FATE

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Newsletter of Foundation Aiding The Elderly

President's Message

WHO'S PROTECTING WHOM....

By Carole Herman

This past year has been another eye opener for us at **FATE**. After 33 years of advocacy, I thought we had learned just about all there is to know about the government system and how it is not working to protect our most vulnerable citizens in long-term care facilities. Unfortunately, I was wrong. We learned more this year about the lack of oversight by the state and federal agencies whose duty is to protect patients. There seems to be enough regulations on the books to ensure our safety in these places; however, with the lack of government oversight, the public continues to be "at risk" in these facilities.

FATE has served over 5,500 families all over the country and we have filed complaints in most states so we feel we have a pretty good handle on the issue.

FATE continues to hit roadblocks with both the State and Federal regulators. When a complaint is filed against a facility, we have found that we are battling the regulators more than the facilities that caused harm to the patients. **FATE** does not file complaints for poor food. The complaints we file on behalf of the public are very serious ones, such as, dehydration, over-medication, bed sores, malnutrition, lack of dental care, falls with injuries, sepsis, blunt force trauma to the head causing hematomas, death and insufficient staffing. Ninety-five percent of complaints we file for insufficient staffing are unsubstantiated by the regulators. Sufficient staffing to meet the needs of the patients is critical and it is a known fact that **insufficient staffing is "the root of all poor care and neglect".**

CAROLE HERMAN

Recently, **FATE** filed a complaint in California that, among other allegations, included insufficient staffing. The regulators issued a deficiency based on the facility's failure to have an x-ray taken in a timely manner after the patient fell out of bed and broke a hip. The regulators also issued a

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FATE's Mission Is:

"Assuring our elders are treated with care, dignity and the utmost respect during their final years when they can no longer take care of themselves."

Services FATE Provides

- Direct & On Site Advocacy
- Patient & Family Rights Advice
- Elderly Service Referrals
- Long Term Care Facility Evaluation

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Update on FATE's Public Interest Suit against the California Department of Public Health

On October 14, 2015, Judge Susanne Bolanos of the San Francisco Superior Court held a third status hearing on the on-going efforts by the California Department of Public Health (DPH) to comply with her March 2015 ruling that DPH had failed to perform certain mandatory duties under state law.

The earlier ruling was prompted by **FATE's** 2013 public interest lawsuit to force DPH to complete its complaint investigation appeals process in a more-timely manner and to provide certain public records sought by **FATE**. At the October hearing, Judge Bolanos expressed disappointment at DPH's performance and ordered DPH to pick up its pace in processing **FATE's** administrative appeals and provide the requested documents.

The Court also ordered supplemental briefings as to the scope of information DPH must provide to patients and their advocates at these appeals. **FATE** believes that all relevant information about underlying investigations should be shared with complainants, while DPH contends that this information should be kept secret. The information that DPH is not sharing is how the department reached its conclusion to determine a complaint is not substantiated. A ruling on that issue is expected in December of 2015, according to the San Francisco based Lexington Law Group that filed the complaint on behalf of **FATE**.

Fallout at CA Department of Public Health

FATE's law suit, along with three critical reports from the California State Auditor and a private audit firm, confirmed serious problems with the Department of Public Health (DPH) leadership, investigative backlogs and chronic inability to handle consumer complaints which prompted the California Legislature's call for Oversight Hearings. However, prior to the hearings, Dr. Ronald Chapman, Director, Kathleen Billingsley, Chief Deputy Director of Policy and Programs and Debbie Rogers, Director of Licensing and Certification all resigned from the Department. These leaders were to oversee the care of some of California's most vulnerable citizens; however, under their watch, the department was slammed for its failure to not only complete consumer complaints, but also for the failure to monitor chain-wide performances of nursing home ownerships.

President's Message

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federal deficiency for insufficient staffing; however, the regulators withheld that information from **FATE**. **FATE** appealed the findings and waited over two years for our appeal hearing. We found out at the hearing that the regulators had also issued the facility a deficiency for insufficient staffing without notifying **FATE**. The deficiency had been dismissed by the regulators in secret after the facility requested an Independent Informal Dispute Resolution (IIDR). Under federal statutes, the facility is entitled to an IIDR. According to regulations, the request must be in writing and the state regulators must give the complainant a copy of the facility's request, along with a copy of the regulators written result. **FATE** was given nothing.

