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FATE

Newsletter of Foundation Aiding The Elderly

President's Message

THE RISING NEED FOR ADVOCACY

By Carole Herman

This past year was not unlike any other year as the need for advocacy continues to increase. We had the privilege of assisting over 300 new families all over the country by providing assistance with problems they are experiencing in acute hospitals, nursing homes, rehabilitation facilities, assisted living facility, residential care homes, hospice care and the escalation of boarding houses, which are unlicensed homes. We continue to inform consumers of their rights, what to expect when the acute hospitals push for discharge, what signs of poor care to look for in long-term care facilities and how to advocate for one's own healthcare. We also continued to file many complaints against facilities when patients are harmed by bedsores, malnutrition, dehydration, falls with sustained injuries, infections, scabies and other horrific poor care and mistreatment. When complaints are not substantiated by state oversight regulators, we exercise our right to appeal the lack of findings, which causes delays in the process. The complaints listed in this newsletter are only a few that were substantiated this past year. The unsubstantiated complaints that we contest are still going through the long process. When **FATE** files a complaint it is not for poor food; our complaints are very egregious violations to the patient that we believe alerts the regulators that there are problems in the facility which may cause harm to other patients. However, the regulators do not seem to have any sense of urgency and without the facilities being held accountable, the violation of patient's rights and poor care continues.

CAROLE HERMAN

FATE also participated as a stakeholder in sessions with the State of California regulators regarding staffing and new regulations in long-

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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

FLORIDA OFFICIALS SQUASH REPEAL OF PUNITIVE DAMAGE AWARDS

FATE began an aggressive march to have legislators in Florida repeal a 2001 law that entitled the State of Florida to be paid 50% of any punitive damage awarded in a civil law suit filed against a nursing home in Florida. The action began after a **FATE** client won a civil case and was awarded punitive damages.

After the jury award, the State of Florida put a lien on the judgment for its share of the $1Million award. The repeal, which was backed by the Florida Trial Lawyers and several Florida Legislators, was voted down in Committee. It was disappointing; however, **FATE** will attempt to re-ignite the action during the next Legislative Session.

Recently, working on a case in Oregon, **FATE** learned that the State of Oregon also has such a law. The Oregon law allows for 70% of any punitive damage award to be paid to the State of Oregon, 20% to be paid to the plaintiff's attorney and only 10% of the punitive damage award to the plaintiff. **FATE** also has been told that there are 10 other states in the country that have the same regulation. **FATE** will continue to look into what other states have this regulation and will attempt to get this type of regulation repealed. A law that pays the state regulators for failing to protect a nursing home patient clearly does not make sense. For the victims who were harmed to have to pay the majority of the punitive damage award to the State regulators whose responsibility is to protect the patients seems unconstitutional to say the least.

NURSING HOME OPERATOR'S $1.5 MILLION DOLLAR BIRTHDAY BASH

Dr. Craig Flashner, who resides in prestigious Westlake Village in California, hosted his 60th birthday bash in March of 2018 featuring music by Roger Daltrey, former member of the rock group "The Who", paying him $1 Million Dollars to perform. Daltrey's fee accounted for the majority of the party's costs which also featured performers From Cirque du Soleil and fire eaters.

Dr. Flashner is a principal of Madison Healthcare and several other operations across the country. The extravagance of his birthday bash certainly flies in the face of the industry's continual statements that they are not being reimbursed enough money to care for long-term care patients.

President's Message

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term care facilities. I personally gave presentations to the management team overseeing assisted living facilities and residential care homes regarding the types of complaints **FATE** is receiving from consumers and how **FATE** believes the department can be more efficient in responding to complaints and dealing with the consumers. By regulations, last year California increased staffing in nursing homes to 3.5 hours per patient per day. However, this has been a big issue for **FATE**, as facilities have a way of not meeting the staffing requirements by claiming there is a lack of qualified people in the employment pool to hire. Along with other advocates, **FATE** suggested that if a facility applies for a waiver to not meet the staffing requirements then new admissions should be stopped. Makes perfect sense… one would think. However, the nursing home industry lobby group cried foul and the California regulators bowed to their resistance to stop new admissions if the facility could not met the required staffing. The waivers could allow the industry to avoid the increased staffing regulations for up to three years. **FATE** learned that over 1/3 of California nursing homes applied for the waiver stating "shortage of workers". This is very alarming as insufficient staffing results in automatic neglect, as patients cannot be properly taken care of without enough staff to meet their needs. Meanwhile, the facilities are still getting paid as if the facility is staffed to meet patient needs.

