FATE

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Newsletter of Foundation Aiding The Elderly

President's Message 2024

A BROKEN SYSTEM

By Carole Herman

Carole Herman

Serving our most vulnerable citizens and their families has been an honor, rewarding in some cases, but frustrating most of the time. Forming **FATE** over 40 years ago, I had no idea of the difficulties working within the walls of government agencies as my career prior to being an advocate was in the business world. Prior to forming **FATE**, I was in the software industry when most people thought software was underwear. Unfortunately, I experienced the good, bad and ugly of Corporate America. I never imagined that I would have similar experiences, and in many cases, worse experiences, working within government systems.

Our clients, now over 9,500 nationally, reach out to **FATE** for help when they or their family members experience abuse, poor care and neglect in long-term care facilities or other health care settings and they can find no one to help them. They also reach out to **FATE** when they feel the complaint they filed with the appropriate agency on the abuse of their loved one did not get properly investigated or in some cases, not investigated at all. What are these agencies that are in place to protect the consumers doing? One of the problems is that since COVID, most government employees are still not physically back in their office and continue to work from home under no supervision.

Earlier in the year, **FATE** had a call from a new client in Tennessee who struggled for months to get answers from the state agency where she had filed a complaint regarding the abuse of her father. **FATE** attempted to contact the state agency to follow up on the complaint. After numerous calls to the appropriate office with no one answering the phone, I found out that Tennessee employees were still working from home. I personally sent a message to Bill Lee, the Governor of Tennessee, and within a day, I received a call from the Governor's Office that someone from the office where the complaint was filed would call me. It should never have been necessary for me to have called the Governor's Office to get an answer to a complaint of abuse. And, this is not just happening in Tennessee either.

Another alarming matter is that the Ombudsman Program is also a broken system. This nationwide program began as a vehicle for consumers who are experiencing problems in nursing homes to get proper care for their loved ones. **FATE** continues to receive complaints about the program in almost every state. One case in particular, **FATE** attempted to reach out to an ombudsman in California to ask for assistance regarding an abusive situation in a nursing home. However, after 18 phone calls made with no call back, **FATE** attempted to reach out to the Head of the California Program and again, no call back. Taxpayers are paying the exorbitant costs of this program expecting to get answers and actions to stop any abuse of our most vulnerable citizens.

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

President's Message

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Over the past forty years, **FATE** participated in three studies by the New England Institute of Medicine on the effectiveness of the Ombudsman Program. The studies all resulted in scathing reports that the system is a failure; however, the failures continue. Why is that?

This past year, **FATE** also received an alarming number of complaints regarding conservatorships, both with private fiduciaries and public guardians. It is our belief that conservatorship abuse is worse than nursing home abuse as it involves the courts. Decisions on peoples' lives take place with a mere slam of the Judge's gavel. **FATE**'s experience with hundreds of clients has shown that even if one has a trust and/or will, the court system can overturn your wishes and appoint some third party that doesn't even know the person being conserved, to handle all that person's money and make all their health- care decisions as well. The power of the probate courts has been under scrutiny for years, but nothing seems to have changed as we still get complaints of horrific abuse of power by those that the courts are appointing to care for vulnerable people. And, the courts are very powerful and extremely difficult to challenge.

I continue to be a part of a monthly advocates' meeting with the CA Department of Public Health, Licensing and Certification Division, along with other advocates and members of the Ombudsman Program. Many years ago, I also was a participant in a similar group that included members of the nursing home industry. We would bring up problems that we all experienced that needed to be addressed by the Department of Public Health to ensure the health and safety of long-term care patients. Long ago, this group somehow stopped having monthly meetings. The meetings were resurrected about a year and a half ago. The difference between the meetings years ago and the meetings now is that participants must submit questions to the Department in advance of the meeting and the department's legal counsel is now in attendance. If time permits, additional matters not on the agenda may be addressed; however, most often than not, the one-hour meeting does not allow for questions that have not been previously submitted to the department.

I want to thank the **FATE** staff — Jane, Eileen and Harris — for their continued hard work and dedication to our worthy cause. Although we are a small staff, we carry a big stick and we work very hard to ensure that the rights of the people are not being violated. A very special thank you to all of our donors as we could not do this much-needed work without their continued financial support.

