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FATE

Newsletter of Foundation Aiding The Elderly

President's Message

35th YEAR OF ADVOCACY

By Carole Herman

This past October, **FATE** began its 35th year of advocacy for the prevention of elder abuse.

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Foundation Aiding the Elderly
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Our efforts continue to be a struggle to hold facilities accountable for the neglect and poor care of our most vulnerable citizens. When **FATE** started, our main focus was in skilled nursing homes; however, that soon changed with the explosion of assisted living facilities, residential care homes, boarding houses, and hospice programs, which caused our work to increase drastically. This year we served 275 new clients from all over the country, as well as Canada, resulting with **FATE** filing 58 official complaints against facilities for harming patients.

The lack of oversight by state and federal regulators continues to be an issue. Our experience and documentation shows that there is a lack of oversight all over the country for the industry's continual violation of federal and state regulations put in place to protect the consumer. We continue to advocate directly with the consumers to inform them of their rights, how to advocate to prevent poor care, neglect and harm of loved ones.

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

CAROLE HERMAN

As the regulators continue to be laxed in their duties to enforce regulations, more consumers are filing civil law suits against these facilities in order to hold them accountable.

This past year, **FATE** participated in several stakeholder's task forces in California pertaining to the attempt by the Center for MediCare Services (CMS), along with all the states in the country, to reduce the use of psychotropic medications in nursing homes; participated in meetings with the Department of Public Health officials to develop the policies and procedures for the implementation of the new staffing ratios in California; worked with Florida

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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

CA Senate Bill Mandates Prompt Investigations of Allegations of Nursing Home Poor Care and Neglect

Effective July 1, 2017, the California Department of Public Health, Licensing and Certification Program, must complete investigations of allegations of poor care and neglect in nursing homes within ninety (90) days after receipt of a complaint. Starting July 1, 2018, the Department will have sixty (60) days to complete investigations. **FATE** filed a civil case in the interest of the public against the department for its failure to investigate poor care and neglect allegations in a timely manner. **FATE** sought to remedy the State's widespread delay in concluding these investigations and to promptly review the findings once rendered. **FATE**'s civil case helped spur the passage of CA Senate Bill 75, which amended California law to reduce the time in which the Department must complete such investigations. **FATE** will monitor all of its complaints to ensure the department is performing according to their mandate. If not, **FATE** will bring the necessary action to enforce the Department to adhere to the regulation.

Fate Continues its Effort to Repeal the Florida Punitive Damage Legislation

Two years ago, while working with the family of pro wrestler "Chief White Owl", who died from infected bed sores in a Florida nursing home, **FATE** became aware of a Florida Law that was enacted in 2001 that allowed fifty percent (50%) of any civil law suit where the jury awards punitive damages to be paid to the State of Florida. **FATE** along with Debbie Dahmer, the daughter of Chief White Owl, contacted many Florida Legislators, the Florida Bar Association and the Florida Justice Association in order to get support to repeal the 2001 law. Through research, **FATE** found that there had never been any punitive damage award in Florida where monies were given to the state. Florida Representative Amber Mariano and Senator Gary Farmer have drafted the proposed legislation to eliminate the section of the law pertaining to punitive damage awards. **FATE** is encouraged that this legislation will pass in Florida in the near future.

President's Message

Continued from page 1

Legislators and stakeholders to repeal the Florida law on punitive damages awarded in civil cases (see article on page 2); and on a daily basis, assist families who are experiencing difficulties with their loved ones in long-term care facilities.

Staffing is still the main reason why negligent and poor care is rampant in long-term care facilities.
If the facility does not have enough staff to meet the needs of the patients, it is automatic neglect. In skilled nursing homes, MediCare and MediCaid (MediCal in California) are the primary funding sources and the facilities are reimbursed according to staffing requirements; thus, our tax dollars are being paid to facilities that do not have proper staffing, which places the patients in jeopardy.

Due to **FATE**'s public interest civil case filed several years ago against the CA Department of Public Health for failing to investigate complaint allegations in a timely manner, legislation was passed that effective July 1, 2017, the department is ordered by law to complete complaint investigations within a ninety (90) day period (see article on page 2).