FATE formally objected and requested a copy of the facility's request for the IIDR and the regulator's written results. **FATE's** request was denied. After this episode, we now wonder how many more times have the regulators issued deficiencies for lack of staffing and then dismissed the deficiency with no one knowing about it, except, of course, the regulators and the facility operators.

The long-term care industry, along with the American Medical Association (AMA) and the Pharmaceutical industry are huge campaign contributors. The elderly are not, especially those who are in long-term care facilities living out the remainder of their lives. The old saying "those that have the gold, make the rules" is alive and well in the political arena. We have not done a nation-wide study to determine the amount of dollars the long-term care industry, the AMA and the Pharmaceutical companies are donating to the politician's war chests, but it must be a huge amount.

Another troubling factor is that in nursing homes alone, approximately 87% of the patient's monthly costs are being paid by MediCare , MediCaid and in California, MediCal. These are our tax dollars going to an industry caring for our most vulnerable citizens and yet the poor care continues with little to no oversight, the politicians are getting campaign dollars from the operators, the regulators are not enforcing regulations and our loved ones are not getting the proper care for which we are paying.

Take note on our list of complaints in this issue that not one nursing home was issued a monetary penalty for violations which affected the health and safety of the patients. The only monetary penalties were three assisted living facilities with $150.00 fines each. Assisted living and residential care facilities are licensed by a different state agency in California with different regulations and very small fines. These complaint results are only a few that have been completed this year. We have many more complaints still pending. As well, many of the complaints that we have appealed are over two year old. As stated above regarding the incident of the dismissed staffing deficiency, the facility did not have to wait very long to exercise its appeal right….but the consumer sure does. So now you decide…

Who's Protecting Whom???

"The best way to find yourself is to lose yourself in the service of others"… Mahatma Gandhi

BOOKS OF INTEREST

"**Being Mortal": Medical and What Matters in the End….**By Atual Gawande, M.D.
This New York Times best seller is about how medicine can not only improve life, but also the process of its ending.
Dr. Gawande tackles the hardest challenge of his profession. In the inevitable condition of aging and death, the goals of medicine seem too frequently to run counter to the interest of the human spirit. Doctors , committed to extending life, continue to carry out devastating procedures that in the end extend suffering. Dr. Gawande shows all of us, doctors included, how mortality must be faced, with both heart and mind. This book is a "must read". Order via Amazon.com….cost $15.95 hard cover.

Aging: Warning – Navigating Life's Medical, Mental and Financial Minefields…by Sharon Sebastian.
Journalist Sharon Sebastian writes a revealing and explosive book that is blunt, unwavering and authentic. The book is about malfeasance of both government and the elder care megalopoly and gives her insight about aging in America. The information in this book is to warn not coddle.. Order via Amazon.com…cost $19.95 paperback.

Florida Punitive Damage Awards from Civil Suits

Civil lawsuits against nursing homes for abuse have escalated all over the country during the past decade. Citizens have turned to suing for accountability as the state regulators continue to not hold the nursing home industry accountable for poor care and harm to patients.

In a Florida case several years ago, the jury awarded the plaintiff $1 Million in compensatory damages and $770,000 in punitive damages for the death of a nursing home patient. However, the defendants lost and had to pay the family the punitive damage award. After three appeals and several years, the defendants lost all appeals and had to pay the family the punitive damage. That's when the family found out that there was a statute in Florida, established in 2001, that any punitive damage award against a nursing home, 50% of the award goes to the State of Florida and placed in a Trust Fund to be used to better the care for the patients. Also, the Trust Fund includes a portion of the fines collected by the Center for Medicare Services that also is given back to the Florida Fund to also be used for the improvement of the care for the patients. This process applies to all states, not just Florida. What Florida has, however, is this statute regarding punitive damage awards from civil litigation. We have not found any other state with this type of a statute.

