VIDEO SURVEILLANCE IN LICENSED CARE FACILITIES

Re Department of Social Services, Community Care Licensing (DSS/CCL) Evaluator Manual – Surveillance Waiver
2-5800 Waivers for Use of Video Surveillance
Distributed to Stakeholders 28 January 2015
Published to Website 18 November 2015

Background:

The Department of Social Services, Community Care Licensing (DSS/CCL) has issued a Video Surveillance Waiver Policy (Evaluator Manual – Surveillance Waiver 2-5800 Waivers for Use of Video Surveillance). Under the policy, facilities choosing to install and activate cameras inside their facilities will be required to (1) submit a waiver request, (2) submit an updated Plan of Operations detailing the individual facility’s policy on the scope and use of video surveillance, and (3) notify residents of the facility’s use of video surveillance via an informed consent document.

Summary:

Video capture (either digitally or on tape) of dependent individuals in licensed adult community care and residential facilities for the elderly (hereinafter ‘facilities’) raises many ethical and privacy concerns, neither of which has been understood nor dismissed prior to the implementation of these guidelines (See Paragraph 1-1998 Video Camera Demonstration Project, Irvine Cottage for discussion). In the absence of this information, it is CARR’s view that families, not facilities, should control the use of video surveillance in all private areas, while use in common areas—resident consent permitting—could be considered as a part of a facility’s operations.

Facilities are not public spaces. Facilities should not be allowed to engage in video surveillance and also hold themselves out as offering residents a private, home-like setting. The two are mutually exclusive, in CARR’s view. Given the increasing use of technologies within the industry, CARR appreciates the Department’s steps toward crafting a formal policy on video surveillance, but is troubled by the Department’s confidential approach to developing the policy. Residents, residents’ families and the public at large deserve to be informed of the reasons, merits, and risks of video surveillance programs and to consider these within the context of the
state’s current regulatory framework and DSS/CCL’s current oversight and enforcement practices. CARR submits that DSS/CCL’s policy fails to consider the entire range of ramifications associated with introducing video surveillance programs into facilities. The policy released for implementation may add unnecessary complexities to DSS/CCL’s already problematic oversight and enforcement practices. CARR’s view is that the Department’s implementation of its ‘Surveillance Waiver’ may expose the Department and its staff to greater challenges and scrutiny, and could undermine a resident’s ability understand and, assert all their rights with regard to video surveillance. In addition, this issue was already presented to the California legislature in the 2011-2012 session, but died in committee. CARR believes the Department’s action to establish this policy under Title 22’s Program Flexibility is disingenuous, and circumvents an essential public debate.

This Position Paper presents CARR’s point of view and position on Video Surveillance and discusses some of the major shortcomings CARR sees with the Department’s policy on video surveillance.


In 1998, the Department authorized a Video Camera Demonstration Project (Attachment 1A) to be implemented within the RCFE, Irvine Cottage. The purpose of the two year (1998 – 2000) pilot was to “collect, analyze and evaluate empirical data to determine whether regulations, policies and procedures governing the use of video cameras in resident bedrooms should be developed”. The demonstration project was to have collected data on six evaluation measures. CARR is not aware that the information to be collected under the project was collected or released for public discussion.

CARR interviewed Jacqueline DuPont, Licensee of Irvine Cottages, in 2010. At that time, and despite the 8/12/2000 expiration of the demonstration project, Ms. DuPont was continuing to use cameras to monitor residents in her facilities. She advocates for camera monitoring programs in California’s assisted living facilities (specifically within resident’s rooms) citing reductions in complications from falls, staff protection and elder abuse.\(^1\) However, the empirical data that might support her claims, data that should have been collected and given to DSS/CCL for evaluation, remains unaccounted for and/or outside the public domain. Further, many stipulated protections contained in the Video Surveillance Demonstration Project Agreement between Ms. DuPont and DSS/CCL fail to be included in the Department’s implemented policy.

Advocates, residents, residents’ families and the public at large deserved quality responses to the following questions prior to the implementation of any video surveillance policy:

Where is the data from the Video Camera Demonstration Project? What were the outcomes of the criteria evaluated under the project? Did the data suggest improved outcomes for resident health and safety? Do the results justify cameras in resident rooms, in addition to common areas?

How will video capture be archived, for how long, how will it be identified, under what circumstances will the video feed be used, and who will be responsible for assuring video feed is untampered?

What do facilities want to monitor by introducing this technology into their facility?

- If it is resident behaviors (falls, wandering, etc.), why is video surveillance more effective than other, less invasive technologies (i.e. bed alarms, motion-activated or personal alert devices)?
- If it is employee activity, how will facilities account for the bulk of caregiving activities that occur in private (i.e. in bedrooms and bathrooms) while still preserving a resident’s right to dignity and privacy?

2. Authority

In 2010, DSS/CCL invoked similar authority (Title 22 §87209 Program Flexibility), to implement a policy that would expedite a facility’s ability to care for total care residents. Total Care, once a prohibited condition, became a component of the Hospice Care Waiver (87632)². Despite the protective requirement built into the policy via Title 22, §87616(b)(1) (designating exceptions as a case-by-case basis), CARR has seen DSS/CCL authorize total care exceptions at time of licensure for multiple beds (Attachment 1B).

Despite CARR’s ongoing concerns and written requests for clarification to DSS’s policy office in 2012 and 2013 the Department never responded to CARR’s request for public comment; the policy was later released. The Department, under new leadership, is now in the position of addressing the very issue this particular policy reinforced—an expanded number of higher acuity and medically needy residents in ill-equipped ‘care and supervision’ facilities.

Similar to the Total Care Policy, the Video Surveillance policy could be another circumstance where the Department’s narrow focus on its regulatory authority will introduce more complexities to its oversight and enforcement practices, possibly exposing the Department’s staff to greater challenges and scrutiny, and residents to elevated risks.

3. Recommended Guidelines, not Regulatory Requirements

Though the Department has referred to this as a “policy”, the term is used loosely. Policies are enacted through statute and implemented through regulation. The Department has actually implemented, as part of its Evaluator Manual, a set of recommended guidelines for facilities to follow regarding video surveillance. In the absence of specific regulatory requirements, each individual facility will now be able to interpret and personalize the set of recommended guidelines resulting in innumerable video surveillance “policies” throughout the state. It is CARR’s view, that specifications should become part of Title 22 to ensure uniform enforcement and preservation of residents’ rights.

Furthermore, similar to other departmental waivers and exceptions, the Video Surveillance Waiver should be denoted in the public file via an individual authorizing document (waiver) and on a facility’s license (LIC 203A). Both should also be posted in a conspicuous place within the facility to indicate proper authorization.

