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FATE

Newsletter of Foundation Aiding The Elderly

President's Message

A PRIVILEGE TO SERVE….

By Carole Herman

In October of 2016, **FATE** celebrated its 34th year of advocacy. We had the pleasure of helping approximately 250 more families all over the country, plus numerous families in Canada, assisting them with information, referrals for elder care issues and filing complaints against long-term care facilities with state regulators for abuse and neglect of their loved ones. **FATE** is proud to say that during all these years, we have been able to serve over 6,000 families from every state in the Union. By serving so many people, we have been able to gather information from families and to keep our finger on the pulse on elder care issues facing so many of us in this aging society. We have gathered information from citizens all over the country on how the system has failed to regulate the long-term care industry, as well as those industries providing services to consumers in long-term care and other facilities, namely, the pharmaceutical, dental, medical, physical therapy and others providing services to the elderly. We have been instrumental in working with the media to expose poor care of our most vulnerable citizens in order for the general public to be aware that their loved ones may be at risk when placed in a long-term care facility. We participated in television and radio programs that aired not only in the United States, but all over the world. I have personally been a member of several stakeholders groups within the State of California working on reducing the use of antipsychotic medications and improving the oversight of nursing homes and other long-term care facilities. Due to the amount of people that call our office for help, we feel we have gathered sufficient evidence that the government oversight to ensure the health and safety of all patients is a failure. Thus, the general

Continued on page 3

CAROLE HERMAN

INSIDE THIS ISSUE:

A Privilege to Serve 1-3
FATE Concludes Public Interest Lawsuit Against the California Department of Public Health..... 2
Failure to Improve No Longer A Denial Of Medicare Coverage 2
Books of Interest..... 3
Violette King Tribute 4
Indiana...Fraud Scheme by American Senior Communities Executives 4
Staffing Fraud in New Mexico Nursing Homes..... 5
Oregon Nursing Assistant Fired for Reported Negligence..... 5
Florida Nursing Homes on Watch List..... 5
U.S. to Bar Arbitration Clauses in Nursing Home Contract..... 6
Antipsychotic Drugs and Heart Attack Risk Increased Mortality Among Patients with Parkinson's. 6
Know Your Rights 7
Long-Term Care Facility Complaints 8-10
Thanks to our Donors..... 11-12

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Warm Wishes for a Very Happy and Joyous Holiday Season with a Safe and Healthy New Year.

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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

FATE Concludes Public Interest Lawsuit Against the California Department of Public Health

In October 2016, **FATE** wrapped up its three-year lawsuit against the California Department of Public Health (DPH) to compel the agency to perform timely investigations and resolve appeals regarding complaints lodged against skilled nursing homes and other long-term care facilities. Initially filed in October 2013 by the Lexington Law Group on behalf of **FATE**, sought to remedy DPH's widespread delay in concluding these investigations within timeframes set by California law, and in promptly reviewing those findings once rendered. The lawsuit secured long-overdue relief for a set of **FATE** clients who had been waiting years for their complaint processes to resolve, as Judge Suzanne Bolanos of the San Francisco Superior Court ordered DPH to comply with strict deadlines for the completion of outstanding appeals. In addition, Judge Bolanos ordered DPH to disclose information about the nature of the agency's investigative findings, so as to allow **FATE** a meaningful opportunity to challenge those findings as insufficiently protective of California's elderly and infirm citizens. **FATE**'s lawsuit has also had an impact beyond the doors of the courtroom. By shining a light on DPH's woeful track record of lengthy delay in completing complaint investigations, **FATE** helped spur the 2015 passage of Senate Bill 75, which amends California law to reduce the time in which DPH must complete such investigations. **FATE** hopes that CPH does a better job in the future….Time will tell.