This Florida case involves the death of George Dahmer, also known in his professional wrestling career as Chief White Owl. He died in a Florida nursing home from bedsores, malnutrition and several other complications. We believe his case to be the first punitive damage award against a nursing home in Florida as our research found Florida had never collected any monies resulting from punitive damage awards against a nursing home.

In the past, the Florida funds have been used by the industry for such things as a family room, a stand-in Table, TV ears, a community courtyard enhancement project, which costs $96,000. These monies granted to nursing home operators had no direct bearing or improvement of patient care, such as increased staffing, better nutrition, more physical therapy, etc.

FATE has numerous clients in Florida and, along with Debbie Dahmer, who represents the Dahmer family, and other advocates in Florida, we will be actively pursuing legislation that will repeal this unfair statute. We have written letters to the members of the Florida Health and Human Services Committee, as well as numerous Florida Senators and Representatives to repeal this statute as it is not in the best interest of Floridians. It certainly does not seem appropriate that a nursing home can be sanctioned for poor care, be found guilty by a jury, only to have the State of Florida take 50% of the punitive damage award away from the family and give it back to the nursing home industry. **FATE** calls that double victimization of the patient and the family.

OHIO NURSING HOMES SCORE POORLY

According to a new rating system under the federal government's recently revised five-star system, Ohio is one of 11 states where at least 40 percent of nursing homes have low ratings. Cristina Boccuti, a senior associate at the Kaiser Family Foundation and co-author of the report, states that it is important to look at this because nursing home patients are some of the oldest and frailest individuals in the United States. The Kaiser study found higher-overall ratings among small and nonprofit nursing homes.

Changes to the rating system were made to give seniors and their families better information to compare and choose amount long-term care facilities. This is important, advocates for the elderly say, because of problems that have arisen nationwide from inadequate staffing and substandard care.

The problem with the rating system is that it is flawed, in that it only reports federal law violations and not state law violations, which in California are more punitive than the federal regulations. For more information, go to **www.4fate.org**, click on "Latest News" and watch the "New York Times" video on this subject.

Head of Georgia's Nursing Home Lobby Resigns

Jon Howell, the long-time head of Georgia's powerful nursing home lobby resigned in April of 2015 after months of internal differences in the organization. Howell's resignation came a few months after he told lawmakers that the industry didn't need all the money that Georgia's Gov. Nathan Deal recommended as a part of a rate hike for select nursing homes in Georgia. Several of the homes are owned and operated by one of Gov. Deal's biggest campaign contributors, the Pruitt family company, United Health Services. The nursing home industry has long been a major campaign backer of Gov. Deal, as it has been for past governors from both parties. Georgia pays more than $1 billion a year to nursing homes to care for Georgians.

Nursing home operators have long been politically active, donating big money to state leaders and not just in Georgia. This scenario repeats itself in every state. Since the majority of patients care costs in nursing homes is funded by Medicare and Medicaid (MediCal in California) we citizens are not only paying for nursing home care, we are paying for the nursing home lobby groups contributions to politicians to benefit the industry and not beneficial to our most vulnerable citizens.

Pennsylvania Dismissed 92% of Philadelphia's Nursing Home Complaints

According to a new report compiled by Community Legal Services of PA (CLS), between 2012 and 2014, complaints of abuse or neglect filed against Philadelphia's nursing homes had a 92% chance of being dismissed by the Department of Public Health. The analysis concluded that of the 507 complaints filed against the city's 46 nursing homes only 43 investigations were substantiated by the Department.

A state bulletin obtained by Legal Services suggested the department began to adopt a loose interpretation of nursing home regulations back in November of 2012. Sam Brooks, a staff attorney at CLS stated "one of the major consequences of the Dept. of Health's failure to properly investigate complaints and to enforce regulations is that the public becomes misinformed. The public relies on the Department to go out into nursing homes and evaluate how safe and clean they are, how well treated the patients are and by not doing that, the public cannot make an informed decision about where to place themselves or a loved one." Pennsylvanians are urged to contact Governor Tom Wolf and Attorney General Kathleen Kane and voice your concerns about the lack of enforcement of nursing home abuse in the state of Pennsylvania.