In addition, given the highly-sensitive nature of videotaping vulnerable seniors, overseeing privacy rights without a statutory foundation undercuts elder justice and dignity. By regulating in this way, it is CARR’s view the Department may have exceeded its authority by playing legislator rather than serving as a state agency.

4. Enforcement in the Field

The Department has a history of inconsistent enforcement and weak oversight. In CARR’s opinion this is due, in large part, to the discretionary nature of Title 22 and the Department’s ongoing reliance on a fragmented and frequently contradictory Evaluator Manual. CARR’s public document research suggests that to authorize camera monitoring programs in facilities through a waiver process, via the Evaluator Manual, where standards and enforcement guidelines will be supplied by an individual facility’s Plan of Operation is a grave mistake. The following six issue items serve to illustrate this point.

**Resident Rights:** Safeguarding residents’ rights and ensuring both residents and facilities clearly understand these rights, should drive the Department’s formulation of a video surveillance policy. This approach would, theoretically, yield a policy that would reduce the risk of violating a resident’s rights and ultimately result in better compliance and/or swift accountability.

The Plan of Operation requirements, as written, are highly discretionary and would permit facilities to craft programs that are entirely self-serving. According to the current requirements, DSS/CCL would only need to verify that certain elements are addressed in the Plan of Operation, but exactly *how* they are addressed would vary from facility to facility. This variability will make it impossible for DSS/CCL to effectively distinguish if any of the Plans they were approving were meaningful to residents. In addition, once a Plan of Operations is approved, the Department’s investigations into personal rights violations will be limited to the context of the
current investigation as it relates to the particular facility’s Plan of Operations versus referencing standardized regulation.

Attachments 1C and 1D illustrate how state evaluators, without clear guidelines, vary in their evaluation of facility practices regarding a resident’s personal rights. In Attachment 1C, despite a complaint regarding a resident’s right and ability to shower independently, the administrator was of the opinion that showers were dangerous for residents and the evaluator did not issue a deficiency for a Personal Rights violation (§ 87468). In Attachment 1D, however, a complaint was filed against a facility for using tape on residents’ Depends. Despite the facility statement that some residents were “confused and at risk of consuming their own feces”, the state evaluator issued a deficiency for a Personal Rights violation. To avoid such disparities, standardization and a clear communication of resident’s rights is imperative. For the benefit of state evaluators and residents, CARR proposes 1) the provisions surrounding residents rights and video surveillance become codified, (2) the creation of a standardized, LIC Consent Form that clearly articulates all parameters surrounding a resident’s rights and a facility’s use of video surveillance, and (3) facilities and residents understand that the LIC Consent Form is a separate form and that though the admission agreement may contain a description of the facility’s video surveillance program, signing the admission agreement does not demonstrate consent.

**Resident Privacy:** Ongoing, the Department has handled resident privacy issues when facilities have used intercoms and baby monitors. Attachments 1E and 1F further illustrate the Department’s tendency to be arbitrary. In 1E, the state evaluator is requiring the facility to install an intercom system, but in 1F, the same regional office is claiming the already installed intercom system is an invasion of the residents’ right to privacy. Without well-defined guidelines, the Department’s ability to adequately regulate and enforce residents’ right to privacy will be problematic.

**Adequate Staffing:** Title 22 does not mandate staffing ratios. Adequate staffing remains at the discretion of the licensee. The risk of allowing RCFEs to employ video surveillance is that some RCFEs may rely on the technology as a substitute for staff. DSS/CCL’s policy stipulates that those facilities who apply for a waiver will need to address, via their Plan of Operation, personnel requirements to ensure this substitution does not occur.

In the event a state evaluation or investigation determines an RCFE is substituting video monitoring for staff supervision, CARR has little confidence that DSS/CCL’s enforcement tools will remedy the situation. Any time state evaluators determine that staffing is inadequate, the only remedy at their disposal is to issue a Type A or Type B deficiency and stipulate that the RCFE submit a Plan of Correction that states additional staff will be present. Attachments 1G and 1H demonstrate how ineffectual this practice can be in reestablishing facility compliance. Both Attachments 1G and 1H spotlight a facility that (1) received three non-compliance conferences in one year, (2) was regularly deficient in the areas of staff and oversight, and (3)
employed an unauthorized intercom system to monitor residents. Despite multiple citations and non-compliance conferences, the state was unable to get this facility into compliance, and its license was eventually revoked in 2012 via administrative action. CARR submits that, similar to this and other cases, the Department will find itself unable to promptly influence facilities who abuse their video surveillance program.

Reporting Requirements and Investigations: Though the efficacy of video surveillance programs has yet to be established, the anecdotal benefits claimed are expedited attention to resident falls, reduction in employee theft, elder abuse and false allegations. These benefits, however, become meaningless if state evaluators are unable to have immediate, unrestricted access to video footage or digital files during their complaint and unusual incident investigations. Inaccurate documentation, unavailable or unresponsive parties and perishable evidence already hamper state investigations. And yet, DSS/CCL’s video surveillance policy fails to address custody issues or to establish essential parameters such as access, record-keeping, manipulation/editing, etc. CARR notes that many of the conditions placed on Ms. DuPont (Attachment 1A) addressing video review, safekeeping, safeguards, etc. (Terms and Conditions 1-14, Page 2) have been omitted from the current waiver policy. DSS/CCL’s policy merely stipulates that those facilities applying for a waiver will need to craft individual policies on retention, etc. within their Plan of Operation. In CARR’s view, this level of facility discretion may prove problematic during state investigations and/or family inquiries.

Attachment 1I, illustrates an administrator’s reluctance to cooperate with a state evaluator during an investigation. Evaluators may issue a civil penalty for a licensee’s refusal to allow entrance into a facility, but cannot issue one for failure to provide records, etc. The Department should consider introducing the accountability tool of civil penalties for a facility’s failure to provide access to or tampering with video media (tape or digital files).

Attachment 1J, illustrates how access to video media during investigations could be helpful and potentially alter outcomes. The allegation in Attachment J is a resident expired “due to hemorrhaging” and “was closed to a room alone for many hours at a time except when Hospice visited”, but because the state evaluator “found no information to support the allegations” the complaint was deemed “unfounded”. It is CARR’s position that families and state evaluators should be authorized to view video footage at their discretion. In addition, the Evaluator Manual should articulate how these videos can be used to aid in investigations (similar to Virginia’s Department of Social Services).3

Complaints and Evictions: It is well-documented in the public files that many Plans of Operation contain boiler plate language purchased from authorized vendors. A facility’s Plan of Operation,

therefore, could be considered the least substantive document in that it may contain little original provider-generated content. It has neither the weight nor reach of Title 22 or statute. Given these circumstances, it is unclear why the Department would choose to house all permissions and resident protections in such an ineffectual document.

