BEVERLY ENTERPRISE
PATIENT CARE CITATIONS
USED FOR PERMANENT INJUNCTION
1999 - 2002

COUNTY	FACILITY NAME & ADDRESS	CITATION CLASS	CITATION DATE	CITATION NUMBER	SYNOPSIS OF VIOLATION
Butte	Beverly Manor Convalescent Hospital 188 Cohasset Lane Chico, CA 95926	B	5-11-99	23-0736-0000846-S	Failed to have a call light system for patients to summon help that worked. During a complaint visit, L&C determined that 7 of 23 call bells checked were non-operational.
Butte	Beverly Manor Convalescent Hospital 188 Cohasset Lane Chico, CA 95926	A	3-22-99	23-0782-0000833-S	LVN argued back and forth with a 93 year old patient who had asked for her meds. LVN took no action to decrease the agitation, did not continually assess patient's changing condition of experiencing signs and symptoms of a heart attack, nor notify attending physician of change in condition.
Butte	Beverly Manor Convalescent Hospital 188 Cohasset Lane Chico, CA 95926	A	3-22-99	23-0782-0000834-S	Failed to ensure 93 year old patient was treated with dignity and respect while she was experiencing a medical change of condition (symptoms of heart attack) and failed to ensure that patient was not verbally and mentally abused
Butte	Beverly Manor Convalescent Hospital 188 Cohasset Lane Chico, CA 95926	A	3-12-02*	23-1507-0000974-S	Failed to provide patient care to prevent formation and progression of a Stage IV pressure sore, provide training in self-care to prevent development and progression of pressure sore, continuously assess patient for increased risk of skin breakdown with decline in mobility and nutritional status, and failed to develop, review and revise care plan for increased risk for skin breakdown. These failures resulted in development of Stage IV pressure sore, which required specialized wound care services in patient who had no prior history of pressure sores.

COUNTY	FACILITY NAME & ADDRESS	CITATION CLASS	CITATION DATE	CITATION NUMBER	SYNOPSIS OF VIOLATION
Fresno	Beverly Manor Convalescent Hospital 2715 Fresno Street Fresno, CA 93721	B	6-07-01	04-1580-0001219-S	Failed to review, evaluate and update resident's care plan to address changes in resident's ambulatory abilities. 77 year old patient, who had been repeatedly diagnosed as being at risk for falls, sustained fall resulting in a left femur fracture.
Fresno	Country View Alzheimer's Center 925 North Cornelia Fresno, CA 93706	B	6-29-00*	04-1012-0001179-F	Failed to provide adequate supervision and assistance devices to prevent accidents. 84 year old resident, diagnosed as at high risk for falls due to history of falls and who had physician's order to use a soft belt restraint when out of bed, fell from her wheelchair and sustained a fracture of the left femur.
Fresno	Clovis Convalescent Hospital 111 Barstow Avenue Clovis, CA 93612	A	3-28-02*	04-0746-0001245-S	Failed to ensure patient treated with dignity and respect and to ensure patient not subjected to verbal or physical abuse. Failed to ensure resident's right to be free from physical (sexual) abuse by CNA. 53 year old female, with diagnoses including Huntington's chorea, reported to her family that she was sexually abused by a CNA. Though reported to facility by resident's family, the facility closed its investigation within 24 hours, determining resident "could have been fantasizing." Family transported resident to hospital for a "rape" examination, where spermatozoa was found. Blood sample was taken from the CNA. The DNA comparison test confirmed sperm from victim and CNA's blood matched.
Fresno	Clovis Convalescent Hospital 111 Barstow Avenue Clovis, CA 93612	B	6-13-02	04-1348-0001255-S	Failed to ensure the right of resident to be free from mental and physical abuse and to treat her with consideration, respect and full recognition of dignity and individuality. An 86 year old female admitted to facility with diagnosis including effects of cerebrovascular disease, hypertension, heart failure and chronic airway obstruction was found laying in bowel movement (BM) with BM all over the linens of her bed and on the floor. Resident's call light cord was curled between the bedsprings beneath the mattress and out of reach and her door was closed and resident was yelling and crying. CNA placed call light cord out of resident's reach and closed the door because CNA was feeling frustrated due to resident using call light fifteen times per night and yelling out about her daughter.