Texas Ranks Last in Nursing Home Care

The Houston Chronicle reported in May of 2015, that a new analysis of federal data showed that Texas has the largest share of low-rated nursing homes in the nation. Fifty-one percent of the state's 1,193 nursing homes that receive Medicare and Medicaid earned only one to two stars out of a five-star rating system. In **FATE's** previous newsletter, it was reported that the Federal five-star rating system was inadequate and misleading. CMS relooked at how it uses data to evaluate nursing homes and changes were put into place starting January of 2015. This latest report by the government rating system is hopefully more accurate. The best way to know about a facility is to observe, ask questions, visit at different times, talk to other family members, approve all procedures and medications and check the facility's public records at the health department in your state.

MAKE A DIFFERENCE….MAKE A DONATION

During 2015, FATE helped over 350 families all over the country. To assist FATE in continuing to serve our most vulnerable citizens and their families, please make a tax deductible donation using the enclosed envelope or go to our web site at www.4fate.org and click on MAKE A DONATION via Paypal. Your contribution will make a big difference.

FINES LEVIED AGAINST CALIFORNIA ASSISTED LIVING FACILITIES INADEQUATE

The son of the patient who was harmed and subsequently died as a result of the negligence in an Emeritus facility in Rancho Solano, California, stated that as an airline pilot if he knowingly allows an intoxicated passenger to board the air plane that he may be liable and have to personally pay a fine of $10,000.00. Yet, the sanctions levied upon this facility for his elderly father's harm and subsequent death resulted in the state regulators issuing a Class A citation with a paltry fine of $150.00. And, the facility operator has the right to appeal this citation. In California, the consumer/complainant does not have the right to an appeal for complaints issued against assisted living or residential care facilities. This is a very unfair business practice of not allowing both sides the opportunity to appeal regulator's decisions. **FATE** will attempt to work with California state legislators to have the penalty for causing a death to be increased substantially and to also allow the consumer the same appeal rights as the facility.

Refer to page 7, complaints, to read about this Emeritus complaint that resulted in a $150.00 fine, as well as, the other two complaints that resulted in Class A citations with $150.00 fines that were also based on deaths. Clearly, something is wrong with this picture.

Antipsychotic Use in Assisted Living Facilities

A recent Government Accountability Office Report (GAO-15-211) revealed a conspicuous absence of action regarding antipsychotic use in assisted living facilities that provide housing and care for almost 750,000 older adults, an estimate by the National Center for Health Statistics. The statistics suggest that the majority of antipsychotic use in assisted living residences is off-label and therefore deemed inappropriate and dangerous as it is for nursing home patients. In December of 2012, The Center for Medicare and Medicaid Services (CMS) launched a national initiative that would reduce antipsychotic medication use in nursing homes; however, the initiative did not include assisted living residences.

The national initiative for nursing homes has not reached its goals to reduce the use of antipsychotics and **FATE** continues to receive complaints from consumers that their family members in nursing homes throughout the country are still being given antipsychotics and, in a lot of cases, without any consent from either the patient or the patient's responsible party. Antipsychotic medications, as well as black-box drugs, can only be administered in a nursing home with the physician obtaining consent from the patient or patient's responsible party. Without the consent, administration of these powerful and dangerous medications is a violation of nursing home regulations. Even so, the Government is still paying for these medications without knowing if they have been approved or not.

"Volunteers don't get paid not because they are worthless, but because they are priceless"...
- Sherry Anderson, Author

KNOW YOUR RIGHTS

Arbitration Agreements

As recently reported by the New York Times, it has been increasingly difficult over the past few years to apply for a credit card, use a cell phone, get cable or internet service or shop online without agreeing to private arbitration. The same applies to getting a job, renting a car or **placing a relative in a nursing home.** William Young, a federal judge in Boston, stated in an interview with the Times that this is among the most profound shifts in our legal history. He further stated that business has a good chance of opting out of the legal system altogether and misbehaving without reproach. Arbitration strips people of their constitutional right to go to court and the right to a trial by jury. Nursing home admission agreements are including arbitration clauses. Often the nursing homes want the responsible party to sign the agreement immediately upon admission. **FATE** strongly urges people to look over admission agreements carefully. Do not sign the agreement until after a thorough review and definitely do not sign an arbitration clause. Facilities cannot refuse admission if the party refuses to sign the arbitration clause.