Failure to Improve No Longer A Denial Of Medicare Coverage

For many years, nursing home patients under Medicare coverage who entered the facility for physical therapy were being denied coverage if the nursing home stated that the patient was not progressing with therapy. This meant that if the family wanted the facility to continue with physical therapy they would have to pay the tab themselves. Medicare beneficiaries often hear this for denying coverage of skilled nursing, home health care or outpatient therapy. Most families cannot afford to self-pay so the patient does not get rehabilitated. Because the Centers for Medicare and Medicaid Services does not publish statistics on why claims were denied, nobody knows how many millions of beneficiaries have been wrongly told that Medicare can't cover continued services because the patient failed to improve.

A federal judge in August of 2016 ordered the Federal Centers for Medicare and Medicaid Services to do a better job of informing health care providers and Medicare adjudicators that the so-called improvement standard was no longer in effect and that Medicare must cover skilled care and therapy when they are "necessary to maintain the patient's current condition or prevent or slow further deterioration". Patients and families still have the right to appeal coverage denials no matter what and **FATE** highly recommends that appeals are filed immediately after a denial of benefits.

President's Message

Continued from page 1

public should be aware that vigilance by family and friends is the best way to ensure proper treatment is being given. During the coming year, we will continue to work on legislative matters in Florida to repeal a 2001 law that mandates that any punitive damages awarded by a jury against a nursing home that 50% of the award has to be paid to the State of Florida. Several Florida Legislators agree with **FATE** that this is not in the best interest of Floridians. Consumers who are harmed in nursing homes should not be giving a portion of their jury awards to the industry that caused the harm. We are also committed to work in other states where over-sight is failing or non-existent. Some states do not even allow the consumer a right to appeal an unsubstantiated complaint, yet the industry is allowed to appeal if a deficient practice is cited.

We will also continue our research and document cases of conservatorship abuse that continues to plague families due to little or no oversight by the government or the courts. Several years ago, while working with the CA State Legislature, **FATE** was instrumental in establishing the California Fiduciary Board. We believe that California is the only State that has such an oversight board for private fiduciaries. Conservatorship abuse is going to be the next big scandal in this country as elderly people are having their wealth stolen from them under the disguise of a conservator, many of whom are unscrupulous. Most conservatorship filings are due to sibling rivalry, which the courts then appoint an unbiased third party to make all financial and medical decisions for the conservatee.

I also want to acknowledge the dedication and hard work by the Lexington Law Group in San Francisco who filed a public interest civil complaint on **FATE**'s behalf against the State of California, Department of Public Health, for its failure to investigate nursing home complaints in a timely manner. Attorneys Howard Hirsch and Joseph Mann worked diligently for almost three years to ensure that the citizens of California were not being denied their rights to a timely due process when a complaint has been filed pertaining to poor care and neglect of nursing home patients. (See article on page 2).
FATE does not receive any compensation for its work on public interest lawsuits as these types of cases are for the benefit of the public only.

As we begin our 35th year, along with all staff members at **FATE**, I am hopeful that poor and negligent care will be past history and all citizens will receive proper care and dignity when reaching the sunset years. We continue our dedication to making a difference in the lives of our most vulnerable citizens and their families.

Thank you for your continued support of our efforts.

"You have enemies…Good, that means you stood up for something"… Winston Churchill

BOOKS OF INTEREST

"Tender Loving Greed"...by Mary Adelaide Mendelson (1917-1997)... Ms. Mendelson taught government and history for five years before joining the Federation for Community Planning Of Cleveland in 1964. It was in this position that she was assigned the task to see if there was a way to improve nursing homes in the Cleveland area. This experience lead her to write "Tender Loving Greed", for which she received the George C. Polk Award. The book discusses how the incredibly lucrative nursing home industry is exploiting America's old people and defrauding us all. The book was re-printed in 2009 by her son and clearly details that what Mary Adelaide wrote about is still going on in 2016. The book can be ordered through Amazon.com at a cost around $6.96.