For the first time, **FATE** was able to have a complaint substantiated pertaining to registered nurses stealing patients' narcotic medications. This misconduct took place in a facility in Oregon. In fact, one of the nurses even admitted stealing the medications. And, to make matters worse, one of the nurses was on probation for the same infraction and was still able to work in facilities and give out medications. For years, **FATE** has filed allegations of missing narcotics, medications not being destroyed according to regulation or not being giving to the patients. However, the allegations were never substantiated by any regulators. Many patients, especially in long-term care facility, don't even know what drugs they are being given and, missing narcotics is not a rare event. **FATE** has brought attention to this issue with some state regulators; however, the complaints were never substantiated until the recent case in Oregon.

Another area of concern that **FATE** continues to work on is conservatorships. Fifteen years ago, **FATE** participated with reporters from the Los Angeles Times in publishing a three-part series on problems with conservatorships. This series of articles prompted California Legislators to establish the California Fiduciary Board, which mandates anyone, other than a family member, who is a conservator to more than one individual has to have a license. As of this date, **FATE** is unaware of any other state that has such an oversight. However, there was never sufficient funding for the California Bureau and thus oversight is lacking and courts continue to appoint private conservators when there are family members willing to care for the person. Unscrupulous conservators are still robbing funds, taking valuables, preventing family members from seeing their loved ones, taking elders out of their homes and placing them in long-term care facilities against their will and no one is being held accountable and the courts continue to sanction these conservatorships.

There appears to be willful blindness on the part of those in government whose core responsibility is to ensure the health and safety of all of us consumers. The rising sea of investigative misconduct encourages those who are harming our most vulnerable citizens to continue to violate federal and state regulations while making a lot of money from our tax dollars. There is no incentive to change as long as they can get away with it. Thus, the importance of advocating has never been so great. **FATE** will continue to be relentless in its advocacy work; however, the general public needs to be aware of their rights and to stand up for those rights as we all may end up in one of these facilities one day.

A special thanks to our donors who make it possible for us to operate and to the **FATE** staff, Eileen Dancause, Jane DeSoiza, Nancy Haycock, Harris Herman and Jacob Vargas, for their hard work and continued dedication to prevent elder abuse. **FATE** could not be effective without all of you.

MEDICARE'S FRAUD HOTSPOT: HOSPICE CARE

According to a report released in August 2018 from the Inspector General's Office at the U.S. Department of Health and Human Services the number of hospices in the United States increased by 43 percent between 2006 and 2016, but so has Medicare fraud, and it is affecting millions of people. Medicare beneficiaries receiving hospice care increased by 53% for the same period of time with 1.4 million Medicare beneficiaries receiving hospice. Spending increased by 81 percent resulting in $16.7 billion in Medicare spending. Medicare fraud is a huge problem. The program spends more than $600 billion a year on health care for tens of millions of seniors with fraudulent billings reaching as high as $60 billion a year. That amount is almost twice as much as the National Institutes of Health spends on medical research each year. Even when fraud is not an issue, the rising spending on hospice services does not mean patients facing the end of life are actually receiving the proper care. The report also found that hospices did not meet plan of care requirements in 85 percent of cases. Payment fraud schemes are rising as hospices purposely bill patients inappropriately. Payments depend on level of care, not the amount of services provided and some hospices are taking advantage of the system. Hospices are cashing in on inaccurate billing, patient referral kickbacks, overcharging and billing for higher-level, more expensive care than is truly needed. The report noted that hospices often charged patients for general inpatient care, the second most expensive level of hospice care, when the patients only receive home care. Suspected fraud should be reported to the Inspector General's Office in Washington DC.

