adults are considered a "highly susceptible population" who are more likely than other people in the general population to experience food borne disease. Citation # 070006375.

B $1000 Feeding Nutrition Patient Rights Dietary Services 07/08/2009
The facility failed to devise an appropriate plan to provide a menu that offered equal quality and service that the residents were accustomed to. The residents became unsatisfied with the new menu of soup, salad, and sandwiches that had been served for three weeks. The facility failed to provide substitutions for a renal diabetic resident who complained there were not many substitute foods on the current "emergency mode" menu that the resident could eat. Citation # 070006333.

Monterey Pines Skilled Nursing Facility
1501 Skyline Drive, Monterey

B $800 Verbal Abuse Dignity 08/31/2009
On 8/15/09, a CNA was observed mocking a resident and later left her in the doorway of her room without any clothes. Another CNA was observed taking food from the residents' buffet. When a resident told the CNA to leave the food alone, the CNA called the resident a bad name. The facility was cited for failing to ensure that residents are treated with consideration and free from verbal abuse. Citation # 070006513.

B $600 08/31/2009
CitationWatch description will be published once citation is received. Citation # 070006514.

Pacific Coast Care Center
720 East Romie Lane, Salinas

B $600 Physical Abuse 06/08/2009
The facility was cited for failing to report an alleged incident of abuse to the Department within 24 hours. A resident stated that one resident hit another resident with a plastic water bottle. During an interview on 5/21/09, a staff member stated "He does it to everyone, throwing water." Citation # 070006263.

B $600 Mandated Reporting 06/08/2009
A group of residents reported that one resident who had a history of being agitated and was persistently angry was seen hitting another resident in the hallway and throwing water at residents and staff. The facility failed to report the alleged abuse to the local Ombudsman, or to Licensing and Certification as is required by law. Citation # 070006228.

B $850 Deterioration 12/31/2009
A resident was admitted into the facility from another facility. Her records indicated that she was ambulatory and no range of motion limitations. After her first day in the facility, the resident could no longer walk and appeared to be in pain. She could not do full weight bearing and was resistant to care. The facility failed to document the resident's change in condition and failed to notify the physician immediately according to policy. Citation # 070006854.

Pacific Grove Convalescent Hospital
200 Lighthouse Avenue, Pacific Grove

B $1000 Physical Abuse Dignity 07/30/2009
On 7/9/09, a CNA physically abused two residents. One resident suffered bruises to both forearms when the CNA grabbed her roughly during morning care, causing her great distress. During the same morning, the CNA mistreated another resident by pulling him up and grabbing his shoulders roughly after the resident told the aide he wanted to sleep in. Citation # 070006421.

Windsor Gardens Rehabilitation Center of Salinas
637 East Romie Lane, Salinas

B $850 Patient Care Neglect 07/06/2009
The facility failed to identify an oral infection for a resident who was admitted with a history of receiving chemotherapy, radiation, and antibiotics; these are predisposing factors of thrush and infection of the mouth caused by Candida fungus. The resident tested negative for an oral infection upon admission however, he devel-

oped difficulty swallowing and he was not reassessed. Upon transferring to an acute hospital, he was found to be dehydrated and to have a fungal infection of the mouth requiring treatment with intravenous fungal medication. Citation # 070006361.

Windsor Monterey Care Center
1575 Skyline Drive, Monterey

B $950 Dignity 07/09/2009
On 6/15/09, a CNA used her cell phone to take a picture of a resident who suffered from Parkinson's Disease and dementia, while he was naked on the floor and then showed the picture to other staff. Several staff who knew about the incident failed to report it immediately. The facility was cited because it failed to treat the resident with dignity and respect. Citation # 070006382.

B $850 Privacy Dignity Mandated Reporting 07/09/2009
On 6/15/09, CNA 1 took a photo of naked resident with cell phone camera, which was witnessed by CNA 2. CNA 1 showed photo to an LVN, but the facility failed to file report until 6/23/09. In a 7/2/09 interview, the administrator stated he received the report, but several staff who knew about incident failed to report it immediately. Facility policy requires reporting incidents either immediately by telephone or to local Ombudsman or law enforcement and to Department of Public Health. Citation # 070006365.

Nevada County

Grass Valley Care Center
107 Catherine Lane, Grass Valley

B $1000 Verbal Abuse Dignity 09/29/2009
On the evening of 9/1/09, CNA 1 yelled at a 70-year-old female resident when she refused to give her tray to CNA 1. In a 9/9/09, interview the resident recalled that she wanted the dinner tray in her room until she finished her coffee and, when CNA 1 insisted on taking her tray, she yelled at CNA 1 but later gave up her tray. On 9/9/09, CNA 1 recalled that she did speak loudly with the resident when asking to take the dinner tray. CNA 2 stated on 9/9/09, that she heard the resident and CNA 1 yelling at each other and that CNA 1 said, "You are being ridiculous" before leaving the resident's room with the dinner tray. Citation # 230006586.

Tahoe Forest Hospital D/P SNF
10121 Pine St., P.O. Bx 759, Truckee

B $800 Verbal Abuse Dignity 10/01/2009
A staff member verbally abused a 93-year-old resident who had difficulty walking and had a mental disorder. When responding to a wheelchair alarm, one staff member heard this staff member yelling at the resident about trying to get up from the toilet. Another staff member heard this same staff member yell at the resident from down the hall about using the bathroom by himself. Yet another staff member heard this same staff member yell at the resident in the bathroom. Citation # 230006587.

Sacramento County

Arden Rehab & Health Center
3400 Alta Arden Expressway, Sacramento

B $1000 Fiduciary 11/17/2009
The facility borrowed patient trust money to pay the operating costs of the facility, when the facility's clearing account had a negative balance. Because the facility was unable to maintain separate accounts and segregate funds, the resident's personal funds were put in jeopardy. Citation # 030006697.

B $1000 Fiduciary 11/17/2009
The facility failed to uphold ample safeguards and accurate records; the facility used unnumbered memorandum note pads resulting in no accountability for the facility. The residents' monthly SSI and pension checks were not consistently recorded in the residents' individual trust fund account ledgers. Failing to maintain detailed inventories of patient purchases resulted in discrepancies. Failing to provide quarterly accounting of the transactions to responsible parties, as well as implementing written facility policies resulted in placing the residents' funds in jeopardy. Citation # 030006698.

B $1000 Fiduciary 11/17/2009
The facility failed to maintain a control account for all receipts and expenditures. The facility failed to maintain supporting vouchers for withdrawals or receipts for purchase, as well as failed to keep the control and subaccounts current. Citation # 030006699.

B $1000 Fiduciary 11/17/2009
The facility failed to maintain records for a minimum of three years from the date of the transaction. Failure to identify trust fund checks, to access account bal-

ances with current or past account detailed information, placed the residents' personal funds in jeopardy. Citation # 030006700.

B $1000 Fiduciary 11/17/2009
An investigation revealed that the facility failed to maintain resident sub-accounts at zero or greater. The residents were charged for their share of cost prior to the receipt of the funds from the resident. The facility borrowed from the resident's trusts to pay for facility costs, and failed to ensure funds were not borrowed from one resident account to the other. Citation # 030006701.

B $1000 Fiduciary 11/17/2009
The facility failed to maintain and provide accurate records of receipts for money and valuables, resulting in unexplained and untraceable transactions. The facility failed to identify personal property as belonging to each resident. Citation # 030006702.

B $1000 Fiduciary 11/17/2009
An investigation revealed that the facility's 05, 2009, reconciliation report disclosed outstanding resident trust fund checks from 2007, which resulted in inaccurate account balances. The facility failed to accurately file reconciliation reports as of 07/29/09, as well as failed to reconcile the total number of patient ledger cards with a summary report. Citation # 030006703.

B $1000 Fiduciary Patient Rights 11/17/2009
The facility failed to ensure that no more than one month's advance of funds were received from a resident's account. Twenty-eight residents were charged for more than one month's share of cost, before services were rendered. Withdrawing the share of cost before patients had funds in their accounts resulted in negative balances for 17 residents. sixteen residents were not receiving access to their monthly personal and incidental money, as it was being withdrawn by the facility and used to pay the facility for the share of cost. Citation # 030006704.

B $1000 Fiduciary 11/17/2009
The facility was cited for failing to ensure the residents' money was made available within three banking days, as well as failed to give residents detailed lists of debts and credits. Citation # 030006707.

B $1000 Fiduciary 11/17/2009
An investigation determined that the facility's Interdisciplinary Team acted as an authorized representative for five residents' personal funds. Citation # 030006709.

B $1000 Fiduciary 11/17/2009
An investigation revealed that the facility failed to surrender all money and valuables to the person responsible for the resident within 30 days, in the event of a resident's death. In addition the facility failed to have the trust fund proceeds accounted for. Citation # 030006708.

B $1000 Fiduciary 11/17/2009
The facility failed to hold the required bonds proportionate to the total amount of patient money, handled per month according to the coverage required by the health and safety code. Citation # 030006710.

B $1000 Fiduciary 11/17/2009
The facility failed to notify residents when their trust account funds were near or at the maximum of $200.00, or less than their resource limit, jeopardizing their eligibility as a qualified recipient of the benefit. Citation # 030006711.

B $1000 Fiduciary 11/17/2009
The facility charged three residents for items that should have been a covered benefit of Medi-Cal/ Medicare. Fifty-one residents also had been charged for monthly bank charges for their trust accounts, which should have been paid by the facility. Citation # 030006712.