Sometimes our work is very frustrating due to government red tape and the lack of accountability on the part of those who do not provide good care and are abusing our most vulnerable citizens. However, no matter how difficult, FATE will continue our advocacy to make a difference.

FATE'S MISSION

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

SERVICES FATE PROVIDES

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

FATE'S GOALS

- Protect the elderly in their remaining years.
- Enhance national awareness of abuse in elderly care institutions.
- Initiate action to improve care.
- Report violations, malpractice and criminal actions to appropriate federal and state authorities.
- Follow-up to see that corrections and redress occur.
- Educate the public of their rights.

CALIFORNIA DEPUTY DIRECTOR JUMPS SHIP

The Deputy Director of California's Department of Public Health, Licensing and Certification Division, the agency that is to protect nursing home patients and make sure the industry is abiding by all regulations, has jumped ship and now is the CEO of the California Association of Healthcare Facilities (CAHF), the nursing home industry lobby group.

FATE was shocked to hear this news. However, this explains a lot when one reviews that lack of deficiencies or citations issued to the nursing home industry for poor care and abuse under her watch.

We consumers depend on this agency and all other agencies in the country to hold this industry accountable for violations of both federal and state nursing-home regulations and most importantly, harming our most vulnerable citizens. This is not the first state employee to go to work for the nursing home industry; however, it is the first we know of a head of the agency leaving to work for the industry they were responsible for monitoring.

JUSTICE MATTERS

This year, **FATE** participated in hearings in front of the California Senate Judiciary Committee pertaining to increase protection of the rights of consumers who are conserved through the Courts in California.

Action to give family members the right to know about their loved ones who have been conserved began with Kerri Kasem, the daughter of Casey Kasem, the famous radio personality, who was conserved by his second wife who was denying his family information on his health and where he was living. After he died in the State of Washinton, his wife had his body sent to Norway against his known wishes to be buried at Forest Lawn Cemetery in California.

After a long battle, Kerri found out from a resident of Norway where her father was buried, and she was able to travel to Norway to place a proper marker on his grave. This took place after giving testimony in front of the Senate Judiciary Committee. The Senate Judiciary Committee voted unanimously in favor of the proposed legislation and the Bill continues to find its way unchallenged through the maze of the California Legislature. Hopefully, this legislation will pass and become law sometime in 2025.

Judges allowed one of New York's most prolific guardians to engage in apparent self-dealing as she transferred $1.5 million of her wards' money to her own company.

A Judge in California for years allowed another private conservator to use her husband's in-home care company to care for her charges when the California Probate Code clearly states that a private conservator may not benefit financially by using services from companies that they own. This private conservator stated the in-home care company was owned by her husband and not her. However, as his wife, she owns the care company as California is a community property state. Her actions warranted her removal or at least a sanction. After numerous complaints filed with the California Fiduciary Board about her behavior, she still has a license and is in control of many consumers and their estates.

Part of the problem is lax of oversight and delays in investigations. Advocates, researchers and even attorneys say that this laissez-faire judicial culture is the product of crushing caseloads, scanty resources and a shallow pool of guardians willing to take these cases.

Along with our client Debbie Dahmer, we will continue to battle the Florida law that allows the State of Florida to receive 50% of awards by juries for

punitive damages for nursing home abuse cases. **FATE** has worked with Ms. Dahmer for years to repeal this 2001 law and will continue to do so. It just does not seem logical, and even legal, that a state agency that failed to protect Debbie's father from abuse in a long-term Florida nursing home would benefit from the struggles that the Dahmer family had to endure during the long and emotionally trying court proceedings. We do not believe that justice was served in this case and that there are probably more of these cases out there that we are unaware of. We will continue to do our best to repeal this law.