The following books can be ordered from Prometheus Books, 59 John Glenn Drive, Amherst, NY 14229 (800)421-0351:

"The Real Trust About Aging"…A survival guide for older adults and caregivers..$21.98
"Eldercare 911"..The caregiver's complete handbook for making decisions…$26.98
"What If It's Not Alzheimers?..The caregiver's guide to dementia…$22.98

Violette King Tribute

July 21, 1942 – January 4, 2016

Violette King passed away peacefully at her home on January 4, 2016. Violette was a very close and beloved colleague and friend of Carole Herman and **FATE**. She worked non-stop for nursing home patients in her state of Illinois after her father died from pressure sores developed in a nursing home in Illinois over 20 years ago. Prior to placing her father in a Beverly Enterprises facility, Violette was sold by the admissions director that the facility was one of the best in the country, was a publically held company with lots of oversight, etc. Violette was so taken by the sales pitch, that she bought stock in Beverly Enterprises. After her father died from infected pressure sores due to negligent care, Violette attended a Beverly Enterprises shareholders' meeting in Fort Smith, Arkansas, where the corporate headquarters was located. When she showed pictures of her father's sores to the shareholders, she was immediately arrested for disturbing the peace and placed in jail. After this horrific encounter, Violette was determined to make a difference for others and founded Nursing Home Monitors. She was a pioneer in her efforts to get video cameras in nursing homes. Violette received multiple national, regional and local awards for her dedicated efforts in that regard. In 2002, the St. Louis Post-Dispatch called her "one of the nation's leading voices for nursing home reform". Violette was also well known for her gardening hobby, which included her extensive plantings of various hydrangeas, her most favorite flower. She was known in her home town of Godfrey, IL as the "Hydrangea Lady". She was married to Dr. Ordie King for over 40 years. She is survived by Dr. King and her children, Catherine King and her husband Michael Krutzsch and her son Alex King and his wife Joyce. She is also survived by her beloved grandson, Elliot King. Silence fell upon the advocacy world the day Violette passed away. She will be sadly missed by many. Rest in peace, Violette.

Indiana...Fraud Scheme by American Senior Communities Executives

In October of 2016, U. S. Attorney Josh Minkler announced the indictments of executives for American Senior communities, one of Indiana's largest nursing home management companies. Former CEO James Burkhart, former Chief Operating Officer, Daniel Benson, along with Burkhart's friend and associate, Steven Ganote, and his brother, Joshua Burkhart, who worked for the accounting firm that prepared cost reports for the defrauded health care companies were all charged with 32 counts including conspiracy to commit mail fraud, wire fraud, money laundering and conspiracy to violate the federal anti-kickback statute. Minkler stated that the four men engaged in a six-year scheme, which is characterize by unbridled greed, deceit and theft from programs we all count on to care for the elderly, the poor, the disabled and the weak. According to the Federal indictment, the defendants conspired to defraud American Senior Communities, the Health and Hospital Corporation of Marion County and Medicare and Indiana Medicaid. The defendants used more than 20 shell companies to falsify and inflate costs for goods and services so they could steal discounts and rebates and To conceal sizable kickbacks. The men are accused of receiving $5.5 million in kickbacks disguised as marketing fees from a home health company, as well as $825,000 disguised as payments to a food provider. If convicted, the defendants would face up to 20 years in prison.

MAKE A DIFFERENCE….MAKE A DONATION

During 2016, FATE helped over 250 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. THANK YOU.

Staffing Fraud in New Mexico Nursing Homes

Back in March of 2016, Hector Balderas, the Attorney General in the state of New Mexico, sued a chain of nursing homes for not having sufficient staff to care for its residents. According to a report by National Public Radio, one of the keys to providing good care in nursing homes is simply having enough staff. The federal government says about a quarter of all nursing home complaints can be traced back to low staffing levels. And, studies have connected low staff levels to lousy treatment. The state of New Mexico connects it to fraud. Attorney General Balderas is suing the chain of nursing homes alleging that the facilities were so severely under-staffed that they could not possibly have provided the care they charged for. Now New Mexico wants its money back.