B $1000 Fiduciary 11/17/2009
A review of individual resident ledgers disclosed that the facility failed to deposit monthly SSI, pension, and other trust fund deposits leaving the residents at risk of loss of interest accrual income. The facility failed to apply polices related to handling of patient funds. Citation # 030006705.

San Benito County

Hazel Hawkins Memorial Hospital D/P SNF
911 Sunset Drive, Hollister

B $1000 Fall 09/03/2009
On 8/7/09, a resident who was at high risk for falls got out of her bed unassisted without setting off her bed alarm. She fell to the floor and injured her head and fractured her hip. The facility was cited for failure to provide the resident with adequate supervision and assistance. Citation # 070006527.

San Francisco County

The Tunnell Center For Rehabilitation & Healthcare
1359 Pine Street, San Francisco

B $1000 Injury Patient Care 12/11/2009
On 7/26/09, a blind resident reached for the overhead trapeze above her bed, causing it to swing and hit her head resulting in a large bump on her forehead. The facility was cited for failure to report the incident to the department within 24 hours as required and failure to reassess the resident's need for the trapeze. Citation # 220006767.

Victorian Healthcare Center
2121 Pine Street, San Francisco

B $1000 Physical Abuse 10/23/2009
On 7/17/09, a female resident asked a CNA for assistance in arranging her bed blankets. The CNA got upset and struck the resident on the arm. The facility substantiated the resident's complaint and terminated the CNA. The facility was cited for failing to ensure that the resident was not subjected to physical abuse. Citation # 220006649.

San Joaquin County

Palm Haven Care Center
469 East North Street, Manteca

B $800 Deterioration 10/23/2009
On 6/6/08, an 89-year-old resident developed a fever, had labored breathing, and was "very lethargic". The nurse administered Tylenol for the fever despite there being no physician's order. The physician was not contacted immediately. When the physician finally was called, the resident was transferred to the hospital where he was found to have a UTI, was very dehydrated and possibly had pneumonia and a high white cell count. The facility was cited for failing to involve the physician in ongoing assessment of the patient and for failing to obtain a physician's order before administering medication. Citation # 030006628.

Santa Clara County

A Grace Sub Acute & Skilled Care
1250 S. Winchester Boulevard, San Jose

B $700 Patient Rights 06/26/2009
The facility accepted $42,950 of a resident's private funds as payment in full, despite the resident having a secondary insurance carrier. There was no evidence the facility submitted a claim to the private insurance company, as requested by the secondary insurance carrier. The facility failed to return the advance rent paid by the resident, to her heirs within two weeks after the resident's death on 9/10/08. Citation # 070006328.

B $950 Patient Care 06/29/2009
On 5/10/09, a resident with physicians orders for a "cuffless" tracheotomy tube was fitted with a "cuffed" tube. According to the Respiratory Therapist, a cuffed tube could have torn the resident's trachea. In spite of the physician's orders and the resident's complaint of discomfort, the tube was not changed for over three weeks. The facility was cited for failure to follow physician's orders. Citation # 070006329.

B $900 Injury Fall Physical Environment 07/27/2009
On 6/28/09, a resident dropped to the floor and suffered a head injury and laceration when the straps on a mechanical lift broke while a CNA was transferring her from the bed to a shower chair. The resident was hospitalized and required follow-up care with a neurosurgeon. The facility was cited because the aide performed the transfer by herself, contrary to the facility policy that at least two staff members must assist with mechanical lift transfers in order to ensure resident safety. Citation # 070006419.

B $850 Dignity Physical Abuse 08/25/2009
On 7/19/09, a CNA threw a wet "diaper" and a soiled towel on the face of a resident. The resident reported the abuse and said he felt devastated at the time. The facility was cited because its staff did not treat the resident with dignity and subjected him to physical abuse. Citation # 070006493.

B $850 Injury Fall Careplan 08/25/2009
On 7/18/09, a legally blind resident fell and suffered a laceration to his head when he got out of his bed and tried to get into his wheelchair. Contrary to his careplan, the wheelchair had been folded shut, causing him to fall and injure his head. He was sent to the hospital for treatment. The resident reported that staples were used to close the wound. The facility failed to provide proper supervision prior to his fall and failed to investigate earlier falls by the resident. Citation # 070006492.

B $900 Medication 09/16/2009
For more than 40 hours, beginning 8/10/09, a resident

with metastatic lung cancer was not being given her scheduled morphine pain medication. The resident was on hospice, comfort care and was in pain throughout the period in question. During the investigation of this complaint the facility's explanation was that they had run out of Morphine and the supply was not replenished until late 8/11/09. The investigation noted that, although the facility was out of Morphine, the evening LVN documented, "routine medication given as ordered". When asked to explain how that was possible, the LVN said he didn't know. The facility was cited for failure to properly medicate the resident. Citation # 070006507.

Amberwood Gardens
1601 Petersen Avenue, San Jose

B $800 Fall 12/10/2009
The facility was cited for failing to inform a resident's physician that the resident refused to walk with the rehabilitation nurse assistant for 58 days after sustaining a second fall. The 91-year-old resident experienced a fall on 8/21/09, and a second fall on 8/31/09. X-rays were taken after the first fall, but none taken after the second as there were were no apparent injuries. The resident was transferred to a hospital for respiratory distress and there she was found to have a fractured hip on 11/3/09. Citation # 070006740.

A $18000 01/05/2010
CitationWatch description will be published once citation is received. Citation # 070006685.

Camden Convalescent Hospital
1331 Camden Avenue, Campbell

B $800 Patient Care Supervision 06/16/2009
On 4/10/09, a resident with dementia and a history of elopement was found three blocks away from the facility on the corner of a busy intersection. In one week the resident had 17 instances of "unsafe attempts to leave the facility." Although the resident's whereabouts were to be monitored every 30 minutes, staff did not hear the alarm when the resident left the facility through the front door. The facility was cited for failure to review, evaluate and update the care plan for the resident to prevent his leaving the facility. Citation # 070006294.

B $750 Abuse/Facility Not Self Repoted 10/19/2009
On 10/8/09, social services received a telephone call from a resident's family member stating that the resident was afraid to shower because she felt rushed. The facility was cited for failure to notify the local Ombudsmen of the allegation within 24 hours, as required by law. Citation # 070006630.

B $750 Physical Abuse 10/19/2009
On 10/8/09, Social Services received a telephone call from a resident's family member stating that the resident was afraid to shower because she felt rushed and that a CNA handled her roughly. The facility was cited for failure to notify The Department of the allegation within 24 hours, as required by law. Citation # 070006627.

Empress Care Center, Llc
1299 S. Bascom Avenue, San Jose

B $800 Fall 09/17/2009
The facility was cited for failure to provide a safe environment, free from accident hazards for two residents. Resident 1 was sent to the emergency room on 4/3/09, for a fracture of the left humerus with displacement, then again for a fall on 7/30. Resident 2 was sent to the ER for a spiral fracture of the left femur. Resident 1, broke her leg while being assisted in the shower and Resident 2 broke her leg after failed to locate her call light then fell while walking to the bathroom in the dark. Citation # 070006453.

Gilroy Healthcare And Rehabilitation Center
8170 Murray Avenue, Gilroy

B $750 Neglect Dignity Patient Care 07/07/2009
On 6/01/09, a resident was taken to a dermatology appointment for a scheduled biopsy, without notifying the responsible party. Even though she was unable to communicate, or propel herself in her wheelchair she was left unaccompanied at the clinic. Citation # 070006369.

B $800 Verbal Abuse 08/28/2009
During an interview on 8/13/09, a resident complained about a CNA who had threatened to put her in the corner with her back to the door and leave her there until morning if she did not stop putting on her call light. As a result of this the resident said she was intimidated and was afraid to ask the staff for help. The facility was cited for failure to to keep the resident free from mental abuse. Citation # 070006502.

B $500 Fall 08/28/2009
On 8/8/10, an unassisted resident fell in the bathroom and injured her head while she was trying to pull up her pants after using the toilet, because she did not

want to bother the CNAs. The resident stated that the CNAs had told her that she urinated too much, used the call light too much, and they were going to take her call light away if she didn't behave and she would be left on a toilet in the dark. The facility was cited for failure to report the incident within 24 hours after they became aware of the intimidation. Citation # 070006503.

B $800 Mandated Reporting 11/23/2009
The facility was cited for failing to report to The Department prior to making alterations to a shower room. Tile and sheet rock were being installed due to some cracks. The facility should have obtained approval from The Department prior to beginning construction. Citation # 070006687.

Golden Livingcenter - San Jose
401 Ridge Vista Avenue, San Jose

B $800 Physical Abuse Verbal Abuse 06/09/2009
A resident with a diagnosis of schizophrenia exhibited aggressive behaviors toward another resident including spitting, yelling and punching her from 5/1/09, to 5/14/09. The punching incident led to the injured resident's transfer to the acute hospital for treatment of bruises. In spite of the repeated incidents and the female resident expressing her fear of staying in the facility, the care plans were never updated to address these issues. The facility was cited for failure to protect the resident from abuse and update the care plans to prevent reoccurrence. Citation # 070006257.

