Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #1

Western Convalescent Hospital
2190 W. Adams Blvd.
Los Angeles, CA 90018

Number of Beds: 129

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Los Angeles County team conducted a survey of Western Convalescent Hospital, located in Los Angeles, on May 26, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. Initial charting of the decubitus ulcers when the patient is admitted lack complete descriptions, and lack complete descriptions during the healing process.

2. One patient complained of feeling isolated as her curtains are pulled blocking her view of the doorway at times. After talking to her at length it was noted that she is extremely talkative and would yell out the door to everyone passing by.

3. Fire Safety Violations:

   a. CCR, Title 19, Sec. 904.5, LAMC 57.138.12, 57.57.03 (C3,4): Relocate stored materials no higher than 3 feet below ceiling and less than 18 inches below sprinkler heads.

   b. LAMC 57.57.04(D): Maintain aisles to allow access to storage areas and room

c. LAMC 57.04.03 and 05: Apply for a Fire Permit

d.. LAMC 57.138.08 (A): Maintain a supply of extra sprinklers on the premises

e. Chief's Regulation No.4/LAMC 57.01.35 and 57.20.15: Test and repair protection equipment. Failure to conduct the required testing w/in 30 days will be subject to penalties. Correction of equipment defects shall be completed asap.

f. CCR, Title 19, Sec. 3.18, Sec. 3.14, UFC 74.107q, LAMC 57.41.30 (B): Provide a rack, chain, or other means to secure upright storage of compressed gas cylinders. Cylinders must be chained.

g. LAMC 57.80.01 (2A&B): Discontinue all inside spray painting.

h. CCR, Title 19, Sec. 904(a5), LAMC 57.141.10:Service extinguishing system semi-annually or immediately after a system activation.

i. CCR, Title 19, Sec. 3.09: A responsible person shall be assigned to call the Fire Dept upon activation of any fire or activation of any fire protection equipment.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #2

California Convalescent Care Center
909 S. Lake Street
Los Angeles, CA

Number of Beds: 66

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Napa County team conducted a survey of California Convalescent Care Center, located in Los Angeles, on July 6, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There was an odor of urine and feces throughout the facility.

2. The medication carts were stored in the utility, which was locked but was opened for us by the housekeeper. One of the two medication carts was left unlocked.

3. The hopper in the utility room was out of order and according to staff had been that way for “a couple of weeks.”

4. Across from the utility room was the required Ombudsman poster, but with an incorrect phone number.

5. The patient rooms had extremely poor lighting and many of the light sockets were empty.

6. Some of the residents' beds were found to have broken side rails.

7. The blood pressure readings documented for one patient were to be taken weekly both lying and standing. The readings were documented as 130/70 nearly every time. When the team attempted to take the blood pressure with facility equipment, first the staff couldn't find a blood pressure cuff, and then it did not inflate properly. Once a working cuff was found our geriatric consultant got pressure readings of 110/70 lying and 98/58 standing.

8. It was noted that one-time physicians' orders are carried over monthly and not properly deleted, indicating that the orders are not being properly reviewed. One order was written three times over a two year period and all three were carried over monthly.

9. One patient complained about not having his pain medication available at the facility. Before the team left, the patient was sent out to the emergency clinic to get his medications.

10. At 10 a.m., some patients were noted to be wearing clothes with multiple food stains and actual food on their clothes from breakfast.

11. Three soiled linen carts were over flowing and strong offensive odors were emanating from them.

12. There appeared to be minimal patient activities on the day of the survey. Most of the patients were in wheelchairs lined against the walls in the hallway.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #3

Angels Nursing Center
415 S. Union Avenue
Los Angeles, CA 90017

Number of Beds: 49

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Los Angeles County team conducted a survey of Angels Nursing Center, located in Los Angeles, on July 10, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. Many of the rooms had very poor lighting.

2. The floors were very sticky in the hallways.

3. Two metal file cabinets located in the corner of the front activity room have drawers that won't close, and the cabinet is unstable and a hazard to residents as it could fall over on someone.

4. Most of the patient assessment forms lacked a date.

5. Nurses notes were incomplete.

6. One resident was positive for Hepatitis B, a serious bloodborne pathogen requiring special precautions. He had an infected abdominal wound which was to have dressings changes, but there were no special precautions being utilized.

There was not a proper care plan.

7. There was a strong odor of urine throughout the facility.

8. Weekly weights were not being documented as ordered.

9. Many patients were not wearing name bands.

10. A half-full bottle of Vodka and a partial bottle of rum were found near the front door of the facility under a counter.

11. The wheelchairs were very dirty; two lacked footrests, and the seats and backs were cracked.

12. At about 11 a.m., a woman showed up outside and parked a shopping cart by the front fence and began selling home-cooked Mexican food out of the cart through the fence to both patients and staff. Most of the facility staff are on special diets.

13. The medication cart was noted on several occasions to be in the hallway unattended and unlocked.

14. The maintenance man was observed in the front patio area removing a lit cigarette from the mouth of a resident, taking a couple of puffs off of it, and returning it to the mouth of the resident.

15. The “crash cart” was dirty, lacked proper equipment and was piled with dirty linen.

16. There were several large cracks in the plaster of the outside of the building, and a broken flower pot was found on the front patio.

17. A large keyring with multiple keys belonging to the facility was found outside where it had been left by the maintenance man.

18. The front rolling gate has a low bar at the bottom which several people were noted to have tripped over, including two members of the survey team.

19. Fire Safety Violations:

a. LAMC 57.20.15(A) Repair fire assembly door to close and latch in dining room.

b. CCR, Title 19, Sec. 3.15, LAMC 57.30.11, and 81: Relocate all flammable liquids.

c. LAMC 57.30.81 Maintain a sign reading “FLAMMABLE LIQUIDS” w/ 3inch red letters on outside housing paint thinner, paint, etc.

d. CCR, Title 19, Sec. 3.14, LAMC 57.74.05: Relocate hazardous materials to a safe location.

e. CCR, Title 19. Sec. 904.5, LAMC 57.138.12, 57.57.03(C3,4): Relocate stored materials no higher than 3 feet below ceiling and less than 18 inches below sprinkler heads.

f. LAMC 57.72.05(A&B): Provide and maintain signs reading “CORROSIVE LIQUIDS.”

g. LAMC 57.113.09.A-E: Fire Safety Manual stamped to be stamped and updated yearly.

h. Chief’s Regulation No.4/LAMC 57.01.35 and 57.20.15: Test and repair protection equipment. Failure to conduct the required testing w/in 30 days will be subject to penalties. Correction of equipment defects shall be completed A.S.A.P.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #4

Willow Lake Nursing Center
2626 Grand Avenue
Long Beach, CA 90815

Number of Beds: 163

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Los Angeles County team conducted a survey of Willow Lake Nursing Center, located in Long Beach, on July 12, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. Blood pressures on five patient files reviewed consistently appear to be rounded off.

2. Intake and output amounts on three patient records appeared to be rounded off to the nearest hundred.

3. A faint odor of urine permeated the facility probably due to the hallway carpeting.

4. While making rounds, four patients were observed to not have armbands or other type of identification.

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #5

Oakridge Care Center
2919 Fruitvale Ave
Oakland, CA 94602

Number of Beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Alameda County team conducted a survey of Oakridge Care Center, located in Oakland, on August 3, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. Blood pressures on the patient files reviewed consistently appear to be rounded off.

2. There was dirty linen found on a stool in one of the shower rooms.

3. A faint odor of urine was noted when the team entered the facility.

4. At least eight patients were noted to lack armbands and were unable to tell the team who they were.

5. Outside the facility there was a concrete stairway leading to a lower level. The gate across the stairway was open and could easily be accessed.

6. At the bottom of the concrete stairway was a landing which was cluttered with a bag of leaves and several wheelchairs and wheelchair parts. This could cause injury to a patient if they wandered or fell into this unsecured area.

7. At the bottom of the concrete stairway were two doors, one of which was unlocked and opened to a small storage area with several pipes which were leaking substantial amounts of water onto the floor. There were also exposed wires which could cause injury to staff or patients.

8. The nurses' notes in the medical records were not sufficiently detailed to describe the condition of the patient.

9. The MDS form did not match the care plan or the nurses' notes descriptions of the patients.

10. Fire Safety Violations:

    a. Elevator Equipment Room - Holes in Walls

    b. Main floor corridor fire door dragging

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #6

Valley Skilled Nursing Facility
2120 Stockton Blvd.
Sacramento, CA 95817

Number of Beds: 59

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Sacramento County team conducted a survey of Valley Skilled Nursing Facility, located in Sacramento, on August 9, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There were several open screen doors which allowed flies and other insects into patient rooms.

2. The front shower room was heavily covered with mildew in one corner.

3. The majority of the wheelchairs were properly fitted to the patient, but most lacked footrests. This would caused the foot to be bent backward when the chair was pushed by another party and also allows for early development of footdrop.

4. Based on interviews of both staff and patients, instances of abuse toward patients are being reported to administrative staff, but staff is not reporting it to the proper agency for investigation.

5. One area of concern for the team was on the roof of the facility. The air conditioning unit was leaking and a pool of standing water was noted, which could lead to rotting of the roof and potential harm to the patients.

6. Significant weight gains and losses were noted in some of the medical records reviewed, with no notation that the physician had been notified.

7. Fire Safety Violations:

a. All fire doors shall be operational which includes not being blocked.

b. Access shall be provided to all part of the facility.

c. Replace rods as needed.

d. Damaged electrical outlet in janitorial room.

e. Remove items that are blocking panel and maintain the minimum of 30 inches in front of all electrical panels throughout the facility. Remove combustible shelves next to the electrical panel.

f. Adjust doors to allow the ‘base” door to close first with the “over-leaf” door closing after the base door.

g. Magnetic release device on door leading to the solarium to be adjusted

h. Television to be 18 inches from all fire sprinklers.

i. Linen closets and soiled linen room have two fire sprinklers. Due to close proximity of sprinklers, water flow would be reduced and ineffective.

j. Decorations are installed within 18 inches of fire sprinklers.

k. Room 16 and Physical Therapy Room has a permanently installed electrical power strip/extension cords to the wall. Remove power strip from the wall.

l. A chair was blocking the exit door on the south end of the facility. All exits shall remain clear and accessible at all times.

m. Gates were padlocked. Due to lack of dispersal area, gates shall not be locked at anytime.

n. Install “Oxygen in Use-No smoking” signs at door of all occupant rooms where oxygen is being used.

o. Replace all painted fire sprinklers.

p. Replace light bulbs as needed.

q. Kitchen hood fire suppression system to be serviced every six months or after any activation of system.

r. Fire lanes not marked.

s. No portable fire extinguisher was located in the main electrical room.

t. Storage of combustibles within electrical room. Remove all combustibles from electrical room.

u. Permit not issued for installation of propane tank (located at the west-end of building). Provide permit for the installation of propane tank.

v. A mobile cart was placed in the stairway for storage. Stairway shall be clear of debris and shall not be used as a storage area at anytime.

w. Wooden dowels and electrical conduit were stored on top of fire sprinkler pipe. Remove all items from all sprinkler pipes.

x. Upstairs office had electrical installed without permits or plan submittal. Light fixture is too close to fire sprinkler. Submit plans and acquire proper permits for all electrical installation.

y. The roof area (next to the upstairs office) has water pooling around the swamp-cooler.

z. Fire alarm panel was not operating correctly. The administrator initiated a Fire-Watch until the panel was back online. The fire marshal is the only person who can initiate a Fire-Watch.

aa. Makeshift construction on the upstairs office shall meet all required building code requirements. Submit plans and acquire permits for all construction throughout facility.

bb. The upstairs office space had no air return.

cc. Decorations hanging from the ceiling in the hallway shall be flame retardant.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #7

Fountain Gardens Convalescent Hospital
222 Santa Ana Blvd.
Los Angeles, CA 90001

Number of Beds: 144

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Sacramento County team conducted a survey of Fountain Gardens Convalescent Hospital, located in Los Angeles, on August 22, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. One janitor's closet containing cleaning chemicals and equipment was left unlocked and unattended.

2. Monthly weights were not documented on a regular basis on six patient files and there was no explanation for the lack of documentation.

3. A filled soiled linen cart was noted in the kitchen near the door.

4. Three personnel files reviewed did not have documentation reflecting that references had been checked.

5. There was a strong odor of urine in the back hallway. Trash was overflowing in three patient rooms' wastebaskets.

6. A ladder was noted propped against the wall leading to the roof in the patients' patio area, and had been left unattended creating a possible hazard for residents.

