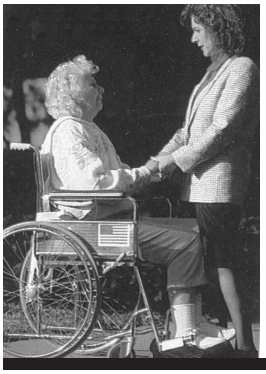

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FATE

Newsletter of Foundation Aiding The Elderly

President's Message

ABUSE COMPLAINTS INCREASE

by Carole Herman

A year ago September, **FATE** moved into its new and larger office to accommodate the growing needs of the organization. The move not only increased in space, but as the old saying goes…"build it and they will come" certainly proved to be accurate. **FATE**'s case load over the past year increased by 342%. As the baby-boomers age, so is their need for services. Since the government agencies regulating acute hospitals, nursing homes, assisted living and residential care facilities have had their resources dwindle with the current economic condition of almost all states in the union, we cannot count on these agencies to properly ensure that the operators are adhering to federal and state regulations. When oversight is reduced, poor care and neglect escalates. Hence, the need for advocacy increases as it did for **FATE** during the past year.

FATE was contacted by many people who were frantically seeking help for themselves or for an elder relative or friend or needed information they could not get anywhere else. The calls pertained to abuse and poor care in acute hospitals, nursing homes, assisted living facilities and residential care homes, as well as abuses by both public and private guardians. **FATE** served each and every person who contacted us by providing hands-on help, referrals, filed complaints with State regulators, and gave information or guidance. Of the hundreds of calls, 150 developed into actual cases that **FATE** worked on. These pleas for help were because the majority of these people could not get any help from a government agency or any other advocacy organizations. The number of calls we received regarding fiduciary abuse also increased drastically.

Elders have been swindled not only by unscrupulous predators, but by family members who the elders thought they could trust and depend on. With the amount

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CAROLE HERMAN

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

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Fate's Mission Is:

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

Services Fate Provides

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

W.VA Supreme Court Says Nursing Homes Can't Use Arbitration To Avoid Lawsuits

The West Virginia Supreme Court says nursing homes can't use arbitration to avoid lawsuits over residents' care. "In essence, our Constitution recognizes that factual disputes should be decided by juries of lay citizens rather than paid, professional fact finders who may be more interested in their fees than the disputes at hand," the court said in a unanimous opinion written by Justice Menis Ketchum in June of 2011. Nursing home patients or their families **give up their right to sue** when they sign a nursing home contract with a binding arbitration clause. An arbitrator's decision can't be appealed in the courts.

"The process of signing paperwork for medical care, specifically a contract for admission to a nursing home, is often fraught with urgency, confusion and stress" Ketchum wrote. "People seek medical care in a nursing home for long-term treatment to heal; they rarely view the admission process as an interstate commercial transaction with far-reaching legal consequences."

The decision came in an appeal by several families whose lawsuits against nursing homes in West Virginia were dismissed by circuit courts because the admission agreements were signed containing binding arbitration. "They lost one of the most common methods by which they avoid accountability," said Charleston attorney Harry Deitzler, who represented the families in the appeal. West Virginia's nursing home industry lobby organization said the ruling would increase nursing homes' cost of doing business and that the costs could be passed along to the consumers. Nursing home advocates do not agree.

Golden Living Centers Targeted in Lawsuit

Golden Living Centers, one of the largest nursing home chains in the country (previously known as Beverly Enterprises), has been targeted in a large class-action lawsuit in California for alleged nurse understaffing. The suit is being handled by a Eureka law firm, Janseen, Mally, Needham, Morrison, Reinholtsen, Crowley & Creigo, which is representing thousands of people who have stayed at the facilities during the period of more than 4 ½ years. The firm states that the facilities have reaped large profits by not providing the required number of nursing hours, and that as a result, patients have not received proper care. Part of the purpose of the lawsuit is to change corporate culture and behavior. Based on statistics compiled by the California Department of Health, facilities generally were understaffed 20 to 25 percent of the time, stated Attorney Crowley. The defendants hold licenses to 28 Golden Living Center facilities in California. Understaffing is one of the main causes of poor care and neglect in nursing homes. The federal government that pays for the majority of care in these facilities has also been negligent in its duty to insure that all nursing homes in the country are properly staffed to meet the needs of the patients.

President's Message

Continued from page 1

of people unemployed and suffering from loss of financial means, relatives are turning to their elders for support and some of the time, they are fraudulently using their elder relative's money to support themselves. We found that most of the complaints came from sons and daughters who wanted to take action against a sibling for taking large amounts of money from the parents. The parents usually are reluctant to file police reports against a child so the siblings are doing it for them.