Herman Health Care Center
2295 Plummer Avenue, San Jose

B $1000 Fall 10/26/2009
A resident's attending physician ordered a lap chair for the resident to sit in that proved to reduce agitation and keep him from wandering. The lap chair broke and was sent out for repair on 10/7/09. During that afternoon, the resident sat in a regular chair. He was left unsupervised, got up out of his chair, walked outside of the facility and fell. The resident did not have an alarm or any other method in place to prevent him from wandering. Citation # 070006653.

B $1000 Fall 10/26/2009
A CNA left a resident unattended in the restroom while the CNA went to retrieve a disposable brief. When the CNA moved, the resident lost her balance and fell, hitting her head on the corner of the stall door and suffering several skin tears, scratches, and bruises. The facility was cited for failing to maintain supervision of a resident during personal hygiene care. Citation # 070006593.

B $1000 Dignity Neglect 12/16/2009
On 11/16/09, a resident was observed (twice) nude from the waist down on a commode from the hallway. He was also not served a meal while he sat at a dining table with another resident and just sat and watched others eat. The facility was cited for failing to treat a resident with consideration, respect and dignity. The resident stated that he didn't like living there, but had nowhere to go and that the staff did not know what it was like to live there. Citation # 070006793.

Homewood Care Center
75 N. 13th Street, San Jose

B $800 Careplan Patient Care Injury Neglect 12/21/2009
The facility was cited for failing to provide the necessary care and services to a resident. The resident had right side paralysis and required a two-person assistance with repositioning. On 7/18/09, a CNA pulled the resident in bed, unassisted. The next day an x-ray indicated that the resident sustained a fracture of her right upper arm. Citation # 070006461.

Los Gatos Meadows Geriatric Hospital
110 Wood Road, Los Gatos

B $1000 Fall 12/29/2009
A resident sustained falls on 8/26/09, 9/19/09, 10/1/09, 10/11/09, and 11/16/09. Each of the falls were sustained when she was in her recliner and even with a chair alarm, the alarms did not sound four of the five times she fell. The facility was cited for failing to ensure that the resident did not sustain repeat falls. The facility did not update the resident's careplan to reflect preventative interventions. Citation # 070006827.

Los Gatos Oaks Convalescent Hospital
16605 Lark Avenue, Los Gatos

B $1000 Patient Rights Neglect 06/17/2009
The facility failed to create and provide individualized quality of life experiences, from the time the resident was admitted to the facility. The facility did not accommodate the resident with outside religious or organizational activities. This resulted in the resident keeping to herself, walking up and down the hallway and spending long periods of time in her bed. Citation # 070006302.

Mission De La Casa

2501 Alvin Avenue, San Jose

B $800 Fall 09/14/2009

An 87-year-old resident who was at risk for falls was left unattended and unsecured in a shower chair. The resident fell and sustained a laceration to the forehead that required suturing and subsequent wound care. The facility was cited for failure to ensure that the resident was adequately supervised and had assistance devices to prevent accidents. Citation # 070006543.

B $800 Physical Abuse 10/01/2009

On 9/20/09, a CNA threw a glove in the face of a resident after providing hygienic care. The resident reported the incident on 9/20/09, at 7:30 pm but the facility waited until the afternoon of 9/23/09, before it notified The Department. The facility was cited for failure to report the incident to The Department within 24 hours, as required by law. Citation # 070006588.

B $800 Fall 10/20/2009

A resident woke up one morning unable to move her left leg. When transferred to the hospital, the physician determined that she sustained left hip and right pelvic fractures that were secondary to a "hard fall". There was no documentation of any fall at the nursing facility. She experienced a great deal of pain and was no longer able to propel herself around the facility in a wheelchair, thus affecting her quality of life. The facility was cited for failing to protect the resident from harm. Citation # 070006634.

Pacific Hills Manor

370 Noble Court, Morgan Hill

B $850 Medication 06/16/2009

On 5/12/09, a resident was administered ten times the normal dose of Roxanol (an opiate derivative) and was consequently transferred to the acute hospital for treatment of medication overdose. The facility was cited for failure to administer the resident the correct dosage of medication. Citation # 070006293.

San Jose Healthcare Center

180 Jackson Avenue, San Jose

B $1000 Sexual Abuse 11/30/2009

A male resident who had a history of making sexual advances toward female residents brought a mentally incapacitated female resident into his room, where she was found by a CNA with her briefs below her knees. Though there was documentation of previous incidents of sexual abuse, there was no abuse report sent to the Department or anything written in an official abuse log. The facility was cited for failing to investigate the incident or previous incidents, thereby putting other residents at risk for abuse. Citation # 070006737.

B $800 Physical Abuse 12/24/2009

The facility was cited for failing to follow their own policy and procedures to protect the residents following an allegation of abuse. A resident reported that a CNA squeezed her upper left thigh too hard during repositioning, however there were no visible markings. The CNA was moved to another station, but was not removed from the facility pending the result of the investigation as stated should have happened in the policy and procedures. Citation # 070006850.

San Tomas Convalescent Hospital

3580 Payne Avenue, San Jose

B $800 Dignity Fall 08/27/2009

On 7/28/09, a resident asked the CNA to lock the wheelchair wheels and to get another CNA to help her use a mechanical lift to assist in transferring the resident to their wheelchair, which the CNA failed to do. The Wheelchair moved during transfer, and the CNA dropped the resident to the floor, which caused the resident's bilateral hip and leg pain for over 14 days, from 7/28/09, to 8/11/09. Citation # 070006504.

B $700 Physical Environment 08/27/2009

The facility failed to maintain sink and shower water temperatures within a safe range between 105 and 120 degrees. On 8/11/09, during an environmental tour the maintenance staff found nine of 18 random water samples to be between 122 and 134 degrees. During an 8/12/09, interview a maintenance worker stated that he has been measuring water temperatures for over a year, but was never trained on any facility policy about safe water temperature. Citation # 070006505.

Skyline Healthcare Center - San Jose

2065 Forest Avenue, San Jose

B $1000 Neglect Notification Injury 07/16/2009

On 5/22/09, the facility failed to prevent neglect of a resident when three different CNAs failed to promptly notify a LVN that the resident's leg was red and swollen. There was a delay of about eight hours before CNAs reported the resident's condition to an LVN, leading to x-rays revealing she had sustained fractures to her lower leg. The facility's failure to promptly

report and investigate the incident increased the risk that the resident would suffer further harm and unrelieved pain. Citation # 070006297.

Terreno Gardens Extended Care Center
14966 Terreno De Flores Lane, Los Gatos

B $500 09/25/2009
CitationWatch description will be published once citation is received. Citation # 070006478.

Vasona Creek Healthcare Center
16412 Los Gatos Boulevard, Los Gatos

B $700 Decubiti (Bedsores) 11/04/2009
The facility failed to assess the pressure ulcers of a resident as required by the careplan. The resident was admitted with redness on both buttocks Stage I which progressed to Stage II twenty-five days later. There was no documentation of this change, and there was no assessment of the ulcers upon discharge. Citation # 070006662.

Willow Glen Center
1267 Meridian Avenue, San Jose

B $600 Fall 10/20/2009
A resident of the facility was a fall risk and had fallen on four separate occasions, the last of which caused a one-centimeter laceration on his left eyebrow. The falls could have been prevented through use of alarms, which the resident did not have on his wheelchair or his bed. The facility was cited for failing to appropriately revise the careplan for the resident who had a history of falls, and include the application of alarms per recommendation of nursing staff. Citation # 070006629.

Santa Cruz County

Country Villa Watsonville West Nursing & Rehab Center
525 Auto Center Drive, Watsonville

B $700 Neglect 11/23/2009
A male resident with advanced dementia began to show signs of physical decline on 7/11/09. That evening, his temperature was measured at 102.1 degrees. The following day, he was unresponsive with poor vital signs. The resident's family was not notified. He was not transported to a hospital until the evening of 7/13/09. The facility was cited for failure to identify and communicate a change of condition to the resident's physician or family. Citation # 070006726.

B $800 Medication 11/24/2009
A male resident with advanced dementia was prescribed several psychotropic medications upon his admission to the facility. His physicians did not inform or seek the consent of the resident or his responsible party. The facility administered 15 doses of three medications. The facility was cited for failing to verify the informed consent for the medications. Citation # 070006561.

Driftwood Healthcare Center - Santa Cruz
675 24th Avenue, Santa Cruz

B $800 Dietary Services Careplan Neglect 12/29/2009
The facility was cited for failing to maintain acceptable parameters of nutrition for a a resident. The resident had decreased food intake over the course of a month,and the staff failed to assess the change and update his careplan. As a result, the resident lost 15 pounds, 11% of his body weight in one month. Citation # 070006791.

Golden Age Convalescent Hospital
523 Burlingame Avenue, Capitola

B $650 Fiduciary 12/30/2009
The facility was cited for failing to purchase a surety bond to assure the security of all personal funds of residents. The administration had the resident's put the facility's name on the checks they received from social security and other pensions upon admission, and the staff would cash the checks at a local bank. The facility would keep their share of cost and put $35.00-$50.00 into petty cash for each of resident's needs. Citation # 070006853.

Santa Cruz HealthCare Center
1115 Capitola Road, Santa Cruz

B $700 Mandated Reporting Verbal Abuse 08/27/2009
On 6/15/09, a female resident asked a CNA for assistance to the bathroom. The CNA told the resident to use a bedpan. When the resident insisted on going to the bathroom, the CNA replied "I have to go to the bathroom, I have to go to the bathroom," in a mocking way. Despite the incident being recorded in the CNA's employee file, it was not reported to The Department. The facility was cited for failing to report an incident of alleged abuse. Citation # 070006501.