7. Nurses' notes did not reflect the current condition of the patient in two instances, in-service was suggested during the exit review.

8. The medical record lacked documentation regarding the facility staff's efforts to contact the primary physician when he/she was late for monthly patient visits.

9. Patient inventory sheets failed to be updated when purchases of clothing or personnel equipment was brought in for the patient.

10. Fire Safety Violations:

    a.. CCR, Title 19, Sec. 1.14, LAMC 57.138.13(C): Affix label identifying sprinkler shut-off valve.

    b. LAMC 57.138.05: Secure sprinkler supply valves in open position. Install padlock and chain on valve.

    c. LAMC 57.138.04: Remove obstructions from around sprinkler inlet.

    d. LAMC 57.57.03(C4): Maintain a minimum unobstructed space of 18 inches below the level of sprinkler heads.

    e. LAMC 57.57.04(D): Provide and maintain aisles and side aisles. Remove storage from hallways.

    f. CCR, Title 19, Sec. 3.18, Sec. 3.14, UFC 74.107q, LAMC 57.41.30 (B): Provide a rack, chain, or other means to secure upright storage of compressed gas cylinders. Cylinders must be chained.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #8

Sunbridge Fountainview Care Center
2540 Carmichael Way
Carmichael, CA 95608

Number of Beds: 178

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Sacramento County team conducted a survey of Sunbridge Fountainview Care Center, located in Sacramento, on September 6, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. Two open doors to the staff lounge allowed patients unsupervised access to vending machines regardless of special diet orders.

2. Monthly weights were not documented on a regular basis on six patient files and no explanation was documented, and there were wide fluctuations, possibly from faulty equipment or technique.

3 One patient who was to be turned every two hours was observed by the team not to have his position changed during a three hour period. This same patient is in need of a public guardian. The facility is already working on the issue.

4. Hallways had wheelchairs and carts on both sides and the middle of hallways, not allowing easy access down the hallways by patients.

5. MDS forms lacked dates of completion and did not always accurately reflect the condition of the resident.

6. Patient personal property inventory sheets were not kept up to date showing new personal property acquired by the resident.

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #9

Pleasant Care Nursing & Rehabilitation Center
2828 Meadowlark Drive
San Diego, CA 92123

Number of Beds: 305

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Los Angeles County team conducted a survey of Pleasant Care Nursing & Rehabilitation Center, located in San Diego, on September 14, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. The facility staff failed to keep the residents' personal property inventory sheets updated.

2. The facility failed to always surrender excess trust account monies to deceased patients' familys within the required five days.

3. There was a strong offensive odor noted on Station 4 at the time of the survey.

4. One patient complained that her privacy curtain was kept drawn all day isolating her from the activity in the hallway.

5. The Minimum Data Sets reviewed did not always appropriately reflect the condition of the resident, particularly in the area of mental status.

6. Patients' weights were not always documented as ordered, and the records lacked documentation regarding the missing weight.

7. Approximately 20 boxes of patient files were found outside the facility stacked next to a portable locked storage unit.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #10

Hillcrest Care Center
4280 Cypress Drive
San Bernardino, CA 92407

Number of Beds: 59

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-San Bernardino County team conducted a survey of Hillcrest Care Nursing Home, located in San Bernardino, on September 19, 2000. The following areas of concern were noted by the team and discussed with the facility administrative staff during our exit meeting:

1. No blinds in the front dining which allowed the morning sun to shine into the eyes of the residents, for which there was no concern expressed by the caregivers.

2. Soiled gloves were found on the ground in the parking lot and in a fenced-in storage area.

3. The door to the laundry room was left open and the room unattended.

4. A separate metal storage shed was noted with phone lines and a heavy duty extension cord leading from the facility to the shed. The shed was being used as an office for the maintenance supervisor.

5. A strong offensive odor emanated from the back hall.

6. Residents were left unsupervised while eating breakfast in the diningroom.

7. The resident in Room 24 was found fully dressed and lying on his stripped plastic mattress, which was torn, for at least 1½ hours without intervention.

8. The nurses' notes were adequate with the exception of the Minimum Data Sets, which did not always appropriately reflect the true condition of the resident.

9. Fire Safety Violations:

   a. Fire Protection Equipment: Service and tag each extinguisher annually, service hood and duct extinguishing system semi-annually, clean and maintain filter and hood and duct system over cooking appliance.

   b. Sprinklers: Provide quarterly maintenance records of proper maintenance, provide sprinkler service by a State Licensed Firm.

   c. Electrical: Discontinue use of extension cords/cube taps in lieu of permanent wiring, replace unapproved wiring with permanent wiring.

HILLCREST CARE
4280 Cypress Drive, San Bernardino, CA 92407
Phone (909) 882-2965 • Fax (909) 886-2895

March 12, 2001

BMFEA Bureau of Medi-Cal & Elder Abuse
State of California Department of Justice
300 South Spring Street
#1300 North Tower
Los Angeles, CA 90013-1231

Dear Mr. Menard,

I received your letter requesting a response from Hillcrest Care in regards to the survey that was conducted on September 19, 2000.

I was not the administrator at the time of the survey; however, I did read the survey report and did some of the plan of correction as follows:

1. New mini blinds have been installed in both dining rooms to prevent the sun from coming into the window.

2. The Chief of Maintenance is checking the grounds including the fenced-in storage for clutter. Monitored by Administrator and Maintenance Supervisor.

3. Housekeeping/Laundry Supervisor gave an inservice to the staff on the importance of keeping the laundry door locked when unoccupied. Monitored by Housekeeping/Laundry Supervisor and Administrator.

4. No plan of correction required.

5. The extension cord was removed.

6. The administrator has implemented a revised cleaning schedule to include deep cleaning throughout the facility. Bed mattress and wheelchairs have been set up for scheduled cleaning. Inservice with the charge nurses and CNAs to monitor the physical and oral hygiene of the residents. Monitored by DSD, DON and Administrator

7. An inservice was given by the DON to the nursing staff on the importance of the 30-minute checks. Monitored by DON

8. The DON and MDS coordinator work together to ensure that the Care Plan and MDS appropriately reflect the true condition of the resident. Monitored by DON and Administrator

Thank you for your part to ensure our residents received the quality of care and quality of life they deserve.

If you have any question, please call me.

Caring for the Elderly,

Fran Morris
Administrator

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #11

Alta Vista Health Care
9020 Garfield Avenue
Riverside, CA 92503

Number of Beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Riverside County team conducted a survey of Alta Vista Health Care, located in Riverside, on September 21, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. One call light was left unanswered for at least 12 minutes, as observed by the team.

2. The front emergency exit was beeping and flashing when the team entered the facility at 7 a.m. It was still beeping and had not been reset when the team conducted the exit meeting at 1:30 p.m.

3. There was a strong odor of stale urine in the back hallway.

4. The medication room on station 2 was found to be unlocked and unattended.

5. There was an unidentified noise in the ceiling of room 2 near the sprinkler head.

6. There was a large deposit of mildew and a hole in one wall in the shower room on station 2.

7. The rail pads being used in two patient rooms were cracked and torn.

8. The air conditioning unit on the roof appeared to be leaking.

9. The patient inventory sheets were not being kept up to date. When patients acquire additional possessions they are not added.

10. Fire Safety Violations:

a. Repair exit sign by room 33. UFC 1212.

b. Repair corridor doors (by business office) to close and latch. UFC 1203.

c. Waste water discarded in storm drain. All waste water shall be discarded properly. UFC Art. 80.

d. Provide and maintain records for the fire alarm, fire sprinkler systems, and fire drills. UFC 1001.5.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #12

Willow Tree Nursing Center
2124 57th Avenue
Oakland, CA 94621

Number of Beds: 82

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Alameda County team conducted a survey of Willow Tree Nursing & Rehabilitation Center, located in Oakland, on September 25, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. The kitchen refrigerator was leaking.

2. The wooden shelves in the kitchen are seriously sagging under the weight of the canned goods.

3. Gasoline was being stored in the generator room.

4. There were holes in walls of the laundry room.

5. There are no occupancy signs for the shower rooms.

6. Vending machines were located on the patient patio allowing unsupervised access to the machines by patients, many of whom are on special restrictive diets or have choking problems.

7. Soiled linen carts and patient lifts blocked clear hallway access.

8. Personnel files lacked updated expiration dates on licensed/certified staff.

9. Medical records frequently lacked monthly weights and vital signs, as well as documentation as to why they were lacking.

10. Minimum data sets information did not always match the charted condition of the patient.

11. Upon entry to the facility the team noted an odor of stale urine, which did not disappear during the survey.

12. Fire Safety Violations:

    a. Number and label electrical panel (in kitchen and nurse station)

    b. Obtain a cover for electrical ceiling fan (med room and laundry room)

    c. Repair ceiling fan (in Ladies room)

    d. Patch hole in wall (laundry room)

    e. Repair door closure (laundry room)

    f. Store 15 gals of gasoline in exterior metal locker (not in building)

    g. Repair corridor fire door (not latching)

    h. Obtain a 5-year certification for sprinkler system

    i. Label emergency light panels properly

    j. Strap water heater with metal bands (exterior of kitchen)

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #13

Beverly Healthcare-Monterey
23795 W.R. Holman Highway
Monterey, CA 93940

Number of Beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Monterey County team conducted a survey of Beverly Healthcare, located in Monterey, on September 27, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. In some cases, breakfast trays sat in the hall for more than 45 minutes before being served.

2. Call lights were left on in a few instances for more than 10 minutes.

3. Records of patient discharges did not disclose the patients' destination.

4. Patients' medical records lacked monthly progress notes and order signatures by the physician on a timely basis. The records also lacked documentation of the staff's attempt to contact the physician to make the necessary visits.

5. Weights were not documented as required, and the records lacked documentation as to why they were missing.

6. The door to the staff lounge was propped open. A microwave and vending machines are located in the lounge and the propped door allowed unsupervised access to the snacks, which could be a danger to patients on special diets.

7. Fire Safety Violations:

a. UFC 1103.3.2.2: Ceiling Clearance. Storage height violations noted in almost all of the storage closets.

b. UFC Art. 74: Compressed Gases. The helium tank in the “activities closet” must be securely chained to prevent the tank from falling over.

c. UFC 8203.2.1.1: Use of LP-gas Containers in Buildings. Permit for liquid petroleum gas cylinder outside must be obtained from the Fire Department.

d.. UFC 1103.3.2.4, 105.8h.1, 5105.1. The Maintenance Supervisors office and work area is in need of attention. There is too much storage for this small area. The room needs some general safe housekeeping practices for fire prevention.

e. UFC 1112: Occupancy and Area Separations. A one-hour rated occupancy separation wall is required. Doors to be replaced by 20-minute fire rated assemblies.

f. UFC 902.2.4: Obstruction and Control of Fire Apparatus Access. The access to the Fire Department connection in the rear of the building is obstructed.

g. UFC 8506.1: Extention Cords. The extension cord attached to the ceiling in the Maintenance Supervisors office needs to be installed with conduit or by other suitable means.

h. UFC Art. 12. Illuminated Exit Signs. Exit sign adjacent to room number 8 needs bulb checked or replaced.

i. UFC 1203: Exit Obstructions. There were numerous areas where beds, equipment, and articles were stored in the hallway.

j. UFC 1207.2: Exit Doors. This section applies to the new iron gates installed on the exit walkways from the facility.

BEVERLY HEALTHCARE

March 26,2001

Larry Menard
Special Agent Supervisor
Bureau of Medi-Cal Fraud and Elder Abuse

RE: Operation Guardian Survey

Dear Mr. Menard:

We received the written comments from the September 27,2000 survey on March 19, 2001. Thank you for sending them on to me.

We appreciate the comments regarding the positive aspects of the survey, i.e. "The Team finding the facility clean and properly staffed. The Residents being clean and proper activities being provide, and the staff being friendly and cooperative with your team."

My staff and I found the team to be very professional, and easy to work with.

We addressed the concerns expressed in the exit in the following ways:

1. The staff was inserviced on the importance of providing meal trays promptly, and while most of the trays did make it to the residents timely, it is important that they all do. In addition to the inservices some procedures were change so that the Licensed Nurses not only monitor but also assist residents with the meals.

2. All staff were inserviced on answering lights timely, and that call lights are everyone's responsibility, often time it something as simple a turning on a light or finding their glasses, which any staff member can do. Should the resident need nursing intervention, that information is passed on to appropriate Nurse or Certified Nursing Assistant.