COUNTY	FACILITY NAME & ADDRESS	CITATION CLASS	CITATION DATE	CITATION NUMBER	SYNOPSIS OF VIOLATION
Fresno	Beverly Manor Convalescent Hospital 2715 Fresno Street Fresno, CA 93721	B	6-13-02	04-1397-0001256-S	Failed to ensure rights of a resident to be free from mental and physical abuse when a Licensed Vocational Nurse forced resident to take medications.
Kern	Beverly Health and Rehabilitation Center 1131 North China Lake Boulevard Ridgecrest, CA 93555	A	6-15-01	12-1606-0001528-S	Failed to ensure resident's needs were continually assessed. 81 year old, admitted to facility following left hip fracture, was alert and conversing on admission. Resident choked while eating lunch. In order to prevent upset to other residents in the dining room, resident was then pushed back to her room, apparently deprived of oxygen for 7 to 8 minutes, where chest compressions were begun. During this process a piece of meat was dislodged. Resident was in a coma for two days and suffered irreversible brain damage.
Kern	Beverly Manor Convalescent Hospital 3601 San Dimas Street Bakersfield, CA 93301	A	6-15-01	12-1606-0001529-S	Failed to provide good nutrition and necessary fluids for hydration. Upon admission to acute care hospital from facility, 81 year old female was diagnosed with severe dehydration and a urinary tract infection, which were listed on the Certificate of Death as significant condition contributing to death.
Los Angeles	Huntington Drive Health & Rehabilitation Center 400 W. Huntington Arcadia, CA 91006	B	1-29-99	95-1310-0001252-S	Failed to provide good oral hygiene which had a direct relationship to patient's health, safety and security. After entering facility, an 85 year old female was observed by family members on numerous occasions to have foul smell coming from her mouth, which was coated with brown, dark mucus. At family member's insistence, staff attempted to clean patient's mouth. Patient began to cough and choke. After nurse attempted to suction patient, her breathing became labored and she turned bluish. Paramedics arrived and en route to the acute hospital, the patient coughed up a peach pit sized chunk of mucus. The acute hospital's pathologist stated he could not remember ever having seen a mucus plug this large and that even in a patient with Chronic Obstructive Pulmonary Disease, it is not common, but rather unusual to see a mucus plug anywhere near this large.

COUNTY	FACILITY NAME & ADDRESS	CITATION CLASS	CITATION DATE	CITATION NUMBER	SYNOPSIS OF VIOLATION
Los Angeles	Beverly Manor Health Care Center 925 West Alameda Ave. Burbank, CA 91506	WMF	6-30-00	92-1332-0001081-S	Willful material falsification in health record. Resident went out on a pass with a family member on June 18, 2000 at 11:30 a.m. and did not come back. Employee wrote an entry on June 18, 2000 at 6:15 p.m., including resident's vital signs, fluid allowed to drink, condition of central line, cardio-respiratory condition, and mental status. Employee stated she wrote the entry thinking that the patient was coming back.
Los Angeles	Beverly Manor Health Care Center 925 West Alameda Ave. Burbank, CA 91506	B	6-30-00	92-1332-0001080-S	Failed to monitor and control the water temperature. Water to 6 rooms exceeded acceptable temperature range. There were 13 cognitively impaired, ambulatory residents residing in those rooms.
Los Angeles	Beverly Manor Nursing and Rehabilitation Center 1041 South Main Street Burbank, CA 91506	B	4-13-01	92-2034-0001124-S	Failed to regulate temperature of hot water after temperatures were discovered to be ranging from 130 to 150 degrees Fahrenheit in rooms of 8 cognitively impaired residents. Appropriate temperature of hot water is to be between 105 and 120 degrees Fahrenheit.
Los Angeles	Beverly Manor Nursing and Rehabilitation Center 1041 South Main Street Burbank, CA 91506	A	1-12-01*	92-1331-0001099-S	Facility staff failed to implement policy and procedures on transferring residents with mechanical lifts and failed to update resident's care plan after nursing assessment of resident's condition. An 85 year old totally dependent resident was injured during a transfer. Upon transfer to an acute care hospital, she was found to have sustained a 3 inch laceration to her left forehead, swelling on left side of head, and a hemorrhage within her left eye . Based on resident's request, no aggressive measurers were taken and the resident died a week later.
Los Angeles	Beverly Healthcare-Community Care Center 3611 Imperial Highway Lynwood, CA 90262	B	10-25-01	94-0579-0001437-S	Failed to provide care to patient to prevent formation and progression of decubitus ulcer on patient's coccyx or to change patient's position according to her needs and failed to carry out physician's order to provide pressure relieving mattress for treatment of the decubitus ulcer. Patient had no decubitus ulcers on admission and developed a Stage IV decubitus ulcer on the coccyx within one month of admission.