There are many more issues about the elderly that need attention. Every person that calls our office gets help…… no matter what the issue. **FATE** continues to receive complaints regarding the abuse of conservatorships and we attempt to help those victims the best we can since we are not attorneys and cannot take any type of legal action. We have gathered over 250 cases of conservatorship abuse all over the country and hopefully in the near future, this scandal will be exposed and appropriate legal action taken by those who are in the position to do something about it.

For 35 years, it has been an honor to serve over 6500 families all over the country. For as long as needed, we will continue to be dedicated to our advocacy to prevent the poor care and abuse of our most vulnerable citizens and their families. Thank you for your continued support of our efforts. Special thanks and appreciation to **FATE**'s staff and volunteers Jane De Soiza, Eileen Dancause, Nancy Haycock, Harris Herman and Jacob Vargas for their on-going commitment and dedication.

POOR CARE, NEGLECT AND ABUSE OF VETERANS

On October 16, 2017, Army Colonel Ronald B. Foss was buried at Arlington National Cemetery with full honors, including the riderless horse, reserved for war heroes.

Colonel Foss received a Silver Star, a Bronze Star with oak leaf clusters for Valor and the Vietnamese Cross of Gallantry for his three tours in Vietnam.

This year saw a rise in the amount of complaints we received regarding the poor care, neglect and abuse of our Veterans. One in particular, Colonel Ronald B. Foss, was a highly decorated Veteran who served three tours of duty in Vietnam. He was not just a Veteran, he was a war hero. He was sent to a California nursing home for rehabilitation after being a patient in the Veteran's Hospital. He was neglected in the nursing home and died from infected bed sores. He was buried in Arlington National Cemetery with full honors, including a riderless horse with a pair of boots in the stirrups facing backwards, which represents a fallen leader looking back on his troops for the last time. This honor is only given to this country's most decorated war heros. Brings back memories of the day John F. Kennedy was buried. Referring to her husband's death, Virginia Walsh stated, **"I would have rather my husband died in Vietnam than to have died from infected bed sores in a California nursing home."** This decorated and honored war hero did not deserve to die the way he did. No one deserves to die a horrific death as he did. This brave man served our country to keep us all free and this is how he ends up. The facility showed no remorse and the state regulators, as of our publishing date, had yet to finish their investigation of the complaint **FATE** filed against the nursing home.

California Nursing Home Operator Agrees to Pay $6.9 Million to Settle Kickback and Fraud Allegations

Four nursing homes operated by Los Angeles-based Brius Management Company were accused of paying kickbacks to hospital staffers in violation of anti-kickback laws per the U.S. Attorney's Office. The nursing homes, Point Loma Convalescent Hospital, Brighton Place/San Diego, Brighton Place/ Spring Valley and Amaya Springs Health Care in Spring Valley, admitted that employees conspired to pay kickbacks. The nursing homes also admitted employees used corporate credit cards to buy gifts, massages, tickets to sporting events and a cruise for hospital staffers in exchange for referrals, according to the statement by the U.S. Attorney's Office. The settlement resolves a lawsuit brought by a former employee under the whistleblower laws. Shlomo Rechnitz, the head of Brius Management, and the largest nursing home operator in California, stated he had no knowledge of the fraud.

Nevada Attorney Charged in Guardianship Case

A Las Vegas attorney, Noel Palmer Simpson, has been charged with guardianship abuse for changing the beneficiary on an elderly client's life insurance policy without court permission while using the legal system to divert and capture more than $25,000. Ms. Simpson worked for private guardian April Parks and three of her associates. The client wanted the money to go to her friends, but Simpson created a probate case so when the client died, she and Parks could charge estate fees. Although Simpson is only facing two charges, court records claim she was involved in many other incidents. Simpson had worked with another disgraced guardian, Patience Bristol, who was convicted for exploiting and stealing from her elderly and vulnerable clients. Bristol is serving up to 8 years in prison. If Simpson is found guilty, she could be looking at one to 10 years. **FATE** has been gathering data on guardian/conservatorship cases since 1986. The data gathered clearly shows that this is the next big scandal to hit the country. Several years back, **FATE** participated in the process to establish the California Fiduciary Board, which requires all private fiduciaries having more than one charge to obtain a license in California. **FATE** has been unable to identify any other state that has such a Board to monitor private fiduciaries.