Santa Cruz HealthCare Center
1115 Capitola Road, Santa Cruz

B $700 Mandated Reporting 08/27/2009
On 6/15/09, a female resident asked a CNA for assistance to the bathroom. The CNA told the resident to use a bedpan. When the resident insisted on going to the bathroom, the CNA replied, "I have to go to the bathroom, I have to go to the bathroom," in a mocking way. The facility was cited for failing to report the incident to the Ombudsman. Citation # 070006500.

Santa Cruz Skilled Nursing Center
2990 Soquel Avenue, Santa Cruz

B $1000 Supervision 08/20/2009
A female resident with severe cognitive impairments due to a brain tumor wandered from the facility on 8/1/09. She was found by a Police Officer near a freeway after falling down. The resident was a known wander risk and had a Wanderguard alert bracelet that may have failed to operate. The facility was cited for failure to provide adequate supervision. Citation # 070006482.

B $800 Evictions 08/20/2009
On 8/8/09, a female resident with multiple sclerosis was given a "notice of discharge" that failed to include a great deal of required information. She was given no location to which she would be transferred nor was she given any preparation or orientation. The facility was cited for failing to provide adequate notice of a proposed discharge. Citation # 070006476.

B $1000 Physical Abuse 09/11/2009
A female resident was physically and verbally abused by another resident with a long history of assaultive behavior on 8/13/09. The incident occurred despite the assaultive resident being on a three day behavioral monitoring program. The facility was cited for failing to ensure the victimized resident was free from abuse. Citation # 070006540.

B $1000 Neglect 12/18/2009
On 9/29/09, a resident who was considered a high risk for elopement, left the facility at about 11:45 pm. The staff heard the alarm go off, as the 87-year-old resident had two wanderguards on, but saw nobody when they went to the door. The resident was found by the police the next day, after spending a cold night out on the street and taken to the emergency room where he was treated for skin tears and complained of pain and swelling in his right knee. Citation # 070006686.

Valley Convalescent Hospital
919 Freedom Boulevard, Watsonville

B $550 Physical Abuse Mandated Reporting 08/26/2009
A resident with dementia, psychotic behavior, depression, and anxiety, engaged in abuse of her roommate, other residents, and staff on 1/6/09, 2/5/09, 5/4/09, 6/13/09, 6/19/09, 6/24/09. The behavior included kicking, screaming, threatening, pushing, and slapping. The facility failed to report suspected abuse to The Department or the Ombudsman for all but the 6/19/09 incident. Citation # 070006491.

B $550 Physical Abuse Verbal Abuse Mandated Reporting 08/26/2009
Between 01/09, and 06/09, a resident who had a diagnosis of dementia with psychotic behaviors hit, kicked and shouted at other residents on several occasions. The staff failed to report the abuse to The Department or the Ombudsman as required. Citation # 070006330.

Shasta County

Canyonwood Nursing And Rehab Center
2120 Benton Drive, Redding

B $1000 Physical Abuse 10/06/2009
Two elderly female residents reported that a CNA had treated them roughly and caused pain. One resident was pulled roughly from a toilet by both wrists. The other resident reported being thrown around by the CNA while in bed and during showers. Investigation revealed the CNA had been the subject of prior complaints of abusive handling and had received warnings. The facility was cited for failing to ensure residents were free from physical abuse. Citation # 230006590.

Mayers Memorial Hospital D/P SNF
43563 Hwy 299 E, P.O. Bx 459, Fall River Mills

B $1000 Dignity Verbal Abuse 09/22/2009
On 7/31/09, a staff member recorded a resident's name and the statement, "quit j..king off" onto a recording device and then repeatedly played it loudly at the nursing station. The perpetrator stated she made and played the recording as a joke because the resident had a history of masturbation. She reported she acted willfully and didn't think about dignity and respect. The resident was 78-years-old and suffered from dementia and depression. A staff member who witnessed the incident reported that, "I thought it was demeaning to him,"

and "It's not nice to make fun of him." The derogatory and demeaning statements violated the resident's right to be treated with dignity and respect. Citation # 230006554.

B $700 Mandated Reporting 09/22/2009
The facility failed to immediately report suspected abuse of a resident that took place on 7/31/09. It did not report the abuse of a 78-year-old resident with dementia until 8/27/09, 27 days later. It was cited for failing to report the abuse to The Department within 24 hours. Citation # 230006553.

B $800 Verbal Abuse Physical Abuse 10/21/2009
The facility was cited for failing to report an incident of suspected abuse to The Department within 24 hours. The incident happened on 9/27/09, and was not reported for four days. Citation # 230006640.

Solano County

La Mariposa Care And Rehabilitation Center
1244 Travis Blvd., Fairfield

B $1000 Physical Abuse Verbal Abuse 09/24/2009
The facility was cited for failing to ensure that a resident was protected from verbal and physical abuse. A staff member hit and called a resident a "bitch" causing her to be fearful and anxious. Citation # 110006575.

Windsor Vallejo Care Center
2200 Tuolumne, Vallejo

A $18000 Nutrition 11/04/2009
The facility was cited for failure to ensure that a 93-year-old resident was being properly fed. The resident, who required close one on one supervision while eating and needed encouragement to eat slowly and to take small bites, lost 18 pounds from 9/16/07, to 3/4/08. The Department determined that the resident's 16% weight loss was a result of not being provided with enough assistance while eating. Citation # 110006646.

A $18000 Decubiti (Bedsores) Careplan Infection 11/04/2009
A resident did not have any pressure ulcers on her body upon admission. The resident developed an ulcer to her right foot and another on her lower back. Her careplan indicated "handle with care" and to "keep her heels afloat at all times." Staff were to document and treat her wounds on a weekly basis, but had never done so. The facility failed to notify staff at the Board and Care home, the resident was transferred to, of her existing ulcers. She was transferred to the emergency room for treatment to a Stage II ulcer on her lower back and a Stage III ulcer on her right foot. The facility was cited for failing to implement a new careplan when the wounds did not respond to treatment. Citation # 110006644.

B $1000 Patient Care Neglect 11/04/2009
A 93-year-old female resident experienced multiple skin tears over a six month period from scratching herself. The facility did not assess the need to keep the resident's fingernails short, the use of protective clothing, or even why the resident was scratching herself to begin with. Shortly after her discharge on 4/4/08, the resident had 24 different wounds. The facility was cited for failure to provide necessary care to the resident to attain or maintain the highest practicable level of physical well-being. Citation # 110006645.

Sonoma County

Creekside Convalescent & Mental Health Rehab Prgrm
850 Sonoma Ave, Santa Rosa

B $1000 Physical Abuse Dignity 10/21/2009
The facility was cited for failing to treat a female resident with dignity and respect. On 7/2/09, a staff member grabbed the resident's arm while they were walking and did not immediately let go when the resident said no, resulting in bruising on her right forearm. Citation # 110006621.

Healdsburg Senior Living Community
725 Grove Street, Healdsburg

B $1000 Decubiti (Bedsores) 10/13/2009
The facility was cited for failing to carefully document and address pressure ulcers that developed for three residents. As a result, one resident suffered from Stage IV ulcers on both heels, and two other residents went without their pressure ulcers being detected and prevented early on. The residents were not adequately assessed or provided with a proper careplan according to their needs. As a result, skin deterioration occurred and ulcers developed that should have been avoided. Citation # 110006408.

Petaluma Care And Rehabilitation
1115 B Street, Petaluma

A $18000 Fall 12/18/2009
The facility was cited for failing to provide adequate

supervision and appropriate assistive devices in order to ensure the safety of a resident when transferring the resident. Because staff used incorrect equipment to make the transfer, the resident fell, sustaining a hip fracture, severe pain, and requiring hip replacement surgery. Citation # 110006189.

Sonoma Healthcare Center
1250 Broadway, Sonoma

A $18000 Neglect Notification 09/17/2009
On 1/17/09, a 77-year-old resident died within 15 minutes of being transported to the hospital with sepsis (a severe systemic blood infection), a 104 degree temperature and decreased level of consciousness. Earlier that day, the staff noted that the resident was not alert enough to take food, appeared ashen, had an elevated temperature and was lethargic. However, the staff failed to promptly notify the resident's physician of these changes, did not assess the changes and failed to follow its policy on responding to a serious change in a resident's condition. These failures presented an imminent danger in which death or serious harm would result. Citation # 110006017.

Tehama County

Red Bluff Health Care Center
555 Luther Road, Red Bluff

B $1000 Verbal Abuse Dignity 10/28/2009
On 9/1/09, a CNA refused to bring a resident her walker to help her transfer from the commode to her wheelchair. The CNA insisted the resident use the grab bar on her left to transfer. The resident had suffered a stroke causing left side weakness. Another staff member brought the resident her walker when she heard the resident crying and saying, "I don't like this, I hate this. I hate this." The same CNA told the resident she was "too big" on two other occasions. The facility was cited for failure to treat the resident with dignity and respect and ensure she was free from verbal abuse. Citation # 230006659.

Trinity County

Trinity Hospital D/P SNF
410 N. Taylor St., P.O. Bx 1229, Weaverville

B $1000 Verbal Abuse Dignity 10/14/2009
The facility was cited for failing to treat an 82-year-old resident with dignity and respect. On 9/4/09, the resident asked a CNA to help her change into a nightgown, the CNA said "You can do everything yourself, you're just lazy" and also called the resident "a baby." Citation # 230006606.