DONATE TO OUR CAUSE

Again this year, problems in long-term care facilities, acute hospitals, assisted living facilities, and residential care homes were on-going and our work load continued to increase. Yet we stayed on our path to serve the most vulnerable and their families. We hope that you will consider donating to our most-worthy and much needed cause. **FATE** takes no government money and relies solely on the public for tax deductible donations. Our services are in great demand and we need your support to continue to serve. Make a donation by using the enclosed **FATE** envelope or go to **www.4fate.org** and donate via Pay Pal.
Your tax-deductible contribution will certainly be appreciated.

NURSING HOME PATIENTS ASSAULTED

Over this past year, **FATE** received quite a few complaints from family members of nursing home patients whose loved ones had been assaulted by other patients. Nursing home operators are responsible for not only the medical care of the patients, but also for protecting the patients from harm. Over the past decade, the make-up of the nursing home patient has changed drastically from just being elderly citizens (mostly women) to homeless people, drug addicts and in some cases, criminals, being admitted into nursing homes and rehabilitation centers. Under the Federal Regulations, nursing home operators must ensure that all patients are free from abuse and that they are protected from being victims of resident-to-resident assaults. In one case, **FATE** had the State of California inspect a CA nursing home for patient-on-patient abuse, which resulted in a 151-page report of problems in this facility, which included numerous patient-on-patient assaults. If you have a family member in a facility and an assault occurs, either report it to **FATE** and we will file an official complaint for you or you can go to **FATE's** web site at **www.4Ffate.org** under Consumer Information and look up the agency in your state and file a complaint yourself keeping in mind that you must continue to follow up with the reporting agency to make sure your complaint is properly investigated and in a timely manner.

"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

SUCCESS STORIES

FATE receives many calls for assistance that do not require an official complaint to be filed with state regulators. We helped many families during the year to resolve issues for them, several are listed below.

A disabled veteran was referred to **FATE** by the Veterans Administration for help with his wife who was on the verge of being sent to a facility by an acute hospital for a short stay prior to surgery for toe amputations. He was very concerned that this temporary move would cause further medical issues with his wife. After a meeting with the medical staff and the hospital's legal counsel, **FATE** was successful in having the acute hospital keep her as a patient until the surgery was performed.

A family member called **FATE** in a panic when the assisted living facility where her father was living wanted to evict him from his apartment and put him in the locked unit of the complex because he had attempted to leave the premises. The resident is a retired military man who was caged as a prisoner during Vietnam and was the first prisoner off the plane at Travis AFB after the war ended. **FATE** was outraged that an assisted living facility would even suggest that he be locked up in the facility like he was in Vietnam. It was an honor for **FATE** to advocate for this war hero, which resulted in him remaining in his own apartment.

A woman who lives in New York reached out to **FATE** to help her visit her bed-ridden daughter in a nursing home in Florida. The daughter had been paralyzed in an accident and had been placed under a conservatorship. For almost a year, the conservator had prevented this woman from visiting her daughter, which also violated the daughter's rights to visitors. **FATE** contacted the attorney for the court-appointed conservator and arrangements were made for the mother to go to Florida to finally see her daughter.

Many calls came in this year, too many to even count, from distressed consumers who were being told that their family members' insurance (mostly MediCare) was running out and they had to leave the hospital immediately. **FATE** intervened and appeals were filed through the MediCare Appeals process and most all potential discharges were stopped, and families were able to keep their loved ones in the hospital for continued treatment.

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:

ASBURY PARK NURSING & REHABILITATION CENTER, Sacramento, CA … Deficiencies … the facility failed to provide appropriate urinary catheter care when a referral to an urologist was not done as ordered for evaluation of neurogenic bladder due to neurological damage and urinary catheter removal which had the potential to result in bladder disfunction or infection; failure to ensure that proper nutritional status was maintained when documentation did not reflect that medical providers were notified of weight loss, which failure resulted in the patient experiencing significant weight loss which had the potential to cause nutritional deficiencies and impede recovery. **FATE** filed an appeal as all the allegations, such as septic shock, pressure ulcer and falls, were not addressed by the California regulators.

BRUCEVILLE TERRACE/SNF OF METHODIST HOSPITAL, Sacramento, CA … Federal Deficiencies … facility failed to follow policy and procedures to conduct an initial skin assessment upon admission, which had a potential for a deep issue pressure injury to not be identified upon admission causing a delay in intervention and treatment. **FATE** will appeal this deficiencies as other allegations were not addressed by the State.

