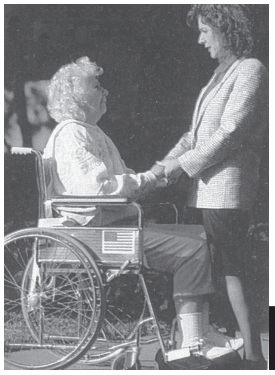
Vol 19 No 1
Winter 2019



FATE

Newsletter of Foundation Aiding The Elderly

President's Message

REGULATIONS REQUIRE ENFORCEMENT

By Carole Herman

FATE had another busy year of advocacy. We served an additional 251 families that resulted in 86 client cases which resulted in 35 official complaints with state regulators and 165 that just needed help with the system and coaching on what the family could do to bring about better care for their loved one. We also provided information on a daily basis to many other families all over the country that we did not add to the count, as we just provided answers to their questions and provided resources for them to look into.

One of our success stories this year was the indictment, arrest and conviction of a nurse in Oregon who was stealing patient's medication. This was the first time **FATE** was able to prove that drugs were being stolen from patients. Our client's initial complaint to Oregon resulted in no action by the Oregon regulators. However, after **FATE** filed its own complaint and proved the theft, the Oregon regulators sanctioned the facility and the nurse involved was indicted by a grand jury charged with 7 felony counts.

FATE continues to be alarmed as to the lack of enforcement by state regulators to ensure the health and safety of our most vulnerable citizens. Our position is, and always has been, that there are plenty of state and federal regulations that have been enacted. However, there is a lack of enforcement by the government regulators to hold the industry accountable for harming our family members. If the industry is not held accountable, there is no incentive to change. In several states where we filed our first complaints with regulators, we were poorly received. We would be asked "who are you?… we have never been asked these types of questions "and why is **FATE** filing complaints from California"? We have to explain that we work all over the country for the prevention of elder abuse and we have the right to file the complaint on behalf of our clients. That puts them on notice that we are documenting what the regulators are doing or not doing.

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CAROLE HERMAN

May the Holiday season fill your soul with joy, your heart with love, and your life with laughter!

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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

ESKATON CORPORATION HIT WITH A GUILTY VERDICT IN ELDER ABUSE LAWSUIT

A jury in Sacramento found the Eskaton Corporation guilty in an elder abuse case pertaining to a resident who died after being in one of Eskaton's Assisted Living facilities in Orangevale, CA. The verdict - $7.5 million in compensatory damages and $35 million in punitive damages – came after seven years of court battles. The civil case was filed by the Dudensing Law Firm against Eskaton's Assisted Living facility, Fountainwood Lodge, on behalf of the niece and sister of the deceased 77 year old resident who suffered with dementia. **FATE** filed the administrative complaint against Fountainwood with the CA Department of Social Services and the allegations that the resident's medication was not given as prescribed was substantiated. Every morning the resident was given Ativan, a black-box drug, which the facility needed informed consent to give. After 26 doses of the Ativan, the resident was so zonked out she chocked on chicken nuggets and died. A contributing factor was that the facility was insufficiently staffed to meet the needs of the residents. Eskaton runs care facilities and residential communities throughout Northern California and filed an appeal on the case, which will cause another delay in settling this long, on-going civil case in order to bring justice to this family.

NURSES IN NEW YORK WIN HUMAN TRAFFICKING LAWSUIT

U. S. District Judge Nina Gershon of the Eastern District Court in New York ruled in October of 2019 that the owners of the Sentosa Group of nursing homes violated the Trafficking Victims Protection Act by using threats of serious harm against more than 200 nurses from the Philippines. The nursing homes owners, Benjamin Landa and Bent Philipson are personally liable for the violations of the anti-trafficking law. Evidence was provided to the court that the Filipino nurses were not paid the wages promised in their employment contracts and that they were required to work in unsafe conditions with inadequate staff. The nurses named in the lawsuit were all recent arrivals from the Philippines and if they wanted to stop working during the first year of employment they would have to pay $25,000 to the employer which provision constituted a threat of financial harm to the nurses. It is not known if the State of New York regulators sanctioned the operators for unsafe and insufficient staffing of their facilities as evidenced in this case.