CARR’s research has revealed that when presented with complaints, state evaluators (without explicit guidance from Title 22) rely on a facility’s Plan of Operation to determine compliance. Frequently, in the face of substandard care or evictions and subsequent complaints, the evaluator will not issue a deficiency or substantiate a complaint because “the facility was following its Plan of Operation” and is, therefore, deemed to be “in substantial compliance”. It is CARR’s view that the regulations are what should control whether a deficiency is issued and the Department should not confuse an individual facility’s Plan of Operation with regulations.

Waiver Revocations: The public record shows that license revocations require several years to resolve once an administrative action has been initiated, and waivers are rescinded only following catastrophic harm to residents. Without clear guidelines outlining under what conditions timely video surveillance waivers will be rescinded, and explicit statutory authority for such rescissions, DSS/CCL may find it difficult to timely protect residents from facilities who exploit or abuse video surveillance programs.

4. Legislative History

Unlike in Paragraph 1 –1998 Video Camera Demonstration Project, Irvine Cottage, the purpose the current policy is unclear. Research on the use of video surveillance inside long-term care facilities indicates other states, which have addressed this issue, were responding to ongoing outrage from families and residents regarding substandard care and a lack of transparency.4 In response, local Attorneys General and state’s legislators weighed in by enacting “pro-resident” statutes with most statutes authorizing residents and/or their families to place cameras in their private rooms.

CARR strongly suggested the Department examine the language and implementation of video surveillance legislation and policies in other states, prior to implementing a statewide policy in the absence of California legislative action. CARR recommended the state review, in particular, the video surveillance statutes of Texas, Washington, Maryland.5

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Further, this issue was already presented to the California legislature in the 2011-2012 session. SB 1400 (Harman-Costa Mesa) would have authorized an RCFE to use video surveillance in a resident’s bedroom if the facility and the resident (or resident’s authorized representative) consented to use.\(^8\) The bill required that all recordings become a part of the resident’s medical record, and that specified persons entering the resident’s bedroom give written, informed consent with respect to the video surveillance. This bill died in committee.

The Department’s policy is nearly identical to SB 1400 bill, except the bill exclusively applied to RCFEs. Why is the Department trying to establish a similar, but slightly more facility-centric policy, when a prior legislative attempt failed? CARR believes the Department’s action to establish this policy under Title 22’s Program Flexibility is disingenuous, and circumvents the important debate residents, their families and the public should have regarding the far reaching issues of personal privacy and appropriate safeguards for protecting resident privacy.

**CARR’s Recommendations:**

CARR recommends that the Department—

1. Pursue authority to create a Video Surveillance Waiver using the legislative process so that appropriate statute and regulatory guidelines can be established.
2. Deliver the outcomes and data set results of the 1998 Video Camera Demonstration Project in the RCFE Irvine Cottage to statewide advocacy groups. Advocacy groups should be allowed to review, study, evaluate and provide feedback to the Department on the findings.
3. Incorporate data collection protocols developed under the Video Camera Demonstration Project into the policy to validate the efficacy of video surveillance in California’s licensed care facilities.
4. Incorporate protections and other salient stipulations contained in the Video Camera Demonstration Project Agreement into the Department’s policy on Video Surveillance.
5. Publically discuss and address all other problematic areas identified in this paper.
6. Present the policy to the Attorney General’s office for an advisory opinion on its constitutionality.

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\(^8\) California Legislative Information. http://leginfo.legislature.ca.gov/faces/billVotesClient.xhtml
CARR strongly recommends these issues be addressed and the policy on video surveillance be revisited. Until adequate protections for resident privacy, and accountability tools are clearly defined, CARR cannot support the Department’s Video Surveillance policy.

For discussion on any subject addressed in this Position Paper, please contact CARR staff at rcfereformorg@gmail.com or via phone at (619) 795-2165.
VIDEO CAMERA DEMONSTRATION PROJECT

PURPOSE

The purpose of this demonstration project is to evaluate the use of currently prohibited video camera surveillance in residents' bedrooms to determine if the potential benefits of video surveillance outweigh its potential abuses.

OBJECTIVE

The objective of the demonstration project is to collect, analyze, and evaluate empirical data to determine whether regulations, policies, and procedures governing the use of video cameras in residents' bedrooms should be developed.

SCOPE

This is a two year demonstration project beginning on August 13, 1998, and concluding on August 12, 2000. Monitoring of the project will be on a continuous basis with a final evaluation and recommendation report submitted to the Deputy Director of Community Care Licensing Division (CCLD) no later than December 1, 2000.

EVALUATION

The following information will be compiled by the district office prior to, and closely monitored during, the project period:

1. The number and nature of deficiencies cited on annual evaluation reports.
2. The number and nature of incident reports.
3. The number and nature of substantiated complaints.
4. The number and nature of inconclusive complaints.
5. The number and nature of deficiencies on case management visits.
6. The facility's ability to maintain substantial compliance.

Staff and family members will also be asked to complete a confidential questionnaire concerning their feelings about and perceptions of video surveillance.

At the completion of the project the above information will be reviewed to determine if the nature and number of deficiencies, incident reports, complaints, or feelings and perceptions, have been significantly affected by the use of video cameras.

BECAUSE OF THE SENSITIVE NATURE OF THE DEMONSTRATION PROJECT, IT WILL BE SUBJECT TO STRINGENT CONTROLS.
TERMS AND CONDITIONS

I/WE AGREE TO THE FOLLOWING TERMS AND CONDITIONS:

1. Video cameras shall not replace staff.
2. Notices must be prominently posted in and around the facility advising visitors of the use of video surveillance equipment in private areas as well as common rooms.
3. Video monitoring equipment must be inaccessible to unauthorized persons.
4. Special incidents captured on video tape must be reported to the licensing agency as required in California Code of Regulations, Title 22, Section 87561, and must be secured until approval is granted by licensing to recycle the tape.
5. Videotapes are to be sequentially numbered, dated, and secured for a four week period before they are reused, unless the facility is instructed otherwise by the licensing agency.
6. Licensing may cite deficiencies based on information contained on video tape.
7. Staff authorized to view, monitor, or change videotapes must have in-service training on the appropriate use, storage, security, confidentiality, liability, and recordkeeping of videotapes.
8. Licensing agents may randomly review video tapes, per section 87344 (a) and 87570 (c)(e), on or off site to ensure compliance with video camera policy and procedure.
9. The facility must comply with residents or responsible parties request that video cameras in bedrooms be turned off.
10. Video cameras must not interfere with any visits that are required by law to be kept confidential, such as conversations with ombudsman, attorney, probate investigator, clergyman, law enforcement, and Licensing Program Analyst during the course of an investigation.
11. The following documents must be completed, submitted, and approved by the licensing district office:
   - Facility Sketch
   - Personnel Report
   - Informed Consent forms for residents.
   - Video Camera Policy and Procedure Handbook
12. Licensee shall obtain approval from the licensing agency prior to making any change(s) that affect the terms and conditions of this project.
13. The licensing agency may make changes to the Terms and Conditions if it is determined necessary for enhanced protection of the residents' personal rights or further data needs.
14. Your participation in the demonstration project may be terminated for misuse of video tapes, video cameras, or video monitors and for violations of any of these terms and conditions.