After Florida Hurricane Irma Deaths, Stronger Oversight Necessary

As the result of the unfortunate death of 14 patients in a Rehabilitation Center in Hollywood Hills, FL after hurricane Irma, legislation has been introduced by U.S. Representative Frederica Wilson designating an official in each state to oversee nursing homes and assisted living facilities. Along with Representative Lois Frankel of West Palm Beach, suggested legislation has been drafted for the increased need to protect frail and dependent people in the future. The legislation will focus on the need for generators at nursing homes. After the deaths in the Florida facility, Governor Rick Scott ordered that starting November 15, 2017, nursing homes have backup generators and enough fuel to run them for 96 hours. The Governor's office estimated the statewide cost of generators in nursing homes to be about $240 million including training for staff on responding and alerting authorities to an emergency and having a plan for evacuation and to also conduct disaster drills to avoid another tragedy that happened after hurricane Irma.

California Nursing Home Pays Settlement for Administering Black-Box Drugs

A highly- rated nursing home in Newbury Park, CA has agreed to pay a $345,000 fine and will undergo spot inspections as the result of a settlement of a class-action lawsuit alleging patients were being given powerful drugs without required consent. The settlement in May of 2017, involves the nonprofit Mary Health of the Sick Convalescent and Nursing Hospital. The settlement calls for the nursing home to use procedures to ensure doctors explain the benefits and risks of psychotherapeutic drugs to patients and or their legal representatives. These types of black-box drugs carry warnings of extreme side effects and increased death risks for patients with dementia. Families of patients alleged doctors at the nursing home prescribed powerful drugs without discussing the impact of the drugs with the patient, family members or people with the power of attorney designations. Several years ago, the Center for MediCare Services began a nationwide campaign to reduce the use of these powerful drugs in nursing homes with emphasis on "informed consent" prior to the administration of such medications. The patient's physician must get "informed consent" from the patient or the responsible party and the proper form must be signed by the patient or responsible party. **FATE** was a participant with the Stakeholders on this topic. Although MediCare has reported a significant drop in the use of these medications, **FATE** continues to receive complaints from family members that the drugs are still being given without consent and we file the necessary complaints with the State regulators for these violations.

Colorado Enacts Mandatory Reporting Laws on Elder Abuse

This last year, Colorado put into place new laws to help protect the state's aging population. The tragedy of elder abuse is growing as the American population continues to age. Baby boomers are turning 65 at a rate of one every ten seconds (www.agingresearch.org). In order to protect this population, Colorado put into place mandatory reporting laws. These laws are meant to ensure that those in the elder community are safe and cared for by requiring certain identified individuals to report any observation or reasonable suspicions of abuse of an at-risk elder. The authorities are to be notified with 24 hours of a suspected or known abuse. The law requires several types of professionals and caretakers to report elder abuse. They are doctors, nurses, chiropractors, psychologist and other mental health professionals, social workers, clergy members, dentists, law enforcement personal, firefighters, bank personnel and caretakers at a license care facility, including nursing homes, residential care facilities and assisted living facilities. The law also allows for those individuals who report abuse or exploitation immunity from any related civil or criminal action as long as the report is made in good faith. Even if one is not a mandated reporter, **FATE** urges one to report any signs of elder abuse. Elder abuse can occur in the elder's home, outside the home or at a nursing home, assisted living facility or a residential care home.

MAKE A DIFFERENCE….MAKE A DONATION

During 2017, FATE helped over 275 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.