Informed Consent and Mind Altering Medications

Prior to being given any antipsychotic medication, black box drugs or mind altering medications, patients have the right to give consent. If the patient is not capable of doing so, the responsible party then must give the consent. FATE has found that some consumers think the consent comes from the physician. Not true. The consent comes from the patient or the patient's responsible party and must be given to the physician prior to the administration of medications with adverse reactions that may be detrimental to the patient. The misuse of antipsychotic medications in nursing homes is quite rampant and very dangerous to elderly patients and as reported by the American medical Association can cause death.

To Be Fully Informed

Each patient has the right to be fully informed of rights, rules and regulations governing long term care facilities, such as services available, all charges for services, refusal of treatment and to be informed of the medical consequences of such refusal, to be transferred or discharged only for medical reasons or for nonpayment of services, to voice grievances and recommend changes in policies and services to the facility staff, be free from restraints, interference, coercion, discrimination or reprisal, to be free from mental and physical abuse and to associate and communicate privately with persons of the patient's choice.

What Are Physical/Chemical Restraints

Federal guidelines define physical restraints broadly, stating that any device or material which "restricts freedom of movement or normal access to (a resident's) body is a physical restraint. Leg or arm restraints, hand mitts, soft ties, vests, wheelchair safety bars and geri chairs are considered physical restraints. A drug prescribed to control mood, mental status or behavior is considered a chemical restraint. Federal law applicable to virtually all nursing homes states that a nursing home patient has "the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the patient's medical symptoms." Restraints may only be imposed to ensure the physical safety of the patient and only upon written orders of a physician specifying the duration and circumstances under which restraints are to be used.

Lost or Stolen Property of Patients

A nursing home is responsible for a patient's lost or stolen personal property if the nursing home had failed to make reasonable efforts to safe-guard the patient's properly. The nursing home's compliance with legal requirements is considered presumptive proof that the nursing home made reasonable efforts, although the resident or family member may be able to show a lack of reasonable efforts regardless of the nursing home's compliance with the legal requirements. Most nursing homes maintain insurance for the patient's lost property, so patients or their family members should not hesitate to request reimbursement for any losses. In any event, make sure that any personal properties of the patient are inventoried with the social services department of the nursing home.

Long-Term Care Facility Complaints

One of FATE's services is filing complaints with the state regulator agencies on behalf of patients and residents in a nursing home, assisted living facility, residential care home or acute care hospital. Although we get complaints on a daily basis, some do not result in an actual filing with the state regulators. Over the past several years, FATE has averaged four to six complaints a month. Although a prompt response is required, state agencies can extend the process for years. Some complaints FATE files do result in the appropriate state department citing these facilities for violations of federal and state regulations. The following are results from some of those complaints:

ALEARDI'S CARE HOME, Farmington Hills, MI….DEFICIENCIES….failure to ensure an appropriate assessment plan was given; failure to provide a required weight record; failure to provide Fire drills; failure to complete an admission plan and to maintain a copy on file.

ALTA VISTA HEALTHCARE & WELLNESS CENTER, Riverside, CA…DEFICIENCY… facility failed to make the medical records available to the resident after written request was provided to the Medical Director, the Administrator, the Social Services Director and the Medical Records Director. This failure resulted in the resident not having access to receiving a copy of his medical records according to federal regulations. This complaint was filed by a **FATE** client.

AMERICAN RIVER CARE CENTER, Carmichael, CA….DEFICIENCIES… facility failed to follow physician orders for wound care which was not provided. This failure had the potential to result in patient's physical decline. Failure to implement physician orders properly and timely is a deviation from the standard of nursing care.

APPLE RIDGE ASSISTED LIVING, Sacramento, CA…DEFICIENCIES….. failure to keep facility free of animal urine smell. The allegation of facility not cleaning animal waste was Unsubstantiated.

ASBURY PARK NURSING AND REHABILITATION, Sacramento, CA….DEFICIENCIES….failure to ensure policies and procedures regarding resident rights to inspect and copy medical records were consistent with federal law; failure to ensure that the patient or his responsible party had the right to choose where to store his glasses and have them easily accessible in his room. The facility constantly locked the patient's glasses in a medication cart. These complaints were filed by a **FATE** client. **FATE** requested an appeal based on some allegations not being substantiated.