FACILITY NAME: Irvine Cottage
FACILITY NUMBER: 306000437
FACILITY ADDRESS: 1 Longstreet
IRVINE, CA 92677
FACILITY TYPE: RCFE/DEMENTIA
CAPACITY: 6

LICENSEE/ADMINISTRATOR ________________________ DATE Aug. 13, 1998

DISTRICT MANAGER ________________________ DATE 8/13/98
VCDP/TC/8 98
In accordance with applicable provisions of the Health and Safety Code of California, and its rules and regulations; the Department of Social Services hereby issues this License to

SILVERADO SR LVG MGT INC/SUBTENANT 1500 BORDEN LLC

to operate and maintain a

RESIDENTIAL CARE ELDERLY

Name of Facility

SILVERADO SENIOR LIVING - ESCONDIDO

1500 BORDEN ROAD

ESCONDIDO, CA 92026

This License is not transferable and is granted solely upon the following:

FACILITY SERVES 104 NON-AMBULATORY SENIOR RESIDENTS WITH DEMENTIA.

FACILITY HAS BEEN APPROVED FOR HOSPICE AND TOTAL CARE FOR 27 RESIDENTS

Client Groups Served:

RCFE / DEMENTIA

Complaints regarding services provided in this facility should be directed to:

CCLD Regional Office

(619) 767-2300

Jeffrey Hiratsuka
Deputy Director,
Community Care Licensing Division

Authorized Representative of Licensing Agency

POST IN A PROMINENT PLACE
This is an official report of an unannounced visit/investigation of a complaint received in our office on 11/02/2005 and conducted by Evaluator Lydia Williams.

**COMPLAINT CONTROL NUMBER:** 08-SC-20051102111632

**FACILITY NAME:** STIDOLPH'S LAGUNA RIVIERA GUEST HOME
**FACILITY NUMBER:** 372004191
**DIRECTOR:** STIDOLPH, GAIL A.
**ADDRESS:** 4814 KELLY DRIVE
**CITY:** CARLSBAD
**STATE:** CA
**ZIP CODE:** 92008
**CAPACITY:** 6
**TELEPHONE:** (760) 729-0318
**DATE:** 11/03/2005
**UNANNOUNCED TIME VISIT BEGAN:** 02:00 PM
**TIME VISIT COMPLETED:** 04:00 PM

**ALLEGATION(S):**
1. The owner stated, "They gave all of the showers and watched them, even if they are able to shower themselves."

**INVESTIGATION FINDINGS:**
A discussion with the administrator revealed the following, residents are showered with the assistance of staff; staff are present during the showers. Although some residents are capable of independent activity it is felt that the shower has inherent dangers for the elderly. Our staff felt that once a client resides here we have an obligation to protect them. Interviews with clients could not be done because of cognitive deficits.

No deficiencies were noted during this investigation.

**Estimated Days of Completion:**

**SUPERVISOR'S NAME:** Yvette Richards
**LICENSE EVALUATOR NAME:** Lydia Williams

I acknowledge receipt of this form and understand my appeal rights as explained and received.

**FACILITY REPRESENTATIVE SIGNATURE:**

LIC3099 (FAS) - (06/04)
This is an official report of an unannounced visit/investigation of a complaint received in our office on 01/10/2005 and conducted by Evaluator Fausto Aguilar.

**COMPLAINT CONTROL NUMBER:** 294191

**FACILITY NAME:** STIDOLPH'S LAGUNA RIVIERA GUEST HOME

**DIRECTOR:** STIDOLPH, GAIL A.

**ADDRESS:** 4814 KELLY DRIVE

**CITY:** CARLSBAD

**CAPACITY:** 6

**CENSUS:** 6

**DATE:** 01/18/2005

**TIME VISIT BEGAN:** 10:45 AM

**TIME COMPLETED:** 12:15 PM

**FACILITY IS VIOLATING THE PERSONAL RIGHTS OF RESIDENTS BY USING TAPE ON DEPENDS OF RESIDENTS.**

**INVESTIGATION FINDINGS:**

1. FACILITY IS USING CLEAR TAPE ON THE DEPENDS OF ALL RESIDENTS. ACCORDING TO CAREGIVER CEBALLOS, SOME RESIDENTS ARE CONFUSED AND AT RISK OF CONFUSING AND CONSUMING THEIR OWN FECES. I CALLED LICENSEE STIDOLPH AND SHE CONFIRMED THE PRACTICE OF USING TAPE AND AN ADDITIONAL PORTION OF ANOTHER DEPEND DURING THE NIGHT. STIDOLPH ALSO SHARED THAT CARE IS TAKEN TO PROTECT THE RESIDENTS BY APPLYING A CREAM TO PROTECT THEM FROM THE WET. CEBALLOS ALSO INFORMED ME THAT SHE AND MS. STIDOLPH CHECK ALL RESIDENTS EVERY ONE AND ONE HALF HOUR FOR INCONTINENCE DURING THE NIGHT.

2. SI INFORMED MS. STIDOLPH TO DISCONTINUE THE USE OF CLEAR TAPE AROUND THE DEPENDS OF RESIDENTS AND TO APPEAL THE DEFICIENCY IF SHE BELIEVED SHE HAS AN ALTERNATE WAY OF MEETING THE NEEDS THAT MAY ALSO BE IN THE SPIRIT OF THE LAW.

**SUBSTANTIATED**

**Estimated Days of Completion:**

**SUPERVISOR'S NAME:** Yvette Richards

**TELEPHONE:** 619 767 2300

**LICENSED EVALUATOR NAME:** Fausto Aguilar

**TELEPHONE:** 619 767 2319

**DATE:** 01/18/2005

I acknowledge receipt of this form and understand my appeal rights as explained and received.