INSUFFICIENT STAFFING LEADS TO SUBSTANDARD CARE

One of the most important measures to ensure good care in any medical surrounding is sufficient staff to meet the needs of the patients. Not only is it an important factor, it is mandated by the Center for MediCare Services (CMS) to have enough staff to care for the patients. Hands-on care of patients, especially in nursing homes, is provided by certified nurse assistants (CNA's). A great many CNA's are very dedicated people who really care about the patients and work hard to ensure that their needs are met the best they can. However, it becomes almost impossible for the CNA's to care for the patients when management does not employ enough staff. Staffing is one of the most costly expenses for the nursing home operators and cutting staff for profit is a common occurrence. Over the past several years, more outside nursing registries have popped up and the nursing home operators could call a registry to send nurses, CNA's or other medical staff to fill in for workers who are not at work on any particular day. The facilities are also complaining that there are not enough people in the work force to hire. That is what registries are for…to provide staff on a temporary basis when workers do not show up for work, are on vacation or on sick leave. Report lack of staff to your state regulators or call **FATE** and we will take the necessary action against the facility.

SURVEILLANCE CAMERAS IN NURSING HOMES

Nursing home patients and their family members might have considered installing surveillance cameras in the patient's room to determine that appropriate care is being given and that the patient is treated with dignity and respect. Surveillance cameras can also be a deterrent to abuse. However, they are not a substitute for personal involvement and monitoring of your loved one. While surveillance cameras can offer information about the type of care, they can also be invasive and may violate the patient or the patient's roommate's right to privacy. As of 2017, Illinois, New Mexico, Oklahoma, Texas and Washington have laws that permit the installation of cameras in patients' rooms, if the patient and roommate or their responsible parties have consented. Each state law addresses issues including consent, and who can provide it. Maryland has issued guidelines for the use of cameras while not having a law in place. New Jersey's Office of The Attorney General will loan camera equipment to families who want to monitor their loved one's care. If your state does not have a law or rules on this issue, or if you have questions about their use, before installing any type of recording device, consult an attorney to discuss your rights and options.

AMAZON SMILE FOUNDATION DONATIONS TO FATE

In June of 2017, **FATE** was contacted by the Amazon Smile Foundation to send in information to Amazon regarding **FATE** and its non-profit status as Amazon wanted to add **FATE** to their list of charitable organizations that Amazon donates to through purchases by consumers. The Amazon Smile Foundation donates 0.5% of the purchase price of products purchased through Amazon.com to be donated to the charity of the purchaser's choice. There is no charge to the purchaser of products through Amazon. **FATE** is very pleased that we have been selected by Amazon to participate in this remarkable program in which Amazon donates to non-profit, charitable organizations. Bookmark this link: **http:// smile.amazon.com/ch/68-0198413** and support **FATE** every time you shop.

Help **FATE** continue its advocacy for the prevention of elder abuse by donating to our cause. **FATE** accepts no government funding and we rely on the general public to fund our work.

KNOW YOUR RIGHTS

To Be Free of Pressure Sores

Pressure sores, also known as bed sores or decubitus ulcers, develop with people who lie or sit in one position for long periods of time. They occur when pressure on the skin shuts off blood vessels depriving skin tissue of oxygen and nutrients. If proper care is not given, large deep sores can develop sometimes exposing the muscle or bone below the skin. Pressure sores left untreated can lead to infection, severe pain and in some cases, even death. Nursing homes must make sure that patients entering the facility do not develop pressure sores and that patients who entered the facility with a sore are given proper treatment to promote healing and prevent infections. The nursing home must keep the patient's skin clean and dry, give the patient good nutrition and hydration and keep the pressure off the vulnerable parts of the body, such as the buttocks, hips, shoulders and heels of the feet and by using pressure relieving devices, such as wheelchair pads, special mattresses and heel protectors. The most important function is that the nursing staff must re-position the patient every two hours to relieve any pressures. The nursing home must also notify the responsible party and the patient's physician if and when a sore develops.

Room Transfers

Federal law prohibits forced room-to-room transfers (also referred to as "intra-facility transfers") with very few exceptions. The law recognizes that involuntary transfers may be disruptive or harmful for patients and generally permits a patient to stay put in the room they are in. The law also requires nursing homes to provide advance written notice of any proposed transfer and allows patients to sue nursing homes for violations of the law. The need for particular types of medical care should never be the basis for a transfer since nurses, doctors and therapists can always go to the patient. Federal law requires that appropriate, individual care be provided to every patient in a nursing home, regardless of where the patients is located within a facility. A nursing home cannot permanently transfer patients to make changes in the facility such as the creation of specialized care units or the closing of certain wings. Under the federal law, the patients have an absolute right to refuse to accept a transfer.