NURSING HOMES NOT MEETING STAFFING REQUIREMENTS

The New York Times last July published an article on nursing home staffing stating "it's almost like a ghost town" in some of the facilities. According to the article, most nursing homes overstated staffing for years. A new reporting system based on payroll-based data indicates facilities have less staffing, especially on weekends, than previously reported to the government under the old self-reported system. The newly implemented payroll-based journal system shows that seven out of ten nursing homes had "lower staffing… with a 12 percent average decrease". A senior vice president at the American Health Care Association, a nursing home industry group, stated that there are legitimate reasons for why staffing varies between weekdays and weekends noting that there are less activities for patients and more family members around. However, patients commented that they have roamed the halls looking for an aide when help is needed on weekends. If you have a loved one at an understaffed home, please know you have rights. Every nursing home patient is entitled to services that attain or maintain his or her "highest practicable physical, mental and psychosocial well-being". Under the federal nursing home reform law, this standard means that each nursing home must have sufficient staff with the competencies and skills necessary to meet the patient's needs, including having a registered nurse on duty for eight hours a day, seven days a week, as well as having 24-hour licensed nursing services. **FATE** encourages patients and families to educate themselves about patient rights and to continue advocating for the health and safety that patients are entitled to by law.

MAKE A DIFFERENCE….MAKE A DONATION

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 or make a purchase at smile.amazon.com/ch/68-0198413 and Amazon donates to FATE at no cost to you. Your contribution will make a difference and is greatly appreciated. THANK YOU.

MISUSE OF ANTIPSYCHOTIC DRUGS

Each week, it is estimated that more than 179,000 people living in US nursing homes are given antipsychotic medications even though they don't have the approved psychiatric diagnoses, such as schizophrenia, to warrant use of the medications. Most of these patients are older and have dementia and researchers say the antipsychotic medications are administered as a cost-effective "chemical restraint" to suppress behaviors and ease the load on staff. A CNN investigation in October of 2017 based on the Human Rights Watch Report, "They Want Docile: How Nursing Homes in the US Overmedicate People with Dementia", revealed how one little red pill, Nuedexta, was being misused and overprescribed in nursing homes. The 157-page report estimates that each week more than 179,000 people living in US nursing homes are given antipsychotic medications. This overuse benefited the drug makers to a tune of hundreds of millions of dollars, largely at the expense of the MediCare system. The FDA has not deemed antipsychotic drugs an effective or safe way to treat symptoms associated with dementia. In fact, the FDA cautions that these drugs pose dangers for elderly patients with dementia, such as severe muscular rigidity, jerking movements, low blood pressure, high blood sugar, blood clots and even doubles the risk of death. When residents were taken off antipsychotic drugs, they and their family members often saw improvements. One daughter stated that her mother could walk again, read again and regained her mental status from being totally incoherent. **FATE** wants to remind the general public that consumers have the right to approve or not approve the use of any medications and for black-box drugs, such as antipsychotics, federal law mandates that informed consent be obtained by either the patient or the patient's surrogate decision maker if the patient is declared incompetent.

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

Lisa Ganas of CSAC Excess Insurance Authority located in Folsom, CA presents Carole Herman, **FATE** President, with a donation check in the amount of $17,668.23, which represents donations from the company's annual charitable silent auction. Each year, employees vote for a local charity of their choice to receive the proceeds from the auction. **FATE** won the majority of the votes and on 7/9/18 was gifted with the donation. A special thanks to all of the employees of CSAC for this most generous donation.

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.