**LICENSED EVALUATOR SIGNATURE:**

**LICENSED REPRESENTATIVE SIGNATURE:**

01/18/2005
NARRATIVE/COMMENTS

1. THE TAPE IS USED ONLY DURING THE NIGHT AND DOES NOT TOUCH THE SKIN.

2. MR. STIDOLPH CAME DURING MY VISIT AND I REVIEWED MY REPORT WITH HIM. HE HAD TO LEAVE BEFORE I FINISHED MY VISIT.

3. I TALKED TO ALL RESIDENTS. THEY WERE IN THE LIVING ROOM AND WERE APPROPRIATELY DRESSED AND I DID NOT PERCEIVE ANY BAD ODORS.

Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

SUPERVISOR'S NAME: Yvette Richards

LICENSENG EVALUATOR NAME: Fausto Aguilar

LICENSENG EVALUATOR SIGNATURE: [Signature]

DATE: 01/18/2005

I acknowledge receipt of this form and understand my appeal rights as explained and received.

LICENSENG EVALUATOR SIGNATURE: [Signature]

DATE: 01/18/2005
**FACILITY NAME:** STIDOLPH'S LAGUNA RIVIERA GUEST HOME

**VISIT DATE:** 01/18/2005

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<th>PLAN OF CORRECTIONS (POCs)</th>
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<tr>
<td>Type B 01/18/2005</td>
<td>87572 87572</td>
<td>THE INFORMATION ON THIS REPORT IS ACCURATE. I WILL GIVE THIS REPORT TO MR. AND ,S. STIDOLPH WHEN I SEE THEM LATER TODAY.</td>
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**Section Cited:**
- 1
- 2
- 3
- 4
- 5
- 6
- 7

**DEFICIENCIES:**
- PERSONAL RIGHTS
- THE DIGNITY OF RESIDENTS IS BEING VIOLATED BY FOLLOWING THE PRACTICE OF PLACING TAPE ON THEIR DEPENDS DURING THE NIGHT.

**SUPERVISOR'S NAME:** Yvette Richards

**LICENSE EVALUATOR NAME:** Fausto Aguilar

**LICENSE EVALUATOR SIGNATURE:**

**TELEPHONE:** 619 767 2300

**DATE:** 01/18/2005

**FACILITY REPRESENTATIVE SIGNATURE:**

**DATE:** 01/18/2005
FACILITY NAME: COTTAGE, THE
ADMINISTRATOR: CORA DULIN
ADDRESS: 221 W 6TH AVE
CITY: ESCONDIDO
CAPACITY: 13
TYPE OF VISIT: Case Management
MET WITH: Cora Dulin, Administrator

FACILITY NUMBER: 374602228
FACILITY TYPE: 740
STATE: CA
TELEPHONE: (760) 743-7133
ZIP CODE: 92025
TIME BEGAN: 01:30 PM
TIME COMPLETED: 05:15 PM

NARRATIVE

1. Unannounced visit by LPA Karen Smith. LPA was met by caregivers Rufina and Eduardo Canlas. LPA reviewed resident records and all had required forms, current assessments and physician reports. There is one physician's report for a resident that has dementia that is due by 12-5-06, LPA advised to get it updated before the 5th of December. Staff records were checked and were adequate.

2. LPA toured facility inside, (there was rain outside) and found the facility adequate. The kitchen had sharps and toxins locked, there was a large family room and dining room and a long hall with doors to resident rooms.

3. LPA interviewed residents and all appeared happy and well oriented to the facility. Several had on sweaters, jackets and those taking naps were wrapped up also. LPA noticed the facility was cool. The LPA checked the rooms & they were much cooler than the rest of the house. LPA checked the resident rooms and found the vents were closed. LPA requested all vents to be opened and it was done. Thermostat was set to 72 degrees.

4. LPA was advised that caregivers Mrs and Mrs Soriano are no longer at the facility. The only mailing address they have for them is the one on the LIC 501.

5. During visit LPA found medication found in a resident room (several containers of vitamin pills), no call system is installed for residents that need assistance, they just yell until someone assist them and bedroom 3 has a bed blocking access to the exit which was corrected during visit, these are all 2nd violation in a 12 month period, civil penalties will be issued. LPA also found 1 bedridden resident, facility will request a bedridden clearance from the fire department and an exception from Licensing to be allowed to keep the resident. LPA discussed with the Administrator that she is responsible for the facility and if residents ask for something against the regulations, it is up to her to uphold the regulations. Also the proper furnishings for each room was discussed.

6. Deficiencies will be cited per Title 22 Regulation, Div 6 Sec 8.

7. Exit interview conducted.

SUPERVISOR'S NAME: Yvette Richards
TELEPHONE: (619) -767-2300

LICENSING EVALUATOR NAME: Karen Smith
TELEPHONE: 619-767-2320


I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:


This report must be available at Child Care and Group Home facilities for public review for 3 years.
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<th>Type A</th>
<th>POC Due Date / Section Cited</th>
<th>Deficiencies</th>
<th>Plan of Corrections(POCs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type Cited</td>
<td>11/27/2006</td>
<td>37577</td>
<td>1 Personal Accommodations - In room 3 there is a bed that does not allow a large enough passageway for a wheelchair to go through.</td>
<td>Corrected during visit.</td>
</tr>
<tr>
<td>Furniture needs to be adjusted to accommodate this.</td>
<td></td>
<td></td>
<td>2 civil penalty: 2nd time in 12 month period</td>
<td>Corrected during visit.</td>
</tr>
<tr>
<td>Type Cited</td>
<td>11/27/2006</td>
<td>87724(f), 87575</td>
<td>1 Care of persons with dementia/incidental medical and dental care-LPA found medications in resident room. All medications must be kept inaccessible to those in care, especially clients with dementia. All medications were removed and locked up immediately.</td>
<td>Corrected during visit.</td>
</tr>
<tr>
<td>2 civil penalty: 2nd time in 12 month period</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type Cited</td>
<td>11/28/2006</td>
<td>87582(c)(d)(1), 2</td>
<td>1 Acceptance and Retention Limitations - Facility has a resident that is bed ridden.</td>
<td>Corrected during visit.</td>
</tr>
<tr>
<td>2 civil penalty: 2nd time in 12 month period</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type Cited</td>
<td>11/27/2006</td>
<td>82572</td>
<td>1 Personal Rights - There is no way other than yelling for resident to get assistance from caregivers. Facility was told to get intercoms and none are present.</td>
<td>Corrected during visit.</td>
</tr>
<tr>
<td>2 civil penalty: 2nd time in 12 month period</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

SUPERVISOR'S NAME: Yvette Richards
TELEPHONE: (619) -767-2300

LICENSING EVALUATOR NAME: Karen Smith
TELEPHONE: 619-767-2320

LICENSING EVALUATOR SIGNATURE:

I acknowledge receipt of this form and understand my appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:

Licensing Program Analyst (LPA) Caitlin Leeger conducted this unannounced Case Management visit to deliver citations and assess civil penalties for failure to complete the plans of correction from the Case Management visit on 4-5-10. LPA was granted entry to the facility by Caregivers Linda Colmenero and Rosa Perez. Licensee Teri Urbon arrived approximately 30 minutes later.