Right to Leave a Facility

Patients in nursing homes or residents in assisted living facilities are often illegally held against their will without a judicial decision or legal process. All consumers have a right to be free from false imprisonment, the right to move freely and to choose where they want to live and whether or not to receive health care services. When someone enters a long-term care facility, they do not leave their rights at the door. There are many options for dealing with a facility that is denying a patient the right to leave. Contact **FATE** and we will advocate on your behalf if this is happening to you, a loved one or someone you know.

DISCHARGE APPEALS

FATE receives many calls every week from families who are very distraught that an acute hospital or a nursing home wants to release a family member when proper placement or a proper discharge has not been agreed to by the patient or the responsible party. Many do not know their rights to appeal a discharge when the patient is on MediCare. The following is the MediCare appeal process:

LEVEL 1 Redetermination by the MediCare Administrative Contractor (MAC)
LEVEL 2 Reconsideration by a qualified independent contractor (QIC)
LEVEL 3 Hearing before an Administrative Law Judge (ALJ)
LEVEL 4 Review by the MediCare Appeals Council (Appeals Council)
LEVEL 5 Judicial review by a Federal District Court.

"Help your brother's boat across the water and your own will reach the shore"… Hindu Proverb

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:

ATRIA CARMICHAEL OAKS ASSISTED LIVING, Carmichael, CA….Class B Citation….facility issued an illegal eviction notice to a resident.

CAPITAL TRANSITIONAL CARE, Sacramento, CA… Deficiencies…facility failed to protect a patient's personal health information when fulfilling a request or medical records for another patient. This failure caused protected health information to be disclosed to an unrelated private party.

ESKATON CARE CENTER GREENHAVEN, Sacramento, CA…Deficiencies…facility failed to provide nursing services by failing to report medication errors to the physician when medications were not provided for the patient as ordered; failure to meet professional standards when nursing staff did not follow physician orders to administer medications. **FATE** appealed the findings as all allegations were not addresses, such as failure to provide copies of the medical records according to the federal regulations, failure to notify family of a change of condition, failure to get consent for treatment of the patient from his responsible party and insufficient staffing.

GRAMERCY COURT, Sacramento, CA…Deficiencies… facility failed to inform patients responsible party of a change of condition, which had the potential for patient to receive unwanted interventions; failure to provide services that met professional standards of quality, which failure had the potential to cause a delay in providing care and treatment required by the patient.

MCKINLEY PARK CARE CENTER, Sacramento, CA… Deficiency….facility failed to provide sufficient nursing staff to meet the needs of the patients when CNA's were not available to answer call lights promptly because all the CNA's were at lunch and not on the floor attending to patient needs. This failure resulted in the patient falling from the bed and sustaining a broken wrist which prolonged her recovery time and placed multiple other patients at risk for harm. **FATE** filed an appeal as a citation with a civil penalty should have been issued to the facility for causing harm to the patient.

MIDTOWN POST-ACUTE, Sacramento, CA… Deficiencies….facility failed to notify the physician of a change in condition which resulted in a delay in medical assessment and intervention, which may have prevented patient's declining health; failure to accurately assess the response of an urgently ordered medical treatment when they failed to assess and document the response to IV fluids and IM antibiotic following patient's change of condition, which prevented the healthcare team from making critical medical decisions for patient's wellbeing; failure to maintain accurate clinical records when medication administration records dated 1/12/14 through 5/12/14 were missing signatures that medications were given. These failures prevented the healthcare team from having access to accurate, complete and vital medical information potentially affecting clinical decision making and ensuring safe and effective care.

MIDTOWN POST-ACUTE, Sacramento, CA...Deficiencies… facility failed to notify patient's responsible party in a timely manner when patient had a second fall, which failure had the potential for the responsible party to be uninformed of the patient's condition and unable to assist in decision making for the patient.