3. Resident records have all been audited and the patients destination been gathered from other locations in the chart and added to the discharge summary form.

4. Physicians were contacted and reminded of their responsibility to visit residents timely, and document the resident's progress or lack of. The Medical Director is also alerted on a regular basis, if his intervention is needed to contact physicians that are delinquent in their visits. It proved to be rather helpful to remind physicians that visits by them are not only important to the resident and us, but that the Attorney General's office had an interest in such matters as well.

5. A new weight monitoring system has been put in place with appropriate safeguards and audits to assure that weight gains or losses are addressed promptly.

6. We inserviced the staff on keeping the staff lounge door closed and we added a reminder sign to the door as well.

Again our thanks to the team for their professional conduct and pointing out issues for us to focus on that will assist us to in our efforts to proved high quality care to our residents.

Sincerely,

Donald C. Phillips
Executive Director

23795 W.R. Holman Highway
Monterey, CA 93940
(831) 624-1875 • FAX (831) 624-7138

YOUR PATHWAY HOME

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #14

Medical Hill Rehabilitation Center
475 29th Street
Oakland, CA 94609

Number of Beds: 124

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Alameda County team conducted a survey of Medical Hill Rehabilitation Center, located in Oakland, on October 11, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There were no occupancy designations on shower or tub rooms.

2. One patient smoker was taken to the patio by a CNA to smoke and was left unattended. The patient is known to be a careless smoker and is care planned to never be left alone to smoke.

3. There was no designation on the discharge census indicating to where the resident was discharged.

4. Wheelchairs were blocking both the hallways and individual resident rooms, which could be a hazard to patients.

5. There was mildew in the corners of most of the shower rooms.

6. Breakfast trays were very late, with some of them still waiting to be passed out at 9 a.m.

7. There was a strong odor of urine and cigarette smoke in the secured units.

8. The trust accounts lacked signed requests for purchases using residents' funds.

9. Weekly nurses' notes were not being completed on a weekly basis.

10. A doctor was found to have failed to sign monthly doctors' orders for as much as six moths at a time.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #15

Courtyard Care Center
340 Northlake Drive
San Jose, CA

Number of beds: 76

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Santa Clara County team conducted a survey of Courtyard Care Center, located in San Jose, on October 12, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. A dirty glove was found on the shower room floor on Station 2.

2. There were missing and broken tiles on the shower room floor on Station 2.

3. There was a heavy buildup of mildew on the window sill on Station 2.

4. Call lights were not answered in a timely manner. The team observed it taking in excess of 10 minutes for lights to be answered.

5. The treatment cart on Station 2 was found unlocked and unattended.

6. The sprinkler system had not received its five year check as required by regulation. The last check was 6/26/95.

7. There were no occupancy designations on the shower room doors, causing a problem with patient privacy.

8. One of the four water heaters in the facility was leaking.

9. One patient medical record revealed that the resident is currently in the acute hospital where she was sent for treatment of a “lesion” on her foot. The acute hospital noted that the foot had both gangrene and maggots on admission. The same record revealed poor documentation in the nurses’ notes.

10. The team found that prior to the arrival of the new administrator one month before the survey, the nurses’ notes were lacking many weekly summaries. There has been improvement since the new administrator’s arrival.

Dear Larry Menard
Special Agent Supervisor
Bureau of Medi-Cal Fraud and Elder Abuse

Response to Operation Guardian Report

First, I would like to thank the Bureau to recognize the need for such operation and the opportunity for facility to respond to the findings. I also like to commend on the professionalism of the investigator and her courteous manners while conducting the "operation". Facility staffs have witnessed an obvious difference between the investigator and state surveyors in her professional demeanor.

I as the administrator of the facility was very surprised of the visit and felt that we were unfairly targeted by misconception of the nursing home industry. I understand that quality of care is the main purpose of the operation. This is also the very reason we often transfer our patients to acute hospital for further evaluation and treatment. However, acute hospital frequently assumed that nursing home should be responsible for any negative findings as the result of poor care.

Having been working in the hospital for many years, I received more gratification from taking care of the elderly. Because I am not only proud of the great care we gave to the elderly, but also from the challenge and the obstacles I have with less reimbursement, lack of support from the family, heavy regulated industry and the opportunity to respond after "Operation Guardian".

Specializing in Rehabilitation and Restorative Skilled Nursing Care
340 Northlake Dr., San Jose, CA 95117 • Phone (408) 249-0344 • Fax (408) 246-4715

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse

My Asian culture background taught me to have great respect for elderly. I am deeply surprised to see how my profession as the administrator in a nursing home could be so discouraging and taunting at times when all we want to do is to do the right thing for those residents. I may not be making good sense here. I would appreciate to have another opportunity to express our thoughts and expertise in a positive manner to improve care for the elderly population. I still believe that the compassion we have for those residents were the reasons many of us staying in the profession. So, Help us and Help those residents!

Sincerely Yours,

Grace Ku
Administrator
March 9,2001

INSPECTION REPORT SUMMARY #16

1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

Hope Manor
1665 M Street
Fresno, CA 93721

Number of Beds: 155

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Fresno County team conducted a survey of Hope Manor, located in Fresno, on October 31, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. The concrete stairway leading down to the electrical room at the back of the facility has a gate but lacks a lock, which could lead to a hazard for wandering patients.

2. Light bulbs in some of the exit signs were burned out.

3. The staff lounge on the second floor was left open.

4. There was an offensive odor present on the third floor at the beginning of the survey, which diminished over the course of the day.

5. The freezer in the kitchen had a large buildup of ice on the outside of the door signaling a worn gasket.

6. On the first floor, near the transition area between the business offices and the first floor patient rooms, there were about a dozen ceiling tiles which were water damaged, warped and falling away from the ceiling.
7. There were snack and soda vending machines in areas of the facility which make them accessible to patients without any supervision and which could be a danger to those on swallowing or choking precautions, or patients on special diets such as

diabetic or low sodium.

8. A doctor's progress notes showed that many months were missing.

9. The medical record of a male patient showed a CBC indicating anemia, but there is no follow up lab work.

10. There were no occupancy signs on the third floor shower room, which could compromise patients' dignity.

11. Some trash containers throughout the facility lacked lids.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #17

Evergreen Health and Rehab Center of San Diego
3520 4th Avenue
San Diego, CA 92103

Number of beds: 194

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-San Diego County team conducted a survey of Evergreen Health and Rehab Center of San Diego, located in San Diego, on November 11, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There were multiple bent screens on patients' rooms sliding doors.

2. There were large cracks and chunks missing in the concrete near the third floor balcony railings.

3. The gutter and drains in the back of the facility were rusting through.

4. There was mildew in the corners of some of the shower rooms and a hole in the wall of the tub room on the fourth floor.

5. The locks were broken on the hazardous waste closet.

6. There was an odor of urine on the fourth floor and the secured unit.

7. The handrails on the fourth floor were found to be loose in many areas, along with noted wall damage.

8. The heaters on the south wall of the fourth floor were not working properly.

9. There was a lack of hot water on the fourth floor. The facility only has three water heaters.

10. Handrails in many areas were in need of sanding and repainting.

11. The ceiling plaster in the bathroom of room 403 was beginning to warp.

12. There were plastic ties holding the back gates closed.

13. There was a large open area in the ceiling in the physical therapy room.

14. There were three carts outside marked “clean linen.”

15. A dirty glove was found on a bench in the tub room on the third floor.

16. The medication cart on the first floor was found open and unattended.

17. Fire Safety Violations:

a. 1001.4. Provide 5-year service for standpipes.

b. 8509.2 Provide minimum 30" clearance perimeter of electrical panels/circuit boxes throughout the facility

c. 1112.1 Maintain fire resistive construction

d. 1210.4 Label stairwells “roof access’ or “no roof access”

e. 1211.1 Emergency backup lighting shall be provided in exit stairwells

f. 1207.4 Exit door with panic hardware shall be openable with maximum 15 lbs. of pressure

g. 7401.6.4 Compressed gas cylinders shall be secured (oxygen storage), label doors to identify boiler room and doors leading to stairwell with roof access and storage closets.

h. 8506.1 Remove extension cords (kitchen fan). Flex cord shall not be “piggy backed” - plug directly to receptacle (medical records room).

i. 8504 Provide cover plate - reception desk wall

j. 1001.7 Maintain minimum 3' clearance of hose cabinet in maintenance shop

k. 1107.1 Remove combustibles storage away from heaters

l. 1001.5.1. Service fire extinguishers - roof

m. 8001.3.3. Complete “Hazardous Materials Information” inventory

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #18

Plott Nursing Home
800 E. 5th St.
Ontario, CA 91764

Number of Beds: 216

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-San Bernardino County team conducted a survey of Plott Nursing Home, located in Ontario, on November 7, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. Odor of urine in the hallway when the team arrived.

2. The utility room door was found to be unlocked at Station 2 and contained harmful cleaning supplies.

3. A resident in shower room B-51 was observed in the shower without the privacy curtains being pulled.

4. A geri-chair was found to have a tear in the back.

5. The electrical box behind the garbage disposal in the kitchen was excessively dirty.

6. One resident had long jagged nails with which she could injure her fragile skin.

7. One resident had food in his room, brought from outside, which was contra-indicated by the resident's diet order.

8. Residents' personal property inventory sheets were not kept up to date.

9. At least one window screen was bent, which allows flies into the facility.

10. There was a hole in the wall in one resident's room.

11. Hallways were blocked when housekeeping mopped the floor, preventing easy passage by residents in case of emergency.

12. There was a gate leading to the maintenance department downstairs which was unlocked and could be a hazard to wandering residents.

13. One water heater used for residents was observed to register above 120 degrees.

14. Gaskets on one of the refrigerators need replacing.

15. Gnats were observed in the kitchen swarming around a bunch of over ripe bananas.

16. Fire Safety Violations:

    a. The 5-year fire sprinkler service is due

    b. Put a quarterly sprinkler inspection program in place

    c. Make sure generator is being serviced

    d. If oxygen storage is more than 504 cubic feet, construction changes may be required.

    e. Do not allow items to be placed which would prevent fire doors from closing

    f. Minimize combustible storage in corridors

    g. Blocking fire exits

    h. Lack of permit for generator

Telephone Number 909 984-8629
Fax Number 909 984-1182

PLOTT NURSING HOME 800 EAST FIFTH STREET ONTARIO, CALIFORNIA 91764

A SKILLED NURSING FACILITY

Serving the Inland Empire Community for the Last 53 years

Office of the Attorney General
Elder Abuse Prosecution Unit
State of California
Department of Justice
Bureau of Medi-Cal Fraud and Elder Abuse
110 west A Street, Suite 1100
San Diego, CA. 92101

December 6, 2000

Dear Mr. Rodriguez:

On November 7, 2000, as you are aware, the team from Operation Guardian conducted an on-site visit of Plott Nursing Home. During their stay, the team was very thourough in its efforts to try and identify items that would be of concern to the public, and strived to report its findings from the stand point of how we would be perceived by the public. I wish to commend the team for the professional and efficient way in which the process was implemented. It was our preception that the survey was conducted so as to minimize the impact upon the staff, residents, and the daily operations of the facility.

The team upon completion of the inspection process, provided the facility with an exit conference, at which time we were verbally provided with several findings as observed by the team. Attached is a listing of each observation by the team, and the corrective action taken by the facility for each item identified.

Plott Nursing Home is sincere in its committment to provide its residents with quality care and services. We strive to be the leader in the community, and are proactive in setting a higher standard of care for all residents we serve. I understand that the team was not here to make reccomendations as to their findings, but we take their comments, and findings to heart and followed up on each issue addressed. I would hope that you would agree that we not only looked at each of these issues, but we took appropriate steps to follow up. We appreciate the time and efforts you have made to help our industry better for our residents. Should you need to contact us in regard to any of the findings presented, we would be happy to be of assistance to you and your staff.

Respectfully Yours,

Tony Scarpelli, Administrator

Attachment
cc: Attorney General Bill Lockyer

Attachment "A"

* The team identified a urine odor by the 700 hallway, and by room 120 when they arrived to the facility at 7:30 a.m. The team later observed the odor was gone a short while later.

  The facility was in the process of providing care to the residents immediately following the breakfast meal service. Nursing assistants were inserviced on November 15, 2000 to ensure that laundry barrells are not over filled to prevent excessive odors.

* The utility room door was found to be unlocked at station 2.