MEDICARE SLASHING RATINGS

In July of this year, after a published report from the Kaiser Health News, MediCare lowered its star rating for staffing levels in one out of 11 of the nation's nursing homes…almost 1,400 of them… due to either inadequately staffed registered nurses or failure to provide payroll data that proves required nursing coverage. Medicare began collecting and publishing payroll data on staffing in early 2018. Payroll records revealed lower overall staffing levels than the nursing homes had previously disclosed. Nursing home industry officials have acknowledged that some facilities are struggling to meet the new payroll reporting requirements. An industry spokesperson stated that lowering the star rating system because of insufficient staffing is disappointing and is attributed to a work force shortage. In California, the industry was successful in getting a waiver to avoid the new staffing ratio of 3.5 nursing hours per patient based on work force shortage. **FATE**'s position is if a facility applies for a waiver based on inability to hire staff, then the facility should stop all admissions until staffing meets the state requirements. Under the California waiver, a facility could possibly be insufficiently staffed up to three years. Insufficient staffing is the number one cause of poor care and neglect. An official with the California Healthcare Facility Association, the lobby group for nursing home operators, stated at stakeholder's meeting that nearly 600 facilities in California will apply for such a waiver. Shocking news to say the least. **FATE** was successful several years ago after filing a public interest civil law suit against the CA Department of Public Health to force the regulators to look at payroll records in order to determine staffing ratios. Prior to that case, regulators were looking at staffing sheets to determine staffing ratios. **FATE** found that in many cases the staffing sheets contained names of people who didn't even work in the facility. Insufficient staffing is the main cause of poor care and neglect and the industry should be held accountable when they cannot meet the staffing needs of the patients that they are being paid to care for.

ASSISTED LIVING…. BILLIONS BEING PAID OUT

Federal investigators say that they have found huge gaps in the regulation of assisted living facilities, a shortfall that they say has potentially jeopardized the care of hundreds of thousands of people serviced by the booming industry. The Government Accountability Office, a nonpartisan investigative arm of Congress, report released in the beginning of 2018, states that billions of dollars in government spending is flowing to the industry even as it operates under a patchwork of vague standards and limited supervision by federal and state authorities. States are supposed to keep track of cases involving the abuse, neglect, exploitation or unexplained death of patients in assisted living facilities. However, more than half of the states were unable to provide information on the number or nature of such cases. Assisted living communities are intended to be a bridge between living at home and living in a nursing home. Residents can live in apartments or houses, with a high degree of independence, but can still receive help managing their medications and performing daily activities like bathing, dressing and eating. Congress has not established standards for assisted living facilities comparable to those for nursing homes. In 1987, congress adopted laws that strengthened the protection of nursing home patients' rights; however, assisted living facilities have largely escaped such scrutiny even though the Government Accountability Office says the demand for their services is likely to increase because of the aging of the population and increased life expectancy. Assisted living was not part of the original Medicaid program, but many states now cover it under waivers intended to encourage "home and community-based services" as an alternative to nursing homes. Under the most common type of waiver, Medicaid covers assisted living only for people who would be eligible for "an institutional level of care" in a nursing home or hospital. For a copy of this report entitled "Improved Federal Oversight of Beneficiary Health and Welfare Is Needed", contact the Government Accountability Office in Washington, D.C.

CALIFORNIA LAWSUIT ACCUSES NURSING HOME OF UNDERSTAFFING TO INCREASE PROFITS

A class-action lawsuit was filed against Cupertino Healthcare and Wellness Center and more than a dozen other California skilled nursing homes accused of deliberately running an understaffed business to make a bigger profit. The facility is one of four Bay Area businesses named in the suit; the other three are in Hayward, Novato and San Rafael. All four, in additional to 11 others sued, are owned by Shlomo Rechnitz, who controls 60 skilled nursing facilities throughout California. The complaint accuses Rechnitz and the facilities' management of deliberately violating laws that protect nursing home patients and taking on new patients without disclosing they did not have the requisite staff to provide adequate care. According to the suit, the alleged transgressions took place in the last three years beginning in 2015. Insufficient staffing is the number one reason for neglect and poor care; however, the regulators rarely hold the facilities accountable for failing to staff according to the state regulations. Without accountability, the industry will never change and will continue to place profits above patients.