Another event that took place at **FATE** this year was the development and implementation of the **FATE** Case Management System. Volunteer Paul Lazio, who has an extensive background in Systems Management, along with the support of board member and volunteer Harris Herman took on the responsibility of this major effort to convert all of the thousands client records and cases **FATE** has accumulated over the past 29 years of advocacy work into a relational data base. **FATE** now has the capacity of monitoring the status of a complaint filed with state agencies; what facilities have complaints against them; a breakdown of the actual complaint, such as bed sores, dehydration, malnutrition, over-medications, etc.; the time duration is takes the state agency to adjudicate a complaint; the name of the treating physician; the cause of the client's death; as well as maintaining all the notes and phone conversations pertaining to each case. While implementing the system, we were able to gather some very interesting data, such as **FATE** has helped families in every state in the union with the exception of Rhode Island; how many complaints are still pending adjudication from state agencies; how many citations were issued for violations of federal/state nursing home regulations based on **FATE** complaints; and how many fines the states have actually collected from the violators of nursing home regulations. With this information, **FATE** is able to have a better picture of the problems and how to better serve our clients.

Also during the last year, **FATE** extended invitations to members of family councils to hold their meetings in the **FATE** office. It is a good idea that these meetings not take place in the facility so that family members can discuss issues freely without the worry of staff members. Most of the family members did not know that facility staff may only attend family council meetings if they are invited by the group. These are private meetings amongst family members to discuss each of their experiences while their loved ones are in the facility and they should not feel intimidated by a staff member being present.

As **FATE** enters its 30th year of advocacy, we are excited about the changes that took place this year that have enabled us to better serve the public. We continue to be committed to working for our most vulnerable citizens and their families in order to ensure proper care with dignity.

Fraction of Elder Abuses Reported

A new research from Cornell University's medical college suggests that the incidence of elder abuse and exploitation is far greater than experts had expected. The study compared the number of cases reported to law enforcement, agencies that serve the aging and other authorities with those stated in a 4,000 random phone survey of people 60 and older. For every elder abuse case reported to a mandated enforcement agency, the survey found 23.5 unreported cases of abuse occurred. There are many mandated reporters, i.e., doctors, nurses, healthcare provides, bankers, etc.; however, it appears that the abuses are not getting reported as they should. The only way to have any effect on ending elder abuse is to report it to the appropriate authorities so that the perpetrators are held accountable for their crimes. And, one does not have to be a mandated reporter… just a caring person.

Soon I will be 95 –
That is if I'm still alive.
I ask my friend who is 98,
"What do you think of our inevitable fate?"
He smiles and turns away.
"I think of life"... I hear him say.

— Kirk Douglas

Doctors Rarely Pay Penalties in Drug Kickback Cases

In 2009, drugmaker Eli Lilly pleaded guilty to illegally marketing its blockbuster antipsychotic Zyprexa for elderly patients. Lilly paid $1.4 billion in criminal penalties and settlements in four civil lawsuits. However, a doctor named as a co-defendant in one suit (for allegedly taking kickbacks to prescribe the drug extensively at nursing homes) never was pursued. In 2010, Alpharma paid $42.5 million to settle federal allegations that it paid kickbacks to doctors to prescribe its painkiller Kadian. But again, the doctors accused of trading prescriptions for paid speaking gigs, faced no consequences. At least 15 drug and medical-device companies have paid $6.5 billion since 2008 to settle accusations of marketing fraud or kickbacks. Again, none of the 75 doctors named as participants were sanctioned, despite allegations of fraud or of conduct that puts patients at risk, per a report published by ProPublica in September of 2011.

In many cases, it appears that not even a cursory investigation was done to see whether the physicians had behaved inappropriately. Sen. Charles Grassley of Iowa, the ranking Republican on the U.S. Judiciary Committee, said in a written statement that it takes "two sides to perpetuate this fraud" and that both need to be held accountable. "Otherwise, the incentive to cheat the taxpayers will still be in place for those willing to take part."