CAREFIELD PLEASANTON, Pleasanton, CA … Class B Citation … the facility failed to safeguard resident's cash resources, personal property and valuables, which have been entrusted to the licensee or facility staff. This failure posed a potential health and safety risk to the persons in care. The complaint also alleged that the resident sustained an injury in care and suffered multiple falls resulting in injuries and the facility was not sufficiently staffed; however, all of these allegations were unsubstantiated and the consumer has no right to appeal the department's decision.

COLONY OF THOUSAND OAKS AT SIDLEE WEST, Thousand Oaks, CA … Deficiency … facility violated the personal rights of the resident by not allowing the family members to visit with resident privately. Resident is under conservatorship and there was no court documents to reflect restrictions on the family visitations.

CUMBERLAND HOUSE, Crossville, TN … (NOTE: The original complaint was filed by a FATE client and then FATE took over the process since the client was not getting any results from the State of TN. After months of FATE attempting to get the results of the complaint, the results were finally received; however, the form had many redactions, which was quite alarming as FATE has never received a finding with redactions.) The results were: facility was out of compliance with Chapter 0720-23, Standards for Residential Hospice. The noncompliance had the potential to place the residents of the facility in a situation which was detrimental to the safety and welfare of the patients; failure to document medications and quantities brought to the facility upon patient's admission; failure to update the plan of care after a change of condition and discontinued medications for patient; failure to document daily communications with patient's spouse; failure to notify family about discontinuing medications; facility not in substantial compliance with the Rules of the Health Facilities Commission Chapter 0720-23, Standards for Residential Hospices and the associated National Fire Protection Association 101 Life Safety Code; failure to maintain the overall environment in such a manner that the safety and well-being of the patients are assured; failure to monthly exercise the generator under load for the emergency power system; failure to conduct an annual drill for tornado and flood disasters and failure to provide documentation of an annual bomb threat drill.

FOOTHILL REGIONAL MEDICAL CENTER, Tustin, CA … Deficiencies … hospital failed to ensure the informed consent was obtained prior to performing the surgical procedure, which had the potential for the patient to not be fully informed of the risks and benefits prior to surgery; failure to ensure the nursing staff followed hospital Policy and Procedures for medication reconciliation, which failure put the patient at risk of not receiving the medications based on the most current information.

GOLDEN PAVILION HEATHCARE, Daly City, CA … Federal Deficiencies … facility failed to train and review the performance of three out of three Certified Nursing Assistants (CNA's) when employee files of all three lacked documentation of initial training as well as a performance review required by facility policy and procedure. This failure has the potential to result in untrained CNAs providing unsafe care that could cause harm to the patients. **FATE** appealed this decision as the original complaint included the facility staff breaking the patient's arm and the investigators did not address this allegation.

FOUNTAIN VIEW SUBACUTE AND NURSING CENTER, Los Angeles, CA … Federal Deficiencies … facility failed to implement their policy regarding investigating and reporting patient injuries and to submit a conclusion report within five days or in accordance with state or federal law, which could have led to a delay in prevention of further injury and potential abuse of patient; facility failed to provide the care and services necessary to prevent urinary tract infections by failing to ensure staff provided all the preventative measures in order to prevent UTIs, which deficient practice resulted in patient developing a UTI.

IRIS GUEST HOME, Orange, CA … B Citation … facility failed to follow physician's dietary orders as a medical necessity and served meals that did not contain the food groups ordered by the physician, which posed a potential health risk to the person in care. This complaint was originally filed by **FATE'S** client.

KENTFIELD HOSPITAL, Kentfield, CA … Deficiencies … the facility failed to provide patients with assistance with essential activities of daily living related to personal care such,as dressing, bathing and toiletting, when the patients were left in soiled briefs and were not repositioned for hours. This had the potential to result in the development of pressure ulcer (bed sores) and underlying tissue injuries resulting from prolonged pressure on the skin. Also caused shame and emotional distress to the patients. **FATE** wanted to appeal this decision as not being punitive; however, there are no appeal rights for acute hospitals.