- Licensee Teri Urbon's Administrator Certificate expired on 8-27-07 and she has failed to get recertified or to submit the necessary paperwork to designate another Administrator to run the facility. The POC was originally due on 4-9-10, but an extension was given until 4-10-10.
- Licensee/Administrator was cited for failure to complete and maintain required personnel documents for herself. This POC was due 4-7-10.
- Licensee was cited for personnel working without proper 1st aid training and was directed to get this staff certified right away and, until certification is obtained, to ensure that any caregiver without current 1st aid training work with another caregiver who has current 1st aid training. However, today and Monday there were two caregivers working together who both do not have current 1st aid certificates. The deadline for this POC was originally 4-9-10, but was extended until 4-10-10.
- In addition, Licensee has an intercom system in the house which is utilized to monitor residents bedrooms. This is a violation of personal rights and must stop immediately. This was originally cited on 3-12-10 and correction was due by 3-26-10. However, an extension was granted by Regional Manager to determine if these could be allowed for monitoring only at night. Licensee was informed today that these are not allowed at any time. It is the duty of caregivers and Administrator to monitor residents for health and safety needs at all times.

Deficiencies were cited and civil penalties assessed per Title 22, Division 6, Chapter 8, of the California Code of Regulations. This report was reviewed with Licensee and a copy was left at the facility.

SUPERVISOR'S NAME: Gladys Figueroa
TELEPHONE: (951) 782-4110

LICENSING EVALUATOR NAME: Caitlin Leeger
TELEPHONE: (619) 913-8002

I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 04/14/2010

This report must be available at Child Care and Group Home facilities for public review for 3 years.
**FACILITY EVALUATION REPORT**

<table>
<thead>
<tr>
<th>FACILITY NAME: CASA DEL MAR</th>
<th>FACILITY NUMBER: 374600761</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADMINISTRATOR: TERESA S. URBON</td>
<td>FACILITY TYPE: 740</td>
</tr>
<tr>
<td>ADDRESS: 13731 NOB AVENUE</td>
<td>TELEPHONE: (858) 755-4280</td>
</tr>
<tr>
<td>CITY: DEL MAR</td>
<td>ZIP CODE: 92014</td>
</tr>
<tr>
<td>CAPACITY: 6</td>
<td>DATE: 04/09/2010</td>
</tr>
<tr>
<td>TYPE OF VISIT: Case Management</td>
<td>TIME BEGAN: 12:35PM</td>
</tr>
<tr>
<td>MET WITH: Teri Urbon</td>
<td>TIME COMPLETED: 03:45PM</td>
</tr>
</tbody>
</table>

**NARRATIVE**

1. Licensing Program Analyst (LPA) Caitlin Leeger conducted this unannounced Case Management visit to cite for deficiencies at this facility.
2. Licensee/Administrator Teri Urbon has allowed three employees, M. Lyerly, A. Tagalog and R. Bell, to work without proper background clearances or exemptions.
3. Facility does not have sufficient staff each day to provide necessary care and supervision for residents. Some days there is only one caregiver for five residents, four of which are unable to independently reposition in bed or transfer from bed to a wheelchair.
4. Five residents are non-ambulatory and this facility is only licensed for up to four non-ambulatory residents.
5. Licensee/Administrator has applied for an increase in total capacity to 8 residents, 7 of whom may be bedridden, however this application is still pending.
6. Deficiencies and civil penalties were assessed per Title 22, Division 6, Chapter 8, of the California Code of Regulations.

This report was reviewed with Teri Urbon and a copy was left at the facility, along with a copy of Appeal Rights.

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**SUPERVISOR’S NAME:** Gladys Figueroa  
**TELEPHONE:** (951) 782-4110

**LICENSES EVALUATOR NAME:** Caitlin Leeger  
**TELEPHONE:** (619) 913-8002

**LICENSES EVALUATOR SIGNATURE:**

I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.

**FACILITY REPRESENTATIVE SIGNATURE:**

This report must be available at Child Care and Group Home facilities for public review for 3 years.
### DEFICIENCIES

<table>
<thead>
<tr>
<th>Deficiency Type</th>
<th>POC Due Date / Section Number</th>
<th>DEFICIENCIES</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Type A</td>
<td>04/10/2010 87411(g)</td>
<td>Personnel Requirements: Three staff have been working in the facility without fingerprint background clearances - A. Tagalog, R. Bell, and M. Lyerly. Civil penalties assessed.</td>
<td>Licensee shall immediately remove all staff without proper background clearances and shall ensure they do not return to work until completed.</td>
</tr>
<tr>
<td>Type A</td>
<td>04/10/2010 87411(a)</td>
<td>Personnel Requirements: Facility has only one caregiver working sometimes during the day, with 5 residents, four of whom are non-ambulatory and one is bedridden.</td>
<td>Licensee shall ensure that facility has sufficient staff at all times. Copy of staffing schedule and staff time-cards to be submitted weekly until further notice.</td>
</tr>
<tr>
<td>Type A</td>
<td>04/10/2010 87204(a)</td>
<td>Limitations - Capacity and Ambulatory Status: Facility has five non-ambulatory residents, but is only licensed for up to four non-ambulatory residents.</td>
<td>Licensee has submitted an application to change the capacity to a total of 8, 6 of whom may be bedridden. Licensee shall submit a request to CCL to temporarily maintain one bedridden resident until this new capacity is approved.</td>
</tr>
</tbody>
</table>

Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

**SUPERVISOR'S NAME:** Gladys Figueroa  
**TELEPHONE:** (951) 782-4110

**LICENSEE EVALUATOR NAME:** Caitlin Leeger  
**TELEPHONE:** (619) 913-8002

**LICENSEE EVALUATOR SIGNATURE:**

I acknowledge receipt of this form and understand my appeal rights as explained and received.

**FACILITY REPRESENTATIVE SIGNATURE:**

DATE: 04/09/2010
This is an official report of an unannounced visit/investigation of a complaint received in our office on 05/03/2011 and conducted by Evaluator Diana Sanchez.