B $700 Mandated Reporting Verbal Abuse 10/14/2009
On 9/4/09, a resident alleged that a CNA had refused to help her change her clothes and had called her a "baby." The incident was not reported to The Department. The facility was cited for failing to report the suspected abuse within 24 hours. Citation # 230006607.

Citation Watch Consumer Report

Below are CANHR summaries of citations received by Southern California skilled and intermediate care facilities as of the print date of this issue of *The Advocate*. Citations printed without summaries will be reprinted with summaries once received by the CANHR office. Citations from earlier months are included if a description was not printed in a previous *Advocate*. Appeals of citations and collection of fines can take up to three years; for that reason the amount collected at time of publication is often zero. For up-to-date information on any citation or facility, visit the nursing home guide on CANHR´s web site: **www.canhr.org**. or call the CANHR office.

Explanation of citation classifications: "AA" citations are issued when a resident death has occurred due to nursing home regulation violations, and carry fines of up to $100,000. A class "A" citation is issued when violations present imminent danger to resident or the substantial probability of death or serious harm, and carry a fine of up to $20,000. Class "B" citations are fined up to $1,000 and are issued for violations which have a direct or immediate relationship to health, safety, or security, but do not qualify as "A" or "AA" citations. "Willful material falsification" (WMF) violations also result in a fine. Fines are not always required to be paid. Citations can be appealed, requiring the Department of Health Services to substantiate the violation. Violations repeated within twelve months may be issued "trebled fines"— triple the normal amount. Call CANHR for information on the outcome of citation appeals.

Fresno County

University Medical Center D/P SNF

445 South Cedar Avenue, Fresno

B $1000 01/06/2010

CitationWatch description will be published once citation is received. Citation # 040006887.

Los Angeles County

Bonnie Brae Convalescent Hospital

420 Bonnie Brae, Los Angeles

A $10000 Physical Environment 01/05/2010

From 12/16/09, to 12/17/09, the facility was without an emergency power supply for over 24 hours. The facility was cited for failure to maintain and provide an alternate source of power and provide written records of routine generator maintenance. Citation # 910006868.

Burbank Healthcare And Rehabilitation Center

1041 S Main St, Burbank

B $600 Fiduciary 09/04/2009

The facility was cited for failing to implement its policy that prohibits employees from receiving money from residents in the facility and protecting the resident's personal checks from theft. In 6/09, through 7/09, two staff members wrote, signed and cashed checks in the amount of $1,320.00, leaving the resident with insufficient funds in his bank account. Citation # 920006537.

Catered Manor Nursing Center

4010 Virginia Rd., Long Beach

A $20000 Neglect 09/15/2009

On 6/13/09, a 64-year-old resident who suffered from congestive heart failure was admitted to the facility. She called her daughter early the next morning reporting she could not breath. The nursing staff had failed to administer Lasix, a heart medication ordered by her doctor. The facility also failed to assess her lungs and failed to call 911 for an Advance Life Support ambulance while she was in severe respiratory distress for over an hour. Instead, she was transported to the hospital by an ambulance service that used emergency medical technicians who were not able to provide the advance life support she needed. The resident required intensive care for two and a half days, and a hospital stay of ten days to treat the overload of fluid in her lungs. After she recovered, the resident stated she did not want to return to Catered Manor because its staff would not do anything for her when she had shortness of breath and she thought she would die there. Citation # 940006515.

A $20000 Medication Neglect 09/15/2009
On 6/13/09, a 64-year-old resident who suffered from congestive heart failure was admitted to the facility. Less than 24 hours later, she was transferred to a hospital in critical condition following Catered Manor's failure to administer Lasix, a heart medication ordered by her doctor, and other ordered medications. The resident was in respiratory distress and unresponsive when she arrived at the hospital. She required intensive care for two and a half days, and a hospital stay of ten days to treat the overload of fluid in her lungs. After she recovered, the resident stated she did not want to return to Catered Manor because its staff would not do anything for her when she had shortness of breath and she thought she would die there. Citation # 940006432.

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

A $10000 Fall 10/29/2009
The facility was cited for failing to keep the resident's merry walker within reach of the resident and failing to prevent a resident's fall. On 1/4/08, a resident fell. The resident was not immediately assessed and was later found to have a fractured left femur. Citation # 940006642.

Country Villa Sheraton Nursing And Rehab. Center
9655 Sepulveda Blvd, Sepulveda

A $16000 09/30/2009
The facility was cited for failing to provide a resident with supervision and a mechanical assistance device needed to transfer him to his bed. This resulted in a fall and the resident sustained a fractured hip. Citation # 920006576.

Dreier's Nursing Care Center
1400 W. Glenoaks Bl., Glendale

B $1000 Verbal Abuse 01/12/2010
On 12/17/09, an investigation was conducted for possible verbal abuse towards a 66-year-old resident by a CNA. The resident had a colostomy and the CNA was reported to have said, "It smells like s----, like a dead animal. Did you eat a dead animal? Get the spray". Upon hearing this the resident began crying. The resident said she felt sad and humiliated. The resident also stated that the CNA was saying these sorts of things on a daily basis. The facility was cited for failure to ensure that the resident was treated with dignity and respect and not subjected to verbal abuse. Citation # 920006907.

B $1000 01/12/2010
On 12/17/09, an investigation was conducted for possible verbal abuse towards a 66-year-old resident by a CNA. The investigation determined that the facility was aware of the allegation but had failed to report it to the Department within 24 hours as required by law. The resident had a colostomy and the CNA had been making comments like, "It smells like s----, like a dead animal. Did you eat a dead animal? Get the spray". The resident said this made her feel sad and humiliated and made her cry. The facility was cited fro failure to report the verbal abuse of the resident to the Department in a timely manner. Citation # 920006908.

Fountain View Subacute And Nursing Center
5310 Fountain Ave., Los Angeles

B $1000 Decubiti (Bedsores) 01/08/2010
The facility was cited for failing to provide the necessary treatment and services to a resident who was assessed for being at high risk for bedsores. The facility did not follow physician's orders to keep the resident's heels off the bed at all times. Additionally, they did not notify the physician when there was a change in condition of the resident's lower leg bedsore. As a result, the bedsore deteriorated to Stage IV over the course of eight weeks. Citation # 920006899.

Meadowbrook Manor
3951 East Blvd, Los Angeles

AA $100000 Supervision Neglect 12/28/2009
On 3/19/08, a 39-year-old resident was pronounced dead after being found with a rope around her neck, hanging from a tree on a patio that was locked and supposed to be off limits to residents. The mentally ill resident suffered from psychosis and schizophrenia and had a history of suicide attempts. On the day of her death, the resident had reported overwhelming feelings of isolation and loneliness. Her care plan called for staff to check on her every 15 minutes. At the time the resident was found hanging from the tree, her whereabouts were unknown for approximately 50 minutes. The facility was cited because it failed to continuously monitor the resident in accordance with her care plan. Citation # 910006747.

New Vista Post-Acute Care Center West L. A.
1516 Sawtelle Blvd., LOS ANGELES

A $17000 Fall Injury 12/23/2009
On 7/10/08, an 85-year-old resident fell and fractured

her hip while an aide was using a mechanical lift to transfer her into bed. The resident was hospitalized and required surgery. Contrary to its policy to provide two people to safely transfer residents with a mechanical lift, only one aide assisted the resident at the time of her fall. The facility was cited because its failure caused the resident to sustain a serious injury. Citation # 910006664.

Rinaldi Convalescent Hospital
16553 Rinaldi Street, Granada Hills

A $15000 Fall Injury 01/14/2010
On 10/19/09, a 77-year-old female resident suffered a fractured arm after a CNA transferred her without the assistance of a second staff member. The resident had a high risk of fractures and required two person transfers. The CNA was fired and the facility was cited for failing to ensure implementation of the resident's care plan. Citation # 920006890.

Topanga Terrace Convalescent Center
22125 Roscoe Bl., Canoga Park

A $10000 Hydration 12/31/2009
The facility was cited for failing to maintain a resident properly hydrated. The resident was at high risk for dehydration, and from 8/18/09, to 10/11/09, the resident had several fevers ranging from 99.7 degrees to 103.2 degrees and had elevated blood urea nitrogen associated with dehydration. The resident's intake and output was not monitored for signs and symptoms of dehydration. Citation # 920006781.

A $10000 Hydration 12/31/2009
A male resident with a G tube and totally dependent on staff care provision went unmonitored for signs of dehydration despite being a high risk for dehydration. On 10/16/09, the resident displayed symptoms of severe dehydration including low blood pressure and tachycardia. The facility failed to ensure the resident was monitored for signs and symptoms of dehydration. Citation # 920006779.

Windsor Gardens Healthcare Center Of The Valley
13000 Victory Blvd, North Hollywood

A $12000 Hydration 01/12/2010
The facility failed to properly maintain a resident's hydration. The resident was at high risk for dehydration. He was not continuously assessed for dehydration signs and symptoms from 7/22/09, to 7/31/09. On 7/31/09, the facility failed to call the paramedics promptly when the resident experienced a change in condition. Eight hours later, the resident experienced shortness of breath, changed mental status, abdominal distention, pneumonia and intestinal obstruction, as he had not had a bowel movement in five days. The resident was diagnosed with sepsis and dehydration at the hospital. Citation # 920006864.