  The assistant director of nursing will monitor this each morning upon her arrival to the facility at 7:30 to ensure compliance. Any employee found to have violated facility policy will be subject to disciplinary action begining with a written warning notice.

* A resident in shower room B-51 was observed to not have the privacy curtain fully pulled around the shower area to ensure complete privacy.

  The administration is monitoring for dignity issues each day. Any staff member observed not to be following policies will be subject to disciplinary action begining with a written warning notice.

* A geri chair being stored in the shower room was observed to have a tear in the upholstery.

  The chair was immediately removed from the shower room and given to the maintenance department to have the fabric replaced with new upholstery. The administrator has verified that repairs have been completed as requested.

* An electrical box on the wall behind the garbage disposal in the kitchen was observed to be dirty.

  The maintenance staff was instructed to clean the electrical box, and to also paint it to match the surrounding area. The administrator has verified that repairs have been completed as requested.

* Employee [redacted] file was checked by the team and found that there was uncertainty regarding the expiration date of her CNA certificate.

  The Director of Staff Development looked at this issue and found that [redacted] certificate is current through July 14, 2002, and no problem existed regarding her certification.

* Resident [redacted] had some jagged edges to her fingernails.

  The Director of Nurses personally provided nail care to the resident to remove any jagged edges to prevent injury to the resident or others. The Director of Staff Development provided inservice training to all nursing assistants on November 21, 2000 regarding resident nail care. The Director of Nursing will continue to monitor all residents.

* Resident [redacted] was observed to have food in his room which was contraindicated for his diet order.

  The resident and his family have been made aware of the resident's dietary order, yet they fail to co-operate. This issue has been documented in the resident's care plan previously. The Director of Nursing has included a new note indicating the resident is aware of the risks associated with eating foods not a part of his prescribed diet, and refuses to follow the orders as written by the physician.

* The team looked at the resident trust accounts and found that many residents had purchased clothing with their own funds. They wanted to be sure that all items purchased for residents were marked and available for the resident.

  The facility assigned a staff member to look in each closet of all identified residents who have purchased items with resident trust funds to be sure that clothing purchased is available for the resident. The residents inventories were compared with current items on hand to verify that all items were accounted for.

* The screen in room 400 was observed to need adjusting so it fits tightly to the window framing.

  The maintenance person was notified to make adjustments to the rollers to ensure that a tight fit was obtained. The administrator has verified that repairs have been completed as requested.

* A resident room on the 100 hallway was identified as needing a hole repaired in the wall from a resident bathroom door knob.

  The maintenance department was instructed to repair the hole, and in addition provide a door stop to prevent further damage. The administrator has verified that repairs have been completed as requested.

* There were closets in all hallways used for storage that were not labeled.

  The administator ordered and installed proper signage on all unlabeled doors throughout the facility. The administrator has verified that repairs have been completed as requested.

* During the walk thru the hallway was in the process of being mopped. Facility equipment was moved to one side of the hallway. The team felt this obstructed the unmopped portion of the hallway for visitors, and residents.

  The housekeeping staff has been instructed by the administrator to be sure that only one side of the hallway is mopped at a time. All equipment not needed should be moved, and equipment that is needed should be kept neatly along one side.

* The gate which leads downstairs to the maintenance department from the patio did not have a lock to prevent access by residents.

  A padlock was purchased and installed on the gate to be used at all times to prevent access by residents.

* The anti scald device high limit indicator was set above 120 degrees.

  The water temperature was taken in the facility and found to be between 105 and 120 degrees. As a precaution, an outside repair person was asked to come to the facility and found all water heating equipment to be operating properly. Temperatures are monitored and recorded in a logbook each week by the maintenance person.

* Door gaskets on one freezer were found to be in need of replacement.

  The gaskets for the freezer had been ordered the previous week by the facilities outside repair company. The parts arrived on 11-08-00 and were installed that same day.

* The team wanted to be sure that the clothing in the laundry room on the rack which did not have names on them were not for current residents.

  The facility assigned a staff person to look at all clothing on the rack to be sure that it did not belong to current residents. The facility utilizes this space in the laundry to have clothing available for any person who does not have clothing, nor has the funds for new clothing to be able to choose something from those items that have been donated for the residents. The administrator has verified that this task has been completed.

* The refrigerator in the medication room at station 3 was found to be at 52 degrees.

  The temperature was monitored and found to be at 35 degrees later in the day once it had been left undisturbed. Temperatures continue to be monitored and recorded each day in the logbook.

* Knats were observed to be in the vicinity of the fruit that was boxed in the kitchen pantry after being delivered.

  The administrator checked on the produce delivered later in the day of the survey, and found the kitchen staff had sorted the delivered fruit to be sure that it was free of pests.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #19

The Bradley Gardens
980 West 7th Street
San Jacinto, CA 92383

Number of Beds: 44

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Riverside County team conducted a survey of The Bradley Gardens, located in San Jacinto, on November 9, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. A heavy floor waxer was being stored in an unlocked utility room, and could be a danger to patients.

2. The shower room in the first hallway had a very rusted door frame with multiple holes eroded in it. This issue was in the planning stages of being fixed.

3. The shower stall 1 in the main shower room had a substantial water leak.

4. The shower rooms were being used for storage of wheelchairs, making showering difficult.

5. The beauty shop was found unlocked and unattended, a potential hazard to patients.

6. The pay phone, which is to be used by patients, was inoperable.

7. Multiple trust account issues were noted, which are still in question due to the poor record keeping of the previous administration.

THE BRADLEY GARDENS
980 W. Th. St.
San Jacinto, Ca. 92582
(909) 654-9347
(909) 654-6106 Fax

01-31-2001

Special Agent
Diana Boutin
2025 Gateway Place, Suite 474
San Jose Ca 95110

Re: Operation Guardians survey

Dear Ms. Boutin,

The Bradley Gardens is in receipt of the survey results dated 01-16-2001. We wish to make the following comments regarding the survey and respond to your findings.

Your survey team was courteous and appeared responsive to the needs of the residents and staff who were preforming there duties of caring for them. We thank you for this. We especially appreciated the time you took to answer questions as to the process and what the team was looking for. This helped to put employees and managers at ease during the survey.

Our response to your the noted finding:

1. **Floor waxer stored in unlocked utility room;** Maintenance has been instructed to store buffer in a secured location when not being use. We have also reviewed safety concerns and have decided that if heavy objects are being used or are stored for short periods of time in a unsecured area, they shall be secured to a stationary object with a cord or materials that would prevent the machine from being pulled over by residents and or staff.

2. **Rusted Shower door frame:** Maintenance has repaired the frame.

3. **Leaky shower head:** This was fixed 11-10-00 by maintenance and period checks by maintenance and Administrator assures that repairs continue have stopped the leak.

4. **Storage of wheelchairs**: All surplus wheelchairs have been move to another storage area. This has freed up some of the congestion in this area. Wheelchairs that are still stored in this area are rearranged or removed during showers to reduce any difficulties.

5. **Beauty Shop Door** unlocked and unattended. Staff and Beautician have been instructed to keep the door locked when not in use. Periodic checks by staff and Administrator has assured that the door remains locked when not in use.

6. **Pay Phone** that was found inoperative was reported to the Telephone Company and was repaired within five days of the survey. Staff and Administrator periodically check it to assure it's working.

7. **Trust account**: Facility policy and procedures have been placed back into effect, and record keeping is done on a monthly basis and reviewed by the Administrator. Records of transactions are being filed according to month, with all back-up paper work.

   Requested information was submitted to Janet Villa, Auditor, for review on 12-06-00 on 12-21-00 the facility spoke with Ms. Villa in which she indicated she had received the documents and did not require any further information at that time.

Should you have any question regarding the above, please contact me.

Sincerely,

Mike Elbert
Administrator

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #20

Valley Skilled Nursing Facility
2120 Stockton Blvd.
Sacramento, CA 95817

Number of Beds: 59

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Sacramento County team conducted a survey of Valley Skilled Nursing Facility, located in Sacramento, on August 9, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There were several open screen doors which allowed flies and other insects into patient rooms.

2. The front shower room was heavily covered with mildew in one corner.

3. The majority of the wheelchairs were properly fitted to the patient, but most lacked footrests. This would caused the foot to be bent backward when the chair was pushed by another party and also allows for early development of footdrop.

4. Based on interviews of both staff and patients, instances of abuse toward patients are being reported to administrative staff, but staff is not reporting it to the proper agency for investigation.

5. One area of concern for the team was on the roof of the facility. The air conditioning unit was leaking and a pool of standing water was noted, which could lead to rotting of the roof and potential harm to the patients.

6. Significant weight gains and losses were noted in some of the medical records reviewed, with no notation that the physician had been notified.

7. Fire Safety Violations:

a. All fire doors shall be operational which includes not being blocked.

b. Access shall be provided to all part of the facility.

c. Replace rods as needed.

d. Damaged electrical outlet in janitorial room.

e. Remove items that are blocking panel and maintain the minimum of 30 inches in front of all electrical panels throughout the facility. Remove combustible shelves next to the electrical panel.

f. Adjust doors to allow the 'base" door to close first with the "over-leaf" door closing after the base door.

g. Magnetic release device on door leading to the solarium to be adjusted

h. Television to be 18 inches from all fire sprinklers.

i. Linen closets and soiled linen room have two fire sprinklers. Due to close proximity of sprinklers, water flow would be reduced and ineffective.

j. Decorations are installed within 18 inches of fire sprinklers.

k. Room 16 and Physical Therapy Room has a permanently installed electrical power strip/extension cords to the wall. Remove power strip from the wall.

l. A chair was blocking the exit door on the south end of the facility. All exits shall remain clear and accessible at all times.

m. Gates were padlocked. Due to lack of dispersal area, gates shall not be locked at anytime.

n. Install "Oxygen in Use-No smoking" signs at door of all occupant rooms where oxygen is being used.

o. Replace all painted fire sprinklers.

p. Replace light bulbs as needed.

q. Kitchen hood fire suppression system to be serviced every six months or after any activation of system.

r. Fire lanes not marked.

s. No portable fire extinguisher was located in the main electrical room.

t. Storage of combustibles within electrical room. Remove all combustibles from electrical room.

u. Permit not issued for installation of propane tank (located at the west-end of building). Provide permit for the installation of propane tank.

v. A mobile cart was placed in the stairway for storage. Stairway shall be clear of debris and shall not be used as a storage area at anytime.

w. Wooden dowels and electrical conduit were stored on top of fire sprinkler pipe. Remove all items from all sprinkler pipes.

x. Upstairs office had electrical installed without permits or plan submittal. Light fixture is too close to fire sprinkler. Submit plans and acquire proper permits for all electrical installation.

y. The roof area (next to the upstairs office) has water pooling around the swamp-cooler.

z. Fire alarm panel was not operating correctly. The administrator initiated a Fire-Watch until the panel was back online. The fire marshal is the only person who can initiate a Fire-Watch.

aa. Makeshift construction on the upstairs office shall meet all required building code requirements. Submit plans and acquire permits for all construction throughout facility.

bb. The upstairs office space had no air return.

cc. Decorations hanging from the ceiling in the hallway shall be flame retardant.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #21

Camarillo Care Center
205 Granada Street
Camarillo, CA 93010

Number of Beds: 114

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-San Bernardino County team conducted a survey of Camarillo Convalescent Center, located in Camarillo, on November 21, 2000. The following areas of concern were noted by the team and discussed with the facility administrative staff during our exit meeting:

1. Plastic bags used by the staff to hold dirty diapers were hung on racks inside each patient room doorway, at approximately shoulder height. This could present a danger to patients as they are quite slippery when they fall on the floor, and could also be a choking hazard should a patient try to put it in their mouth or over their head.

2. There were no occupancy designations on the shower rooms for patient privacy and dignity.

3. The employee lounge door was propped open allowing patients unsupervised access.

4. There was a hole in the wall of the whirlpool room near room 30.

5. There was a large crack in the ceiling extending down the wall by room 30.

6. The exit doors in the back were alarmed, but open as the alarm is not operating.

7. A weevil infestation was noted in the kitchen dry storage area near the flour and cake mixes.

8. There was a faint odor of urine in the back hallway.

9. Patients complained that the staff are sometimes very slow in answering call lights.

10. A male patient was noted to be on Lasix, a diuretic, and has not had a potassium level run recently.

Camarillo Convalescent Hospital

March 13, 2001

Larry Menard
Special Agent Supervisor
Bureau of Medic-Cal Fraud and Elder Abuse

Dear Larry Menard,

First of all let me please apologize for not responding to your first letter timely. I have been so engrossed in ensuring that this facility was prepared for our annual DHS survey that I neglected to follow up on my correspondence. .

