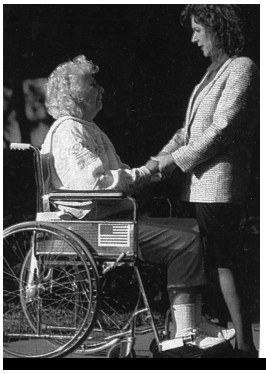

FATE

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Newsletter of Foundation Aiding The Elderly

President's Message

The Need for Advocacy Increases

by Carole Herman

With the current fiscal problems facing our country, more and more services to the public are being cut. Some of the most important services to be cut are in healthcare and services to the elderly. Since FATE's inception in 1982, our main goal has always been to protect our most vulnerable citizens…those in long-term care facilities. Since most citizens that are infirmed can not speak for themselves and far too many have no families to protect them, the need for advocacy has always been there and will undoubtedly increase over the next decade. About 20 to 30 percent of all Americans can expect during their lifetime to spend some time in a nursing home. Currently there are about 2 million people…mostly women…living in a long-term care facility with the number expected to grow dramatically as the population continues to age.

The thrust of social services in recent years has been to develop ways to keep the elderly out of nursing homes, through respite care, home health care, adult day care centers, assisted living facilities and residential care homes. Although many are now in these homes rather than nursing homes, nursing homes are still housing many people and government reports continue to cite alarming results of findings of abuse and poor care in these facilities. The primary responsibility of inspecting nursing homes to ensure the home is in compliance of federal/state regulations lies with the state licensing offices. These agencies are funded by the federal government and state government via our tax dollars. Also involved in this process is the Ombudsman Program, which is funded primarily by the Older American's Act with some monies coming from state and local government agencies.

Carole Herman

Given the current financial constraints and limitations shackling these government agencies, there emerges the need for stronger consumer protection through private organizations and advocacy groups. Some of these groups, like FATE, distribute newsletters about conditions in long-term care settings, respond to concerns of the resident's families and even file formal complaints with the regulators to bring about better care. All of us feel overwhelmed by the task and we share the dismay about the lack of improvements in spite of govern-

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Foundation Aiding the Elderly
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Warm Wishes for a Very Happy and Joyous Holiday Season with a Safe and Healthy New Year!

Foundation Aiding the Elderly
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Fates 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."

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- Patient & Family Rights Advice
- Elderly Service Referrals
- Long Term Care Facility Evaluation

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FATE Wins Staffing Lawsuit Against State of California

FATE brought a lawsuit against the State of California, Department of Public Health, for the department's failure to issue regulations setting minimum staff-to-patient ratios in California nursing homes. The state law required the department to issue regulations setting minimum staff-to-patient ratios in nursing homes by 2003; however, for over four years, the department failed to do so. Insufficient staffing has a direct link to poor care and neglect in nursing homes, which prompted FATE to file the lawsuit. The lawsuit sought a writ of mandate compelling the department and its personnel to comply with their statutory obligations to issue regulations regarding staff/patient rations in skilled nursing homes.

The Superior Court in San Francisco ruled in favor of FATE and ordered the department to immediately promulgate the staffing regulations. However, with the current fiscal problems in California, the department has yet to fund the regulations.

FATE was represented by attorneys Mark Todzo and Howard Hirsch of the Lexington Law Group in San Francisco, CA.

HHS Inspector General Releases Report

A report by the HHS Inspector General's Office has gotten a great deal of press attention because of its findings of how nursing homes in this country continue to provide poor and inadequate care. The report released in September of 2008 found that the percentage of nursing homes with deficiencies increased from 91.1% in 2005 to 91.9% in 2007. 94% of for-profit facilities were cited in 2007 compared with 88% of non-profits.

Despicable for an industry being paid billions of dollars to care for our most vulnerable citizens. Contact your Representatives and voice your concern about how are elderly are being treated.

For the entire report, you can access the OIG website, Trends in Nursing Home Deficiencies and Complaints. (OEI-02-08-00140)
http://intranet/oiginternet/oei/reports/oei-02-08-00140.pdf.

Advocacy

- *Cont. from page 1*

ment attempts for reform.