OMBUDSMAN COMPLAINTS LARGELY UNACCOUNTED FOR

According to state ombudsman data collected and published by the United States Administration on Community Living in August of 2018, one in five ombudsman complaint referrals were "never acted upon" or they were "never substantiated" by government officials. The Long-Term Care Ombudsman program is a federal and state mandated resident advocacy program that operates in every state. Ombudsmen seemingly act as the "eyes and ears" of enforcement agencies to alert them when serious issues arise in nursing homes and other long-term care settings. According to the report, when ombudsman offices refer a complaint to another agency, it's normally after an investigation with little or no progress being made to resolve the problems. While data shows a significant downplaying of ombudsman complaint referrals by government regulators, what is even more alarming is the staggering number of referrals that have gone largely unaccounted for. Nearly 100,000 ombudsman complaint referrals seem to have fallen into some bureaucratic black hole. Ombudsman data reveals enforcement agencies neglected to report back to ombudsman offices what happened with 80 percent of the referred ombudsman complaints. **FATE** receives frequent calls from consumers all over the country stating that they have been disappointed by the lack of the Ombudsman Program being proactive when they have issued complaints of poor care and neglect of their family members in long-term care facilities.

KNOW YOUR RIGHTS

While in a nursing home, the consumer has the right to refuse treatment, be transferred or discharged only for medical reasons or for their welfare or for non-payment; be fully informed by a physician of their medical condition; to voice grievances and recommend changes in services without retaliation; be free from physical and chemical restraints; to be free from mental and physical abuse and be allowed visits from family 24/7.

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:

AMERICAN RIVER CENTER, Carmichael, CA…facility failed to ensure a comprehensive care plan was developed for the patient. This failure had the potential for the patient's bilateral lower extremity edema and swollen left knee not to be adequately monitored and treated. **FATE** will appeal the findings based on the department not substantiating other serious allegations that caused harm to the patient.

ARDEN POST ACUTE REHABILITATION, Sacramento, CA… deficiencies…facility failed to document the informed consent for the continuation of an antipsychotic medication upon admission to the facility. This failure had the potential to place the patient "at risk" for side effects of long-term antipsychotic medication usage; failure to obtain prior approval form the Department of Public Health for the purpose of off-site storage of medical records. **FATE** will file an appeal on these findings as the failure to document was a records violation and there was no informed consent by the responsible party and thus should have been a violation for antipsychotic medications with no informed consent.

ATRIA CARMICHAEL OAKS ASSISTED LIVING, Carmichael, CA... deficiencies…facility failed to follow payment methods agreed to upon admission when the facility continued to withdraw monies from the resident's accounts while also billing for the same services and facility obtained the resident's banking information when they should not have; failure to properly train personnel to prevent accidents which caused injuries to a resident.

BROOKDALE SANTA MONICA, Santa Monica, CA…deficiencies, Class A and Class B citations….facility failed to respond to the emergency call button in a timely manner and due to insufficient staffing and not meeting the residents' needs; failure to follow physician orders relating to the administration of resident's blood pressure medication; facility failed to have hot water in resident's bathroom; facility failed to provide resident with personal property; facility failed to keep the bathroom clean; facility failed to show the resident dignity by several staff members agitating a resident resulting in a Class B citation.

CARLTON CROWN PLAZA…. Sacramento, CA…Class A Citation… Enhanced Civil Penalty $10,000.00……facility retained resident that required a higher level of care and resident sustained multiple falls resulting in injury and subsequent death. Facility failed to provide further intervention to prevent falls resulting in 24 falls with sustained injuries. Facility retained resident who required a higher level of care based on resident's declining condition and needing more supervision and assistance with mobility and ADL's. Facility failed to properly observe resident and re-evaluate resident's placement in assisted living as evidenced by information provided during the resident's record review. Based on review by State investigators, the facility failed to provide the necessary care and supervision to ensure resident's safety and prevention of falls, which resulted in the resident sustaining serious bodily injury and subsequent death. The violations warrant an enhanced civil penalty, which the department levied at $10,000.00.