First of all please let me take this opportunity to share with you that we found the Operation Guardian survey to be an educational experience for all of us. Your surveyors were very polite and complimentary of my staff and the survey process was so quick and painless. I also shared this experience with the Ventura District DHS Supervisor as well as members of the Ventura Chapter of California Association of Health Facilities..

Regarding the deficiencies that were identified during the survey. They were corrected within several days of the survey visit with the exception of the plastic bags that were found in all of the resident's rooms. We supply these plastics for the connivance of the CNA's so they can discard soiled items in before carrying them out of the resident room. As you know, several of these plastic bags were found on the floor in the resident's rooms and could pose as a safety issue if a resident or staff member were to slip on one of them. Through many unsuccessful attempts the Safety Committee finally came up with a very simple solution and implemented it immediately.

Once again, please accept my apologies for not responding timely to your first request.

Sincerely,

Cynthia Poulsen, Administrator

205 Granada Street, Camarillo, CA 93021 • (805) 482-9805 • Fax (805) 388-8242

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #22

Milpitas Care Center
120 Corning Avenue
Milpitas, CA 95035

Number of Beds: 35

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Santa Clara County team conducted a survey of Milpitas Care Center, located in Milpitas, on November 28, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. The facility had no sign on it to identify it as Milpitas Care Center.

2. Patient inventory sheets had not been updated since 1998. Items added to the patients' personal belongings cannot be tracked or returned to the family when the patient is discharged.

3. There were no occupancy signs for the shower rooms, disrupting patient privacy.

4. Eight personnel files reviewed did not have documentation reflecting that expired certifications had been checked and updated.

5. Two broken windows were noted and had been covered over with paper. The temperature inside the facility at the time of the survey was 64 degrees and many patients were complaining of the cold.

6. The facility had several bent screens on patient room windows which would allow flies into the facility if the windows were opened.

7. There was a strong odor of stale urine throughout the facility which did not

disappear over the length of the survey.

8. It was noted by the team that one patient was being transported to the shower room by shower chair and she was not properly covered. Only the front of the patient was covered by the sheet.

9. All doors leading outside had alarms at the door, but none of them appeared to be working. The team entered the facility by way of an unlocked door at the back and no alarms went off.

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #23

Bay View Nursing & Rehabilitation Center
516 Willow Street
Alameda, CA 94501

Number of Beds: 180

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Alameda County team conducted a survey of Bay View Nursing & Rehabilitation Center, located in Alameda, on November 29, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. The facility temperature at the time of the survey was registered at 80 degrees.

2. Many patient rooms and the dining room in the Alzheimer's unit had the sliding glass doors open along with the screens, allowing flies access to the patients.

3. In room an aide was observed transferring a patient to a wheelchair without locking the wheels of the chair.

4. Patients in the Alzheimer's unit dining room were eating without assistance or supervision.

5. Room needs the light bulbs changed.

6. Wide gaps were noted between the glass double doors in two sets of doors leading outside, allowing flies access to the facility.

7. The medical record of a particular male patient , room , lacked an up to date history and physical.
8. Call lights were slow to be answered, one in the 200 hallway was on for more

than 10 minutes before being answered.

9. Patient inventory sheets were blank, missing, or not updated.

10. Purchases were made from patient trust accounts without the authorizing signature of the patient or their representative.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #24

Asbury Park Nursing & Rehab Center
2257 Fair Oaks Blvd.
Sacramento, CA 95825

Number of Beds: 131

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Sacramento County team conducted a survey of Asbury Park Nursing and Rehabilitation Center, located in Sacramento, on December 11, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There was a strong odor of urine throughout the facility.

2. Mildew was noted in the floor corners of the shower rooms.

3. Disposable razors and blades had been left on a shelf in the shower room.

4. Slip strips in the shower rooms were peeling up.

5. Poor staffing per patient interviews, especially at night.

6. Call lights were not answered in a timely manner, some left unanswered for more than 15 minutes.

7. Nurses' notes were lacking sufficient patient updates and minimal information regarding patient care.

8. History and physicals, required on an annual basis, for the patients were lacking information and physical findings in many instances and were entirely missing in some instances.

9. Personnel files lacked updated certification expiration dates for patients' care staff. They also lacked documentation of reference checks and background checks. They were fragmented and incomplete.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #25

Community Convalescent Hospital of Glendora
638 Colorado Avenue
Glendora, CA 91740

Number of Beds: 96

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Los Angeles County team conducted a survey of Community Convalescent Hospital of Glendora, located in Glendora, on December 13, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. The team noted an odor of stale urine throughout the facility.

2. There was no covering or securing straps on the fire extinguishers. This would be a hazard should a patient grab one to steady himself when ambulating in the hall, or grabbed the extinguisher for any reason.

3. The Patient Rights poster was displayed in the facility lobby, but was posted behind a tree, which obstructed the view.

4. Several patients complained about poor staffing at night.

5. The team noted staff was slow to answer call lights, some taking in excess of ten minutes to be checked.

6. The medical records need upgrading of the documentation. The nurses' notes did not fully disclose the condition of the patient. The physicians' progress notes were poorly documented and the history and physicals were frequently missing or inadequate.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #26

Madison Care Center
1391 E. Madison Ave.
El Cajon, CA 92021

Number of Beds: 96

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-San Diego County team conducted a survey of Madison Care Center, located in El Cajon, on December 14, 2000. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. One shower room had mildew beginning to grow in one corner.
2. Handrails were loose in two areas.
3. The lock was broken on the treatment cart.
4. One sliding door screen was off its track.
5. Both washing machines were leaking.
6. The Patients Rights sign, though very large, was hidden by the Christmas tree.
7. One janitor's closet was left unattended and unlocked.
8. The beauty shop was left unlocked and unattended.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #27

Shea Convalescent Hospital
867 E. 11th Street
Upland, CA 91786

Number of Beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-San Bernardino County team conducted a survey of Shea Convalescent Hospital, located in Upland, on January 3, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. Strong offensive odor throughout the facility, especially the back halls.

2. Bent screens on three windows, which could allow flies access.

3. Two of three patients examined at noon by the team physician and RN had not received AM care yet. One was lying partially on a plastic air mattress with the bottom sheet bunched up under him. He was comatose and could not have caused the situation himself. The hospice patient was found lying in a wet, soiled bed.

4. Patients complained of short staffing, especially at night, and of having to wait long periods of time for lights to be answered.

5. History and Physicals were not completed or up to date on four of ten charts reviewed.

6. Both snack and soda vending machines were located in the patient dining room allowing unsupervised access by patients. This is a hazard to those patients who are on restricted diets or those prone to choking.

7. The hallway handrails need to be sanded and revarnished to prevent patients from getting skin tears or other injury. Also two rails were loose.

8. The front door and a door leading to the patients' patio were difficult to open.

9. During a final tour of the facility, lunch trays were being passed out. Many trays were left on overbed tables in front of sleeping patients who had not been awakened or set up properly, or the patients were not present at all. The meals had been left uncovered, and could dry out and get cold before being eaten.

10. Overall staffing was assessed to be too low for the needs of the patients. This was verified by the patient interviews, offensive odor in the facility, and the patients found in wet soiled beds who had not received AM care by noon.

11. The Patient Rights poster was located in a short back hallway next to the employees' time clock. It is supposed to be prominently displayed in an area where it can be seen by all residents and their visitors.

(909) 985-1981

Shea CONVALESCENT HOSPITAL

867 East 11th Street • UPLAND, CALIFORNIA 91786

January 24, 2001

Ms. Diana Boutin
2025 Gateway Place
Suite 474
San Jose, CA 95110

Dear Ms. Boutin:

RE: Plan of Correction

We request that you accept this Plan of Correction as evidence of our achievement of substantial compliance of the alleged concerns. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the statement of concerns. The Plan of Correction is prepared and/or executed even though it is not required by the provisions of Federal and State law.

1. After surveying the entire facility to ascertain the cause of the odor, one room [redacted] was determined to be the cause of the most odor. Therefore, the entire room and adjacent bathroom were thoroughly cleaned including beds, curtains, and linens. Housekeeping and nursing staff were instructed of their responsibilities by Administrator, D.O.N., and Housekeeping supervisor. Director of Nursing, Director of Staff Development, and Housekeeping supervisor will monitor for compliance.

2. All bent window screens were repaired by Maintenance department. Regular inspection will be done by Maintenance supervisor and will be monitored by same.

3. An inservice was done regarding resident hygiene and proper care. Director of Staff Development, R.N.supervisor, and charge nurses will monitor daily for compliance.

4. Director of Nurses and Director of Staff Development have reviewed the staffing schedule to ensure adequate staff will be present on a daily basis. Nursing staff was inserviced to reiterate their duties as nurses with emphasis on answering call lights promptly.

5. Medical Records Designee will audit charts on a regular basis to ensure timely completion of History and Physical records. Director of Nurses will ensure that audits are completed; D.O.N. and M.R.D. will monitor.

6. Snack machines were removed from patient dining room and relocated to non-patient access area in the facility.

7. All handrails in need of revarnishing and/or sanding were repaired and all loose rails were re-affixed. Maintenance supervisor will monitor for compliance.

8. Lobby door and door leading to patio were repaired and oiled by Maintenance supervisor. Maintenance supervisor will monitor on regular basis.

9. An inservice was given to C.N.A.s regarding tray passes and serving of food at appropriate time. Director of Staff Development will monitor.

10. Please refer to #4.

11. The Patient Rights poster was relocated where it can be seen by all residents and their visitors.

We would like to thank Ms. Boutin and her staff for their professionalism. Please feel free to call me at 909-985-1981 if I can be of any assistance.

Sincerely,

Kam Amirshahi
Administrator

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #28

Indio Nursing & Rehabilitation Center
47-763 Monroe Street
Indio, CA 92201

Number of Beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-San Bernardino County team conducted a survey of Indio Nursing & Rehabilitation Center, located in Indio, on January 4, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. Two screens on administration windows were bent and could allow flies access into the building.

2. One roof tile was noted to be broken on the front of the building and could fall injuring someone.

3. Patient interviews revealed that the food is sometimes cold when it reaches the patients.

4. The drain in the women's shower room was dirty.

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #29

Alice Manor
8448 E. Adams Avenue
Fowler, CA 93625

Number of beds: 46

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Fresno County team conducted a survey of Alice Manor, located in Fowler, on January 9, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. The freezer in the kitchen is in need of a gasket replacement.

2. The faucets were leaking in the shower room in both the tub and the shower.

3. Handrails were loose in the back hall and near room 3.

4. Patients' annual physicals are not being documented as required.

5. There is a bent screen on a patient room window on the south side of the facility.

6. There is a tree in need of trimming in the back of the facility, before it damages the roof.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #30

Pacific Grove Convalescent Hospital
200 Lighthouse Avenue
Pacific Grove, CA 93950

Number of beds: 51

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Monterey County team conducted a survey of Pacific Grove Convalescent Hospital, located in Pacific Grove, on January 11, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. Due to the frequent use of registry personnel, the licensed staff charting lacks continuity.

2. Three of eight personnel files reviewed lacked a date of expiration on the certification and/or had not been updated in the file since their certifications were renewed.

3. Several screens were noted as bent, out of alignment or off track. This could allow flies entrance into the facility.

4. A dirty glove was noted on the floor of the utility room on Station 2.

5. The sliding glass door in room 2 was found open during a brewing storm. It was noted when the door was closed that it was extremely difficult to slide and could not be closed completely.

6. Patients interviewed complained about short staffing and that the facility is frequently cold in the early morning and early evening.

7. Staffing levels were checked and found to be low on 10 of 20 days in December,

2000.

8. It was noted that inventory sheets are not signed by anyone when a patient has been discharged. There is no evidence that the patients belongings were offered to the family after death or discharge.

9. Fire Safety Violations:

   a. UFC 8506. Remove extension cords running through openings.

   b. UFC 8504. Provide cover plates.

   c. UFC 8507. Discontinue use of multi-plug adapters.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #31

Parkmont Rehabilitation and Care Center
2400 Parkside Drive
Fremont, CA 94536

Number of Beds: 85

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Alameda County team conducted a survey of Parkmont Rehabilitation and Care Center, located in Fremont, on January 18, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. Multiple screens on patient rooms were bent and/or torn.