President's Message

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All last year, **FATE** fought the fight in order to bring about better oversight. It is a continual struggle going up against the system especially when government employees do not seem to be held responsible for not citing facilities that harm our most frail and helpless members of society who have worked hard, paid their taxes and now need to be protected. Billions of our tax dollars are going into the long-term care industry with little to no accountability of how our elders are being treated. The dollars going for care seem to end up in the pockets of the operators of the facilities who are more concerned about bottom line profits than patients. In over 30 years of advocacy, I have never known or met a poor nursing home operator.

FATE also continues to be a stakeholder with the California Department of Public Health and attending many meetings in regards to the department's functions as regulators. Most of the time, these meetings are frustrating because it is obvious that the nursing home industry lobby group wields power over the state and the department genuflects to them instead of serving the consumers by enforcing the laws put in place to protect us.

We also are continuing our efforts with Deborah Dahmer in Florida to repeal the 2001 law regarding punitive damage awards against nursing homes. The Florida regulation states…"if punitive damages are awarded in a civil case against a nursing home, 50% of the award is to be paid to the State of Florida." This same regulation is also on the books in 11 other states. In Oregon, the amount of the punitive damage award to the state is 80%. **FATE**'s position on this matter is that it appears unconstitutional for the states to take part of a civil award to the family of the victim of abuse when the state regulators should have prevented the abuse in the first place.

The continual growth of the hospice industry is also a great concern of **FATE**. We have had many calls about this industry and have filed numerous complaints with state regulators about the poor care and over-drugging of hospice patients. Years ago when hospice care first started, it was meant to provide care for patients who had 6 months to live. That no longer is the case as we are seeing patients who have been on hospice for years. MediCare pays for hospice care so it appears this Medicare service is being used to provide more money and extra care when it is not necessary. Again, Medicare should be overseeing charges being billed for hospice care that may not be warranted.

FATE is committed to continuing to assist families at no charge in order to bring about better care no matter how long it takes. FATE does not accept government funding, which enables us to act immediately when abuses occur without the fear of losing funding by the government. We know of no other organization in the country doing this work that is not funded by the government. For us to continue our work, we need the financial support of the public. Considering a donation will be greatly appreciated.

Special thanks to the **FATE** staff…. Eileen Dancause, Jane DeSoiza, Nancy Haycock, Harris Herman, Christopher Huskey and Jacob Vargas…. for their continued hard work and dedication this past year in support of the **FATE** mission.

NURSING HOMES LACK STAFFING

Based on research from Harvard and Vanderbilt Medical Schools, 75% of nursing homes in the country never meet federal staffing expectations for registered nurses and registered nurses often are missing from facilities on weekends and holidays. Researchers wrote that adverse events such as falls and medication errors might be more likely to occur during understaffed days. **FATE** has always maintained the position that insufficient staffing is automatic neglect. Without stronger enforcement to meet staffing needs, our most vulnerable citizens will continue to not receive proper care.

"Courage is what it takes to stand up and speak; courage is also what it takes to sit down and listen."
— Winston Churchill

FLORIDA STOPS ADMISSION AT ASSISTED LIVING FACILITY

In September of 2019, the Florida Agency for Health Care Administration suspended admissions at Living Well at Courtyard Plaza, a 120-bed assisted living facility located in Miami after determining that the facility operators had repeatedly overlooked the regulatory mechanisms designed to keep residents safe from harm. A 16-page report showed how Living Well employees neglected to seek medical attention for a resident who fell and suffered swelling and bruising, bleeding from the mouth with broken bones in the face. With warning signs days before the fall, staff became aware that the resident's condition was changing rapidly and appeared weak, dizzy, disoriented with impaired breathing. Even with all these warning signs, the caregivers neglected to initiate any precautionary interventions to prevent injury to the resident. The regulators also found that Living Well compounded these failures by neglecting to undertake any post-event action to assess the performance of its staff to prevent similar occurrences and by failing to submit statutorily mandated adverse incident reports to state officials. It was determined that Living Well's negligence constituted an "immediate" threat to the public's welfare and any lesser enforcement action would not ensure current and future residents would be provided safe and appropriate health care services.