PUBLIC

COMPLAINT CONTROL NUMBER: 08-SC-2011050314

FACILITY NAME: CASA DEL MAR
ADMINISTRATOR: TERESA S. URBON
ADDRESS: 13731 NOB AVENUE
CITY: DEL MAR
CAPACITY: 6
FACILITY NUMBER: 37460
FACILITY TYPE: 740
STATE: CENSUS: 5
TELEPHONE: (858) 755-761740
ZIP CODE: 92108
DATE: 05/10/2011
TIME VISIT BEGAN: 10:10 AM
TIME COMPLETED: 04:43 PM

ALLEGATION(S):
1. There's not enough staff to care for residents
2. Resident has a deep pressure sore

INVESTIGATION FINDINGS:
Licensing Program Analyst (LPA) D. Sanchez, made an unannounced complaint visit to the facility today. LPA met with caregiver Jessica McGraff and advised her of the reason for today's visit. Administrator Teresa Urbon and Co-Administrator Donald Stroebel arrived to the facility later during this visit.

Complainant stated that There is not enough staff to care for residents.

LPA noticed that caregiver Jessica McGraff was the only caregiver on duty during this visit caring for five non-ambulatory residents. Teresa stated that she is the second caregiver during the day, but was not at the facility this morning, because she had a last minute meeting to attend. Mr. Stroebel stated that they did not have a chance to look for a back up person due to the urgency of the meeting.

LPA interviewed all residents present in the facility. Some residents stated that usually the caregiver takes a while to response. Some other residents stated that sometimes they have to yelled loud for assistance.

Substantiated

Estimated Days of Completion:

SUPERVISOR'S NAME: Gladys Figueroa
TELEPHONE: (951) 204-6346

LICENSING EVALUATOR NAME: Diana Sanchez
TELEPHONE: (619) 929-7590

I acknowledge receipt of this form and understand my appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 05/10/2011

This report must be available at Child Care and Group Home facilities for public review for 3 years.
Complainant stated that resident has a deep pressure sore.

LPA checked residents' feet with the assistance of Caregiver Jessica McGriff. When caregiver Jessica removed the sock from resident #1, LPA noticed what it seems to be a healing wound on his left foot heel. Caregiver Jessica stated she never noticed it. Administrator Teresa stated she didn't know resident #1 has that healing wound, but will have his physician evaluate it.

LPA reviewed resident #1 records, but his last physician's report is dated 11/05/2007 and does not mention an existing healing wounds.

Based on this investigation, interview staff, residents, Teresa Urbon and Donald Stroebel, review of resident #1 facility file, the above allegation was substantiated. See deficiency cited today per Title 22, Division 6, Chapter 8, on LIC-809D. An exit interview was conducted with caregiver Jessica McGriff & a copy was provide as well as appeal rights.

Teresa Urbon and Donald Stroebel advised LPA D. Sanchez, that they had a meeting to attend at 3:30 pm and could not wait on the LPA to finish the reports. LPA made both administrators aware of this complaint findings.

I acknowledge receipt of this form and understand my appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:
## DEFICIENCY INFORMATION FOR THIS PAGE:

**FACILITY NAME:** CASA DEL MAR  
**FACILITY NUMBER:** 374600761  
**VISIT DATE:** 05/10/2011

### DEFICIENCIES

<table>
<thead>
<tr>
<th>Deficiency Type</th>
<th>POC Due Date / Section Number</th>
<th>DEFIENCIES</th>
<th>PLAN OF CORRECTIONS (POCs)</th>
</tr>
</thead>
</table>
| Type A          | 05/11/2011 Section Cited 8761(a) | 1. General Requirements for Allowable Health Conditions  
2. Resident #1 have a healing wound on his left heel. | 1. Administrator Teresa Urbon, shall ensure to get an updated physician's report, to include the stage of the wound and develop a care plan for resident #1.  
2. Teresa shall ensure to fax a written statement to CCLD, advising the date the resident is scheduled for his medical assessment, by the due date of 5/11/2011. |
| Type B          | 05/11/2011 Section Cited 8741(a) | 1. Personnel Requirements-General. Personnel shall at all times be sufficient in numbers and competent to provide the services necessary to meet resident needs.  
2. LPA noticed that only one caregiver was providing the care to 5 nonambulatory resident during the today's visit. | 1. Administrator Teresa shall ensure to have sufficient staff coverage to meet resident needs.  

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Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

**SUPERVISOR’S NAME:** Gladys Figueroa  
**TELEPHONE:** (951) 204-6346  
**LICENSENG EVALUATOR NAME:** Diana Sanchez  
**TELEPHONE:** (619) 929-7590

**LICENSENG EVALUATOR SIGNATURE:**

---

I acknowledge receipt of this form and understand my appeal rights as explained and received.

**FACILITY REPRESENTATIVE SIGNATURE:**

---

I acknowledge receipt of this form and understand my appeal rights as explained and received.

**FACILITY REPRESENTATIVE SIGNATURE:**
Resident #1 pressure ulcer

Complaint Visit dated 5/10/2011

# 08-SC-20110503141032
Licensing Program Analyst (LPA) D. Sanchez, was conducting a complaint visit to the facility today. During this visit it was notice that two residents seemed to be bedridden. LPA asked caregiver if staff repositions the residents and caregiver stated yes that she repositions them every half hour.

Facility admitted a seventh resident on or about the beginning of February 2010. Facility was operating over capacity for approximately one month until yesterday (3/11/10), one of their hospice resident passed away. Additionally, facility currently have one resident on hospice, but the resident that passed away yesterday (3/11/10) was also on hospice. Facility currently has a hospice waiver for one resident only. Facility was operating over the waiver limitations.

LPA also notice all rooms have intercom radio and let the administrator know that is a violation of residents rights for privacy. Administrator did not agreed and refused to show LPA the main device were all the intercoms are connected to. Administrator stated it was located in her bedroom, but will not let LPA into her private room located on the second floor of the facility.

Additionally, Administrator refused to provide LPA with residents and staff records. Administrator stated she has them upstairs all over the place and needed to go to the store to buy some supplies needed for the facility. LPA made her aware that is a violation not providing the LPA with these records. Administrator stated that she does not trust leaving this documents with this LPA and asked the LPA to come another day to review these files.

Administrator also refused to show this LPA the location where all medications are being stored. Administrator stated that it was located in her bedroom upstairs and will not allow this LPA to come into her private room. Administrator stated that she provides the morning staff with residents daily medications every morning. Then the staff will dispense the medications to each residents throughout the day.
Caregiver Linda Colmenero, has been working at this facility since 12/24/2009. She is fingerprint clear, but not associated to this facility.