As numerous studies over the years have indicated, and as residents and families too often know first-hand, inadequate staffing is a pervasive problem in U.S. nursing homes. Though widely acknowledged, state and federal survey agencies systematically fail to hold providers accountable for insufficient care staff. **FATE** has stated publically for many years that insufficient staffing is automatic neglect and is rampant in U. S. nursing homes yet, as the NPR report stated, the state and federal agencies fail to hold the industry accountable and the government continues to pay the facilities for full staffing. Another serious failure by the government regulators causing great harm to our most vulnerable citizens.

Oregon Nursing Assistant Fired for Reported Negligence

On October 2, 2016, the Oregonian Newspaper reported that a certified nursing assistant (CNA) has sued Healthcare at Foster Creek, an intermediate care facility in Portland, Oregon, for wrongful termination as a punishment for reporting that a patient had been seriously harmed by negligent care in the facility.

The CNA states that she faithfully cared for a high-needs patient, but while she was on leave with the flu, other staff members failed to tend to the patient and he developed a pressure sore on his leg so deep that the bone was exposed. The CNA alleges in her suit that two co-workers took photographs of the wound and forwarded her a copy. In turn, the CNA forwarded the photo to a medical educator with whom the CNA had previously discussed concerns about the patient's care in an effort to report what the CNA believed was medical neglect. When the CNA's supervisor asked if she had done this and she admitted that she had, the CNA was fired. The CNA subsequently found out that the patient died shortly after she was fired. The facility's is defending the case stating that the CNA violated the patient's privacy by showing pictures of his wound. Hopefully, the negligence on the part of the facility will be exposed during the law suit process.

Florida Nursing Homes on Watch List

Two Florida nursing homes were recently added to the Center for Medicare and Medicaid Services' Special Focus Facility List, a federal watch list for nursing homes with a "history of serious quality issues". The homes are Palm Garden in Winter Haven and University City East in Deland. The State of Florida past inspections showed gross and chronic abuse and neglect of patients. The inspection of Pal Garden disclosed that a dementia patient was physically abused by six staff members on seven different occasions. The patient was hospitalized with skin tears and bruising up and down his arms. The patient's family members installed a hidden camera in the room and recorded several abusive incidents by a number of staff members. Surveyors inspecting University of City East found widespread medication errors, sloppy medication records and numerous medication variances linked to a licensed practical nurse who allegedly stole patient's controlled drugs. On one occasion, the nurse was found staggering, stumbling and slurring her words after she returned to her shift following a break. Fourteen other nursing homes in Florida were newly added to the Special Focus Facility list, which is updated monthly.

U.S. TO BAR ARBITRATION CLAUSES IN NURSING HOME CONTRACT

The federal agency that controls billions of dollars in Medicaid (MediCal in California) funding has moved to prevent nursing homes from forcing claims of elder abuse, sexual harassment and even wrongful death into the private system of justice known as arbitration. The Department of Health and Human Services issued a rule that bars any nursing home or assisted-living facility that receives federal funding from inserting an arbitration clause into its contracts. The rule, which would affect 1.5 million nursing home patients/residents, promises to deliver major new protections. Arbitration clauses embedded in the fine print of nursing home admissions contracts have pushed disputes about safety and the quality of care out of public view and into arbitration. The system has helped the nursing home industry reduce its legal costs, but it has stymied the families of nursing home patients from getting justice, even in the case of murder. The new ruling, effective November 28, 2016, comes after officials in 16 states and the District of Columbia urged the government to cut off funding to nursing homes that use the clauses, arguing that arbitration kept patterns of wrongdoings and abuse hidden from prospective patients and their families. This decision restores the fundamental right of millions of patients to their right in court and their right to a trial by jury.