ARKANSAS NURSING HOMES SUE OVER FEDERAL ARBITRATION RULE

Two Arkansas nursing facilities are asking a federal court to declare a rule that prohibits long-term care facilities from requiring residents to sign a binding arbitration agreement as a requirement for being admitted or to continue receiving care as unlawful. The suit was filed in September against the Centers for Medicare & Medicaid Services (CMS) and Department of Health and Human Services (HHS) by Northport Health Services and NWA Nursing Center in the Western District of Arkansas. Both companies are based in Springdale, AR, and operate 140-bed skilled nursing facilities. The operators claim that the amended arbitration rule is in violation of the Federal Arbitration Act (FAA) and that neither CMS or HHS has the "statutory authority" under the Medicare & Medicaid acts to regulate alternate dispute resolutions. Providers and the federal government have previously clashed over binding arbitration agreements. In 2016, under the Obama administration, a CMS rule banned binding pre-dispute arbitration agreements in LTC facilities. The rule was prohibited from being enforced by a federal court after a complaint filed by the American Health Care Association (the industries lobby group) and other nursing groups. In 2017, under the Trump administration, the agency proposed a rule that would remove the ban. Under the 2019 rule, a LTC facility must comply with certain criteria, including not requiring a resident or the resident's representative to sign an agreement for binding arbitration as a condition of admission to receive care at a facility and to grant a resident a 30 calendar day period during which they may rescind their agreement to arbitrate.

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.

CALIFORNIA REGULATORS REVOKE WAIVERS NOT TO CALL 9-1-1

The California Department of Social Services, Community Care Licensing Division, in the interest of promoting a uniform and consistent statewide policy on the use of emergency medical services within residential care facilities for the elderly, revoked the waiver program for facilities to bypass calling 9-1-1 in case of a health issue with residents. Effective July 1, 2019, all facilities that were under this waiver allowing them to use private ambulance services and not to call 9-1-1 was revoked. The facilities are expected to comply with the requirement to immediately dial 9-1-1 if an injury or other circumstance has resulted in an imminent threat to a resident's health, including, but not limited to, an apparent life-threatening medical crisis. **FATE** became aware of this unusual waiver when notified by a client's attorney that there were signs outside the door of a resident in the assisted living facility to not call 9-1-1 but to call a local private ambulance service in case of an emergency. As well, the local fire department had for some time been concerned about this waiver as it was fire official's opinion that the private ambulance service could not speedily answer an emergency call as could the fire department. Officials with Community Care Licensing stated that this waiver had been issued to approximately 50 facilities in Northern California only. The California Legislature introduced a bill intended to affirm and clarify a public agency's duty and authority to develop emergency communication procedures and respond quickly to a person seeking emergency services through the 9-1-1 emergency telephone system. Consumers are encouraged to call **FATE** if a similar situation exists in the facility where a loved one is residing.

"Never believe that a few caring people can't change the world. For, indeed, that's all who ever have."
— Margaret Mead

TROUBLING PICTURE OF AMERICA'S HOSPICE SYSTEM

In July of 2019, the U. S. Department of Health and Human Services Office of the Inspector General (OIG) released a pair of startling reports which paints a troubling picture of America's hospice system that is riddled with serious deficiencies in some cases and a lack of action from the federal government to remedy the problems. According to the report, 87% of hospices that were surveyed over a five-year period had deficiencies, which means that they failed to meet one or more Medicare (CMS) requirements to provide adequate care. And, most of the hospices with a deficiency had multiple deficiencies. One of the problems identified in the report was a lack of accountability. None of the hospices associated with the cases in the report faced any serious consequences from CMS for causing harm. According to the reports, the top four poor-performing states are California, Missouri, South Carolina and Texas. The OIG listed a series of recommendations for CMS to adopt to improve its quality of care including making all of its deficiency and complaint data available to the public, increasing oversight of hospices with a history of serious deficiencies and strengthening requirements for hospices to report abuse, neglect and other harm. Per Nancy Harrison, the Deputy Regional Inspector General, there are a lot of great hospices with highly skilled professionals who are dedicated to helping people leave this life with comfort and dignity and the public should know about them. As well, consumers should have access to information regarding hospices in order to ensure quality care and the protection and safety of their loved ones who are on hospice.