See deficiencies cited today per Title 22, Division 6, Chapter 8, on LIC-809D. An exit interview was conducted with Teresa Urbon and a copy of this report and LIC-809D left at the facility as well as appeal rights. During the course of this evaluation LPA advised, Teresa Urbon, that all request for extensions of any citations/Proof of Corrections (POCs) must be made within 10 days to the issuing LPA on or before the date the POC is due. Appeals to citations must be made within 10 days in writing to the issuing LPA's supervisor on or before the date the POC is due.

SUPERVISOR'S NAME: Gladys Figueroa
TELEPHONE: (951) 204-6346

LICENSENG EVALUATOR NAME: Diana Sanchez
TELEPHONE: (619) 929-7590

I acknowledge receipt of this form and understand my appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:
DATE: 03/12/2010
FACILITY EVALUATION REPORT (Cont)

FACILITY NAME: CASA DEL MAR
FACILITY NUMBER: 374600761
VISIT DATE: 03/12/2010

Deficiency Type | POC Due Date / Section Cited | DEFICIENCIES | PLAN OF CORRECTIONS (POCs)
--- | --- | --- | ---
Type A 03/15/2010 87411(g)(2) | PERSONNEL REQUIREMENTS - GENERAL | Licensee will ensure to fax to the Community Care Licensing Department (CCLD) the Criminal Background Clearance Transfer Request with a copy of employee's valid identification by the due date of 3/15/2010. In order to associate employee.
Type A 03/12/2010 87204(a) | LIMITATIONS - CAPACITY AND AMBULATORY STATUS - Facility was operating with seven residents for approximately one month. | No plan of correction required at this time, since one of the residents passed away on 3/11/10, and the facility is now back operating with the six remaining residents.
Type A 03/12/2010 87204(a) | LIMITATIONS - CAPACITY AND AMBULATORY STATUS - Facility was operating with two residents on hospice and only have a hospice waiver for one resident. | No plan of correction required at this time, since one of the hospice residents passed away on 3/11/10, and the facility is now back operating with on resident on hospice.
Type A 03/15/2010 87455(g) | ACCEPTANCE AND RETENTION LIMITATIONS | Administrator will submit a LIC-200 request for bedridden and fire clearance immediately to the Community Care Licensing Department by the due date of 3/15/2010.

Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

SUPERVISOR'S NAME: Gladys Figueroa
TELEPHONE: (951) 204-6346

LICENSING EVALUATOR NAME: Diana Sanchez
TELEPHONE: (619) 929-7590

LICENSING EVALUATOR SIGNATURE:

I acknowledge receipt of this form and understand my appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 03/12/2010

ibr.com
FACILITY NAME: CASA DEL MAR

DEFICIENCIES

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</tr>
</thead>
<tbody>
<tr>
<td>Type B</td>
<td>03/26/2010</td>
<td><strong>PERSONNEL RECORDS</strong> - Administrator refused to provide LPA with the staff records.</td>
<td>Administrator will ensure to provide LPA with staff records when requested.</td>
</tr>
<tr>
<td>Section Cited</td>
<td>87412(f)</td>
<td><strong>RESIDENT RECORDS</strong> - Administrator refused to provide LPA with the residents records.</td>
<td>Administrator will ensure to provide LPA with residents records when requested.</td>
</tr>
<tr>
<td>Section Cited</td>
<td>87506(d)</td>
<td><strong>INCIDENTAL MEDICAL AND DENTAL CARE SERVICES</strong> - Administrator refused to show LPA the location where medications are being stored.</td>
<td>Administrator will ensure to provide LPA with residents medications and medication log when requested.</td>
</tr>
<tr>
<td>Section Cited</td>
<td>87465</td>
<td><strong>PERSONAL ACCOMMODATIONS AND SERVICES</strong> - Facility have intercom radios on all residents' rooms. All intercoms are connected to a main device located in the second floor of the facility in the administrator's room.</td>
<td>Administrator will ensure to disconnect or dismantle the intercoms in all rooms. Administrator needs to provide proof from a professional company that the intercoms are not operable.</td>
</tr>
</tbody>
</table>

Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

SUPERVISOR'S NAME: Gladys Figueroa
TELEPHONE: (951) 204-6346

LICENSING EVALUATOR NAME: Diana Sanchez
TELEPHONE: (619) 929-7590

DATED: 03/12/2010

I acknowledge receipt of this form and understand my appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 03/12/2010
This is an official report of an unannounced visit/investigation of a complaint received in our office on 12/22/2004 and conducted by Evaluator Christine Focosi-Mckelvey.

**COMPLAINT CONTROL NUMBER:** 294172

**FACILITY NAME:** SECURE SENIORS

**DIRECTOR:** SANDY KRASOVEC

**ADDRESS:** 2614 E. WASHINGTON AVE

**CITY:** ESCONDIDO

**CAPACITY:** 16

**FACILITY NUMBER:** 374601847

**FACILITY TYPE:**

**TELEPHONE:** (760) 746-5123

**STATE:** CA

**ZIP CODE:** 92027

**DATE:** 12/30/2004

**TIME VISIT BEGAN:** 12:00 PM

**TIME COMPLETED:** 03:15 PM

**ALLEGATION(S):**

1. RESIDENT #1 DIED AT FACILITY 10-14-04 WHILE ON HOSPICE. DIED DUE TO HEMORRHAGING. #1 WAS CLOSED TO A ROOM ALONE FOR MANY HOURS AT A TIME EXCEPT WHEN HOSPICE VISITED.

2. LICENSEE MADE MANY DECISIONS REGARDING #1'S HEALTHCARE TREATMENT WITHOUT CONSENT OR KNOWLEDGE OF CONSERVATOR.

**INVESTIGATION FINDINGS:**

1. I INVESTIGATED THESE TWO COMPLAINTS AND FOUND NO INFORMATION TO SUPPORT THE ALLEGATIONS.

2. I REVIEWED THE HOSPICE FILES, TALKED TO LICENSEE WHO WAS THERE AND A CAREGIVER WHO ALSO WAS THERE WHEN #1 DIED.

3. THE ALLEGATIONS ARE DETERMINED TO BE UNFUNDED.

**Unfounded Estimated Days of Completion:**

**SUPERVISOR'S NAME:** Yvette Richards

**TELEPHONE:** 619 767 2300

**DATE:** 12/30/2004

**LICENSING EVALUATOR NAME:** Fausto Aguilar

**TELEPHONE:** 619 767 2319

**DATE:** 12/30/2004

I acknowledge receipt of this form and understand my appeal rights as explained and received.

**FACILITY REPRESENTATIVE SIGNATURE:**

**DATE:** 12/30/2004