COUNTY	FACILITY NAME & ADDRESS	CITATION CLASS	CITATION DATE	CITATION NUMBER	SYNOPSIS OF VIOLATION
Los Angeles	Beverly Healthcare-Community Care Center 3611 Imperial Highway Lynwood, CA 90262	B	8-03-00	94-0451-0001401-S	Failed to access resident as needed for development of decubitus. Resident was admitted to facility with Stage II bedsore, which progressed to a Stage IV decubitus, which was not identified until day of discharge.
Los Angeles	Beverly Healthcare-Community Care Center 3611 Imperial Highway Lynwood, CA 90262	WMF	9-14-99	94-2009-0001357-S	During a survey it was observed that the Medication Administration Record (MAR) had been pre-charted for 36 residents. Staff member could not provide any explanation for her action and why she pre-charted prior to providing the service and medications.
Los Angeles	Beverly Health and Rehabilitation Center 615 West Duarte Road Monrovia, CA 91016	B	7-15-99	95-1273-0001281-S	Failed to monitor fluid intake and output per physician orders for four patients, who had, or were at risk of having, urinary tract infection.
Los Angeles	Beverly Health and Rehabilitation Center 615 West Duarte Road Monrovia, CA 91016	B	1-22-01	95-1276-0001380-S	Failed to assess 85 year old patient's reddened and discolored left arm and shoulder for 3 days. Four days after reddened area was discovered, an X-ray at acute care facility indicated dislocated shoulder.
Los Angeles	Beverly Healthcare 6700 Sepulveda Blvd. Van Nuys, CA 91411	B	6-30-99	95-1310-0001276-S	Failed to do a continuing assessment of patient for constipation and pain over a period of 29 days. Patient had been admitted to facility with severe constipation and chronic erosive gastritis and admission orders by physician included three medications to prevent or treat constipation, including Metamucil. Charge nurse denied there was an order for Metamucil. Patient was transferred to acute hospital where he died. The autopsy report listed fecal impaction as one of the acute medical problems at time of death.
Madera	Westgate Manor Convalescent Hospital 1700 Howard Road Madera, CA 93637	B	5-14-02*	04-1493-0001249-S	Failed to implement each resident's care plan. A 90 year old female admitted to facility with diagnoses of late effects of cerebrovascular disease, with left sided paralysis, hypothyroidism and congestive heart failure, was left unattended in the bathroom by staff. Resident fell and sustained a laceration on the left forehead above the eye. Resident went to acute care hospital for evaluation and received sutures for the laceration.

COUNTY	FACILITY NAME & ADDRESS	CITATION CLASS	CITATION DATE	CITATION NUMBER	SYNOPSIS OF VIOLATION
Monterey	Beverly Healthcare 23795 W. R. Holman Highway Monterey, CA 93940	A	3-20-02*	07-1418-0002436-S	Failed to provide resident with sufficient fluid intake to maintain proper hydration. Care plan indicated patient at risk for dehydration. There was no indication the facility followed care plan to measure and document patient's intake and output to determine risk for dehydration. Patient hospitalized with severe dehydration.
Monterey	Beverly Healthcare 23795 W. R. Holman Highway Monterey, CA 93940	A	3-20-02*	07-1418-0002434-F	Failed to provide adequate supervision to prevent resident from accidents. Even though resident was identified as at risk for falls, and able to get out of her Merry Walker, supervision was not provided to prevent accidents and injury. Patient fell and sustained a facial laceration and a left wrist and left hip fracture.
Napa	Sierra Vista Nursing and Rehabilitation Center 705 Trancas Street Napa, CA 94558	B	3-22-01	11-1365-0001833-S	Failed to treat residents with dignity and respect, failed to provide care that showed evidence of good hygiene, and failed to answer call signals promptly. An 88 year old resident was discovered by family member to be saturated in urine from her shoulders to her knees and observed to have raw buttock and perineum. Her 82 year old roommate, incontinent of bowel and bladder and requiring total toileting assistance, stated she was wet because she could not get help because staff was too busy. Her call light had been left unanswered for 45 minutes.
Napa	Sierra Vista Nursing and Rehabilitation Center 705 Trancas Street Napa, CA 94558	B	9-24-99	01-1366-0001401-F	Failed to ensure resident free of any significant medication error. Resident continued to receive two medications for 17 days after they were discontinued by physician's order.
Orange	Beverly Healthcare 340 Victoria Street Costa Mesa, CA 92627	B	8-27-99	06-1245-0001003-S	Failed to assess resident's hydration status. Resident sent to emergency hospital where it was determined that she was dehydrated. Resident given intravenous fluids in acute care hospital for six days before returning to facility.