ANTIPSYCHOTIC DRUGS AND HEART ATTACK RISK INCREASED MORTALITY AMONG PATIENTS WITH PARKINSON'S

A review of nine studies published in the British Journal of Clinical Pharmacology found that antipsychotic drug users were nearly twice as likely to experience a heart attack than non-users. In the elderly, the risks were even higher. Antipsychotic drugs were also linked to increased mortality among Parkinson's disease patients. The research analyzed about 15,000 patient records and found that Parkinson's patients who began using antipsychotic drugs were more than twce as likely to die during the following six months compared to a matched set of Parkinson's patients who did not use such drugs. These findings are not the first to link antipsychotic drugs to increased mortality. Studies dating back to the early 2000's found increased mortality with these drugs among patients who have dementia. As far back as 2005, the Federal Drug Administration has mandated "black box" warnings on antipsychotic drug packaging, noting the apparently increased risk of death when these drugs are used in dementia patients. Federal Regulations also mandate that prior to the administration of any antipsychotic medication or black box drug that informed consent be obtained from the patient or if the patient is not capable of making a decision, the responsible party. The doctor must get the consent in writing and must list the drug suggested, the reason why the drug is being suggested and the adverse side effects of the medication. Without the proper consent, it is a violation of the federal code of regulations and the facility and/or doctor should be reported.

"I raise up my voice – not so that I can shout, but so that those without a voice can be heard"...
Malala Yousufzai,
Pakistani Nobel Prize Laureate

KNOW YOUR RIGHTS

Visiting Hours

Visiting hours are usually posted at the entrance to each facility. The posted visiting hours are for non-family members only. The posting does not tell the visitor that there are no visiting hours for family members and whether the posting is intentional or not. Under the Federal code of Regulations, immediate family members have access to the patient 24/7. Posted visiting hours of the facility do not apply to family members.

Obtaining Copies of Medical Records

The patient or his/her legal representative has the right upon an oral or written request to access all records pertaining to the patient including current clinical records within 24 hours and after receipt of the records for inspection, to purchase at a cost not to exceed the community standard of the records or any portion of them upon request and two (2) working days advance notice to the facility. Thus, under the Federal Code of Regulations, namely 42 CFR 483.10 (b)(ii), the facility has two business days to produce the copies of the medical records.

Notification of Changes

A facility must immediately inform the patient, consult with the patient's physician and the patient's legal representative or an interested family member when there is an accident involving the patient which results in injury and has the potential for requiring physician intervention; or, when a significant change in the patients physical, mental or psychosocial status; or, there is a need to alter treatment; or a decision to transfer or discharge the patient from the facility.

Protection of Funds

Patients who are on MediCaid (MediCal in California) and have a share of cost are entitled to $35.00 a month for personal spending. The facility must maintain a patient's personal funds in an non-interest bearing account, interest-bearing account or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting of each patient's personal funds entrusted to the facility on the patient's behalf. The system must preclude any commingling of patient funds with facility funds or with the funds of any person other than another patient. The individual financial record must be available through quarterly statements and on request of the patients or his/her legal representative. Upon death of the patient who has a personal fund account, the facility `must convey within thirty (30) days the patient's funds and a final accounting of those funds to the individual or probate jurisdiction administering the patient's estate.

Food, Eating and Nutrition Care

Food and eating are important parts of everyone's daily life. As a patient in a nursing home, this enjoyable activity should not change. A nursing home patient has certain rights regarding the type of diet and nutritional services they are to receive. The facility has certain responsibilities to ensure that the patient receives adequate nutrition. The patient has a right to be involved in planning for nutritional needs, be allowed to make informed decisions regarding the texture of food, be told in advance and be involved in any changes in the diet and participate in the treatment for weight maintenance, weight loss of weight gain. The patient also has the right to choose when and where to eat and whether to eat with others or alone, be served in a reasonable period of time and be allowed to receive gifts or food according to the facility policy. Every nursing home must provide meals that meet daily and special dietary needs of each patient and all diets must be prescribed by the attending physician.