HEALTHCARE SURROGATES CAN'T AGREE TO ARBITRATION IN FLORIDA

The Fourth District Court of Appeal in Florida ruled this year that standing as a health surrogate doesn't allow appointees to enter nursing home arbitration agreements or other business agreements with providers. The decision was the result of a case surrounding a former nursing home patient at Manor Oaks Nursing and Rehabilitation. The Ft. Lauderdale nursing home argued that the patient had appointed his son and a friend as healthcare surrogates. His son, acting as a healthcare power of attorney, signed an arbitration agreement at the time of admission. The six-page ruling by the Court determined that a lawsuit filed by the son after the death of his father in 2017 could proceed to trial because healthcare appointees do not have the power to make non-health-related decisions. Judge Robert Gross wrote "The heart of this case is whether a document that designates a healthcare surrogate is broad enough to allow that surrogate to consent to an arbitration provision in a nursing home admission form and the court holds that the narrow focus of the document is on the surrogates'power to make healthcare decision, not business choices concerning dispute resolution." **FATE** has always recommended to families who contact our office to not sign arbitration agreements that deny one's right to a trial by jury.

MICHIGAN ATTORNEY GENERAL NESSEL CREATES ELDER ABUSE TASK FORCE

More than 73,000 older adults in Michigan are victims of elder abuse according to Attorney General Dana Nessel who recently established a task force to look into the financial exploitation, emotional abuse and neglect of the state's senior population. Nessel said that the symptoms and treatment of abuse against our most vulnerable population are complex and demand a concerted effort to tackle what is an often unrecognized and unreported social problem. Also involved will be Michigan Supreme Court Justices Richard Bernstein and Megan Cavanagh, Midland County Prosecutor J. Dee Brooks, Michigan Rep. Brian Elder and Michigan State Senator Paul Wojno. Also joining will be 30 organizations, including law enforcement, state agencies, the state House and Senate and advocacy group. The task force will seek to require professional guardians to become certified with limited number of wards per guardian. In 2000, the Michigan Legislature passed reforms of the probate code; however, there is more work to do to protect vulnerable adults subject to guardianships and conservatorships. Back in 2013, **FATE** worked with the LA Times to expose guardianship abuse in California which resulted in California establishing the California Fiduciary Board, which was the first oversight of guardians/conservators in the Country.

"As you grow older, you will discover that you have two hands, one for helping yourself, the other for helping others"
—Audrey Hepburn

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 (g)(2)(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 or 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.

How to Appeal a Discharge

The patient or his/her legal representative has the right to appeal a discharge from an acute hospital or a skilled nursing facility. Once the patient has been discharged and the patient or his/her legal representative does not think the patient is well enough to be discharged, an appeal to MediCare may be made. There are five levels of appeals as follows:

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.

"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

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:

ALEXANDRIA CARE CENTER, Los Angeles, CA…Class B Citation with a $2,000 penalty and Deficiencies…facility failed to ensure that the patient received care consistent with professional standards of practice to prevent pressure ulcers (bed sores) and patient with pressure ulcers receives necessary treatment and services to prevent infection and prevent new ulcers from developing; failure to ensure patient received care to promote healing of a Stage II pressure ulcer and prevent the development of two new pressure ulcers; failure to implement the plan of care for wound treatment and failure to ensure patient's calorie count of food consumed was monitored.