MISSION CARMICHAEL, Carmichael, CA…Class A Citation, $20,000.00 penalty assessment….facility failed to ensure the patient did not develop an avoidable pressure sore (bed sore). The sore progressed to a Stage 4 with extensive destruction, tissue necrosis of damage to muscle, bone or supporting structures (e.g. tendon, joint capsule, etc.), which lead to his death; failure to document a care plan regarding the prevention of the skin breakdown nor was a care plan developed regarding patient's left sided hemiplegia (paralysis); patient also developed MRSA, Methicillin Resistant Staphylococcus Aureus, bacterial infection, that is resistant to numerous antibiotics; failure to document skin assessment findings. These violations, separately or jointly, presented imminent danger that death or serious

Long-Term Care Facility Complaints

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harm to patient would result and there was a substantial probability that death or serious physical harm to the patient would result there from.

PINES AT PLACERVILLE HEALTHCARE, Placerville, CA….Deficiencies…facility failed to notify family of a change of condition; failure to follow professional standards of practice to ensure timely assessment and transport to the emergency room, which failure delayed treatment for a stroke; failure to maintain a complete and accurately documented clinical record when admission papers were not completed, which had the potential for inaccurate treatment and billing for treatment received.

ROSEVILLE POINT HEALTH & WELLNESS CENTER, Roseville, CA…Class B Citation…$600.00 penalty assessment…facility failed to meet the requirements for CA Health and Safety code Section 1418.9(a)(2) when it failed to ensure the physician notified the patient's responsible party within 48 hours of the emergency order for Haldol; failure to get informed consent from the patient's responsible party for the Haldol; failure to get a signed physician order for the Haldol within five (5) days of the order. The State of California took almost 4 years to complete this investigation process with results that were not accurately reported by the facility and without taking into consideration that the responsible party had left strict written instructions with the facility that no antipsychotic medications were to be administered to the patient. The CA and Federal regulations both clearly state that no antipsychotic medications can be administered without consent from the responsible party.

ROSEVILLE POINT HEALTH & WELLNESS CENTER, Roseville, CA….Deficiencies with a Class B Citation with a $2,000 penalty assessment… facility failed to ensure a safe and orderly transfer when the patient was transferred to an unlicensed room and board house for continuing care, which compromised the patient's health and safety. The patient was totally dependent on two staff members to transfer between bed and chair, could not walk, could not self-propel her wheelchair, could not dress herself, use the toilet or perform her own personal hygiene and yet they discharged her to an unlicensed house where they placed her in the garage and when she fell an hour later, she was transferred to an acute hospital for treatment and then was placed in a nursing home that could care for her. As a result of this failure, the patient was at risk of injury or neglect.

ROSEWOOD POST ACUTE REHAB, Carmichael, CA…. Deficiencies….facility failed to provide services that met professional standards of quality of care when an assessment for predicting pressure sores was not completed as ordered and when the pressure sore was not monitored weekly. This failure had the potential for inaccurate care. **FATE** appealed the decision and is awaiting a hearing as the patient was harmed and there should have been a citation issued with a civil penalty.

SACRAMENTO POST-ACUTE, Sacramento, CA… Deficiencies….facility failed to assess and monitor patient's skin condition and failed to prevent the formation of pressure sores when care plans were not developed for a high risk patient and preventative interventions were not provided. These failures potentially contributed to the patient developing four (4) pressure sores. This decision was appealed by **FATE** as other allegations, such as insufficient staffing, failure to prevent a urinary tract infection and causing the patient to suffer unnecessary pain were not addressed by the state investigators on this complaint.

SACRAMENTO POST-ACUTE, Sacramento, CA..Class A Citation…$20,000 Penalty Assessment….facility failed to assess and monitor patient's skin condition to prevent the formation of pressures sores which contributed to the amputation of the patient's leg.