Privacy and Confidentiality

In August of 2016, the CMS's Center for Clinical Standards and Quality/Survey and Certification Group addressed recent media reports about nursing home staff taking unauthorized photographs and video recordings of nursing home patients. Some photos showed patients in compromising positions. The photos were subsequently posted on social media networks, including Facebook, Snapshot and Instagram. CMS clearly outlined that taking photographs or records of a patient and/or his/her private space without the patient's or designated representative's written consent is a violation of the resident's' right to privacy and confidentiality. Violations could potentially be considered abuse.

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:

ALTA VISTA HEALTHCARE & WELLNESS CENTRE, Riverside, CA….Deficiency….facility failed to maintain adequate records for their infection control surveillance data by failing to document multiple residents' infections such as the type of the infection, their signs/ symptoms. This failed practice had the potential for the facility to not be able to detect contagious infections, the need for patient isolation, unusual or unexpected outcomes, trends, increased infection rates for 87 patients.

AMERICAN RIVER CENTER, Carmichael, CA….Deficiency…. patient's rights violation for failure to present patient rights information to the responsible party at the time of admission, which had the potential for misunderstanding rights and obligations of the facility. The original complaint was filed on 5/22/2012 with allegations of falls with injury, failure to treat the injury, failure to notify family/ physician of a change of condition; weight loss; failure to chart intake and output; failure to provide copies of medical records and insufficient staffing. The original finding was that the facility failed to provide copies of medical records according to the federal regulations. **FATE** went through the entire appeal process, which took three years resulting in the additional deficiency for patient rights violations.

ARDEN POST ACUTE REHABILITAITON…Sacramento, CA….Deficiencies….facility failed to ensure antibiotics were administered timely for patient that resulted in a delay in treatment for a bladder infection and increased patient's risk for discomfort; failed to provide the necessary care and services to maintain the highest practicable physical well-being of patient after a reported fall. This failure increased the patients risk for undetected injury and lack of appropriate diagnosis and treatment; failed to conduct a comprehensive assessment related to the use of a urinary catheter and failed to provide on-going assessment and care planning that included consideration of possible complications related to the use of a urinary catheter. Failure resulted in patient having a urinary catheter at the time of admission without follow-up for indication for use and increased patient's risk of infection.

ARDEN POST ACUTE REHABILITATION….Sacramento, CA…Deficiencies….facility failed to maintain clinical records that were complete and accurate for a patient as wound treatment record omitted staff initials on three separate days wound treatments were to be done. This failure may indicate that wound treatments were missed.

CARLTON SENIOR LIVING LLC (Previously known as CARLTON PLAZA OF ELK GROVE), Elk Grove, CA…A Citation....$150.00 civil penalty assessment….facility failed to provide adequate supervision resulting in client's death. The Licensee that serves residents with dementia shall ensure an adequate number of direct care staff to support each resident's needs. An altercation occurred in the memory care unit between two residents resulting in the death of one of the residents.

COUNTRY CREST POST ACUTE, Oroville, CA….Deficiencies…facility failed to prevent an avoidable fall with injury receiving physical therapy services. Patient was left unattended in a bed that was raised to a height of three feet above the floor and fell sustaining a broken right upper leg, a broken nose and a subarachnoid hemorrhage (bleeding in the area between the brain and the tissues that cover the brain that can cause coma, paralysis and even death). **FATE** will appeal this decision based on the harm to the patient that should have resulted in a Citation with a civil penalty rather than a deficiency.

CYPRESS HEALTHCARE CENTER, Paradise, CA….Deficiencies… facility failed to promptly notify the physician or responsible party of a change of condition when the patient had nose bleeds, thumb injury causing swelling, decreased mobility and pain, of a fall with injury on two occasions causing patient's condition to worsen; failure to develop and implement a care plan for patients' care needs after tooth extraction dental surgery; failure to provide necessary are as recommended by the dentist; failure to reduce fall risks and failed to implement its falls management policy to provide adequate supervision and interventions to reduce the risk of falls; failure to ensure patients received proper medications as ordered by the physician; failure to ensure patient was free from significant medication errors.