Lutheran Health Facility - Alhambra
2021 Carlos Street, Alhambra

A $12000 09/15/2009
Facility staff failed to take preventative measures after a resident was observed to have a rash on her face. They were cited for failing to follow physicians orders in applying treatment to all infected persons and implementing their infection control policy and procedure resulting in an alleged scabies outbreak. The Department was never notified of the outbreak. Citation # 950006523.

San Diego County

Carmel Mountain Rehabilitation & Healthcare Center
11895 Avenue of Industry, San Diego

B $1000 Physical Abuse 11/13/2009
In the early morning of 10/28/09, a CNA was observed covering the mouth of a resident with a clean diaper to prevent her from screaming and then slamming a pillow next to her head. The CNA admitted placing a diaper over the resident's mouth "as a joke" but denied slamming a pillow. The facility was cited for failing to protect the resident from abuse and for allowing the CNA to continue to care for the resident after learning about the incident. Citation # 080006715.

Eldorado Care Center, L.L.C.
510 E. Washington Avenue, El Cajon

B $800 Physical Abuse 5/22/2009
On 3/13/09, a resident was assaulted when his hands and wrists were grabbed and squeezed by a CNA. Two other CNAs saw and reported the incident to a Licensed Nurse but the nurse failed to report to the facility's management or the resident's physician. The abusive CNA continued to provide care to other residents for four hours after the assault. The facility was cited for failure to implement its abuse policy. Citation # 090006207.

Emeritus at Carmel Valley
13101 Hartfield Avenue, San Diego

B $1000 Mandated Reporting Mental Abuse 11/23/2009
On 10/28/09, a CNA told a resident not to use her call light between 3 am and 4 am The resident reported the alleged abuse to the DON who failed to report it to The Department within 24 hours as required. Citation # 080006725.

Escondido Care Center
421 E. Mission Ave., Escondido

B $1000 Medication 01/05/2010
A resident with chronic pain was without her pain medication for three days from 10/3/09, through 10/60/09. The facility records indicated they had run out of morphine but the pharmacist claimed to not have received an order for the medication until 10/5/09. The facility was cited for failure to obtain the needed medication and failure to notify the physician of their inability to medicate the resident. Citation # 080006874.

Las Villas Del Norte Health Center
1335 Las Villas Way, Escondido

B $1000 Physical Abuse 11/18/2009
On 10/2/09, a Friday night, the facility received a report that an x-ray technician had roughly handled and hurt a 78-year-old resident. The Administrator was notified of the incident but wanted to wait until talking with the resident on the following Monday before reporting the allegation to The Department. The facility was cited for the failure to report an abuse allegation to The Department within 24 hours. Citation # 080006718.

Palomar Heights Care Center
1260 E. Ohio Street, Escondido

B $1000 Mandated Reporting 11/13/2009
On 10/24/09, an Activity Assistant observed a male resident grabbing a female resident's breast. The male resident had a history of abusive and socially inappropriate behavior. She quickly removed him from the room. The Activity Assistant left a note on the Activity Director's desk. An LVN did not report the allegation to the charge nurse, the DON or the administrator. The charge nurse stated that the allegation was not reported to her until 10/26/09. The LVN failed to follow facility policy and the facility was cited for failing to report an abuse allegation to The Department within 24 hours as required by law. Citation # 080006714.

B $1000 Mandated Reporting 11/13/2009
A resident and her friend went to the bank to withdraw money when she noticed that her ATM card was missing. She discovered that her son withdrew all her money in her account, stole her car and moved out of the area. Bank staff contacted the facility and told the Charge Nurse to contact the police immediately. Police came to the facility to investigate but the abuse was never reported to the Director of Nursing or the Administrator. The facility was cited for failing to follow their policy and procedure in reporting abuse allegations to the Department within 24 hours as required by law. Citation # 080006706.

Villa Rancho Bernardo Care Center
15720 Bernardo Center Drive, San Diego

B $1000 Physical Abuse 11/05/2009
On 10/24/09, a resident's family member noticed bruising on both of the resident's arms and reported this to the nurse. On 10/26/09, which was more than 24 hours after the occurrence, The Department received notice of the incident. The resident was interviewed and he said he had been roughly handled and pushed down by a CNA while he was being transferred. The facility was cited for failing to report an allegation of abuse to The Department within 24 hours. Citation # 080006689.

A $20000 Medication 11/10/2009
A resident with metastatic cancer was admitted to the facility on 7/16/09, wearing two fentanyl patches that had been administered at an acute care hospital. On 7/17/09, the resident was given two more patches without having the older patches removed. Shortly after, the resident showed signs of respiratory distress and was transferred to a hospital and died on 7/26/09. The facility was cited for applying two fentanyl patches without removing the older patches. Citation # 080006668.

Santa Barbara County

Buena Vista Care Center
160 South Patterson Avenue, Santa Barbara

B $1000 Patient Care Notification 12/16/2009
On 4/18/08, nurse's notes indicated changes in a resident's condition including low blood pressure and an unsteady gait. On 4/19/08, the resident was found on the floor and the physician was notified via fax. It was a Saturday and the physician's office was closed. When physician ordered blood work was finally received on

4/20/09, the resident was transferred to the acute hospital with diagnoses including gastro intestinal bleeding, anemia and altered mental status. The facility was cited for failure to promptly notify the physician of a change to the resident's status. Citation # 050006780.

B $1000 Patient Care 12/16/2009
The facility was cited for failing to provide laboratory services in a timely fashion to meet the needs of an 84-year-old resident. From 4/18/09, to 4/19/09, the resident experienced low blood pressure, a change in level of consciousness, increased confusion and lethargy. The resident's family was concerned and ordered lab work, that was not returned for over ten hours, because the lab was over 100 miles away from the facility. The lab results concluded that the resident needed immediate attention by a physician. Citation # 050006291.

Tulare County

Visalia Nursing And Rehabilitation Center
1925 East Houston Avenue, Visalia

B $1000 Physical Abuse 09/23/2009
On 6/9/08, a resident was interviewed about incidents of alleged abuse that had occurred involving the resident and a CNA. The resident stated that she had been grabbed around her neck, pulled and yanked by the CNA and that the CNA had pushed her bedside table and wheelchair into the wall and and threw items around the room. The resident said she was afraid of the CNA. The facility was cited for failure to keep the resident free from fear and physical harm. Citation # 120006560.

B $1000 Mandated Reporting 09/23/2009
On 6/2/08, a resident informed a social worker of an incident of alleged abuse. The social worker did not report the abuse to the department within the 24 hour mandated time frame because she did not interpret the grievance as abuse. The facility was cited for failure to report an allegation of abuse. Citation # 120006556.

Ventura County

Country Villa Oxnard Manor Healthcare Center
1400 W Gonzales Rd, Oxnard

B $1000 Evictions 12/22/2009
A 57-year-old female resident with multiple ailments was issued a discharge order by her doctor on 4/6/09. The doctor erroneously believed that the resident was ineligible to receive chemotherapy if she continued to live in the facility. The facility staff discharged the resident the next day without counseling, correct health insurance information, and sufficient preparation. Citation # 050006820.

Shoreline Care Center
5225 South J Street, Oxnard

A $8500 Patient Care Fall Injury 01/11/2010
A resident with partial paralysis from the neck down sustained a right shoulder fracture after two CNAs manually lifted the resident during a transfer from the shower chair to the bed. The facility has a "no manual lifting" policy and has two mechanical lifts for transfers, but the facility failed to implement this policy for the resident. Citation # 050006759.

A $5000 Injury Fall Patient Care 01/11/2010
A resident was assessed at a high risk for falls upon admission and received medications that factored into a high fall risk, but the facility failed to provide timely supervision and assistance for transfers. On 8/8/09, the resident fell after using a bedside commode. The resident had pushed the call light for assistance but waited 45 minutes and tried getting back into bed, falling and sustaining a fractured ankle with a partial dislocation. Citation # 050006778.

B $800 Dignity 01/11/2010
The facility was cited for failing to provide the necessary care and services to maintain optimal well-being when they did not provide a resident with a wheelchair lift during transport back from a doctors appointment. The 94-year-old resident was put into the back seat of an employee's car and returned to her wheelchair upon returning to the facility. This incident caused the resident emotional distress and pain in her left leg and hip. She described the incident as "it was awful; it was horrible." Citation # 050006242.

WMF $500 Patient Care Patient Records 01/11/2010
A nurse falsely documented fluid intake for an 82-year-old male resident for nine consecutive shifts that she did not work, from 2/21/09 to 2/23/09, after another nurse who was taking care of the resident did not document the resident's fluid intake. Citation # 050005987.

Thousand Oaks HealthCare Center
93 W. Avenida de Los Arboles, Thousand Oaks

B $1000 Neglect 12/18/2009
From 4/10/08, to 4/14/08, a resident's ability to per-

form activities of daily life decreased and her intake of fluids and food decreased as well. The staff failed to perform continuing assessments and failed to identify the changes and notify the resident's physician. Staff administered Ativan for agitation on 4/10/08, and 4/12/08, without cause. The resident was identified with abdominal pain, mental status changes and diagnosed with a UTI. Citation # 050006091.