2. Handrails inside the facility were loose in two areas.

3. The patient patio consisted of large concrete squares which were dangerously not level. The patio gate lacked any locking mechanism, which allows strangers access to patient rooms and would allow wandering patients to leave unnoticed.

4. A dirty glove was found on a wheelchair being stored in a linen closet.

5. The light bulb in Bath C lacked a cover.

6. Unmarked food was found in the medicine prep room refrigerator. When pointed out to the charge nurse it was removed immediately.

7. One shower room in the back had no light.

8. The therapeutic grooming room was left unlocked and unattended, and contained a large number of chemicals which could easily be accessed by patients.

9. The facility floor polisher was being stored in a small alcove in a patient hallway, which could allow the polisher to fall over onto a patient.

10. There was a small pile of dirty gowns found on the floor of one shower room.

11. The patient inventory sheets were frequently blank or not updated. There were no signatures on them.

12. History and physicals in the patient charts sometimes lacked information and/or dates.

13. Personnel files lacked documentation regarding the alien status of employees who are not citizens of the U.S. Two of them had documentation, but six did not.

14. Fire Safety Violations:

    a. 2.3 Exit light illumination (front exit)

    b. 20.3 Extinguisher in office need service

    c. 5.1 Exposed electrical wiring in employee lounge

    d. 5.2 Extension cord used as permanent wiring

    f. 1.4 Exit door swing - panic hardware off kitchen

    g. 7.3 Hood system in kitchen needs service. Ensure emergency backup lights are on a generator circuit or have backup power

    h. 5.2 Therapeutic cleaning/grooming room: extension cord used - change to outlet.

    i. 11.2 LP6 Storage - Permit required.

    j. 24 Hazardous materials - 704 placards required for LP6/Oxygen storage

PARKMONT REHABILITATION
& CARE CENTER

January 24, 2001

(510) 793-7222
FAX (510) 793-4361

Diana Boutin
Special Agent
Bureau of Medi-Cal Fraud and Elder Abuse
2025 Gateway Place, Suite 474
San Jose, CA 95110

Dear Special Agent Boutin,

Please consider this letter as my response to the areas of concern noted during our Operation Guardian survey that took place on January 18, 2001.

1. We are currently getting bids from several vendors and will be having our screens replaced.

2. The handrails have been checked to assure their stability and safety.

3. We will be addressing the safety of our patient patio area to eliminate any tripping hazards. The patio gate is now and usually locked for safety, this was an isolated incident that it was not locked.

4. The dirty glove has been removed from the linen closet.

5. A cover will be installed over the light bulb in Bath C.

6. The DON and nurse supervisors will ensure that unnecessary food is not stored in the medicine prep refrigerator.

7. The shower room light has been replaced.

8. Staff have been reminded that the therapeutic grooming room must remain locked when unattended.

9. The floor polisher has been removed from the alcove in the hallway and will be stored in a safe location.

2400 Parkside Drive
Fremont, CA 94536-5394

10. Staff will be inserviced again regarding linen storage and transfer.

11. The DSD will inservice staff on patient inventory sheets and the need to complete and update in a timely manner and ensure proper signatures.

12. The Admissions Director and Medical Records Coordinator will ensure that History and Physicals are complete.

13. The DSD will audit I-9 forms and ensure that proper documentation is copied.

Please be assured that we will use your observations to improve the quality of care and life that we provide for our residents here at Parkmont Rehabilitation and Care Center.

Sincerely.

Jennifer Oldfather
Administrator

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #32

Buena Vista Care Center
160 South Patterson Avenue
Santa Barbara, CA 93111

Number of Beds: 150

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Santa Barbara County team conducted a survey of Buena Vista Care Center, located in Santa Barbara, on January 30, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There was an odor of urine noted when the team first arrived.

2. There were multiple bent screens on windows throughout the facility. In addition, there were several screens on sliding doors in the patients' rooms which were bent off track. The sliding doors also had broken locks, or did not close completely. Specific room numbers were discussed at the exit conference.

3. Vending machines were located in patient areas allowing unsupervised access by patients on special restricted diets, as well as patients who may have swallowing problems.

4. There was a broken downspout noted on the driveway side of the facility.

5. The utility room on Station one was found unlocked, despite a sign on the door stating that the door was to be locked at all times. In addition, the treatment cart was found in the utility room, unattended and unlocked.

6. Holes were noted in the ceiling of a shower room on Station one. One shower room door also had a hole in it.

7. The fire extinguishers lacked covers and were not securely fastened in place, causing a possible hazard to patients.

8. The baseboard in room 228 was pulling away from the wall.

9. The shower drain cover was off leaving a hole in the floor. It was found upside down, with the prongs pointing up, in the corner of the shower stall.

10. A storage closet on station two was left unlocked, with an unsheathed scalpel lying on one shelf.

11. In room 109 an extension cord was attached to a TV set and crossed the path of anyone walking to the room's bathroom, causing a possible hazard to patients and staff.

12. The patient charts lacked complete up to date descriptions of decubiti and the treatment being provided.

13. Patients' personal inventory sheets were not up to date, and lacked signatures on those of discharged or expired patients.

14. Many patients complained about the lack of podiatry care. This was an observable issue confirmed by the team.

15. The patient in room 204A is on continuous oxygen, but there was no "oxygen in use" sign in place.

16. Many charts reviewed lacked up to date history and physical exams as required.

17. Many charts lacked physicians' signatures on orders.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #33

Windsor Gardens Convalescent Center
3232 E. Artesia Blvd.
Long Beach, CA 90805

Number of Beds: 240

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Los Angeles County team conducted a survey of Windsor Gardens Convalescent Center of Long Beach located in Long Beach, on January 31, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There were multiple bent screens on the patients' windows.

2. There were two broken windows which were covered with cardboard.

3. There was a sliding screen door in room 307 leading to the patio which was off track.

4. There were cracks noted in the facility foundation.

5. The light was burned out in the station one oxygen closet.

6. There were vending machines located in the patio which allow unsupervised access to sweet and salty drinks and snacks which could be detrimental to the health of patients on special or restricted diets.

7. There was an odor of stale urine throughout the facility.

8. There was overflowing soiled linen in the cart in shower room three.

9. There was a heavy buildup of mildew on the floor of shower stalls on station three.

10. Many of the staff failed to wear identifying name badges.

11. There were ants found in several places in the facility, but were especially heavy near rooms 101 and 102.

12. The bathrooms in the facility were generally dirty.

13. The patients complained about the food being cold when it is served, the rooms are too cold in the morning, and staff at night failed to treat patients with respect.

14. It was noted that patients' call lights were left on for long periods, in excess of ten minutes.

15. Patients complained that the staff at night do not answer lights and do not change patients in a timely manner.

16. Personnel files did not reflect undated certification and license expiration dates.

17. The bed in room 304B does not properly raise and lower the head of the bed without someone from maintenance manually manipulating it.

18. Soiled paper was found on the floor of the shower room on station one.

19. Soiled linens were found on the floor of the shower room on station one.

20. A used bandage was found on the floor of the shower room on station one.

21. There was a heavy musty smell and humidity in the shower rooms.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #34

Winchester Convalescent Care Center
1230 S. Winchester Blvd.
San Jose CA 95128

Number of Beds: 166

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Santa Clara County team conducted a survey of Winchester Convalescent Care Center, located in San Jose, on February 2, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. Two bent screens were noted on patients' room windows and one in the laundry, which could allow flies entry into the facility.

2. There were large gaps noted between the southwest fire exit doors and the front lobby entrance doors, alllowing for cold air to get in along with flies.

3. The faciliy is badly in need of painting, for which the facility is already preparing.

4. There was mildew in the corners of some of the shower rooms. There was evidence of recent caulking over the mildew, but the mildew is growing through.

5. The soap containers in most of the shower/tub rooms were leaking soap on the floor creating a slippery floor.

6. Oxygen tanks were improperly chained in the front oxygen closet. There was a tank of helium used for balloons, which was improperly stored on a shelf in a closet.

7. There were broken floor tiles in the kitchen which could be a danger to kitchen staff.

8. There was condensation noted on the freezer which was causing large areas of frozen water outside the doors. The gasket needs to be replaced.

9. The baseboard in room 3 was peeling away from the wall.

10. Vending machines were located on the patients' patio which causes a potential danger, by creating a situation of unsupervised access to the vending machines by patients with choking problems, as well as those on diabetic, low sodium, or calorie restricted diets.

11. Handrails in many areas were in need of sanding and repainting.

12. Water damage was noted on the ceiling near room 12.

13. There was a leaking faucet in the back of the building.

14. The brick fence on the side of the driveway is missing in a large area. It lacks any safety barriers, while repair is being planned. This creates a danger for both patients and visitors, as well as staff.

15. There was a large broken flower pot on the patient patio.

16. The hallway in the subacute area was congested with carts and chairs on both sides of the hall.

17. Some personnel files lack an expiration date for the license/certification. One staff person who was originally hired as a CNA became an RN, but the file lacks any evidence of an RN license.

18. The progress notes written by a doctor are very inadequate.

19. Fire Safety Violations:

    a. Provide a hazardous material business plan

    b. Remove all door stops for all exit doors

    c. All chemicals shall be in secondary containment

    d. Service Ansal System every 6 months

    e. Remove deadbolt from exit door (kitchen)

    f. No extension cords in place of permanent wiring (office)

    g. Discontinue "daisy chaining" of surge protectors

h. All rooms with “Oxygen” will have approved sign posted

i. Secure all compressed gas containers

j. All compressed gas containers shall be capped when not in use (empty storage)

k. All electrical panels shall be free and clear of obstruction

l. Remove latches from patient’s exit doors number 22 and 24

m. Remove obstructions from patient’s exit door number 25

n. All storage shall be kept in orderly manner room number 2, station 4

o. Post approved sign for “Bio Hazards” room

p. Provide one 40BC fire extinguisher for main electrical room

q. Remove storage from main electrical room

r. Place all flammable liquids in an approved “flammable cabinet.”

s. All rooms with flammable liquids shall have approved signs posted stating “flammable liquids” “no smoking”

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #35

Pacita Pinero, Administrator
Woodruff Convalescent Center
17836 S. Woodruff Avenue
Bellflower, Calif. 90706

Number of Beds: 140

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Los Angeles County team conducted a survey of Woodruff Convalescent Center, located in Bellflower, on February 6, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. Many sliding door screens were either bent, off track, torn or did not slide appropriately.

2. The outside of the facility was littered with trash.

3. The facility is badly in need of painting and plaster repair for multiple areas of plaster damage, water damage, peeling and blistering paint.

4. Paper records of billing, training, and patient care were found stacked outside by the facility building.

5. Many outside doors were out of alignment.

6. The front doors to the facility, and other outside doors were left open most of the morning, allowing poor pest control.
7. The facility has a roach problem. The team found many roaches, both dead and alive.

8. Numerous leaking faucets were noted in the kitchen, showers and patient rooms.

9. Dirty linen carts were overloaded with wet urine-soaked linen causing an offensive odor in the hallways. The carts' lids were cracked and/or not tightly in place.

10. The base boards in many areas were missing.

11. Vending machines were located in the patient's dining room, which causes a potential danger, by creating a situation of unsupervised access to the vending machines by patients with choking problems, as well as, those on diabetic, low sodium, or calorie restricted diets.

12. Handrails in many areas were in need of sanding and repainting.

13. Water damage was noted on the window sills in the dining room.

14. Vertical blinds located in patients' rooms were missing up to 15 blades each, causing a lack of privacy for patients.

15. The facility's temperature was inconsistent throughout the various patient areas.

16. The floor in the dining room, especially near the kitchen, was very sticky.

17. The shower head in shower room S4 was missing.

18. Some personnel files lack a certification number and expiration for new aides, one was hired a year ago.

19. Call lights were on the floor or out of reach by patients in at least five rooms.

20. The restraint on patient Tefulo was tied in knots.

21. Staff was observed returning linen taken from a patient room, to the clean linen cart. Another staff person was observed dropping linen on the floor, picking it up, shaking it out and returning it to the clean linen cart.

22. Most patients lacked name bands.

23. The gas can for the emergency generator was empty.

24. Mr. Tucker in room 11 was found smoking in his room. He stated he did so with the knowledge of the staff.

25. There was a large buildup of mildew above the sink in the kitchen.

26. An uncovered garbage can was found in the kitchen.

27. A wire or cable was hanging outside the facility looped from the roof, causing a potential hazard to anyone walking in the area.