DOUBLE TREE POST ACUTE CARE CENTER, Sacramento, CA…Deficiencies….facility failed to implement physician orders as written when therapy was not initiated in a timely manner; failure to provide requested clinical records according to federal regulations; failure to safeguard patient's personal belongings. **FATE** filed an appeal regarding findings as allegations for verbal abuse, medication errors, failure to diagnose and treat pneumonia, failure to notify family and physician of a change of condition; giving patient a flu shot and pneumonia shot without consent and placing patient outdoors on a cold night were not addressed .

EAGLE CREST (peviously known as SunBridge Carmichael Rehabilitation Center), Carmichael, CA…CLASS A CITATION..$4,000.00 civil penalty….failure to perform a comprehensive assessment and provide necessary care and treatment to prevent the development of a pressure sore (bed sore). The facility's failure resulted in the development of an avoidable pressure

Long-Term Care Facility Complaints

Continued from page 8

sore and put the patient at risk for pain, infection and further skin breakdown. Facility failed to ensure the patient received care to prevent formation and progression of the sore and failed to provide care to maintain clean, dry skin free from feces and urine by changing linens and other items in contact with the patient as necessary to maintain clean and dry skin. This deficient practice resulted in substantial probability of death or serious physical harm to the patient. This citation was written as a result of an appeal by **FATE** when the original findings were unsubstantiated. This process took three (3) years and six (6) months.

FAIRMONT REHABILITATION HOSPITAL, LODI, CA… Deficiencies….facility failed to prevent unauthorized disclosure of private health information for a patient when the facility faxed 11 pages of another patient's records to a third party. This was a violation of a medical records breach under the Federal Health Insurance Portability and Accountability Act (HIPAA) which establishes national standards to protect individuals medical records and other personal health information.

IRVINE COTTAGE VI, Irvine, CA… Class A Citation, civil penalty assessment $150.00…..facility failed to have an auditory device or other staff alert feature to monitor exits and this failure allowed the patient to escape the facility and sustain an unexplained head injury resulting in death; the facility was cited for lack of care and supervision based on the resident's elopement from the facility and the injury sustained causing death.

MANOR CARE , Citrus Heights, CA…Class A Citation, civil penalty assessment $20,000.00…facility failed to ensure a comprehensive care plan was developed based on patient assessments and necessary standards of care. Patient developed a urinary tract and respiratory tract infection, neither of which were addressed in the care plan. Further services were not provided to ensure monitoring and treatment was appropriately provided to prevent harm resulting with immune system being compromised and multiple infections occurring including the decreased ability of the body to fight infection due to low white blood cell count and a decline in patient's health, oral candidiasis, a fungal infection of the mouth, difficulty swallowing and possible aspiration of the lungs and urinary tract infection. Patient died from severe sepsis, aspiration pneumonia and a urinary tract infection.

MARYSVILLE POST-ACUTE, Marysville, CA…Deficiencies…. facility failed to protect confidential medical information for one resident when a document was faxed in error to an unauthorized recipient which had the potential that patient's rights to privacy was validated; failure to ensure the use of a necessary assistance device (Hoyer lift) was used to lift patient to prevent an avoidable accident with significant injury..(NOTE: The deficiencies were issued after **FATE** filed for an appeal based on the violations not addressed in the original findings by the Chico Licensing Office Investigators).

McKINLEY PARK CARE CENTER, Sacramento, CA…Deficiency…. facility failed to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection; failure to appropriately implement policy regarding cleaning and disinfection of patient's bedpans by not using solution of ethyl alcohol as indicated in the guidelines of the Centers for Disease Control. This failure created the potential for infection of patients. NOTE: The original complaint allegations were for failure to notify physician and or family of a change in the patient's condition; failure to provide adequate fluids to prevent dehydration; unexplained brain bleed discovered after an MRI was taken; failure to provide appropriate personal hygiene; unsanitary conditions and insufficient staffing. **FATE** filed a request for an appeal based on the lack of findings by the Department of Public Health.