ASBURY PARK NURSING AND REHABILITATION, Sacramento, CA…DEFICIENCIES…failure to obtain informed consent prior to the administration of antipsychotic medications and failure to document the use of a fall mat next to the bed to cushion a fall. This failure may have had the potential for increased severity of injury to the patient. Appeal was requested based on not all allegations were substantiated.

CAPITAL TRANSITIONAL CARE, (previously known as Emerald Gardens).. SACRAMENTO, CA…DEFICIENCIES…. failure to develop and implement care plan; failure of staff to provide adequate supervision in a safe manner; failure to maintain a complete and accurately documented clinical record, which resulted in patient receiving inaccurate care; failure to ensure policies and procedures were current for informed consent, which had the potential to expose patient to complications and side effects of antipsychotic drugs without the patient's knowledge and failure to ensure the licensed healthcare practitioner obtained consent before administering antipsychotic drugs. This complaint also alleged elder abuse and insufficient staffing which the Department of Health unsubstantiated.

CAPRA HOUSE CARE HOME, San Francisco, CA….DEFICIENCIES….facility altered the admission agreement and moved the resident to a different room that was originally agreed upon without proper notice to the family members. Other allegations of non-nutritious food and a higher level of care was required were both unsubstantiated. This complaint was originally filed by the **FATE** client.

DOUBLE TREE POST-ACUTE CARE CENTER, Sacramento, CA…DEFICIENCIES…facility failed to ensure the physician was made aware of and evaluated a significant change in the patient's condition; failure to notify family member of a significant change in condition. These failures had the potential to result in delayed treatment and lack of appropriate care to meet the patient's needs; failure to effectively recognize and manage patient's pain. This failure had the potential to result in a decline in functional mobility and a diminished quality of life.

EAGLE CREST (Genesis Healthcare), Previously knowns as CARMICHAEL CARE….Carmichael, CA…DEFICIENCIES….failure to ensure sufficient staffing to meet the needs of the patients; failure to promptly notify the patient's family when there was a room change; failure to inform the family of worsening of an existing pressure ulcer (bedsore); failure to provide necessary treatment and services to promote healing, prevent infection and prevent worsening of pressure sores; failure to prevent weight loss for patient who was receiving tube feedings through the stomach; failure to prevent dehydration; and failure to maintain a complete clinical record of treatment.

EMERITUS AT AUSTIN GARDENS, LODI, CA…..Citation…$150.00 assessed penalty….staff failed to follow the care plan; resident fell and sustained injuries resulting in a questionable death.

EMERITUS AT RANCHO SOLANO, FAIRFIELD, CA….Citation…$150.00 assessed penalty….failure to prevent seven (7) falls and five head trauma injuries and facility failure to make the corresponding changes to meet needs of the resident which contributed to the resident's last fall resulting

Long-Term Care Facility Complaints

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in the need for medical treatment, hospitalization, decline and subsequent death.

GILROY HEALTHCARE AND REHBILITATION CENTER, Gilroy, CA…DEFICIENCIES…..facility failed to ensure the responsible party of the patient was notified when the patient's diet changed to a pureed diet with honey thick liquid, which resulted in the patient not receiving the prescribed diet; facility failed to meet professional standards of care. **FATE** filed an appeal as the investigation did not address the allegations of antipsychotic medication given without consent; overmedication, failure to provide proper dental care, failure to provide nutrition, dehydration and insufficient staffing.

HARBOR VILLA CARE CENTER, Anaheim, CA…DEFICIENCIES….facility failed to notify family of change of condition and transfer to the acute hospital causing family confusion and anxiety; failure to ensure patient received care and treatment to help maintain or attain highest level of physical well being; failure to conduct thorough assessments; failure to ensure patient consumed a meal after administration of insulin; Failure to show an assessment of resident's stools for the period 2/19/15 to 3/5/15.