APPLEWOOD POST ACUTE, Sacramento, CA…Deficiencies…failure to document informed consent for an antipsychotic medication. This failure had the potential to place the patient at risk for side effects of antipsychotic medication usage; failure to obtain prior approval from the Department of Public Health for the purpose of offsite storage of medical records. FATE filed an appeal as the State did not cite the facility for bed sores, lost dentures, malnutrition, failure to provide copies of the medical records according to Federal Regulations and failure to notify the physician of a change of condition. Still waiting for the results of the appeal held in November of 2018.

BLOSSOM VALLEY INN…Holtville, CA… three Class A Citations and one Class B Citation with an Enhanced Civil Penalty of $10,000.00…facility failed to access resident's needs comprehensively, provide safety and update the care plan after resident's first fall to prevent further falls and injuries; facility failed to provide the appropriate assistance when facility staff observed changes in resident's condition; resident was a high risk for falls and facility staff knowingly failed to provide the proper care, supervision and/or services to meet the resident's needs; facility failed to provide 1-person assistance with resident transfers as stated in the admission agreement and appraisal. All of these violations posed an immediate health and safety risk to resident's care.

BROOKDALE SANTA MONICA…Santa Monica, CA…two Class B Citations… facility failed to ensure a written report of the resident's eviction notices were submitted to the California Department of Social Services, Community Care Licensing Division, which is a potential health and safety risk to residents; facility failed to ensure the terms and conditions of the Admission Agreement were complied with by failing to notify the responsible party of a consent form the facility had the resident, who is not competent, sign giving a third-party production company permission to use the resident's image, voice, photograh, etc. for promotional purposes of the facility.

BURBANK HEATHCARE & REHABILITATION…Burbank, CA… Federal Deficiencies…the facility failed to ensure that patient who was assessed as risk to develop pressure ulcers and had no skin breakdown prior to entering the facility was provided with a pressure relieving device to prevent skin breakdown; facility failed to assess skin condition accurately; facility failed to address facility's pressure ulcer management policy and procedures to prevent pressure ulcers which the patient was at a high risk to develop.

CARESTAT IN-HOME PROVIDER SERVICES…Alice, Texas…Federal Deficiencies…the supervising nurse failed to ensure the plan of care was followed for a Foley catheter and failed to document a catheter change when due, which placed the client receiving in-home care at risk of receiving inadequate care which may have contributed to the client's health deterioration and eventual death.

CUPERTINO HEALTHCARE & WELLNESS CENTER…Cupertino, CA… Federal Deficiencies…facility failed to ensure patients received restorative nursing exercises per physician orders. This failure had the potential to decrease patient's range of motion and increase contractures of the joints and muscles; failure to ensure the social service designee followed-up with the patients and responsible party regarding the continuation of podiatry services in a timely manner. This failure had the potential to result in the delayed provision of patient's podiatry needs and may have resulted in developing foot problems. This complaint was filed by a **FATE** client.

MARYSVILLE POST-ACUTE, Marysville, CA…Federal Deficiencies…the facility failed to ensure the physician was notified timely of all pertinent information related to pain management; failure to revise the care plan for the patient when there were changes in the resident's status and condition; failure to ensure the patient was provided with pain management consistent with patient's diagnosis of carcinoma (cancer). These failures had the potential to result in undermanaged and inadequate pain control for the patient. It took the CA Department of Public Health almost three years to investigate this complaint and to reinvestigate after FATE filed an appeal of the original findings.

MEADOW OAKS OF ROSEVILLE, Roseville, CA…Enhanced Civil Penalty $15,000.00…facility failed to provide adequate care and supervision to the resident during a heat storm on June 30, 2018 ensuring that resident avoided exposure to the sun and heat. The facility was originally fined $2,000 in 2018 when the resident was found unresponsive outside on the memory care patio by facility staff. He had been placed outside in the heat and forgotten by the staff. Upon arrival at the hospital, resident was dehydrated and had multiple areas of sunburn and redness on his body. The death certificate lists cause of death to be from the resident's extreme exposure to heat. The additional penalty of $15,000 is the highest level fine to be levied by the California Department of Scial Services, Community Care Licensing for a resident's death.