MID-TOWN OAKS POST ACUTE, Sacramento, CA…Deficiency…. facility failed to prepare a comprehensive plan of care to address patient's behavior issues identified in a comprehensive assessment which failure had the potential to impact the patient's overall well-being, including adequate hydration. Note: **FATE** learned of this deficiencies, which was issued to the facility back on 9/29/14, as a result of the complaint filed by **FATE**, at an appeal hearing on 4/22/16. **FATE** filed for the appeal hearing based on the Department of Health's lack of findings on the original complaint that included dehydration, failure to assess, falls with injury and insufficient staffing, all of which were unsubstantiated on the findings presented to **FATE** on 9/25/14.. **FATE** obtained the deficiency after this hearing, which occurred almost two years after the original complaint was filed.

NAZARETH PARK PLACE, Sacramento, CA…Deficiency…. facility violated the resident's personal rights when the facility removed and retained smoking and failed to conduct an updated assessment upon the discovery of the smoking in resident's room and did not issue the 30-day eviction as stated in policy nor did they execute an updated needs and services plan around the smoking that includes the resident and their responsible parties prior to implementing the policy to centrally store cigarettes and lighters. This complaint was originally filed by the **FATE** client.

"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

Long-Term Care Facility Complaints

Continued from page 9

NAZARETH PARK PLACE, Sacramento, CA..Deficiency…. facility failed to maintain resident's records and files; facility staff not qualified or properly trained to ensure regulation compliance for each individual working at the facility.

RIDEOUT MEMORIAL HOSPITAL, Marysville, CA….Deficiencies….the hospital failed to ensure that nursing staff followed policy for the prevention of pressure ulcers by not repositioning patients every two hours as required to avoid bedsores. These failures contributed to the development of pressure ulcers in several patients. **FATE** filed the complaint on 10/31/12 and did not receive the results until 2/24/16, a period of 3 years and 4 months.

ROSEWOOD POST ACUTE, Carmichael, CA ……Deficiencies…. facility failed to administer a medication as prescribed, which failure had the potential of exacerbating patient's medical condition. **FATE** appealed this decision to seek a Citation with a penalty assessment since the patient was harmed and subsequently died.

ST. JUDE CARE CENTER, MANTICA, CA….Deficiencies…. facility failed to operationalize facility policy and procedures for reporting suspected abuse when the facility failed to notify the appropriate agency, sign the required form and fax the information to the appropriate agency. The complaint alleged failure to prevent sexual abuse; failure to prevent loss of bottom dentures resulting in weight loss; failure to properly clean top dentures; failure to prevent theft of personal property; failure to prevent bedsores and failure to reposition patient every two hours,; failure to treat the bedsores; failure to change soiled bed linens and leaving diapers with feces on patient's bed; failure to prevent malnutrition and insufficient staffing. The complaint is now in the appeal process.

SIKESTON CONVALESCENT CENTER, Sikeston, MO…. Citation…..facility failed to notify the responsible party of a fall with sustained injuries. **FATE** is attempting to have this complaint re-investigated as the allegations stated the patient was harmed, fell and broke a hip that was untreated for 11 days causing the patient to experience pain and suffering; the facility failed to treat the patient's UTI; patient suffered a heart attack and it was alleged that the facility was insufficiently staffed to meet the needs of the patients. None of these allegations were addressed in the State findings. As well. **FATE** was not provided with the results per the federal regulations until **FATE** made numerous calls to the department requesting the outcome and would only be provided upon a written request from **FATE** to the Missouri Department of Health and Senior Services. **FATE** received part of the findings 6 weeks after the department notified the nursing home of the citation.

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