CARLTON CROWN PLAZA… Sacramento, CA…two (2) Class A Citations and (2) Class B Citations…. One A Citation was issued as the resident was unstable on a walker yet the staff continued to allow the resident to use a walker. Resident was also getting feces on toilet, the walls and the carpet and facility failed to update the care plan to address these issues. The other A Citation was issued because the facility failed to prevent a stage 3 pressure ulcer (bed sore) by not following the hospice care plan, not escorting the resident to the toilet and not ensuring the resident was using a wheel chair per hospice instructions. One B citation was issued for no re-appraisal or updates to the care plan per Title 22 of the California Code when there is a change in condition for the resident. The administrator did not ensure staff followed through the care plan and hospice care plan as the care plan notes instructed the staff to reposition, change and ensure staff were following fall precautions. The other B citation was issued for the facility's failure to prevent the resident from falls and for the resident using the toilet on his own and getting feces on the walls, toilet and other areas. The facility had no updated care plans to address these issues as the resident was not regularly observed for changes in physical, mental, emotional and social functioning and that proper documentation was brought to the attention of the physician and the residents responsible party as evidenced by resident was unstable on walker yet staff continued to allow the use of a walker. There may be an enhanced penalty assessment at a later time.

COUNTRY CREST POST ACUTE, Oroville, CA….Class B Citation, $1,000.00 Penalty Assessment…. facility failed to prevent an avoidable fall with injury as patient was left unattended in a bed that was raised to a height of three feet above the floor and patient fell out of bed and sustained 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 a coma, paralysis and even death). This citation was issued subsequent to **FATE** filing an appeal from the original findings of only a deficiency. Since the patient was harmed, a citation was warranted.

DOUBLE TREE POST ACUTE, Sacramento, CA…Deficiencies…. facility failed to provide safe storage of patients clinical record. This failure prevented review of the clinical record and increased the potential for unauthorized use; failure to obtain consent for patient for medication he was administered during this admission. This failure had the potential to expose patient to unnecessary medication and adverse reactions; failure to obtain approval of a program flex for offsite storage of records. This failure had the potential to prevent storage and retention of clinical records per regulations..

Long-Term Care Facility Complaints

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EMBRACING ARMS CARE HOME (RESIDENTIAL CARE FACILITY)…. Fair Oaks, CA…Five (5) Class A Citations….temporary closed facility…. Failure to be free from corporal or unusual punishment, humiliation, intimidation, mental abuse or other actions of a punitive nature; staff engaging in conduct that is inimical to the health, morals, welfare or safety of the residents, which posed an immediate health and safety risk to the residents; facility failed to check, change or take resident to the restroom all night when family paid extra for all-night assistance; facility staff made false statements regarding the facility and services being provided by stating a recliner was not placed directly next to a resident's bed, which was false and staff also stated that the resident was not yanked by the neck/head, which was also false; the administrator of the facility demonstrated lack of knowledge of and ability to conform to the applicable laws, rules and regulations and/or have good character and continuing reputation of personal integrity which posed an immediate health and safety risk. Facility was closed and all of the residents had to be moved out of the facility. The original complaint was filed by the family prior to contacting **FATE** for assistance.

FREDA'S RESIDENTIAL CARE… Santa Maria, CA…Six (6) A Citations…$500.00 Penalty Assessment….facility failed to notify resident's physician and/or family of a dermal ulcer located on resident's tailbone, which posed an immediate health & safety risk to residents in care; failure to ensure sufficient staffing during an extreme heat wave as only two employees on duty were required to keep residents hydrated, cool and comfortable along with resident's daily needs. Failure to recognize the resident's dermal ulcer resulting in Stage 4 diagnosis which posed an immediate health & safety risk;9-1-1 responders noted that the room temperature of the facility was 100 degrees which posed an immediate health & safety risk to the residents; sickness, injury or death of a client has occurred and resulted in civil penalties. NOTE: the department is still considering an enhanced Civil penalty for $15,000 based on Health and Safety Code 1569.49(d) for the facility's violation of the same deficiencies and an amended report and/or citation will be issued once the decision is reached.