Pursuit of Profits

In May 2011, the American Journal of Infection Control published a study conducted by the University of Pittsburgh's Graduate School of Public Health in which the study found a strong correlation between low staffing levels and the receipt of an infection control deficiency citation at nursing homes. According to the report, infections are the leading cause of nearly 400,000 deaths per year in nursing homes. Inadequate staffing levels leave the people who are working with too much to do, and that seems to be what leads to the increase in infections. The authors of the study further stated that with low staffing levels, these caregivers are likely hurried and may skimp on infection control measures, such as hand hygiene. Research found the percentage of nursing homes nationally that received deficiency citations from the Centers for Medicare and Medicaid Services (CMS) for infection control was 17.3% in 2007. That percentage was up sharply from 12.9% in 2000. The increase comes as no surprise when you know the study also found a strong correlation between infection citations and nursing homes with for-profit status. Similar findings came from a federal study in 2008. Infection rates can be reduced all the way to zero with proper procedures, but those procedures take time to execute. The busy healthcare workers may be not keeping their hands clean when the workload is increased as the result of understaffing. There are good reasons why many states have minimum staffing requirements for nursing homes and why there are penalties for failure to meeet those requirements. The risk of speading lethal infections is one of those reasons.

Another GAO Report on Fiduciaries and Court Appointed Guardians

The General Accounting Office (GAO) recently released a second report on incapacitated adults who are under guardianship. The report found that there is a need for stronger screening and oversight of guardians appointed to make financial decisions for these adults. The GAO found that only 13 states require criminal background checks on all potential court-appointed guardians and that there are gaps in information sharing that can adversely affect incapacitated adults. "The bottom line is that we need to ensure that the people being put in charge of someone else's social security checks are using the money appropriately and we must do more to combat abuses in the system," said Senator Herb Kohl, chairman of the U.S. Senate Subcommittee on Aging. Earlier this year, Kohn introduced legislation to prevent elder abuse, including abuse perpetrated by fiduciaries and guardians. The Elder Abuse Victims Act would establish an Office of Elder Justice within the Justice Department that would protect seniors by strengthening law enforcement's response to elder abuse. The GAO report can be found at http://gao.gov/products/GAO-11-678

Veterinary Hospitals vs Nursing Homes

By Joann Marie Donahoe, DVM, Pebble Beach, CA

Fifty plus years ago I won the Mom Lottery, when I was born in Pebble Beach, CA, to Mary Jo Bayley (Donahoe). She gave of herself all of her life, as a fourth grade teacher at the Carmel Mission, as a realtor at Fouratt-Simmons and single-handedly raised five kids, while taking care of her bedridden Mother for forty years.

If you fast-forwarded fifty years and told me my Mom would be a victim of horrific elder abuse leading to her death, by two publicly funded "nursing" homes, within 5 miles of where I was born and raised, I would say there is absolutely no way and I would be absolutely wrong.

As a veterinary professional for 39 years, a medical advocate for human acute care for 30 years and a mandated reporter for decades, I know we don't do to animals what was done to my Mom and other residents in nursing homes.

Veterinary hospitals don't bully and terrorize their patients, beat them, starve them, dehydrate them, or allow them to fall and ignore impactions and urine burns. Veterinary hospitals wouldn't do it and the public wouldn't allow it, and yet those are daily occurrences I witnessed, happening to our parents and grandparents, members of "The Greatest Generation," confined to nursing homes. And there is a deafening silence about this heinous reality. If these were animals being abused, there would be non-stop media coverage and accountability as animals have moved from the backyard to the bedrooms of our homes.

Despite non-stop 24/7 advocating and reporting, I couldn't get my Mom moved, safe or protected, and virtually no government "protective agency" or "official" would step in and stop the abuse. Horrifyingly, they were part of the problems and not the solution.

If residents report there is retaliation, if staff report they can be fired. This predatorial situation demands silence, and the power of the elder abuse predators rests in the silence of their victims.

It is old news to elder abuse experts to have these corporations violate human, state and federal rights of residents; overturn conservatorships; make perjured statements; file false police reports; and issue restraining orders...anything to get a reporting witness of poor care and abuse out of the building.

My Mom's last earthly wish was to "Break this Wide Open," and 10 months after her death, I was referred to a phenomenal resource book that tells the truth about this unconscionable nightmare... "Tender Loving Greed–2009 Notes". This book can be purchased on Amazon.com.

I implore all animal lovers and life lovers to learn the facts, network and tell your family, friends, and the media about what is happening to our greatest generation living in nursing homes. Just like what we've done for the animals, let's create a paradigm shift to end this nightmare for our loved ones.