HIGHFIELD GARDENS RESIDENTIAL CARE HOME, Sacramento, CA…CITATION…..$150.00 assessed fine…facility was cited for its failure to ensure residents are regularly observed for changes in physical, mental and emotional and social function and that appropriate assistance is provided. Resident sustained an unexplained fractured clavicle, which the facility was unable to determine when and how the injury occurred to the resident. Subsequently, the facility closed.

LINCOLN MEADOWS CARE CENTER, Lincoln, CA….DEFICIENCIES…. facility failed to maintain an infection program to help prevent the development and transmission of potentially infectious conditions when they had an ineffective system to track and treat a rash outbreak occurring on one nursing unit during December of 2014. This failure had the potential for the spread of infection to and between residents and staff.

MANORCARE HEALTH SERVICES OF CITRUS HEIGHTS, Citrus Heights, CA…. DEFICIENCIES….facility failed to consult with the physician regarding a significant change of condition when the patient's blood glucose levels dropped to a critically low level; failure to ensure a comprehensive care plan was developed to ensure patient was monitored and treated appropriately for depressed immune system, thrush infection of the patient's mouth, difficulty swallowing and possible aspiration of food into the lungs and a urinary tract infection; failure to ensure necessary standards of care and services were planned and provided when the patient was not monitored appropriately for potential life threatening complications, which resulted in the patient's condition deteriorating. This failure contributed to the patient developing a respiratory infection, a urinary tract infection, and a systemic infection which caused the patient's death.

MARYMOUNT GREENHILLS RETIREMENT CENTER, Millbrae, CA….DEFICIENCIES….IMMEDIATE CIVIL PENALTY $150.00 AND $1,000,00 FOR VIOLATION WITHIN A 12 MONTH PERIOD WITH A $100.00/DAY VIOLATION UNTIL CORRECTED. Determination for serious violation of patient's rights, which resulted in injuries to the resident. Serious violation for absence of supervision due to lack of staff resulting in resident sustaining injuries. Facility failed to ensure adequate number of direct staff was present to support each resident's needs and to prevent this dementia patient from jumping out of a window in the facility and being injured.

MARYSVILLE CARE CENTER, …Marysville, CA…DEFICIENCIES….facility failed to follow the federal code of regulations by not providing copies of the patient's medical records to the responsible party after the death of the patient. This complaint will be appealed as other allegations, i.e., fall with sustained injuries, bedsores and death were not substantiated.

MISSION CARMICHAEL HEALTHCARE ENTER, Carmichael, CA….DEFICIENCIES….facility failed to obtain informed consent for anti-depressant medications, antipsychotic medications and anti-anxiety medications prior to administration of the medications; failure to accurately assess and code the minimum data set (MDS, an assessment and care planning tool) regarding patient's behavior problems, which had the potential for unmet medical and psychological needs; failure to develop a comprehensive plan of care related to patient's complaint of pain, which had the potential for patient' s pain needs not being met and increased unwanted behaviors; failure to ensure professional standards of quality care were met when physician's orders were not carried out for lab work and a neurology appointment was not carried out, which had the potential for not recognizing possible infection, anemia, prolonged bleeding times and missed neurological diagnoses, which could possibly lead to harm; failure to provide adequate pain management according to physician orders and patient's complaints of pain, which had the potential for patient to feel helpless and hopeless with increased risk for unwanted behaviors; failure to complete a health and skin assessment upon readmission to the facility when the patient was readmitted after mid back surgery for an infection which failure had the potential for increased risk of developing pressure sores and infection.

OAKMONT OF ROSEVILLE, Roseville, CA….DEFICIENCIES….facility failed to ensure the facility was kept clean, safe, sanitary and in good repair as on more than one occasion, used gloves were not properly disposed of in resident's room; facility failed to follow hospice care plan and documentation showed numerous gaps in care; Failure to reposition resident every two hours; failure to properly secure resident's medications and failure to store medications in a safe and locked place not accessible to persons other than employees responsible for the supervision of medications. The

Long-Term Care Facility Complaints

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original complaint was filed by the family and followed up by **FATE** until resolution.

PONTE PALMERO, Cameron Park, CA… DEFICIENCIES…facility was altering times of medication distribution without permission of the physician, pharmacist or responsible party; an audit of medications and review of medication records did not correlate; several dosages of medications unaccounted for in facility records.