GARDEN PARK CARE CENTER… Garden Grove, CA…Deficiency… Nursing Services….facility failed to administer medications ordered by the physician when the patient had a temperature of 102.1 degrees Fahrenheit. The physician's order was to deliver the medication every four hours as needed if the patient's temperature was greater than 100 degrees Fahrenheit. This violation was only issued after **FATE** had to file two appeals after the original findings were "unsubstantiated".

GOOD SHEPHERD HEALTH CARE CENTER OF SANTA MONICA, Santa Monica, CA…Deficiency….facility failure to immediately inform the responsible party when an accident involving the resident which results in injury and has the potential for requiring physician intervention or a significant change in the patient's physical, mental or psychosocial status, or there is a need to alter treatment, or a transfer or discharge is specified. The deficient practice placed the patient at risk of not receiving necessary care and services in a timely manner; failure to provide sufficient staffing to meet the patient's needs. This deficient practice placed the patients at risk of poor care.

GORMLEY'S RETIRMEMENT HOME…Elk Grove, CA…B Citation… facility staff were sleeping on the couch in the living room while on shift. Personal rights violation as each resident shall be accorded dignity in his/her personal relationships with staff, residents and other persons….Staff yells at residents and tells them to do things themselves when they need assistance.

LAGUNA WOODS RESIDENTIAL CARE….Elk Grove, CA… Deficiencies…staff failed to protect resident from physical assault by another resident; facility failed to manage resident's aggressive behavior which posed an immediate safety risk to residents. CA Department of Social Services, Community Care Licensing, failed to substantiate that the neglect by the staff led to resident's death, which **FATE** alleged. **FATE** believes this episode falls under the enhanced remedies due to the death and **FATE** will attempt to have the complaint re-opened for further review. As well, the state investigators did not look into all the allegations, such as insufficient staffing and failure to provide copies of resident's records upon request.

LINCOLN MEADOWS CARE CENTER, Lincoln, CA….Deficiencies….the facility failed to ensure patient's confidentiality was securely maintained when parts of the patient's medical records were electronically sent to another patient's family. This failure caused the patient's medical records to be viewed by an unintended recipient.

LINDA VISTA NURSING AND REHABILITATION… Ashland, Oregon….Federal Citations…..$4,000.00 Penalty Assessment…. Facility failed to follow physician orders for medication administration; facility failed to notify responsible party of a change in condition; facility failed to provide care and services to prevent pressure sores; facility failed to ensure the theft of resident property did not occur; failure to assure proper hydration; failure to provide sufficient staffing to meet patient needs. This complaint filed by **FATE** also uncovered that staff members of this facility admitted to stealing patient's medications, which most were narcotics. The proper authorities (Medicaid Fraud, State Nursing Board, Attorney General) were notified in order to conduct further investigations into possible criminal charges.

MARYSVILLE POST-ACUTE, Marysville, CA…Deficiencies… facility failed to notify the physician when the patient was not eating meals, which contributed to weight loss and dehydration; failed to ensure the consistent implementation of skin care management to promote healing and prevent the progression of bedsores, which failure contributed to the progression of bed sores to a Stage IV; failure to ensure the physician supervised the medical care of the patient, which resulted in a delay in the patient receiving antibiotic treatment for a urinary tract infection. Since the patient was harmed, a citation with a civil penalty should have been issued against the facility by the Department of Public Health.

MEADOW OAKS OF ROSEVILLE, Roseville, CA..A Citation with an immediate $1,000.00 Penalty Assessment….facility failed to monitor

Long-Term Care Facility Complaints

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patient after being left outside on the patio for several hours in a heat storm. When the patient arrived via ambulance at the acute hospital emergency, his body temperature was 103.4 (F), he was severely dehydrated, had multiple areas of sunburn (basic blister burns) and redness on his body. He was diagnosed with a heat stroke and admitted to intensive care. He expired several days later from heat stroke due to prolonged exposure to sun and heat, which caused severe dehydration. Due to the patient's death, this complaint is currently being reviewed for an additional enhanced penalty, which could result in an additional $15,000.00 fine.