COUNTY	FACILITY NAME & ADDRESS	CITATION CLASS	CITATION DATE	CITATION NUMBER	SYNOPSIS OF VIOLATION
Orange	Beverly Healthcare 240 Hospital Circle Westminster, CA 92683	B	8-18-99	06-1241-0001002-S	Failed to identify care needs of 74 year old resident based on initial and continuing assessment of wound behind the left knee, which resulted in a Stage IV pressure ulcer, with exposed tendon. Resident was admitted to acute hospital for incision and drainage of the left knee, release of left knee contractures and skin graft flap to the left knee.
Orange	Capistrano Beach Extended Care & Living Center 35410 Del Rey Capistrano Beach, CA 92624	B	5-12-99	06-0840-0000994-S	Failed to provide an on-going assessment of resident's needs and potential side effects of medication administered.
Riverside	Rancho Mirage Healthcare Center 39950 Vista Del Sol Rancho Mirage, CA 92270	A	10-1-99	25-1156-0001466-S	Failed to continually assess skin condition of a resident who was admitted to facility with skin incisions. Resident was transferred to acute care hospital with diagnoses of severe dehydration and severe infection of her right and left groin incisions. Infections in resident's groin area apparently caused by overflow of fecal matter which had occurred at the time the resident had diarrhea.
Sacramento	Royal Oaks Convalescent Hospital 144 "F" Street Galt, CA 95632	B	1-12-99	10-1321-0001918-F	Failed to notify legal representative of resident of the transfer or discharge and the reasons for the move in a language and manner they understand and failed to record the reasons in the resident's clinical record.
San Bernardino	Beverly Manor Nursing Center 700 East Highland Ave. Redlands, CA 92374	B	2-16-99	24-0368-0001447-S	Failed to notify physician promptly after resident's fall and failed to review and update care plan.
San Diego	Escondido Care Center 421 E. Mission Ave. Escondido, CA 92025	B	9-29-00	08-1259-0002766-S	Failed to ensure prompt physician notification related to a laboratory report indicating urinary tract infection and need for antibiotic and failed to provide physician services for treatment of urinary tract infection resulting in urinary tract infection going untreated for 18 days after symptom of burning upon urination had been identified and 13 days after facility obtained results of laboratory tests.

COUNTY	FACILITY NAME & ADDRESS	CITATION CLASS	CITATION DATE	CITATION NUMBER	SYNOPSIS OF VIOLATION
San Joaquin	Fairmont Rehab. Hospital #676 950 So. Fairmont Lodi, CA 95240	A	3-8-00	10-1421-0002001-S	Failed to follow own policy and procedure in failing to provide continuous assessment, failing to provide change of condition assessment, failing to provide nursing assessment, and failing to provide care and failed to notify physician promptly of sudden and/or marked adverse change. Resident, in great pain, was transferred by ambulance to acute care hospital where she was diagnosed with dehydration and septic shock. Surgery was ordered because she had a gangrenous gall bladder. Resident died shortly thereafter at acute care hospital.
San Joaquin	Fairmont Rehab. Hospital #676 950 So. Fairmont Lodi, CA 95240	A	8-12-99	10-0810-0001971-F	Failed to provide adequate supervision to resident during a transfer from a wheelchair to resident's bed. During the transfer the resident went to her knees and was placed on the floor. Resident subsequently found to have a fracture of her right hip.
Santa Barbara	Beverly La Cumbre Convalescent Hospital #561 3880 Via Lucero Santa Barbara, CA 93110	B	4-1-99	05-1039-0001314-F	Failed to ensure all residents receive adequate supervision to prevent accidents which resulted in the residents sustaining injuries. Facility failed to provide adequate supervision for two forgetful, totally dependent residents, who were identified as being at risk for falls; resulted in both residents sustaining injuries of unknown origin for suspected undocumented falls.
Santa Barbara	Beverly La Cumbre Convalescent Hospital #561 3880 Via Lucero Santa Barbara, CA 93110	B	6-14-00	05-1464-0001387-S	Failed to provide adequate care and continuing assessment to prevent progression of a bedsore. 89 year old female admitted with no identification of skin breakdown, but developed a bedsore during her stay. Redness found on her right heel and she was given heel protectors. Physician was not notified for alternative prevention. With no continuing assessment and after she complained of pain, a black scab measuring the size of a golf ball was found on her right heel.