KENTFIELD HOSPITAL, Kentfield, CA … Deficiency … The facility failed to provide the patient, who is paralyzed, scheduled daily sponge baths. This failure resulted in the patient to feel neglected and unclean which had the potential to negatively impact his physical and psychological wellbeing. **FATE** wanted to appeal this decision as all allegations were not dealt with; however, the facility is an acute hospital and there are no appeal rights for acute hospitals.

IRIS GUEST HOME, Orange, CA … Two (2) Class B Citations … facility failed to provide services to continue and promote, to the extent possible, independence and self-direction when needs and services did not provide actionable items to assist residents in any given category; facility failed to ensure that incontinent residents are kept clean and dry and that facility remains free of odors from incontinence. The facility was not meeting resident's needs and the facility is malodorous. These two violations posed a potential risk for the persons in care.

MANORCARE HEALTH SERVICES , Palm Desert, CA … Three (3) Federal Deficiencies … the facility failed to ensure skin evaluation was conducted on admission and failed to ensure monitoring and treatment for non-pressure skin injuries were provided; failure to prevent/heal pressure

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Long-Term Care Facility Complaints

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ulcer and failed to provide care and services in preventing development of pressure injuries (soft or skin tissue injuries that form due to prolonged pressure exerted over specific areas of the body); failure to ensure nutritional assessment were completed on admission and weights were not completed in accordance with the policy and procedure. These failures placed the patient at risk for compromised nutrition, a delay in necessary treatment and services, which had the potential to result in further decline of the patient's health status. **FATE** filed an appeal as not all allegations were investigated and based on the death of this patient, a State Class AA Citation with a penalty assessment was warranted but not issued by the state regulators.

MANORCARE HEALTH SERVICES, Palm Desert, CA … Class A Citation … Civil Penalty of $60,000.00 … This citation also relates to the three deficiencies listed above for the same patient. The citation was issued based on the facilities failure to conduct a skin evaluation in accordance with the policy and procedures for Skin Management; failure to develop interventions to address patient's risk for pressure injury on admission; failure to initiate treatments for the patient's pressure injury on the right and left heel, sacrococcygeal and right buttocks five (5) days after the pressure injuries were identified. These violations jointly, separately or in any combination, presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result. Since the death did occur, **FATE** appealed the Class A Citation as it should have resulted in a Class AA Citation with up to a $100,000.00 civil penalty.

MEADOWOOD HEALTH AND REHABILITATION CENTER, Stockton, CA … Federal Deficiencies … facility failed to ensure patient received treatment and care in accordance with professional standards of practice by not following physician's instructions for treatment of low blood sugar levels and failure to ensure medications ordered by the physician were acquired and administered in a timely manner. These failures resulted in patient missing six doses of medication which had the potential to negatively affect the patient's health. The original complaint was filed by a **FATE** client, which the state regulators unsubstantiated. **FATE** filed the appeal and another hearing was held and the state issued the above deficiencies as a result of the appeal.

NOVATO HEALTHCARE CENTER, Novato, CA …… Federal Deficiencies … facility failed to implement the interventions to reduce the risk of elopement (leaving the facility without knowledge of the staff) for one patient who left the facility undetected and was found by the local police department face down on the side of a road with scrapes and bruising on his body … This failure had the potential to result in serious injuries, including bruising, lacerations, head injury and broken bones. The facility also received a violation for failure to ensure one resident was discharged safely from the facility and was sent to a Board and Care home that was not licensed by the State of California, which is a requirement. **FATE** requested an appealed as the regulators did not address all the allegations in the original complaint, such as dehydration, over-medication, malnutrition, weight loss, injuries and insufficient staffing.

OXNARD MANOR HEALTHCARE CENTER … Oxnard, CA … Deficiencies … facility failed to keep air vents clean in four of sampled residents' rooms, This failure had the potential for airborne diseases to spread in the facility. NOTE: The CA Department of Health, Licensing and Certification Office in Oxnard failed to notify **FATE** of these findings for over 4 months.