Since FATE is on the internet, we are contacted daily from people all over the country seeking help and getting answers to their question. We answer a wide variety of questions and have helped many families resolve issues. Some of the questions we have been able to answer and the state where the person calling us lives are:

TN.....*How do I file a complaint? My mother is being treated like a prisoner in the nursing home and she is not getting better.*

OK.....*How do I get the nursing home to provide care to my mother that they are getting paid to do?*

UT....*We are seeking help for nursing home patients to receive better oral care. Can you help us?*

MA....*My father is not getting the care he needs. Staff treat him very disrespectful. Lots of things being done and given to him without my consent. Please help.*

NJ.....*Hospital wants to send my father to a nursing home too far from the family. The hospital discharge planner says it is the only nursing home with an available bed. Can the hospital just send him there when we do not approve?*

SC.....*My mother is in a nursing home and the staff is verbally abusive to her. Can you help?*

NY.....*I am the power of attorney for my mother. I've asked the charge nurse many times to call me for approval for any changes to my mother's care. I am never called. What do I do?*

CA...*my grandmother was severely injured in a nursing home. She was also overmedicated and in a stupor. When we complained, the facility restricted our visits. Can they do this?*

PA.... *my father is in an assisted living facility…They said they could care for him; however, he has been admitted to an acute hospital 5 times in two months and lost 25% of his body weight. We are bringing him home. What are his rights and what should we do about this?*

These questions should have been easily answered by the agencies that license long-term care facility; however, people are contacting FATE because they are frustrated with not getting help from these agencies. With more and more government spending cuts and staff reductions in the government regulator offices in the health care arena, the need for advocacy has never been so great. Thus, the importance of advocating for your loved ones and turning to private organization, such as FATE, for help has never been so great.

Mandatory Reporting of Elder Abuse

Elder abuse is a serious problem that often goes undetected. According to a study published in the American Journal of Public Health, elder abuse is not only underreported, it is also treated inconsistently throughout the nation.

State laws related to elder abuse often cover who is protected, who must report elder abuse, how elder abuse is defined, investigation requirements and penalties.

Under the California Welfare and Institution Code 15630(b)(1); 15630(b)(1)(A) mandatory reporters must report known or suspected abuse to the state ombudsman program office or local law enforcement either by phone immediately, or as soon as possible, after suspicion of abuse. Abuse is defined as physical abuse, including physical and sexual assault, physical and chemical restraints and deprivation of food and water; psychological abuse; including verbal threats and harassment, emotional distress and confinement; financial abuse, including theft, embezzlement, fraud, extortion and coercion; Neglect, including withholding of basic daily living necessities and medical care, failure to protect one from health and safety hazards and abandonment.

A mandatory reporter in California is any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency. Any person who fails to make a required report shall be guilty of a misdemeanor, punishable by not more than six months in the county jail, by a fine of not more than $1,000, or both.

For mandated reporting in other states, contact the National Center for Elder Abuse on their web site at ncea.aoa.gov and proceed to the page on elder abuse help lines in your state.

The only thing necessary for the triumph of evil is for good men to do nothing…

Edmund Burke, Irish Politician and Writer

Surveillance Cameras in Nursing Homes

By Violette King

Interest in surveillance cameras is not dead. State licensing agencies, AARP, Service Employees International Union and the Federal Ombudsman Program once opposed to cameras have come around to accepting that this may be the only way to protect nursing home patients from poor care and abuse by monitoring what care is not given.

NY Attorney General Andrew Cuomo is now leading the Nation in using hidden surveillance to protect patients and to prosecute owners and/or employees.

Cuomo has stated..."hidden camera surveillance has revealed despicable cases of callous treatment and my office is watching like a hawk". In the last three years, twenty-six NY nursing home employees and licensed staff have been convicted based on hidden video cameras. The method is inexpensive, dependable, efficient and a state-of-the-art life saver.

Clearing the tragic mess of nursing home abuse has proven to be an impossible task for the states, the federal government, police, families, advocates and our society in general. The abuse and neglect that is American's shame continues due to the wealth and power of the nursing home industry and the massive number of politicians lacking in integrity.