COUNTY	FACILITY NAME & ADDRESS	CITATION CLASS	CITATION DATE	CITATION NUMBER	SYNOPSIS OF VIOLATION
Santa Barbara	Beverly La Cumbre Convalescent Hospital #561 3880 Via Lucero Santa Barbara, CA 93110	B	4-19-00	05-1464-0001375	Failed to treat resident with dignity and respect; failed to ensure resident was not subjected to verbal or physical abuse; and failed to report, investigate, and take corrective action on a prior alleged abuse incident. A resident was physically abused by a CNA on two occasions. The first occurred with the CNA hitting resident in the head and pulling his ears. The second incident happened with the CNA hitting resident 4-5 times in the arm. Resident sustained a bruise the size of a baseball.
Santa Barbara	Beverly La Cumbre Convalescent Hospital #561 3880 Via Lucero Santa Barbara, CA 93110	B	11-20-00*	05-1462-0001400-S	Failed to continually assess resident's skin condition and failed to implement resident's plan of care, resulting in a delay of treatment and the progression of a pressure ulcer. A resident, totally dependent on staff, developed bedsores. Plan of care was not implemented and bedsore became a Stage II. A second bedsore was not assessed after its diagnosis 11 weeks later when resident was transferred to a hospital.
Santa Barbara	Beverly La Cumbre Convalescent Hospital #561 3880 Via Lucero Santa Barbara, CA 93110	A	3-10-99	05-1093-0001305-F	Failed to provide an effective system of supervision, and to recommend and provide effective assistance device on 3 separate occasions, resulting in a 71 year old resident, who was at risk for falls, sustaining a fractured right hip which required surgical intervention.
Santa Barbara	Beverly La Cumbre Convalescent Hospital #561 3880 Via Lucero Santa Barbara, CA 93110	B	9-20-00*	05-1368-0001395-S	Failed to ensure that resident was treated with dignity and respect and was not subjected to verbal and physical abuse of any kind. A 75 year old female pressed her call button and waited for an hour before a CNA arrived. When resident informed CNA that she needed to be changed and told him that her call light had been on an hour, the CNA picked her up roughly, put her in bed, and raised her dress to shoulder height. The CNA then turned to the resident's husband, who shares a room with his wife, and said "Make her apologize to me, I'm angry," and threatened to leave the room and not change her. Both residents were afraid of the CNA, so the female resident apologized.

COUNTY	FACILITY NAME & ADDRESS	CITATION CLASS	CITATION DATE	CITATION NUMBER	SYNOPSIS OF VIOLATION
Santa Barbara	Beverly La Cumbre Convalescent Hospital #561 3880 Via Lucero Santa Barbara, CA 93110	B	9-29-00*	05-1368-0001396-F	Facility failed to thoroughly investigate resident's injuries and failed to implement its written abuse policies and procedures pertaining to screening of employees. An 85 year old resident diagnosed with dementia was found with a 1 ½ inch bruise on her cheekbone, a 2 ½ inch diameter bruise on her shoulder, and a 1 ½ inch bruise on left side of her forehead. Of the 7 CNA's who cared for resident, 5 denied having seen any bruises, 2 remembered seeing the facial bruise, but there was no evidence the bruises were reported to the Administrator. A review of the personnel files revealed that 11 of the 12 CNA's assigned to resident either had no reference checks, criminal background checks, or verification of CNA certification screening done in accordance with facility policy.
Santa Barbara	Beverly La Cumbre Convalescent Hospital #561 3880 Via Lucero Santa Barbara, CA 93110	B	10-5-00*	05-1464-0001398-S	Facility failed to provide the required minimum number of equivalent nursing hours (3.2) per resident; failed to provide a Registered Nurse for six (6) 11 p.m. to 7 a.m. night shifts in one month. These failures resulted in a lack of personal care, a failure to assist residents out of bed, and failure to respond to resident call lights in a timely manner.
Santa Barbara	Beverly Manor Convalescent Hospital 2225 De La Vina Santa Barbara, CA	B	1-12-01*	05138501426 (one of 25 citations issued for 25 resident transfers)	Failed to give 30 day notice to residents and/or guardian, agent or responsible; failed to provide medical assessment for the event of transfer; and failed to provide a written plan of transfer. Facility transferred residents to other facilities over a two week period. 25 citations were issued for these transfers.
Santa Clara	Oak Meadows Extended Care Center 350 De Soto Drive Los Gatos, CA 95030	A	6-16-00	07-1416-0002329-S	Failed to use two persons while transferring 92 year old resident. Patient sustained a hip fracture while being transferred from his bed to a wheelchair by a single CNA.