PINE CREEK CARE CENTER, Roseville, CA … Federal Deficiencies … facility failed to ensure services provided by the facility met professional standards of practice when medications were not administered according to physician orders. The failure had the potential to result in patients suffering negative side effects of the missed and late doses such as worsening tremors, increased rigidity and pain.

PRESTIGE ASSISTED LIVING AT OROVILLE … Oroville, CA … Class B Citation … facility failed to ensure that residents were allowed to have a camera in their apartment, which is a personal rights violation to residents in care. This violation posed a potential risk to residents in care.

ROSEVILLE POINT HEALTH & WELLLNESS CENTER, Roseville, CA … Federal Deficiencies … facility failed to immediately notify the Nurses Practitioner and responsible party of an injury sustained by the patient from another patient who hit her in the face; failure to report an incident of abuse within the regulatory time frame; failure to ensure the safety of the patient injured and failure to provide care per professional standards. These failure decreased the facility's potential to provide nursing care, which encompassed nursing practices. **FATE** appealed the results as the allegations of over-medication, administering mind-altering medications without informed consent and under staffing were not addressed.

SALLY'S RESIDENTIAL CARE HOME … Camarillo, CA … Class B Citation … facility failed to comply with the CA Health and Safety Code section by directing resident's responsible party to pay a management company representing a potential buyer that had not been approved by the Department of Consumer Affairs, Community Care Licensing Division, which posed a potential personal rights risk to residents in care.

SUMMERSET LINCOLN ASSISTED LIVING & MEMORY CARE, Lincoln, CA … Two () Class A Citations, Two (2) B Citations … A) facility failed to meet requirements to prevent resident from having repeated falls and wandering and having a DX of seizures; failure to ensure injections were administered by an appropriately skilled professional as evidenced by allowing an employee who did not have a nursing license administer insulin injections; B) failure to ensure that incontinent residents are kept clean and dry and that the facility remains free of odors from incontinence; false or misleading statements regarding the facility or any of the services when the unlicensed staff member charted false information into the medication administration records. The above violations posed an indirect threat to the health and safety of residents in care.

THE HILLS POST ACUTE … Santa Ana, CA … Federal Deficiencies … the facility failed to ensure the call lights were answered promptly and failed to ensure call lights were in patient's reach; failure to maintain the comfortable temperatures in patient rooms. These failures had the potential for negative affects on the patient's health and well-being and the potential for the patients to not get their needs met. The **FATE** complaint was investigated along with numerous other complaints that resulted in a 116- page report of the problems in this facility.

THE REHABILITATION CENTER OF NORTH HILLS … North Hills, CA … Federal Deficiencies … the facility failed to ensure the peripheral intravenous catheter was implemented to provide safe care to prevent complications; the facility failed to ensure Registered Nurse (RC) administered medications as ordered by the physician and had the potential to result in a delay of necessary care and treatment and could lead to an adverse health outcome. (These findings were appealed and resulted in the issuance of additional deficiencies as listed below.)

THE REHABILITATION CENTER OF NORTH HILLS … North Hills, CA … Federal Deficiencies … the facility failed to provide care in a manner that maintained patients' dignity by failing to ensure the urinary drainage bag via a catheter was covered with a privacy bag. This deficient practice had the potential to negatively affect patients' psychosocial wellbeing and loss of dignity; failure to ensure staffing information of the actual hours worked by license and unlicensed nursing staff directly responsible for resident care per shift was posted daily as indicated in the facility's policy and procedure on nurse staffing information. This deficient practice had the potential to keep residents and visitors unaware of the total number of staff and the actual hours worked by the staff ; failure to implement infection control practices by failing to ensure urinary drainage bags were not touching the floor. This deficient practice had the potential for contamination of the urinary bag which may in turn cause an infection.

WALNUT CREEK SKILLED NURSING & REHABILITATION CENTER, Walnut Creek, CA … facility failed to provide three showers per week as ordered by the physician. This failure resulted in the patient's inability to exercise his rights in how he received care causing emotional distress. **FATE** filed for an Informal Conference as other alleges were not addressed, such as physical abuse, unfit meals, failure to administer pain medications, staff smoking marijuana on premises and insufficient staffing.

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IN MEMORY

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