MISSION HILLS HEALTH CARE, INC., San Diego, CA…Deficiencies…facility failed to immediately inform the patient, consult with the patient's physician, or notify the patient's responsible party of a change of patient's condition; failure to notify the family that the patient had a fall, which required physician intervention, and the family did not have the opportunity to participate in the medical decision making process; failure to keep accurate medical records; failure to keep records confidential; failure to safeguard medical record information against loss, destruction, or unauthorized use; failure to ensure accurate clinical record documentation when staff documented patient received range of motion and a

Long-Term Care Facility Complaints

Continued from page 8

shower when patient was no longer in the facility; failure to ensure the tracking of skin rashes as part of the infection control surveillance program and as a results, there was the potential for unidentified outbreaks of scabies in the facility.

ORCHARD POST ACUTE, Vacaville, CA…Deficiency…facility failed to treat and care for patient according to professional standards by not administering an antibiotic medication according to physician orders. Four doses of the medication were not given to the patient, which placed him at risk. Original complaint was filed by the patient's family. FATE took over and filed additional allegations of malnutrition, bed sores, bowel impaction, lack of oral care and stolen personal property, which the Department of Public Health unsubstantiated. FATE is now in the appeal process to have the complaint re-investigated.

SKYLARK MEMORY CARE, Ashland, OR…civil penalty $2,500.00…facility failed to provide a safe environment by not implementing interventions and appropriate care plans relating to alleged patients behaviors. The facility was informed that patient displayed inappropriate sexualized behavior prior to and shortly after moving into the facility. Patient was not being monitored according to the care plan and no other measures were taken to ensure the safety of opposite sex residents. The failure resulted in inappropriate sexual contact with approximately 5 residents. The facility's failures are a violation of residents rights are considered negligent care and constitutes abuse. **FATE** filed a complaint; however, it had already been investigated by the State of Oregon.

STOCK RANCH ROAD RETIREMEN, Citrus Heights, CA…three Class A citations…failure to submit a written report to the CA Dept. of Social Services within seven (7) days of a death; facility omitted information from the report which constituted conduct inimical on the part of the licensee; failure to observe patient for at least 24 hours, which posed an immediate risk to the resident, as resident was found dead by an outside caregiver. The coroner determined that the resident bled out from an injury and had been dead for at least two days. The staff at the facility failed to check on the resident even though two newspapers were in front of the door and the resident had no meals for two days. FATE has filed an appeal as it is believed that an additional fine is warranted due to the death.

STOLLWOOD CONVALESCENT HOSPITAL…Woodland, CA…facility failed to ensure a care plan was developed in a timely manner to include interventions derived from the risk factors and patient's clinical condition to prevent development of pressure ulcers. This failure resulted in the patient developing a stage 3 pressure ulcer to the coccyx; failure to receive care to prevent the development of an avoidable pressure ulcer when assessments were incomplete and preventative measures were not identified and implemented upon admission and failure to ensure the clinical record was complete and accurate when the physician did not document pressure ulcer assessment, the weekly summary was incomplete, pain was inaccurately documented and the skin monitoring sheets were incomplete. These failures had the potential to results in the provision of inaccurate care. FATE took over this complaint that was originally filed by the family and has petitioned the department for the appeal process.

THE PINES AT PLACERVILLE HEATHCARE CENTER…Placerville, CA.. Deficiencies…facility failed to ensure a resident's health records were maintained when the inventory of belongings was not signed by a representative of the facility or the patient on admission and discharge to prevent the theft or loss of personal belongings.

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TOLUCA LAKE MANOR SENIOR ASSISTED LVIING, Sherman Oaks, CA… Deficiency…facility failed to ensure that the premises were kept clean, safe, sanitary and in good repair at all times and free of pest infestation. There were bed bugs in resident's rooms and cockroaches in the kitchen. This posed a potential health and safety risks to the residents.
Deficiency…facility failed to allow authorized representative access to resident records within the federal time limit and also failed to give all the records to the responsible party;
Class A Citation…two staff members working in the facility without criminal record clearance and/or association to the facility. This posed an immediate health and safety risk and personal rights risk to the residents in the care home.
(2) Class B Citations…facility failed to ensure staffing is sufficient at all times as private companions were completing basic services for resident, which posed a potential health and safety risk to resident in care; facility failed to provide all basic services such as laundering, grooming and dressing, which was being provided by a private companion. This posed a potential health and safety risk to resident in care.