ROSEVILLE CARE CENTER, Roseville, CA…Deficiencies and Class B Citation…$2,000 Penalty Assessment….facility failed to notify physician and responsible party of a change of condition when the patient had signs of impaired circulation in his lower right leg and there was a delay in notifying the physician, which failure led to a delay in medical treatment that eventually led to the amputation of the patient's right lower leg; facility failed to assess, monitor, intervene and report changes which caused amputation of the right lower leg. **FATE** appealed these findings based on serious injuries to this patient which should have resulted in a higher citation level citation with a higher penalty assessment.

ST. ELIZABETH HEALTHCARE CENTER…Fullerton, CA… Deficiencies….the facility failed to protect two patients from unauthorized disclosure of their medical information. The breach occurred when copies of medical records of five (5) patients were mixed in with other patient records. Administrator held in-services with facility staff on the topics of HIPAA compliance and proper medical information handling to avoid another occurrence.

SAYLOR LANE HEALTHCARE, Sacramento, CA…Deficiencies…. the facility failed to obtain physician orders for oxygen therapy upon patient's admission, which failure to obtain specific orders had the potential to decrease the patient's ability to participate in therapy and contribute to physical decline; facility failed to develop and implement a comprehensive, personalized care plan which placed the patient at risk for failure to improve or decline when care was not coordinated to meet chronic and rehabilitation needs; facility provided oxygen therapy without a physician's order, which placed the patient at risk for inconsistent care that could have contributed to patient's respiratory decline.

SAYLOR LANE HEALTHCARE, Sacramento, CA…Deficiency….facility failed to ensure sufficient nursing staff to provide a minimum of 3.2 nursing hours per patient. This failure had the potential to negatively impact care for all patients..

VALLEY HOUSE REHABILITATION CENTER,…Santa Clara, CA…. Deficiencies…facility failed to ensure services were provided to meet the professional standard of practice when staff did not notify the physician or the family regarding a bed sore and failed to assess, measure and monitor the wound, which failure could compromise the patient's care and affect the wound healing progress; failure to ensure sufficient nurse staffing was employed to provide a minimum 3.2 nursing hours per patient day. This failure resulted in non-compliance with State regulations.

WHITNEY OAKS CARE CENTER…. Carmichael, CA….Deficiencies… facility failed to meet the pharmaceutical needs of patient when 9 of 16 medications ordered by the physician were not given to the patient. Such failure placed the patient at risk for harm. **FATE** will be filing an appeal based on the State not thoroughly investigating all of the allegations of the complaint, i.e., insufficient staffing; failure to place call bell within reach of the patient; failure to provide trained staff; oxygen condenser not working properly and having patient sign papers at 3 a.m. in the morning without explaining the purpose of the documents.

WINDSOR CHICO CREEK CARE AND REHAB CENTER, Chico, CA… Class B Citation, $2,000.00 Penalty Assessment….facility failed to prevent two avoidable falls when patient was not assessed as being a fall risk and had no fall risk precaution in place when patient fell and sustained a broken pelvis and neck fracture requiring long-term use of a neck brace. This failure caused harm to the patient. The Class B citation was issued subsequent to **FATE** filing an appeal from the original findings of only deficiencies being issued.

YUBA SKILLED NURSING CENTER, Yuba City, CA…Deficiencies… facility failed to ensure a resident request to receive hospice care management from a provider outside of the facility was relayed to the physician. This resulted in the patient not receiving hospice care and services from a specialized hospice provider; facility failed to have a complete and accurate Minimum Data Set (MDS), a standardized comprehensive assessment of the patient when the MDS did not indicate the patient's urinary tract infection; facility failed to ensure that the patient's attending physician supervised her medical care and provide consultation when the physician did not respond to telephone communications regarding end of life care, which resulted in the patient not being provided end of life management for physical needs and psychosocial support; facility failed to ensure the physician conducted comprehensive visits when physician's monthly progress notes were not completed for three (3) consecutive months, which posed a risk for unidentified complications due to the lack of physician oversight.

"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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