Having tried every available avenue to hold facilities accountable, Nursing Home Monitors (NHM) began an effort years ago for legislation to give residents and their families the right to use surveillance cameras in their rooms without retaliation. Other grassroots advocates began to do the same and meetings were held with state licensing agencies and state attorney generals. NHM offered free cameras, installation and legal representation to families who visited regularly and who had care concerns. The effort kicked up a storm that began in 1996 and lasted almost a decade. The nursing home industry feared exposure of hard evidence would bring about legitimate lawsuits. What became their litany was their "concern for invasion of patients' privacy and dignity". In 2004, a case in NC was tested and the equipment was installed by NHM and was removed two hours later by the facility. In court the next day, the judge ruled that the patient had the right to have and to use the camera. The camera was re-installed but one day later the patient was sent to the emergency room and then told she could not return to the facility. The greatest blow was that the NC state licensing agency, after finding the facility guilty of involuntarily discharging the patient, accepted the facility's discharge anyway. However, hundreds of stories appeared across the nation resulting in laws being passed in Texas and New Mexico. Grassroots advocates continue to work with legislation and several states have initiated pilot projects.

Statistically, facilities with extensive surveillance enjoy increased retention rates and better moral among employees. Staff has an incentive to do better work and cameras somewhat alleviate the public's fear of nursing homes. Use of Granny Cams should be allowed, encouraged and even mandated to insure the safety of all patients.

Whether cameras are legal or not, should not concern families if they suspect neglect or abuse. A covert surveillance camera should be installed and numerous brave families have done so with good outcomes.

Violette King is the President and Founder of Nursing Home Monitors based in Godfrey, ILand is a nationally known nursing home advocate and force behind Granny Cams.

Eric Arthur and **Julio Valenzuela** of *Wells Fargo Bank* presented FATE President Carole Herman with a charitable contribution from the Wells Fargo Capitol Valley Market and Wells Fargo Foundation at the Bank's Annual Community Partners Breakfast held on November 21, 2008 at the Sutter Club in downtown Sacramento.

FATE was among 60 organizations chosen to receive a $1,000 donation in appreciation for charitable work in the Northern California Region.

Prescription Abuse Seen In U.S. Nursing Homes

The Center for Medicaid Services, known as CMA, has recently reported that Medicaid (Medical in California) has spent more money on antipsychotic drugs for Americans than on any other pharmaceutical, including antibiotics, AIDS drugs or medicine to treat high-blood pressure.

One of the reason is that nursing homes across the U. S. are giving these drugs to elderly patients to quiet symptoms of Alzheimer's disease and other forms of dementia. CMS, says nearly 21% of nursing-home patients are on antipsychotic drugs.

It was reported that an 84-year old Alzheimer's patient in New York likes to wander and to address her behavior, which was considered disruptive by the nursing home, she was given the powerful antipsychotic drug called Seroquel, a drug approved for bipolar disorder.

This 84 year old woman was not psychotic and Seroquel, like other antipsychotics, carries a "black box" warning that elderly dementia patient face a higher risk of death while on this medication. These drugs are being given way too much to this frail elderly population, CMS states.

Federal and some state regulators are questioning the use of these drugs and citing some facilities for using them in ways that violate federal rules. New York has increased its focus on antipsychotics in nursing homes and is training inspectors to spot signs of medication abuse. The $122 billion-a-year nursing home industry's use of drugs raises complex issues in an aging society.

Former practices such as tying down and sedating disruptive elderly patients led to the 1987 landmark federal law setting limits on how and when nursing homes can physically or chemically restraining patients. However, the practice continues and most patients and their family members do not realize that these drugs are antipsychotics and that informed consent must be received from the patient or in the event the patient is not capable of making decisions, by the patient's decision maker, i.e., holder of the Durable Power of Attorney, before these drugs can be administered to the patient.

"Use of antipsychotics in nursing homes can be an indication of inadequate staffing… We know the more staff there is, the higher the quality of care and the less need for antipsychotic usage" says Bruce Pollock, President of the American Association of Geriatriac Psychiatry.

British Legislator Says:
Anti-psychotic Drugs Kill 23,000 Alzheimer's Victims a Year

More than 23,000 elderly people with Alzheimer's living in England could be dying prematurely in care homes each year after being given drugs to keep them quiet. A recent report by Paul Burstow, the Liberal Democrat MP and a campaigner for the rights of elderly people in England, cites a study by King's College in London that gave placebo to one group of Alzheimer's patients and anti-psychotics to another. The study, funded by the Alzheimer's Research Trust, found that after 24 months, the placebo group had a 78 percent survival rate compared with 54.5 percent for the rest.