SAINT FRANCIS SENIOR RESIDENCE, Sacramento, CA…DEFICIENCIES…. although the facility does provide a lock on the bedside cabinet drawer as specific in the theft and loss policy, the facility failed to properly safeguard the resident's personal belongings when the resident had to be hospitalized. The facility moved a resident into a room that was not compatible at the time and personal belongings went missing.

VALLEY GARDENS, Stockton, CA…..DEFICIENCIES…facility inappropriately authorized themselves as resident's health care decision maker even though patient had family members available to act on her behalf. This failure resulted in patient's responsible party being denied the right to advocate for the patient; facility failed to provide care which showed evidence of good personal hygiene, included cleaning and cutting of fingernails and toenails. This failure had the potential to contribute to a decline in patient's general health as a source of infection; failure to promptly notify the patient's responsible party when the facility moved the patient to another room, which resulted in family member not knowing where the patient was; failure to provide the necessary services to maintain good personal hygiene as patient was found covered in filth as was evident by heavily soiled wash clothes and towels used for a bed bath, which had the potential to contribute to the decline in the patient's general health; failure to ensure patient who entered the facility without a pressure sore did not develop a pressure sore; facility failed to communicate with the dialysis center or provide resources or provide enough to ensure pressure relieving interventions were being implemented while the patient was in the dialysis center, which resulted in the development and progression of a pressure sore.

WINDSOR HEALTHCARE OF OAKLAND, Oakland, CA…DEFICIENCIES….failure to assure patients were provided privacy; failure to provide services for untreated and unassessed skin ulcers and untreated pain for patients resulting in the neglect of patients with skin ulcers resulting in the patients being placed at risk for infection and neglect of patient who did not receive pain medications in a timely fashion; failure to provide the necessary training for abuse prevention resulting in the potential for staff to be unable to both identify and act upon abuse or neglect when it occurs; failure to accommodate the communication needs for patient with limited communication skills and did not provide an interpreter nor did they utilize the available communication board; failure to provide housekeeping and maintenance services that maintained a clean home-like environment when the sheet rock was peeling and there were holes in the walls of patient's rooms; failure to provide bed linens and gowns that were in good condition which resulted in the patient's living in an environment that was not well maintained; failure to complete Minimum Data Sets (MDS) within 14 days after admission. This failure had the potential for the patient's health status and functional capability not to be accurately identified and assessed; failure to ensure that the MDS was accurate for several patients; failure to develop a plan of care which accurately reflected the medical and psychosocial needs for patients; failure to provide nursing services to meet professional standards of quality; failure to accurately complete the diagnosis on the pre-admission screening for 8 patients, which resulted in patients being agitated and combative and being transferred out of the facility via a 5150, which is a 72 hour involuntary psychiatric hospitalization; failure to provide the necessary care and services for numerous patients by not assessing or monitoring pain medications and by failing to follow physician orders for dialysis care; failure to assess, plan and provide care to ensure that patients did not develop pressure sores and that the patient received the appropriate treatment to promote healing; failure to administer an insulin injection subcutaneously (directly below the skin) as ordered as this failure had the potential for the insulin to be absorbed into the muscle which can absorb the insulin too fast; failure to ensure that the facility was free of medication errors as this deficient practice had the potential for patients to have a worsening of their illnesses; failure to ensure patients were free of significant medication errors; failure to provide sufficient registered nurses to administer intravenous antibiotics, which put the patients at risk of continuing infection and bacterial growth; failure to post the daily staffing and patient census information and did not post it in a prominent place accessible to patients and visitors; failure to make sure physician orders were signed in a timely manner; failure to maintain a system for accurately reconciling controlled medications and record of receipt for medications that arrive in the facility from the pharmacy, which resulted in the facility not having accountability for medication delivered and administered to the patients; failure to establish and maintain an infection control program to provide a safe and sanitary environment and to help prevent the development and transmission of disease and infection.

"Our prime purpose in this life is to help others. And if you can't help them, at least don't hurt them"….Dalai Lama

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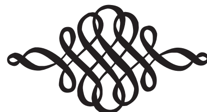

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