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7 case studies show nursing home lapses

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These cases offer a glimpse of the conflicts and lapses that have occurred in mixed nursing home populations. The facts set forth are included in state and federal inspection reports. The owners are identified in the federal government's Nursing Home Compare database. Federal quality ratings range from 1 star (much below average) to 5 stars (much above average.) The listed ratings reflect the facility's current status.

Cops called over shoehorn threat

Home: Asbury Park Nursing and Rehabilitation Center, Sacramento

Owner: John Lund

Federal rating: ☆☆☆☆

Officers responded to the Fair Oaks Boulevard nursing home in July 2014 to investigate reports of a beating and an alleged follow-up threat by one resident to stab another with a shoehorn. One female resident claimed another had come into her room four days earlier, repeatedly hit her and threw her onto the bed. She was accused of retaliating by going to the other patient's room and threatening her with a shoehorn. The resident told law enforcement she was only trying to scare the other woman, not stab her. The facility was issued a deficiency for failing to report the alleged abuse to the state.

Male patient, 56, punches female resident, 92

Home: Ridgecrest Regional Hospital Transitional Care and Rehabilitation Unit D/P, Ridgecrest

Owner: State and federal ownership records conflict

Federal rating: ☆

A 92-year-old female resident was sent to an emergency room in November 2013 after a male patient, 56, struck her face twice with an open hand and once with a closed fist. The man, whose diagnoses included psychosis, was able to move freely about the hallways, tipping an 86-year-old female patient out of her wheelchair 13 days later. A certified nursing assistant told inspectors he

was a “danger to the patients,” and staff members also reported being attacked. The state found the facility placed its patients and staff at risk and issued a citation and $20,000 fine, and another citation for failure to report.

Facility accused of ‘patient dumping’

Home: Tarzana Health and Rehabilitation Center, Tarzana

Owner: Ownership status changed post incident

Federal rating: ☆☆

A mentally ill woman, whose diagnoses included bipolar disorder and anorexia, was sent to an emergency room in August 2012 with the facility physician’s order for the “resident not to return to the facility under any circumstances.” The facility’s director of nursing told inspectors the patient had been exhibiting extreme agitation and physically aggressive behavior toward staff and another resident. The state’s review found that her anti-anxiety medication had not been administered for three days, and her personal physician expressed frustration that the facility’s medical director was trying to “dump” her at the hospital. The home was cited and fined $2,000.

Resident unmonitored after suicide attempt

Home: Hearts & Hands Post Acute Care & Rehab Center, Santa Cruz

Owner: A.J. Rana; Trilochan Singh

Federal rating: ☆

Police were summoned to the facility in October 2014 after a resident, who had been crying earlier in the day, was seen by a certified nursing assistant placing a plastic bag over her head. Police were called and the resident was placed on a 72-hour psychiatric hold and transferred to an emergency room, but she returned to the facility the following day. Health inspectors found that – despite the nursing home’s reported plan to check on the woman every 15 minutes – the director of nursing admitted three days after the incident that no one was monitoring her. The facility was issued a federal deficiency.

String of fights erupts among residents

Home: Vernon Healthcare Center, Los Angeles

Owner: Brius Management Co; Shlomo Rechnitz; among others

Federal rating: ☆

The state investigated four fights involving seven residents over a six-week period in 2014. Four of the seven residents were diagnosed with mental illness, including schizophrenia and psychosis. One resident punched another in the stomach. Two residents' wheelchairs became entangled, and one resident allegedly swung at the other. Another threw a tennis shoe at a fellow patient. The state found that one of the residents also hit a certified nursing assistant and punched a security guard. The facility was fined $2,000 for failing to properly report the incidents. It was fined another $60,000 for failing to supervise one of the patients, who also was scaring female patients by entering their rooms. The facility appealed both citations; the appeals remain open.

Mentally ill resident flouts smoking rules

Home: Windsor Vallejo Nursing & Rehabilitation Center, Vallejo

Owner: Windsor Norcal 13 Holdings LLC

Federal rating: ☆

Regulators declared in July 2014 that all 151 of the facility's residents had been in danger after staff failed to stop a non-ambulatory resident with "a mental disorder and limited judgment" from frequently smoking in bed unsupervised. The facility's signage at the entrance stated it was "tobacco-free and smoke-free." Physicians' orders stated that the woman was a "safety risk for herself, staff and other residents." The state issued a citation and $20,000 fine after concluding that, for more than a year, staff had smelled tobacco smoke, observed ashes on linens and reported ignition of a towel – yet failed to implement the facility's smoking policies. The fine was dropped to $13,000 on appeal.

Patient threatens staff with butter knife

Home: Jacob Health Care Center, San Diego

Owner: Jacob Graff

Federal rating: ☆☆

The nursing home received a federal deficiency in 2014 after staff failed to seek medical support for a patient, who was regularly agitated, verbally abused workers and tried to stab a certified nursing assistant with a butter knife. The resident had a history of aggression, cursing and throwing things at staff. Over four consecutive days in July 2013, the resident refused care; threw pillows, a telephone and a table on the floor; and removed his clothes while threatening staff. On the fourth day, he threw a food tray and threatened to stab a certified nursing assistant. The director of nursing was unable to explain why there had been no involvement by a physician or psychiatrist.

Sources: California Department of Public Health; U.S. Centers for Medicare and Medicaid Services; Sacramento Bee research

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