TOLUCA LAKE MANOR SENIOR ASSISTED LIVINGS, Sherman Oaks, CA…Class B Citation…facility failed to assure that the living accommodation and grounds were used as related to the facility's function. An adult individual, assisting residents, was sleeping in the living room on a sofa. This posed a potential health and safety risk to the residents care. All other allegations of residents suffering from dehydration, failures to repositioning residents to prevent pressure injuries, residents being restricted to their rooms, staff failing to follow doctor's orders, staff eating resident's food were all unsubstantiated.

VILLAGE AT HERITAGE PARK, Sacramento, CA…Two Class A Citations and One Class B Citation…the A citations were failure to provide care by failing to call 9-1-1 after resident fell sustaining a fracture to her leg and foot and failure to ensure that residents are regularly observed for changes in physical, mental, emotional and social functioning as she stated she had pain after the fall. The B citation was issued for the facility's failure to provide a copy of the incident report to the responsible party, which posed a potential health and safety risk. **FATE** took over and filed additional allegations as the resident died due to the injuries and an additional citation should be issued with an enhanced civil penalty. Results of **FATE** complaint below..

VILLAGE AT HERITAGE PARK, Sacramento, CA…Two class A Citations…$1,000.00 penalty assessment…the facility failed to ensure that appropriate assistance was provided to the resident after physical changes were noted until resident requested to be sent to the hospital and was hospitalized in the intensive care unit for profound hypernatremia, which posed an immediate health and safety risk to the resident; faciltiy failed to ensure that physician orders were on file for all medications, including blood sugar checks since resident was diabetic, prior to resident moving in, which posed an immediate health and safety risk to the resident. The regulators are also reviewing this complaint for a possible enhanced remedy fine due to the resident's death.

WINDSOR GARDENS HEALTHCARE OF THE VALLEY, North Hollywood, CA…

Long-Term Care Facility Complaints

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Deficiencies…failure to administer wound care treatment as ordered by the physician. This deficient practice placed patient at risk for worsening of pressure ulcers; failure to ensure that the patient was provided with pressure relieving devices, which placed patient at risk for worsening pressure sores.

WINDSOR HAMPTON CARE CENTER, Stockton, CA…Deficiencies…failure to develop a patient centered baseline care plan that did not include information pertinent to the patient's care; failure to complete a care plan within 48 hours of placement; failure to have a care plan with interventions to address prevention and treatment of constipation, which failures placed patient at potential risk of abdominal discomfort and a decrease in appetite; failure to recognize and address fluid needs of the patient as possible dehydration were not identified and patient's bowel status was not assessed accurately; failure to care plan for fluid needs and prevention of dehydration despite identified risk factors, which had the potential to result in a decline in health from dehydration; failure to ensure adequate supervision of patient care when the director of nursing served as a charge nurse in the absence of a registered nurse, which placed patients at risk for inadequate oversight and supervision of the delivery of care; failure to ensure patient received fluid that accommodated listed allergies when resident received a juice the patient was allergic to; failure to develop a patient centered baseline care plan when such failure had the potential to result in poor care and failure to treat constipation, which placed the patient at risk of abdominal discomfort and a decrease in appetite; failure to recognize and address fluid needs of the patient, which had the potential to result in a decline in health from dehydration and failure to ensure adequate supervision of patient care when the director of nursing served as a charge nurse in the absence of a register nurse.

WOODSIDE HEALTHCARE CENTER, Sacramento, CA…Deficiencies... facility failed to initiate a care plan after patient developed a bed sore; facility failed to administer a pain medication to patient as ordered by the physician. **FATE** filed an appeal on this complaint as not all of the allegations were investigated.

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