Mr. Burstow states that there are approximately 244,000 people in England with dementia living in care homes and the Alzheimer's Society estimates 100,000 are being given anti-psychotic drugs. Of those, 23.5 percent could be dying prematurely as a result of being prescribed these drugs that have horrific side effects, some of which are confusion, delirium, disorientation, blurred vision, increased body temperature, trouble swallowing, loss of appetite, dizziness, fast or irregular heartbeat and, in some cases, can increase the risk of strokes. Despite studies that show these harmful side effects, the report claims the Government has failed to act to reduce their use. The claims in the report will fuel the debate over the use of powerful drugs because of their strong sedative effect on care home residents.

Neil Hunt of the Alzheimer's Society stated that the over-prescription of anti-psychotic drugs to people with dementia is a serious abuse of human rights and should be used only as a last resort. Mr. Burstow states that using drugs to restrain vulnerable older people with dementia is no different to strapping them to a chair. It is an abuse of their rights yet the Ministers are guilty of being complacent. He also states that there should be a ban on prescribing anti-psychotics in all but the most severe cases of dementia.

In the United States, prior to the administration of any anti-psychotic medications, the patient or the patient's surrogate decision maker must give informed consent.

Nursing Home Complaints

One of FATE's services is filing complaints with the state regulatory agencies on behalf of nursing home, assisted living, residential care and acute care hospital patients and residents. Some of these complaints result in the appropriate state department citing these facilities for violations of Federal and State regulations. The following are the results of some of those complaints:

ARDEN REHAB AND HEALTH CENTER, SACRAMENTO, CA…CLASS B CITATION….PENALTY ASSESSMENT $1,000.00 Unnecessary Drugs…Facility failed to ensure patient's drug regimen was free from unnecessary drugs by not reducing the dose of Depakote (a drug that alters behavior) and for not documenting the indication for use and monitoring the effectiveness of each dose of Ativan (a drug for anxiety); Faiure to maintain a system of drug records of receipt and disposition of all controlled drugs by not ensuring the medication records, nurses' medication notes and the controlled drug records for patient's Ativan administration These failure resulted in the patient being placed at a high risk of being overmedicated and was transferred to an acute care hospital in a somnolent state and the emergency room doctors had to administer Narcan, a drug that releases narcotics from the body. The violation had a direct or immediate relationship to the health, safety and security of patients.

ARDEN REHAB AND HEALTH CENTER, SACRAMENTO, CA …DEFICIENCIES…..Failure to provide sufficient staffing to meet the needs of the patients; failure to assess and complete patient's dehydration risk assessment; failure to complete patient's fall risk assessment; failure to assess and complete patient's Braden pressure ulcer risk assessment; failure to review and update patient's care plan for dehydration; failure to review and update patient's care plan following a suspected fall with bruising; failure to update patient's care plan to include interdisciplinary team recommendations; failure to notify attending physician of change of condition; failure to notify attending physician of the patient's significant weight loss; failure to have a registered nurse on duty 24 hours a day for a census of 129 patients; failure to follow policy for fluid intake/output measurements, change in patient's condition, failure to assess patient's risk of falls, and failure to update wound care protocol by not completing quarterly skin risk assessments

CENTURA HEALTH-NAMASTE ALZHEIMER CENTER, COLORADO SPRINGS, CO…. DEFICIENCIES…..facility was cited for deficient practice F225 (abuse) and F241 (Dignity). Facility failed to ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator after FATE reported that a nursing aide video-graphed the naked backside of a resident with a cell phone and showed it to a fellow co-worker.

CHANDLER CONVALESCENT HOSPITAL, NORTH HOLLYWOOD, CA….DEFICIENCIES…. failure to provide treatment and services to ensure that the patient who entered the facility without a pressure sore did not develop a Stage IV pressure sore, failure to frequently turn and reposition the resident to keep pressure from bony prominences, failure to provide pressure relieving surfaces in bed and in the wheelchair prior to the formation of pressure sores and failure to involve the registered dietitian for nutritional recommendations when patients was identified with pressure sores and when the status of the pressure sore worsened. This complaint was originally filed by a FATE client and followed up by FATE.