COUNTY	FACILITY NAME & ADDRESS	CITATION CLASS	CITATION DATE	CITATION NUMBER	SYNOPSIS OF VIOLATION
Santa Clara	Oak Meadows Extended Care Center 350 De Soto Drive Los Gatos, CA 95030	A	8-18-99	07-0942-0002271-S	Failed to make arrangements for a physician to be available and furnish emergency medical care after resident experienced sudden change in condition; failed to observe and assess resident's overall condition, monitor change in condition and initiate assessment worksheet per facility policy and procedures; failed to implement facility's emergency care policy and procedure and send resident to ER; failed to monitor, maintain and record resident's vital signs when indicated once change of condition was established. An 86 year old resident's condition was not treated as an emergency. Approximately two hours after first symptoms appeared, resident arrested and later died at acute care hospital.
Santa Clara	Oak Meadows Extended Care Center 350 De Soto Drive Los Gatos, CA 95030	B	4-8-99	07-1344-0002234-S	Failed to provide and document an accurate and ongoing assessment, identify care needs in a timely manner, and update and individualize a plan of care. A 94 year old female was admitted to facility weighing 93 pounds. Facility obtained physician order for Haldol for dementia. There was no documentation of other interventions attempted. Facility failed to use less restrictive measures before giving a daily antipsychotic medication. Resident became increasingly confused and agitated and her weight was reduced to 79 pounds over a 3 month period.
Santa Clara	Terreno Gardens Extended Care Center 14966 Terreno De Flores Lane Los Gatos, CA 95030	A	11-14-00	07-1199-0002359-S	Failed to plan resident's care by reviewing, evaluating and updating care plan. An 86 year old female, with history of climbing over her bed rails and getting out of her restraints, climbed over her bed rail and fell, sustaining head and neck injuries. She died three days later.
Santa Clara	Terreno Gardens Extended Care Center 14966 Terreno De Flores Lane Los Gatos, CA 95030	A	4-14-99	07-1316-0002236-S	Failed to ensure all physician orders were carried out; failed to identify care needs at time of admission; failed to administer medications as prescribed and failed to accept and retain only those residents for whom it can provide adequate care. Resident was not given medication at required intervals and may have resulted in resident's deterioration in condition, including grand mal seizure.