28. One fire extinguisher was missing a gauge and at least two others with gauges indicated they needed to be recharged.

29. A small bottle of lubricating oil was found in a puddle of oil on a shelf in the kitchen pantry with the facility's emergency food supply.

30. The internal supply closet was cluttered with empty boxes and supplies.

31. The electrician room in the facility was unlocked, causing a potential patient hazard.

32. No water temperatures had been logged since 12/28/00.

33. Individual patient medical issues were discussed at the exit conference, including lack of lab testing, lack of documentation on two possible cancer symptoms, and needed services such as nail clipping and hearing testing.

34. At least three wheelchairs were in need of repair.

35. Nurses notes were documented through a checklist system, which does not adequately describe the patients condition.

36. Physicians' progress notes were lacking adequate documentation describing an examination by the physician.

37. MDS forms lacked completion and signatures in some cases.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #36

Fredericka Manor Care Center
111 3rd Street
Chula Vista, CA 91910

Number of Beds: 174

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Santa Clara County team conducted a survey of Fredericka Manor Care Center, located in Chula Vista, on February 8, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. Multiple bent screens on facility windows which could allow entry into the facility by flies and other pests.

2. There were multiple loose handrails throughout the facility.

3. There was mildew in the corners of the shower rooms which had been improperly caulked over.

4. There were unsecured oxygen tanks in the storage closet.

5. Multiple soiled linen carts were found to be uncovered and/or without the lids secured properly, causing an odor throughout the facility.

6. There were plastic bags hanging on the hallway handrails.

7. The utility room was posted as being locked at all times, but was found unlocked and unattended, with chemicals being stored in the room.

8. The employees' break room door was propped open, and contained staff's personal property, as well as a microwave, etc., which could be of danger to patients.

9. There was dirty linen found on the floor of several shower rooms.

10. The door by room 420 does not close properly.

11. Fire extinguishers were not properly secured in various parts of the facility.

12. The soiled linen carts being stored in the soiled linen closet were overflowing with soiled linen and had no covers.

13. The second floor janitor's closet was found to be unlocked and unattended, with chemicals being stored in the closet.

14. The second floor central supply room was left unlocked and chemicals (bleach) was stored in the room.

15. A toothbrush and used gloves were found in the third floor shower room.

16. Fire Safety Violations:

    a. UFC 1001.5.2 Provide 5-year certificate for sprinkler system

    b. UFC 1001.5.2 Show proof of one year fire alarm

    c. UFC 1201.1 Remove cart from exit in gift shop

    d. UFC 1207.3 Remove side-look from exit doors in Saylor Building

    e. UFC 7401.6.4 Chain compressed cylinders of oxygen

    f. UFC 1201.1 Keep aisles clear at all times (carts, chairs)
    Show proof of fire drills

    g. UFC 1103.3.2.2 Remove storage in mop closet 24" below ceiling

    h. UFC 1002.1 Add an additional fire extinguisher to the opposing side

    i. UFC 1001.5.1 Extinguisher to be secured in the garbage shoot room

    j. UFC 1103.3.2.4 Remove storage from electrical room

    k. UFC 103.3.1.1 Remove door stops to maintenance shop

    l. Remove deep fat fryer in Activities Room

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #37

Marlinda Convalescent Hospital
830 Pratt Avenue
St. Helena, California 94574

Number of Beds: 70

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Napa County team conducted a survey of Marlinda Convalescent Hospital, located in St. Helena, on February 13, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There were screens on several sliding doors which did not slide smoothly. There were many windows which were missing screens. This would allow flies entry into the facility when the windows are opened.

2. There was a toilet between rooms 13 and 14 which would not flush properly, which was being repaired before the team exited.

3. The facility is badly in need of painting, for which the facility appears to be in the preparation stage.

4. There was an odor of urine in the station two hallways caused by the failure of the staff to properly close the soiled linen carts.

5. The handrails were in need of sanding and re-finishing. One rail was slightly loose.

6. The station one medication cart was found on two separate occasions during the survey to be unlocked and unattended.

7. There was wall damage noted in the kitchen which went across the ceiling and down one wall.

8. There were janitor closets, housekeeping closets and the sterilization room which contained chemicals and disinfectants. The doors were found to be unlocked when the team was touring the facility.

9. Two patients were noted to be in their rooms with the doors open, no curtains drawn, wearing only an open backed gown and no underwear. This exposed both the resident and anyone passing by to possible dignity issues.

10. Vending machines were located in patient accessible areas which could cause a potential danger, by creating a situation of unsupervised access to the vending machine by patients with choking problems, as well as those on diabetic, low sodium, or calorie restricted diets.

11. One area of the hallway was obstructed when breakfast carts were present.

12. One personnel file lacked an expiration date for the CNA re-certification.

13. There was a cable hanging from the ceiling in room 26 which could pose a hazard to patients as it is not secured as it comes down the wall.

14. The attic access in the station one bathroom was open, but no one was working in the area.

15. There was a ladder left against the outside of the building unattended when observed by the team both the day of the survey and the day before.

16. The thermostat inside the external refrigerator in the kitchen should be on the shelf for a true reading rather than up against the refrigerating cooling unit.

17. Floor tile in the shower room across from room 22 is missing grout in spots.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #38

Folsom Convalescent
510 Mill Street
Folsom, CA 95630

Number of Beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Sacramento County team conducted a survey of Folsom Convalescent, located in Folsom, on February 14, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. Although most of the window screens appeared to be new, it was noted that many were bent, which could allow flies entry into the facility.

2. The review of personnel files showed that in one case no CNA certification number or expiration date was noted. On all other licensed/certified staff it was noted that there was no current expiration date in the file.

3. The inside of the facility is badly in need of painting.

4. There was a heavy buildup of mildew in many of the patients' bathrooms. There was also wall damage in some of the bathrooms around the sink.

5. Outside the facility there was trash noted all over. The trash containers outside the facility lacked lids which attracts flies and other bugs, which could easily gain access to the facility and the patients.

6. Oxygen tanks were not properly chained in the oxygen closet.

7. Fire extinguishers were not secured, which could be a danger to patients in the event of an earthquake.

8. It is strongly suggested that an accounting system be established to keep track of items, such as televisions, which have been donated to the facility.

9. It was noted that a doctor uses a stamp to note his annual history and physical update. This does not adequately document that a physical exam was performed as there are no findings documented.

10. Vending machines were located in patient-area patio which causes a potential danger, by creating a situation of unsupervised access to the vending machine by patients with choking problems, as well as those on diabetic, low sodium, or calorie restricted diets.

11. There was a strong offensive odor throughout the facility, a combination of urine, feces and cleaning chemicals.

12. Water damage was noted in the outside water heater closet. This was rain damage, not a leaking water heater.

13. A patient who is on on Lasix has not had a potassium level done recently.

14. A vial of Heparin and an IV tray were noted in the Medicare Med Room, where both doors were open during the entire survey. The room was usually left unattended.

15. There were shower chairs with mesh seats which were showing mildew, particularly around the seams.

16. The outside maintenance room was found unattended and open.

17. Many call lights were not turned off for more than 15 minutes.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #39

Western Healthcare Center
1700 E. Washington Ave.
Colton, CA 92324

Number of Beds: 109

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Napa County team conducted a survey of Western Healthcare Center, located in Colton, on February 22, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There were many bent and torn window screens on residents' room windows. This would allow flies entry into the facility when the windows are opened.

2. There was a pervasive odor of urine throughout the facility.

3. The trust accounts lacked resident requests for items and the receipts did not detail what items were purchased.

4. One personnel file for a CNA had an expired certification date of 1/15/01.

5. Outside there was a section of broken roof tiles on the back parking lot side, and missing tiles on the street-side of the building.

6. There were open doors leading to the smoking patio which allowed the cigarette smoke and odor into the facility, along with flies.

7. There were cracks in the ceiling by station two.

8. There were door frames pulling away from the wall in many areas.

9. There was a heavy buildup of mildew around the hand washing sink in the kitchen.

10. The floors in the patient rooms were dirty and needed mopping when rounds were made at about 10 a.m.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #40

Sunbridge Fountainview Care Center
2540 Carmichael Way
Carmichael, CA 95608

Number of Beds: 178

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Sacramento County team conducted a revisit of Sunbridge Fountainview Care Center, located in Sacramento, on March 8, 2001. The team found your facility to have made significant changes since our previous visit of September 6, 2000.

The facility showed improvement in the overall look. It was much cleaner and had only a faint odor of urine. The clutter was considerably less restricting to the movements of the patients.

The medical records were greatly improved. The nurses' notes showed the most dramatic improvement, but the annual history and physicals, and the physicians progress notes were also up to date and complete on the records reviewed.

The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There was dirty linen on the floor of one shower room and room 616.

2. There was a half empty can of soda left propped on a handrail in a patient area hallway.

3. There were two bent window screens.

4. There was mildew coming through the caulking in the shower rooms which had

been improperly repaired after our last visit.

5. The staff lounge door had been propped open with a chair.

6. Dirty gloves were found on the floor of the shower room by room 20.

7. In the shower room by room 20, there was a leaking faucet and a dirty linen cart that was overflowing.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #41

Valley Skilled Nursing Facility
2120 Stockton Blvd.
Sacramento, CA 95817

Number of Beds: 59

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Sacramento County team conducted a revisit of Valley Skilled Nursing Facility, located in Sacramento, on March 8, 2001. The team found your facility to have made significant changes since our previous visit of August 9, 2000.

The facility has a new roof, new medication carts and several new wheelchairs. The newly caulked areas in the shower and tubs rooms were noted, although they have not been completed. This certainly enhanced both the working and living conditions at the facility. This was confirmed by the patients in the interviews performed.

The medical records were greatly improved. The nurses' notes showed the most dramatic improvement, but the annual history and physicals, and the physicians progress notes were also up to date and complete on the records reviewed. The staffing levels had also improved.

The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There were several broken tiles in the shower/tub rooms, which are in the process of being repaired.

2. There were leaking faucets in one shower room and the hopper in one utility room.

3. There was a razor left in the shower room across from room 18.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #42

Victoria Care Center
5445 Everglades Street
Ventura, CA 93003

Number of Beds: 188

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Ventura County team conducted a survey of Victoria Care Center, located in Ventura, on March 13, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There were screens on several windows on the front of the building which were torn or bent. This would allow flies entry into the facility when the windows are opened.

2. Several sliding doors and their screens do not slide properly; thus, are left open allowing flies in to the facility.

3. Food was not appropriately covered and dated in the kitchen refrigerator.

4. There was an odor of urine in the hallways caused by the failure of the staff to properly close the soiled linen carts.

5. Staff members were hanging their coats and purses in the utility room.

6. There was food improperly stored in the medication refrigerator on the London Station.

7. There were some loose handrails throughout the facility.

8. There were some minor leaks in the washing machines.

9. The floors in the kitchen were very dirty.

10. There were several patients on multiple medications, in excess of 15 medications per patients and up to 25 medications in at least one case.

11. Fire Safety Violations:

    a. Remove storage from exit corridor between dining room and kitchen

    b. Maintain doors closed between kitchen and dining room (exit corridor)

    c. Remove extension cords in lobby and maintenance room, and discontinue any use of any other extension cords

    d. Move table away from exit door in small dining room

    e. Repair exit doors near rooms 87 and 126

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #43

Camarillo Care Center
205 Granada Street
Camarillo, CA 93010

Number of Beds: 114

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Ventura County team conducted a revisit of Camarillo Care Center, located in Camarillo, on March 14, 2001. The team found your facility to have made significant changes since our previous visit of November 21, 2000.

All issues previously noted had been repaired. The greatest improvement was in the medical records. The nurses' notes were exceptional. The annual history and physicals were complete and up to date with only one exception, and the physicians progress notes were very complete. The MDS forms were dated and complete.

The following areas were noted to be of concern:

1. There were two leaking sprayers in the kitchen, probably from worn washers.

2. The employee staff lounge was propped open.

3. The advance directive form for a male patient had not been signed by the doctor.

4. A male patient needs follow up lab work for previous abnormal results from 3/5/00.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #44

Golden Cross Health Care of Fresno
1233 A Street
Fresno, CA 93706

Number of Beds: 80

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Fresno County team conducted a survey of Golden Cross Health Care of Fresno, located in Fresno, on March 20, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There were screens on several windows which were bent or off track. There were many windows which were missing screens. This would allow flies entry into the facility when the windows are opened.

2. The roof is in need of repair in many areas. There are roof slats missing, bulging, or rotting from the moss overgrowth.