COUNTRY VILLA HEALTHCARE, NOVATO, CA…DEFICIENCIES….failure to notify attending physician and family promptly after patient fell and sustained injuries resulting in suffering by the patient; failure to treat patient with dignity and respect after the patient fell; failure to implement the facility's policy of change of condition by failing to contact the medical director after patient fell and sustained injuries.

EL DORADO CARE CENTER, PLACERVILLE, CA…CLASS A CITATION..PENALTY ASSESSMENT $20,000.00….Failure to prevent patient from becoming severely dehydrated resulting in hospitalization with a diagnosis of severe dehydration and renal failure. Patient died at the acute hospital within 4 days. Class B Citation…Penalty Assessment $1,000…. failure to provide the minimum staffing requirements. Also determine that during this part of the time period of insufficient staffing, facility failed to ensure patient's plan of care for fluid needs and failed to ensure the fluid needs were monitored and failed to prevent patient from becoming dehydrated which resulted in the Class A Citation listed above. Deficiencies…attending physician failed to see patient during his admission from 7/17/06 to 11/13/06; failure to ensure medications were given as prescribed then failed to give oxygen as ordered and failed to give pain medication for coughing; failure to attended to medication carts; failure to lock medication carts; failure to implement patient goals, failure to implement policy regarding change of condition; failure to have an interdisciplinary team conference to plan patient's care; failure to establish a policy related to patient evaluation visits by physicians or documentation of alternative schedules for such visits; failure to ensure patient was afforded the opportunity to participate in his total plan of care; and failure to maintain clinical records for patient that contained meaningful nurse's notes or the conditions and diagnoses.

ELK GROVE CARE AND REHABILITATION, ELK GROVE, CA…(WINDSOR HEALTHCARE)…CLASS A CITATION….PENALTY ASSESSMENT $20,000.00. Failure to plan patient's fluid needs based on a continuing assessment to include issues of wound healing, temperature elevations, infections, diarrhea episodes and decreased intake.; failure to identify fluid needs and update hydration care plan; failure to provide patient with necessary fluids to ensure adequate hydration and prevent clinical effects of dehydration; failure to implement facility's policy and procedure for hydration. These violations presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm to the patient would result.

ELK GROVE CARE AND REHABILITATION, ELK GROVE, CA (WINDSOR HEALTHCARE)… CLASS A CITATION….PENALTY ASSESSMENT $20,000.00. Failure to develop and implement a care plan to provide skin care for the prevention of pressure sores; failure to prevent pressure sores from developing and progressing; failure to provide the care and ser-

Continued on page 7

Nursing Home Complaints

- *Cont. from page 6*

vices per facility policy and procedures for skin management and according to the patient's plan of care; failure to ensure that sufficient fluid and nutrition were provided to promote pressure sore healing and to maintain health. These violations presented either imminent danger that death or serious harm would result or serious harm would result or a substantial probability that death or serious physical harm to the patient would result.

FOOTHILL OAKS CARE CENTER, AUBURN, CA….DEFICIENCIES…failure to develop a written care plan for patient; failure to ensure that the nursing staff promptly notified patient's physician of a sudden change in mental status and behavior; failure to ensure that the nursing staff notified patient's physician of a weight loss of 8.6 Lbs. over a 12-day period; failure to ensure that the nursing staff administered medications as prescribed; and failure to provide a pressure-reducing mattress for patient to help prevent the development of Stage II pressure ulcers on buttocks.

FOOTHILL OAKS CARE CENTER, AUBURN, CA….DEFICIENCIES… failure to provide minimum staffing according to regulations.

GRAMERCY COURT, SACRAMENTO, CA…. CLASS AA CITATION, $90,000 PENALTY ASSESSMENT. Failure to continually assess patient's hydration needs to help prevent a urinary tract infection and dehydration; failure to implement and update a care plan for hydration; failure to provide necessary fluids to prevent dehydration and failure to implement their policy regarding care planning. These failures resulted in the patient becoming severely dehydrated, developing a urinary tract infection with sepsis resulting in acute renal failure and death.