B $1000 Hydration 12/18/2009
The facility was cited for failing to provide a resident with sufficient fluid intake to maintain proper hydration and health. The resident had trn bowel movements from 2/04/08, to 2/06/08, and despite the resident's excessive loose stools, the staff continued to administer medication prescribed for constipation. The resident lost 14.5 pounds (11.6% of her weight) over two weeks. Citation # 050006536.

Twin Pines Health Care
250 March Street, Santa Paula

B $1000 Physical Abuse 01/04/2010
The facility was cited for failing to protect a resident from physical abuse. On 3/13/09, a resident was attacked by his roommate with a shoe horn. The roommate had hallucinations and exhibited mood and behavioral symptoms. The victim was transferred to the emergency room, where he received eight stitches to repair a laceration on his neck, five stitches to his finger and his right index finger and right forearm were placed in splints. Citation # 050006592.

Victoria Care Center
5445 Everglades Street, Ventura

A $8000 Injury Careplan Fall 01/06/2010
The facility failed to accurately assess the resident's fall risk upon admission. The resident fell on 2/28/08, after trying to use a urinal while unassisted and sustained a skin tear on his arm. The resident fell on 3/12/08, in the bathroom after slipping on his non-skid socks. During this time, nursing staff developed plans to prevent more falls. However the facility failed to implement plans correctly or revise plans as needed, such as when resident's physician prescribed medications that factored into a fall risk. The resident fell out of his wheelchair on 3/21/08, and fractured his right hip. Citation # 050005101.

B $1000 Medication 01/06/2010
After a resident fell out of her wheelchair, injuring her left arm and head, the nurse reported the incident to the physician and was instructed to take her to the hospital. The nursing staff administered a narcotic pain medication without an order from the physician, and did not take the resident to the hospital for another hour and a half. Up to that point, there was no documentation of continued neurological assessments being performed. Additionally, the nurse failed to provide a complete and accurate report of the incident. Citation # 050005086.

B $1000 Fall 01/06/2010
When a resident fell on 3/21/08, he was transferred to an acute hospital for treatment. X-Rays were taken at the facility revealing a hip fracture in addition to the more obvious injury on his shoulder that was swelling. The facility failed to notify the hospital of the fractured hip and the injury was not identified by hospital staff. As a result, the resident returned to the facility in worsened condition and non-ambulatory. The facility was cited for failing to ensure that the resident received appropriate care and treatment for a fractured hip sustained in a fall at the facility. Citation # 050005100.

The Problem with Foreclosures

Residential Care Facilities for the Elderly have hardly been immune from the massive number of housing foreclosures in California. There are approximately 8,000 RCFEs in California and the vast majority are housed in single-family dwelling units, operated by a lone individual or family with a mortgage on the property. Over the past two years, CANHR has had a surge of reports regarding RCFE properties in foreclosure.

Foreclosures are often terrible events for tenants. Historically, foreclosures have terminated the tenancy, sometimes casting the residents into the streets because they received no notice of the impending loss of their home. Foreclosures leave residents and/or responsible parties looking for new placement, with little time, which can be extremely difficult for RCFE residents. Issues like finding the quality of care desired, paying costly pre-admission fees to new facilities, and residents' susceptibility to transfer trauma are major concerns.

Both the federal and state governments have recently attempted to address the particularly cruel plight of tenants by requiring advance notice to tenants to warn them of the possible loss of their home. These efforts have significant shortcomings however. The federal "Protecting Tenants at Foreclosure Act of 2009" primarily applies to federally-related mortgages, meaning only those backed by Fannie Mae or Freddie Mac. Meanwhile, state law requiring notification to tenants can be undermined by unscrupulous RCFE operators who simply pocket the notice and do not share it with residents or their family members. Compounding the problem of notice is the fact that the important resident protections during an RCFE's closure (from AB 949 passed in 2007) do not explicitly apply to banks that take over an RCFE during a foreclosure.

The particular vulnerability of RCFE residents in a foreclosure has been in full display during a recent case in the Bay Area. In that case, the RCFE operator withheld notice of the foreclosure proceedings from her residents and from Community Care Licensing because there was no law requiring such notice. Instead, the operator chose to contest the foreclosure in court. As a result, the residents were totally unprepared for the news that the operator's court contest had failed and they had to find a new place to live.

To protect residents from the surprise loss of their home due to a foreclosure, CANHR is working with State Senator Mark Leno on a legislative remedy, the RCFE Residents Foreclosure Protection Act of 2010. If passed into law, the Act will:

1. Require RCFE operators give notice to all residents and their legal representatives of any foreclosure proceedings as soon as they are initiated, allowing residents to assert whatever rights they have to contest the foreclosure and to prepare for a possible transfer to a new facility.
2. Require RCFE operators give notice to Community Care Licensing of any foreclosure proceedings or other significant events (such as a missed mortgage payment) indicating financial distress that would threaten the housing security of the residents.
3. Apply the RCFE closure procedures to any successor-in-interest of an RCFE property that has been foreclosed.

If you have experienced an RCFE foreclosure or would like any additional information about resident rights or the foreclosure protection act, please contact Tony Chicotel, CANHR staff attorney at 415-974-5171 or tony@canhr.org.

Assisted Living Waiver Expanded

California's Assisted Living Waiver Program, which provides assisted living Medi-Cal benefits to those who live in residential care facilities for the elderly or publicly subsidized housing and who would otherwise be eligible for nursing home services, is expanding into several more counties. Since the programs inception, it has only been available in San Joaquin, Los Angeles and Sacramento counties. The Waiver program is in the process of expanding into Fresno and Sonoma counties and plans to expand to San Bernardino and Riverside counties by March 1, 2010. Although the program is not currently enrolling new beneficiaries, more information on eligibility requirements and how to enroll in the Assisted Living Waiver program can be found at:

www.dhcs.ca.gov/SERVICES/LTC/Pages/ALWPP.aspx

Care Planning for Residents of CCRCs: Know Your Rights!

By Lillian L. Hyatt, M.S.W

When a resident enters a skilled nursing facility, California law requires that the nursing home perform a comprehensive assessment of the resident's health and physical condition and identify what type of assistance the resident needs. The assessment must be done within 7 days of admission and at least once a year thereafter. Within 7 days of completing the assessment, the nursing home must complete an initial care plan that addresses all of the resident's needs and concerns. Care planning conferences are required to be held soon after admission and at least every three months to design and update the care plan. The resident, family members and/or representatives have the right to be invited and to be involved in each meeting. This is a great opportunity to make sure the care plan honors the resident's choices about care, services, daily schedule and life in a nursing home.

Residents of Residential Care Facilities for the Elderly (RCFEs)/assisted living have similar rights in California. In addition to a pre-admission appraisal that evaluates a prospective resident's functional capabilities, mental condition and social factors, the RCFE is required to meet with the resident, the resident's family and/or representatives within two weeks after admission to develop a care plan. A reassessment and care plan revisions are required at least annually, or more frequently if there is a significant change in the resident's condition.

Pre-admission assessments, frequent reappraisals and individualized care planning involving the resident, the resident's family and the resident's health care providers are important factors in ensuring that the resident receives the highest level of care in order to attain and maintain the resident's optimal physical, mental and psychosocial well-being.

Unfortunately, residents of Continuing Care Retirement Facilities that offer long term life care, i.e., Assisted Living/RCFE and Skilled Nursing Home care, are often unaware of their rights when they are threatened with a transfer out of independent living into a higher level of care. CCRC residents should become familiar with their rights under Health and Safety Code §1788 – Provisions of Contract, required by California Law. Even when a resident of an independent living unit has significant medical needs due to mental illness, memory loss, or physical disabilities that would potentially justify the transfer to a higher level of care, California law provides important due process protections.

Before a CCRC can transfer a resident, the provider must involve the resident, the resident's responsible person, and upon the resident's request, the resident's family members, physician or other appropriate health professionals in the assessment process that forms the basis for the level of transfer decision. Prior to sending any notice of transfer, the provider must conduct a care conference with the resident, the resident's family members and health care professionals to explain the reason for the transfer. The law also includes important notice provisions, the right to review the transfer decision at a subsequent care conference and, for a disputed transfer decision, the right to a prompt and timely review by the Continuing Care Contracts Branch. These and other rights to contest a disputed transfer are required to be included in your CCRC contract.

I personally experienced the problem that the lack of information about your CCRC rights can pose. At age seventy-six, after living in my independent living apartment only a year, I developed a physical condition called Crico Phatengeal spasms. This condition required that I receive pureed and soft foods as a needed service from my CCRC kitchen. Since two doctors had certified this condition as required by law, that it was a medical necessity I felt confident that this service would be provided. However, CCRC informed me that I had to be moved out of my apartment to the SNF in order to receive proper service. I required no help with any activities of daily living. My contract and state law both assured me that this

CCRC Corner(continued on page 10)

Upcoming Events

- **March 5th Alameda County Family Support Group**.
  Long Term Care Advocate, Hannah Knafo, will present information about Medi-Cal, resident rights, and family councils at this family support group meeting. Refreshments will be provided and helpful fact sheets and CANHR materials will be available to attendees. Noon-1:30 at the California Endowment Oakland Conference Center, 1111 Broadway, 7th Floor. Open to all who have relatives or friends in Alameda County Nursing Homes.

- **March 16th Medi-Cal & Estate Recovery - Webinar**
  For Social Workers and Long Term Care Professionals, this training will include a basic overview of Medi-Cal estate recovery issues, including the individuals and assets exempt from estate claims, hardship waivers and appeals and how to avoid Medi-Cal claims in the first place. Noon- 1 p.m. Presented by CANHR Executive Director, Patricia McGinnis.