3. The facility is badly in need of painting. What painting has been done has been sloppy and haphazard, but the administrative staff seems to be aware of the problem.

4. There was a strong odor of urine and feces throughout the facility.

5. The were some handrails which were loose and in need of tightening for the safety of the patients.

6. There was a large tank of helium in the corner of the dining room. Although properly anchored this would still allow patients unsupervised access to the

helium gas and could result in serious damage to the health of the patients.

7. There was wall damage, door frame damage, ceiling damage and floor damage noted throughout the facility.

8. The kitchen floor was dirty, as were the pantry shelves. There were rodent droppings on the pantry shelves.

9. Multiple patients were noted to be in their rooms with the doors open, no curtains drawn, wearing only an open backed gown and no underwear. Many were being bathed or dressed by staff without the curtains drawn or the doors closed. This exposed both the resident and anyone passing by to possible dignity issues.

10. Vending machines were located in patient accessible areas which could cause a potential danger, by creating a situation of unsupervised access to the vending machine by patients with choking problems, as well as those on diabetic, low sodium, or calorie restricted diets.

11. The women's bathroom on station two has a chipped toilet seat

12. Three personnel files lacked an expiration date for the certification/license.

13. There were no occupancy designations on the shower rooms. Staff were seen going in and out of the shower rooms without knocking, exposing the patients to dignity issues.

14. Room 16 was a mess with plastic gloves, clothing, trash, and cigarette butts strewn around the room and the bed. There were several gloves in the sink and an odor of cigarette smoke permeated the room. The patient is very probably smoking in the room, causing a hazard to other patients.

15. The faucet in the kitchen sink was leaking substantially.

16. The gaskets on one of the refrigerators were cracked and not sealing properly.

17. There was food in the refrigerator that was unlabeled and undated.

18. When the team entered the building at 7:15 a.m., it was noted that many of the staff were not wearing name badges.

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #45

Pacific Gardens Nursing and Rehab Center
577 South Peach Street
Fresno, CA93727

Number of beds: 180

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Fresno County team conducted a survey of Pacific Gardens Nursing and Rehab Center, located in Fresno on March 21, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There were screens on several sliding doors which did not slide smoothly. There were many windows and screens which were bent sufficiently that they would allow flies entry into the facility when the windows are open.

2. There were vending machines on the patio which allow unsupervised access to reside4nts who are on special diabetic or sodium-restricted diets, or who need special consistency of the food to prevent choking.

3. Many patients were missing name bands used for identification purposes.

4. The team observed a red call light flashing above the door of one resident room for more than five minutes. During that time, four different healthcare staff passed by the room without looking in. One team member asked the staff person at the desk if someone was going to answer the light. Two more staff people passed the room before the licensed nurse passing meds finally answered the light. This entire process took in excess of ten minutes.

5. The light in shower room D was not working.

6. There was food in the medication refrigerator at station 4.

7. The faucet in the kitchen was looking; needs a new gasket.

8. The medication cart on station 1 was left unattended and unlocked.

9. Review of the medical records revealed one physician who does not visit his patients in a timely manner, despite documentation of frequent reminders by the nursing staff.

10. There was a faint odor of urine throughout the hallways of the facility when the team arrived.

11. There was a razor left in shower room C and feces on the floor.

12. There was used gauze and a used glove on the floor of the shower room B.

13. Room A has cracked wall tile near the floor and there were used gloves on the floor.

14. Room F had soiled linens left on the floor.

15. Room H had a feces-covered rag left on the floor.

16. Residents complained that staff are noisy at night and they would appreciate it if staff would not come in at 4 a.m. to change the drinking water.

17. Residents' personal inventory sheets were not kept up to date. They are also not signed by the resident or responsible party when the resident is discharged.

18. Fire Safety Violations:

    a. Remove door stop on weight room

    b. Install/repair exit sign(s) in activity room

    c. Install portable fire extinguisher

    d. Repair defective automatic fire sprinkler system, fire alarm system

    e. Repair fire door near whirlpool room #1 (not latching)

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #46

Oakridge Convalescent Center
2919 Fruitvale Avenue
Oakland, CA 94602

Number of Beds: 99

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a revisit at Oakridge Convalescent Center, located in Oakland, on March 22, 2001. It was obvious to the team that you had reviewed the issues brought out during our initial survey and had made great progress in improving the facility. We were very impressed by the hard work and dedication you and your staff has shown towards making the facility a better place to both live and work. Your staff was very cooperative during this visit, as they were during the first visit.

We found only minor issues during this surprise revisit. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There was a bent downspout noted outside the facility.

2. On the back door of the facility, there was a wire being used as a hook to keep the door open by hooking it over the railing nearby. This is a door which if kept open would have to be screened.

3. The floor in room 25 had a large gouge in it.

4. There was mildew noted in the corner of shower room 8.

5. There was a dirty glove on the floor in hopper room 2.

6. There was one improperly chained oxygen tank in Oxygen closet 2.

7. Janitorial closet 3 was unlocked and unattended, and contained chemicals.

8. There was a small leak found in the back of the washing machines in the laundry room.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #47

South Pasadena Convalescent Hospital
904 Mission Street
South Pasadena, CA 91030

Number of Beds: 156

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Los Angeles County team conducted a survey of South Pasadena Convalescent Hospital, located in South Pasadena, on March 27, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There were screens on several sliding doors which were off track. There were many windows with bent screens. This would allow flies entry into the facility when the windows are opened.

2. The exit door next to the TV room was propped open allowing flies and wasps into the facility.

3. The front door of the facility lacked weather stripping between the doors allowing insects access into the facility.

4. There was damage to the stucco near the front door, and the caulking/weather stripping was hanging from one of the large front windows.

5. The brick fence between the facility and the adjoining property has a large crack and a capper brick which is no longer set in place.

6. The outside Biohazard storage door is severely damaged and there is a used vinyl glove stuck to it.

7. There were not the appropriate number of Ombudsman signs posted in the required locations.

8. The handrails between room 311 and the hallway and next to room 301 are loose.

9. While passing room 208 at 11 a.m., I noted the care staff person giving perineal care to a female patient without privacy curtains being pulled, thus violating the residents' right to privacy.

10. Vending machines were located in patient accessible areas which could cause a potential danger, by creating a situation of unsupervised access to the vending machine by patients with choking problems, as well as those on diabetic, low sodium, or calorie restricted diets.

11. The fire extinguisher across from room 119 had a thermostat cover jammed into the top of the storage cupboard.

12. In the enclave next to room 124, gloves were found on the floor and a dirty towel and dirty spoon on the shelf.

13. In the kitchen there was mildew on the sink, broken coving tiles at one end of the kitchen, a wasp and flies in the pantry, and covered but unlabeled food in the refrigerator.

14. Patients' only complaint was that there was low staffing at night and on weekends.

15. There were several wheelchairs with cracked vinyl backs.

16. Multiple patients were missing armbands or legbands.

17. There was oxygen in use in room 304B, but no "oxygen in use" sign posted.

18. The wiring to the call light in room 122B is beginning to fray.

19. There were half full sharps containers located on the counters at the nurses' station. They should be locked up as they are a hazard to both staff and patients.

20. The inside biohazard waste closet was the only door unlocked in the facility. This should be locked at all times.

21. Ten personnel files were selected at random. Three lacked an up to date expiration date on the certification/license of the staff person.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #48

California Convalescent Center #1
909 S. Lake Street
Los Angeles, California 90006

Number of Beds: 66

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians team conducted a surprise revisit of California Convalescent Center #1, located in Los Angeles, on March 28, 2001. The facility showed great improvement in most areas since our initial inspection. Congratulations on the improvements. The following new areas of concern were noted by the team and we are sure you will take the appropriate action:

1. The team arrived early and were able to observe patients having breakfast in the dining room. Although very pleasant there was no staff person present in the dining room should a patient choke or some other emergency arise.

2. The supply closet by room 12 contains syringes and other supplies and should be locked at all times; it was unlocked. This was corrected immediately.

3. The medication cart was left unattended and unlocked, as was observed by your own nursing consultant. This was a problem noted during our initial visit also. This was corrected immediately and inservice has been scheduled by your staff.

4. There was a large hole in a window screen on the James Wood St. side of the building. There were also two bent screens which could allow flies into the facility.

5. There was a soda vending machine located on the patio which allows residents on special diets (diabetic, low sodium, etc.) unsupervised access to the soda's which

could be detrimental to their health. This could also lead to civil lawsuits should a resident have a health episode following their ingesting the soda, even without your knowledge.

6. There were two ladders stored against the building on the patio. They were not in use and were left there unattended. This was being corrected as the team left.

7. The tile in Bath 2 needs re-grouting.

8. There were some physicians who were not making their monthly resident visits on time. Possible solutions were discussed with the nursing consultant.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #49

Angels Nursing Center
415 S. Union Avenue
Los Angeles, CA 90017

Number of Beds: 49

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-Los Angeles County team conducted a surprise re-visit of Angels Nursing Center, located in Los Angeles, on March 28, 2000. The facility showed improvement in most of the areas previously identified as problems when we visited July 10, 2000. The following new areas of concern were noted by the team and we are sure they will receive the same attention as our previous concerns:

1. There were a couple of bent screens on the north side of the building, and one with a hole in it.

2. There were old dirty mattresses piled up next to the facility, which we assume are going to be removed shortly.

3. The facility has a problem with flies, which can lay eggs in residents' wounds and/or sores, causing maggots. This was traced to the fact that both staff and residents are leaving screen doors and exit doors open. This is unacceptable. Doors must be closed or screened when opened.

4. There was a small leak in the medication room faucet and in the utility room faucet.

5. There is damage to the sink in the nurse's station. The sink itself needs to be reset and new caulking added.

6. There was a dirty glove on the floor of the shower room and a razor left on the window ledge.

7. There is wall damage in the utility room.

8. There are vending machines that are providing unsupervised access to residents who may be on diabetic or sodium-restricted diets. This is a danger to the health and safety of the residents in your facility who are very confused.

9. Staff still appear to be rounding off blood pressure. Please provide them with in-service in proper charting, as well as properly taking a blood pressure.

10. There was a considerable amount of oil on the basement floor surrounding the elevator machinery.

Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

Office of Attorney General
Bill Lockyer

Bureau of
Medi-Cal Fraud
and Elder Abuse
1425 River Park Drive
Suite 300
Sacramento, CA
95815-4524

Information: (916) 263-3896
Facsimile: (916) 263-0855

INSPECTION REPORT SUMMARY #50

Alvarado Convalescent & Rehabilitation Center
6599 Alvarado Road
San Diego, CA 92120

Number of Beds: 269

IMPORTANT NOTE REGARDING THIS INFORMATION:

Information concerning facts which have lead to a referral to a law enforcement, licensing, or regulatory agency are not included in this Inspection Report Summary.

The Operation Guardians-San Diego County team conducted a survey of Alvarado Convalescent & Rehabilitation Hospital, located in San Diego, on March 30, 2001. The following areas of concern were noted by the team and discussed with the facility staff during our exit meeting:

1. There were screens on several windows which had bent, torn, or missing screens. This would allow flies entry into the facility when the windows are opened, which was also identified as a problem.

2. There was food found in the medication room refrigerator on station 'A'.

3. The facility is badly in need of painting and repair of damaged eaves and window frames.

4. There was a faint odor of urine throughout the facility.

5. There were leaking faucets found in the shower rooms and the staff lounge.

6. Oxygen tanks were not properly stored and were very loosely chained.

7. Call lights were noted to be unanswered in excess of five minutes.

8. Personnel files were not up to date for certifications. One file had the person

working as a CNA for several weeks without assurance that the person had in fact passed the fingerprint check.

9. Trust accounts were not reconciled on a regular basis. Patient accounts were six months behind in some instances.

10. Several wasp nests were noted in the patient patio areas.

11. There were flies and bees in the facility.

12. The housekeeping in the facility was poor. Closet housing patient supplies and clean linen had not been mopped and dirt was caked on the floors.

13. There were several soiled linen hampers that were overflowing, possibly causing the urine odor throughout the facility.

14. There were no occupancy signs on patients' shower room doors, causing a problem when staff open the door, exposing patients.

15. A Xero form dressing was found by the payphone on station 'A'.

16. There is a hole in the wall of the shower room on station 'A' which is covered by duct tape.

17. There is one patient room being used for storage with multiple plastic bags strewn around which could be a hazard to patients.

18. There is stucco damage in many areas on the outside of the facility.

19. There is a cracked and raised area of concrete on one of the patient patios which would be a hazard to patients.