KAISER FOUNDATION HOSPITAL SOUTH SACRAMENTO, CA…DEFICIENCIES….hospital failed to follow policy and procedures called Enternal Tube Management when medical and nursing staff did not ensure that a guide-wire was removed from patient's gastric tube prior to discharging the patient home with a caregiver; hospital failed to maintain confidentiality of patient's medical records when discharge instructions and orders for the patient were not given to the legal guardian. Medical records were given to an acquaintance of the patient's family without proper authorization from the legal guardian; hospital failed to ensure that enternal feeding formula was provided to the patient's caregiver prior to discharge from the hospital.

KAISER FOUNDATION HOSPITAL, WALNUT CREEK, CA….DEFICIENCIES…hospital failed to assess and document all the necessary data for developing a patient plan of care from time of admission to discharge.

MANOR CARE, CITRUS HEIGHTS, CA…DEFICIENCIES….facility failed to ensure that patient was returned to the acute hospital burn clinic for follow-up on foot grafts to prevent amputation.

NORWOOD PINES CARE CENTER, SACRAMENTO, CA….CLASS A CITATION…PENALTY ASSESSMENT $18,000.00. Failure to adequately and continuously assess the Patient; failure to develop appropriate plans of care for patient; failure to continuously review, evaluate and update patient's care plan as needed when the patient's condition changed; failure to adequately and continuously assess the patient's nutritional status and fluid status; failure to develop appropriate plans of care for patient's hydration risks and daily hydration needs; failure to continuously review, evaluate and update patient's care plan as needed when patient's condition changed. These violations presented either imminent danger that death or serious harm would result and substantial probability that death or serious physical harm to patient would result therefrom.

PARKLAND MANOR LIVING CENTER, PRAGUE, OK…..DEFICIENCIES…..Failure to protect residents from physical abuse; failure to have a way for residents and visitors to identify staff and failure to check to determine if an aide was currently certified and to do a criminal background check.

ST. CLAIRES NURSING CENTER, SACRAMENTO, CA…CLASS B CITATION…PENALTY ASSESSMENT $1,000.00…Failure to ensure that patient was monitored to receive sufficient fluid to maintain hydration; failure to ensure that the facility's policies and nurtritional assessment, dietary oversight and monitoring and accurate recording of intake and output were followed; failure to implement a plan of care to ensure sufficient fluids were provided.

ST. CLAIRES NURSING CENTER, SACRAMENTO, CA…CLASS B CITATION…PENALTY ASSESSMENT $1,000.00. Failure to notify family immediately after a fall; failure to consult with the physician when there was an accident involving the resident with an injury; failure to implement the patient's written plan of care.

SMITH RANCH CARE CENTER, SAN RAFAEL, CA…DEFICIENCIES…Failure to conduct ongoing nursing assessments and to develop a plan of care for patient who had swelling and bruising on the right leg; failure to assess and develop a plan of care for bowel care. These failures placed the resident at risk for exacerbation of a hip injury causing further damage and pain and increased anxiety; failure to administer medications and treatments as ordered, which could result in life threatening blood clots and which could result in adverse changes in the patient's condition; failure to ensure physical and occupational therapy was provided in accordance with patient's treatment plan causing the potential for reduced functional ability.

SUNBRIDGE BRITTANY CARE CENTER, CARMICHAEL, CA….DEFICIENCIES…Failure to obtain all necessary diagnostic and therapeutic services prescribed by a healthcare provider; failure to ensure confidentiality of patient's clinical records, except as authorized by law.

SUNBRIDGE BRITTANY CARE CENTER, CARMICHAEL, CA…DEFICIENCIES…Failure to document referrals to the dentist for further evaluation of patient's problems although the dental hygienist indicated patient should be seen by the facility dentist.

SUNRISE ASSISTED LIVING/MONROE, SACRAMENTO, CA…. Failure to properly document medication logs and dispensing medications to the residents as specified by doctor's orders; failure to sufficient staff facility to meet the needs of the residents; failure to properly provide medications to residents; failure to provide services to the residents that were outlined and agreed upon through admission documents to meet the needs of the residents.

VILLA MONTE VISTA, POWAY, CA…… DEFICIENCIES….Failure to provide copies of policies and procedures for bedsores, bowel impaction and insufficient staffing as requested by family members; failure to review the policy and procedures on an annual basis.

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