- **March 23rd Conservatorships in California - Webinar**
  For Social Workers and Long Term Care Professionals, this webinar is designed for social workers and other professionals interested in the basic laws and procedures for conservatorships in California. We will first investigate the process by which conservatorships are obtained and then review the powers that different conservators may exercise. We will also briefly review the differences between probate and LPS conservatorships. Noon to 1 p.m. Presented by Staff Attorney, Tony Chicotel, Esq.

- **May 4th Institute on Aging's Mind Body Spirit: Pathways to Improving Health**
  Part of an Institute on Aging educational series for long term care professionals at Saint Mary's Cathedral, 1111 Gough St., San Francisco. CANHR will have a table set up with helpful information and resources. Register at IOAging.org/education.

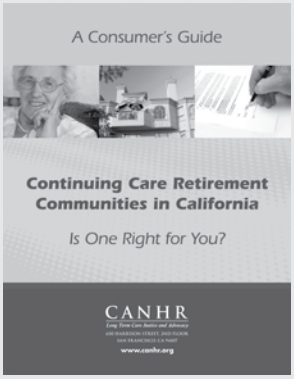
CCRC Corner .....(continued from page 9)

demand by the CCRC administration was unjust. The law stated that if it was a certified medical necessity it was my right to remain in my apartment. I had to hire an attorney at a $3,000 fee and puree my food for one year before I was given this service in my apartment. Apart from the financial burden, I was made most uncomfortable and anxious since I had to fight the very people who were supposed to be caring for me for the rest of my life.

Become familiar with your rights under California law and read the fine print of your CCRC contract to make sure they comply with the law. This will save you undue stress and enable you to live independly as long as possible. After all, this is why you chose a CCRC in the first place.

*(Ms. Hyatt is a resident of a CCRC and an AARP Policy Specialist on CCRCs)*i

A Consumer's Guide
Continuing Care Retirement Communities in California
Is One Right for You?
This consumer's guide provides essential information to make an informed decision regarding whether a Continuing Care Retirement Community (CCRC) is right for you.



To order: visit www.CANHR.org or call (415) 974-5171

Past Speaking Engagements, Panel Discussions and Training Sessions

- **November 18:** Tony Chicotel participated in the Legal Aid Association of California's 2009 "Traveling Training" in Fresno. Tony spoke to legal services providers about advocating for clients who have questionable mental capacity for decision-making.

- **November 21:** CANHR's one-day fall attorney training on Medi-Cal and Long Term Care Planning was presented at the Portola Plaza in Monterey with over 150 private bar and legal services attorneys attending.

- **December 2:** Tony Chicotel provided a webinar training to CANHR's social worker "SWAP" members. The training was about evictions from California long-term care facilities including nursing homes, assisted living, and acute care hospitals.

- **December 8:** Tony Chicotel present a training for Napa and Solano County Ombudsman and legal services providers. The topic of the presentation was health care decision making laws and issues.

- **December 10:** Staff Attorney Tony Chicotel provided a webinar training to over 200 legal services providers as part of the Legal Aid Association of California's "Armchair Training" series. The presentation covered California conservatorships.

- **January 6:** Tony Chicotel attended the quarterly meeting of the Marin County Elder Abuse Task Force and made a presentation on elder abuse in the long-term care system and the plight of unrepresented patients.

- **January 6:** Tony Chicotel participated in a Family Council meeting at Creekside Health Care Center in San Pablo. He made a brief presentation about health care decision-making and then discussed a number of resident rights issues, including staffing, theft and loss, and personal choices.

- **January 12:** Long Term Care Advocate Hannah Knafo gave a presentation on Medi-Cal for Long Term Care at the Mastick Senior Center in Albany.

- **January 13-February 17:** Tony Chicotel presented four webinars as part of his annual series for legal services programs. The webinars were given at noon on alternating Wednesdays and covered the topics of POLSTs and health care decision making, conservatorships, dealing with clients who lack capacity, and locked door long term care facilities.

- **January 20:** Mike Connors spoke to the Motion Picture Home Family Council in Woodland Hills about residents' rights.

- **January 22:** Prescott Cole gave a presentation to 54 attendees at the Santa Clara County Court Employees Continuing Education Forum. The attendees were Public Guardians, Public Administrators, Public Defenders, Superior Court personnel and court investigators. This presentation gave an overview of California's Medi-Cal long-term care program, problems with recommending reverse mortgages, and "trust mill" type activity around the Veterans Aid and Assistance program.

- **February 2:** Tony Chicotel and law clerk Nicole Platt provided legal research training to the San Mateo County Ombudsman staff. The training is designed to assist Ombudsmen identify long-term care laws and regulations to assist in their important work.

- **February 4:** Mike Connors conducted a training for ombudsman staff and volunteers in Los Angeles on resident rights concerning psychoactive drugs and informed consent.

- **February 9:** Tony Chicotel gave a presentation in San Jose at a joint meeting of the Santa Clara,

CANHR on the Move .....(continued on page 12)

CANHR on the Move ..... (continued from page 11)

Monterey, and Santa Cruz County Ombudsman programs. The presentation focused on health care decision making laws, including informed consent, surrogacy, and incapacity.

- **February 12:** Mike Connors spoke to the Elder Law Section of the Orange County Bar Association on nursing home evictions and drugging problems in nursing homes.

- **February 16:** Senior Staff Attorney Prescott Cole presented to San Mateo County HICAP on financial elder abuse scams.

- **February 23:** Prescott Cole conducted an Alameda County District Attorney Consumer Fraud Training to Financial Abuse prosecutors, investigators and staff.

- **February 25:** Pat McGinnis presented on The Status of Long Term Care in California at the first of three Trust Protection Seminars hosted by O'Donnell & Associates in Menlo Park.

In Memory of Walter Rosen

Our friend and colleague, Walter Rosen, passed away on November 14, after a lengthy illness. Walter was a one-of-a-kind person, attorney and friend, and we will miss him dearly. Walter will be remembered for his passionate advocacy for ethics in the law and for justice for our elders. Walter was a long time member of CANHR's LRS Advisory Committee, a renowned elder law attorney and an ardent supporter of CANHR's work. He was truly beloved by his colleagues and by us at CANHR.

Recent donations to CANHR in Walter's memory were made by the following persons:

Jaqueline Kanofsky
Linda Trinidad
Eugene & Doris Kane
Marian Barney & Jo Ann Gamble
Rae & Howard Mintz
Susan Spencer
Megan McKernan
Jeanne Elias
Diana Van Buren
Candace Tesler
Ann Townes
Walt Cooper
Charles Smith
Robert Powell
Anonymous

IN HONOR OF

Colette Robin Brown
Colleen Adams

Tony Chicotel
Kathy Loo, Rhonda & William Bump

Peter Lomhoff & Prescott Cole
Susan Zeman West

Michael Connors
Ventura County Ombudsman

Wilma Ethel Downs
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Bernice Forbes
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Mary Gerber

Pat McGinnis
Anna Spinella, Donna & Tom Ambrogi, Lyle & Lucille Connick

Paula Peterson
Lisa Ferreira

Stephen Peter Rosen & Family
Steven Bloomfield

Walter Rosen
anonymous

Pamela Smith
Martha Taylor

Paula Sundance
Barbara Christensen

Gilda Tometich
Tom Tometich

Frances Williams (91 years)
Jackie Johnson

The Holidays
Judith Copeland

CANHR welcomes memorial and honorary gifts. This is a great way to honor a special person, or a loved one who has been a nursing home resident, while helping those who are nursing home residents. Recent gifts have been made in the names of the following persons:

MEMORIALS

Lula Corine Turner Bishop
Gwendolyn Bishop

Classie Blakey
Cornelia Kelly - Gates

George Bower
S. Avenal Fehder

Lucille Bruskin
Susan Steinberg

Doris Burrell
Sue Burrell

Mrs. Cele Charnow
James & Linda Branson

Alice & Herman Chetlen
Martin Chetlen & Susan Zneimer

Lai Yee Chin
Bruce Chin

William E. Dolton
Theodore & Catherine Dolton

Beryl Dubois
Candie Brady

Charles Etherington
Mary Etherington

Howard P. Foote
Geneva Carroll

Ernest Gallo
La Vonne Gallo

Maxine Gallo
La Vonne Gallo

Abraham Geller
Sondra Geller & James Douglas

Esther Lindberg & Cecilia Harrison
Lorenzo & Patricia Sandoval

Edward A. Jaworski
Joanne Jaworski

Sue & Norvel Jones
Pamela Brown

Leopold Jourdan - Father
Karin Jourdan

Francis X. Kelly
Colette Kelly

Ann Kolito
Mike Kolito

Israel Kunofsky
Judith Kunofsky

Josephine Luckjohn
Georgia Riportella

Jacqueline Martin
Thomas Martin

Sherry O. McIlwain
Gloria McIlwain, Joyce McGriff, Charlotte Lawrence

Richard Miller
Steve Higaki

Louis L. Mitchell
Neil & Laura Mitchell

my Mom
Linda Paquette

Helen Vail Muller
Helen Drachkovitch

Mary Nagel
Ann & Franz Tittiger

Patrick Nobis
Carole Nobis

William & Mary Ellen O'Brien
Ellen & Don Sovie

Rosalie Ortega
Shirley Ortega & Jodi Garcia

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