COUNTY	FACILITY NAME & ADDRESS	CITATION CLASS	CITATION DATE	CITATION NUMBER	SYNOPSIS OF VIOLATION
Santa Clara	San Jose Care & Guidance Center 401 Ridge Vista Avenue San Jose, CA 95127	B	9-15-00	07-0374-0002355-S	Failed to implement an established standard of care that provides for the safe environment of patients. A 62 year old ambulatory resident, with a diagnosis of schizophrenia, paranoid type, was admitted to facility and considered an elopement risk. Patient was unable to be located for breakfast. After making a report to the local police, the facility was notified that a "Jane Doe," fitting description of resident, had been found and taken to the County Hospital, Emergency Psychiatric Services. After identification of resident, plan for transfer back to the facility was made. Resident had been documented as being at the facility when she was, in fact, out wandering.
Santa Clara	Westgate Rehabilitation and Speciality Care Cntr. 1601 Petersen Avenue San Jose, CA 95129	B	11-5-01	07-1426-0002409-S	Failed to supervise Resident A's written care plan for supervised ambulation. Resident B grabbed Resident A from behind and caused Resident A to fall and break his hip.
Santa Clara	Westgate Rehabilitation and Speciality Care Cntr. 1601 Petersen Avenue San Jose, CA 95129	A	2-14-01	07-1291-0002366-S	Failed to ensure all orders written by the physician were carried out and that resident's care plan included a continuing assessment of resident's needs. An 88 year old resident, diagnosed with insulin dependent diabetes and congestive heart failure, was to be monitored for food consumption and blood sugar. Staff failed to carry out orders and resident was admitted to an acute care facility with a diagnosis of metabolic acidosis and sepsis. Resident died a week later.
Santa Clara	Westgate Rehabilitation and Speciality Care Cntr. 1601 Petersen Avenue San Jose, CA 95129	B	5-21-99	07-1344-0002249-S	Failed to implement the plan of care according to methods indicated. The care plan for a 76 year old blind and totally dependent resident called for using two persons to assist with bed mobility and transfers. Resident fell backwards while sitting in a shower chair while a single CNA was attempting to move him without a second staff person. Resident suffered injury to back of his head and was taken to acute care hospital for Cat-Scan.

COUNTY	FACILITY NAME & ADDRESS	CITATION CLASS	CITATION DATE	CITATION NUMBER	SYNOPSIS OF VIOLATION
Santa Clara	Westgate Rehabilitation and Speciality Care Cntr. 1601 Petersen Avenue San Jose, CA 95129	A	3-19-99	07-1088-0002226-S	Failed to ensure resident was provided with good nutrition and with necessary fluids for hydration. An 86 year old 168 pound man was admitted to facility after a fall and fracture at his home. Resident required assistance with eating and within two weeks after his arrival at the facility, he had lost 33 pounds. Resident was diagnosed at acute care hospital as being severely dehydrated. The resident died the next day.
Siskiyou	Beverly Manor Convalescent Hospital 1515 Oregon Street Yreka, CA 96097	A	12-20-99	23-0736-0000867-S	Failed to follow physician's orders regarding administration of resident's insulin medication; failed to notify physician when blood sugar test was outside parameters set by physician; failed to notify physician when error in insulin administration occurred. Physician cautioned that errors could cause a fatality. Resident with diabetes required acute care hospitalization to stabilize her condition after being found with a dangerously low blood sugar after the licensed nurses administered bedtime regular insulin two nights in a row.
Siskiyou	Beverly Manor Convalescent Hospital 1515 Oregon Street Yreka, CA 96097	B	4-23-01	23-0736-0000935-S	Failed to continually assess a resident who demonstrated poor fluid and food intake, signs of lethargy, and decreased levels of consciousness; failed to notify physician in a timely manner of resident's change of condition; and failed to ensure that a discontinued medication was not administered.
Sonoma	Beverly Manor of Petaluma 101 Monroe Street Petaluma, CA 94952	B	11-02-01*	01-1351-0001903-F	Failed to ensure that resident was provided with adequate supervision and assistance devices to prevent accidents. A 92 year old resident was documented as being at risk for falls. Resident fell while sitting on the side of her bed in preparation for a transfer, sustaining a hematoma and lump on the top of her head. Resident died within six days of the fall. The cause of death was determined to be unrelated to the fall.