ST. ELIZABETH HEALTHCARE CENTER, Fullerton, CA…. Deficiencies…facility failed to prevent bowel impaction of a patient, which had the potential to cause pain and injury; failed to monitor weight loss and recommend interventions to possibly prevent further weight loss; failed to maintain showers in a clean and sanitary manner when it was discovered that showers had a thick build-up of black residue in the shower and a cockroach was observed crawling across the floor of the shower; failed to accurately document meal intake when the facility recorded that the patient ate 70% of lunch when the patient was in an acute hospital and not in the facility and transferred a patient to another room without notification or permission from the responsible party.

Long-Term Care Facility Complaints

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SAYLOR LANE HEALTHCARE CENTER, Sacramento, CA ….Deficiencies….facility failed to prevent the elopement of a patient when staff members did not report previous elopement attempts and the facility failed to develop interventions and update the plan of care. This failure had the potential to cause serious harm or death to the patient; facility failed to provide a completed inventory list for the patient's responsible party and this failure caused unnecessary emotional difficulty to the family as a result of the loss of personal property.

SUNRISE ASSISTED LIVING OF CARMICHAEL, Carmichael, CA.. Type A Citation, $150.00 penalty Assessment….facility failed to reassess resident and update the Needs and Services Plan in a timely manner. Failure to reassess resident posed an immediate health and safety risk to resident and may have contributed to resident's subsequent serious injury to her head which resulted in death.

VIBRA HOSPITAL, Sacramento, CA…Deficiencies….hospital failed to develop and implement a written policy and procedure to define cohesive laboratory and nursing processes for blood draws from Central Venous Catheters (CVC) and Peripherally Inserted Central Catheters (PICC) which increased the likelihood of unnecessary needle sticks; hospital failed to follow the pharmacy policy and procedure titled "automatic stop dates" which had the potential for patient to not receive necessary medications due to expiration prior to renewal; hospital failed to ensure a patient's record was completed and authenticated by a licensed health practitioner acting within the scope of his or her professional licensure; hospital failed to ensure nonverbal patients had call lights readily accessible ensuring adequate communication between them and nursing personal. This failure had the potential to result in unmet patient needs and compromised patient safety.

WINDSOR CARE CENTER, Sacramento, CA….Deficiency… facility failed to provide copies of the patient's medical records according the federal regulations. This failure denied the responsible person the opportunity to obtain patient's data needed to make informed decisions regarding current and future medical decisions. The findings may be appealed as the facility was not cited for the allegations of severe stage 4 bed sores, osteomyelitis, failure to treat/diagnose a stroke and failure to admit to an acute hospital for treatment, failure to inform the responsible party of a hospital admittance and insufficient staffing.

WINDSOR CHICO CREEK CARE AND REHAB CENTER, Chico, CA….Deficiencies…facility failed to notify physician and responsible party of a change of condition after a patient had a second unwitnessed fall; failure to prevent two avoidable falls; failure to implement care plan interventions to prevent falls; failure to assess; failure to receive assistance devices to prevent accidents when care planned interventions to reduce the risk for falls indicated the use of a bed alarm and mat on the floor and this was not implemented; failure to notify the CA Dept. of Public Health of the unusual occurrence when the patient had an unwitnessed fall and sustained a significant pelvic fracture. **FATE** will file an appeal as all allegations were not addressed.

WORDEN CARE HOME, Roseville, CA….Citations….(civil penalty is under review as of 1/30/17)…. Two Type A Citations and One Type B Citation… failure to provide timely medical attention for a resident who was seriously ill for several days prior to receiving medical attention. Facility failed to meet the resident's needs and also did not notify the physician or seek emergency. Resident was left in a room without medical attention for a prolonged period of time. Resident had a temperature of 103 degrees and was diagnosed with "severe C-Diff" after daughter had to call 911 herself. Resident was admitted to an acute hospital for treatment. Resident also had severe diarrhea which posed an immediate health and safety risk to the resident. By not providing medical treatment for diarrhea impacted the resident's dignity.

"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

Special Thanks to our Donors

Gifts received from December 2016 to publishing date.

IN MEMORY OF MATILDA ANTICEVICH
Carole and Harris Herman, Sacramento, CA

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An Air Force Family in Texas

IN MEMORY OF GEROGE DAHMER
Aka Pro Wrestler "Chief White Owl"
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