COUNTY	FACILITY NAME & ADDRESS	CITATION CLASS	CITATION DATE	CITATION NUMBER	SYNOPSIS OF VIOLATION
Sonoma	Beverly Manor of Petaluma 101 Monroe Street Petaluma, CA 94952	A	2-05-02*	01-1001-0001921-F	Failed to conduct an on-going assessment of resident who was demonstrating abnormal signs and symptoms; failed to provide care and services to maintain the resident's highest level of well-being; failed to provide care in accordance with facility's procedures regarding resuscitation; and failed to consult with the resident's physician when resident experienced significant changes in her medical status. Resident was brought to facility from acute care hospital in poor condition. Changes in her condition were not reported to the physician and when EMTs arrived, they found no CPR being given. Resident died with EMTs present.
Sonoma	London House Convalescent Hospital - Santa Rosa 4650 Hoen Avenue Santa Rosa, CA 95405	B	8-30-01	01-1366-0001868-S	Failed to ensure that care plans were reviewed and updated as resident's condition changed, and implemented according to methods indicated; failed to provide care, which showed evidence of good personal hygiene, including care of skin and to keep resident free of offensive odors. Resident, taken to acute care hospital for convulsive coughing and chest pain, had extremely poor hygiene. Nurses at hospital filed elder abuse complaint against facility.
Sonoma	London House Convalescent Hospital - Santa Rosa 4650 Hoen Avenue Santa Rosa, CA 95405	A	4-9-99	01-0992-0001357-F	Failed to consistently implement care plan; failed to review and revise resident's care plan; failed to provide the necessary care and treatment to prevent development of a pressure sore; and failed to prevent infection. Resident developed Stage IV pressure sore on buttock two months after admission to facility; resident did not have proper nutrition intake and lost 15% body weight in two months.
Sonoma	London House Convalescent Hospital - Sonoma 678 2nd Street West Sonoma, CA 95476	B	11-17-00	01-1351-0001797-F	Failed to provide adequate supervision and assistance devices to prevent accidents. A 95 year old resident, determined to be at high risk for falls, fell two times in a two month period. Resident sustained a broken hip in second fall.
Stanislaus	Hy-lond Convalescent Hospital #548 1900 Coffee Road Modesto, CA 95350	B	3-7-02*	10-1565-0002138-F	Failed to ensure resident was supervised and provided with assistive devices during an outing in the facility van, resulting in resident falling and fracturing her femur.

COUNTY	FACILITY NAME & ADDRESS	CITATION CLASS	CITATION DATE	CITATION NUMBER	SYNOPSIS OF VIOLATION
Tuolumne	Beverly Healthcare Sonora 19929 Greenley Road Sonora, CA 95370	AA	6-13-01	03-1321-0002067-S	Failed to ensure resident was under continuing supervision of a physician who saw resident at least every 30 days; failed to review, evaluate and update care plan of resident as necessary; failed to notify attending physician in a prompt manner of any sudden and or marked adverse change in signs, symptoms or behavior of resident; failed to perform continuing assessment of resident's condition; failed to provide care to prevent formation and progression of decubiti by carrying out physician's orders. Resident became severely dehydrated, developed multiple gangrenous decubiti, and died as a result of Urosepsis due to renal insufficiency, due to dehydration.
Tuolumne	Beverly Healthcare Sonora 19929 Greenley Road Sonora, CA 95370	A	6-13-01	03-1321-0002068-S	Failed to initiate and continually assess resident for hydration needs; failed to review, evaluate and update care plan as necessary with the involvement of nursing staff and other professional personnel; failed to notify resident's attending physician in a prompt manner of any sudden and or marked adverse change in signs, symptoms or behavior exhibited by resident; failed to ensure resident provided with good nutrition and with necessary fluids for hydration.
Ventura	Glenwood Care Center 1300 North C Street Oxnard, CA 93030	A	4-3-01*	05-1386-0001449-S	Failed to develop an individual, written care plan which specified type of assistance to be used to safely transfer resident; failed to implement its written policy regarding transfer of residents via mechanical lift. A mechanical lift was not used for transfer of 98 year old resident with a diagnosis of Alzheimer's, who sustained a fractured right tibia when CNA manually transferred resident from her bed to her wheelchair.
Ventura	Victoria Care Center 5445 Everglades Street Ventura, CA 93003	A	12-11-01	05-1371-0001484-S	Failed to identify resident's care needs when he experienced a marked decline in his mealtime food and fluid intake that continued and became progressively worse over a seven day period of time; failed to promptly notify resident's attending physician of the adverse change in signs and symptoms exhibited by the patient. An 89 year old male resident was admitted to the facility weighing 111 pounds, significantly below his ideal weight of 133 - 163 pounds. Within two weeks, the resident's weight was down to 102 pounds.

*** Case is pending**

Citation Classes:

Class AA: The most serious violation, AA citations are issued when a resident death has occurred in such a way that it has been directly and officially attributed to the responsibility of the facility, and carry fines of $25,000 to $100,000.

Class A: Class A citations are issued when violations present imminent danger to patients or the substantial probability of death or serious harm, and carry fines from $2,000 to $20,000.

Class B: Class B citations carry fines from $100 to $1000 and are issued for violations which have a direct or immediate relationship to health, safety, or security, but do not qualify as A or AA citations.

Class WMF: Willful material falsification citations are issued when patient records are falsified, and carry fines of up to $10,000.