BOOKS OF INTEREST

Alone and Invisible No More *...by Allan S. Teel, M.D.*
This book written by Dr. Teel discusses how grassroots community action and 21st century technologies can empower elders to stay in their homes and lead healthier, happier lives. The current state of elder care in America is appalling, expensive and unsustainable. This book empowers older adults to serve as resources for one another. Dr. Teel's project moves our dialogue about aging forward in one great leap. Published by Chelsea Green Publishing. Order at http://media.chelseagreen.com/alone-and-invisible-no-more

AGING – The Road to Prevention *…by Barry Klein*
This book contains helpful hints for those over 60 and the positive side of getting old. It covers conditions such as obesity, osteoporosis, Alzheimer's disease, high blood pressure, the importance of sleep, taking aspirin and the benefit of laughter. It also provides information on hundreds of organizations, associations, research centers, mail order catalogs for seniors, senior travel, as well as a bibliography of more than 200 books with their authors on the subject of aging. This 197 page book sells for $12.95 and can be ordered through the distributor, Atlas Books, at www.bookmasters.com/marktplc/0316.htm

"The Caregiving Tool" Managing your Caregiver *..by Fay Mikiska*
This book was developed to help family caregivers and care recipients gain the structure, accountability and confidence to effectively direct independent caregivers without the fear of being exploited. Ms. Mikiska, who suffers from Rheumatoid Arthritis and has used caregivers for about 30 years, wrote this book to facilitate a harmonious and productive relationship between caregiver and care recipient and clearly defines what is expected of the caregiver. The books sells for $29.95 and can be ordered through the web site www.caregivingtool.com

State Licensing Bribery Investigation

A California state licensing inspector at the center of a bribery investigation repeatedly cleared complaints filed against the operator of a Mira Mesa residential care facility for the elderly. accordingly to records from the California Department of Social Services. Records show that the operator of the facility admitted to giving the inspector $2,800 in cash and paying $1,044 for the inspector's vacation flight to the Philippines. The records released by the Community Care Licensing Office in Mission Valley detailed the inspection history at four care homes owned by the operator. The inspector was assigned to monitor all four facilities between 2009 and early 2010. Records revealed a series of complaints filed against the facilities.

A total of 10 alleged violations were later dismissed by the state inspector. Time and time again, she determined the allegations were "unfounded" and "dismissed the complaint" and took no action against the facility's owner. It wasn't until 2010, after the bribery investigation began, that a new licensing inspector took over and started finding problems. Two other inspectors were also terminated from state employment, one allegedly accepted bribe money in 2009 and the other for accepting a $3,000 "loan" from another facility operator.

As of the date of this publication, the California Attorney General has yet to file criminal charges against the three former inspectors.

Report Finds Criminals Able to Offer In-Home Care for Elderly

Lax oversight of in-home care agencies is opening the door for caregivers with criminal backgrounds to offer services to the elderly and disabled, according to a California Senate oversight report issued in April of 2011. The Senate Office of Oversight and Outcomes' review of Craigslist.org advertisements for in-home caregivers uncovered five confirmed cases where the individuals offering services had extensive criminal records, including arrests for burglary, narcotics trafficking and prostitution. It also found that more than 25 percent of caregivers identified in media reports as being convicted or accused of wrongdoing on the job had previous offenses on their records. The report found that without criminal background checks these consumers may unwittingly open their homes and finances to those who have shown a willingness to exploit or harm others. California is one of six states that does not regulate private in-home caregivers. While the state now screens workers providing care for the mostly low-income, blind, disabled and elderly Californians enrolled in the In-Home Supportive Services program, a similar system does not exist for private providers. The Legislature has approved legislation in recent years aimed at helping consumers conduct criminal background checks on prospective caregivers, but the report found that those services are not being used. Authors of the report, whose office was established by Senate President Pro Tem Darrell Steinberg, issued several recommendations for creating more oversight in the industry, including launching a public awareness campaign to inform consumers of their options for obtaining background reports and establishing standards for agencies that claim to conduct criminal checks on their employees.

Elder Abuse and Nursing Home Investigations

The nursing home industry has failed to police themselves and the state agencies that regulate the facilities have failed to police them as well. This lack of self-policing is causing families to come forward in increasing numbers to file lawsuits against nursing home facilities all across the country. Large jury awards are being handed out in these cases because most jury members have parents and relatives who may be subjected to this type of inhumane treatment and they can identify with the victims and their families. The way to stop these lawsuits is simple…**stop the abuses**. The state agencies that regulate the facilities are just as much to blame for the abuse as anyone. Their job is to license and police the facilities... that's what our tax dollars are paying for. However, what the public is hearing is that these agencies don't have enough money or staff. Unfortunately, neither is true. If the state agencies were holding the violators responsible for mistreating our most vulnerable citizens, perhaps that would also **stop the abuses**. Abuses are becoming more widely discovered because some of the employees of these facilities are unsung heroes who step forward to tell the truth about what is going on in these places. Quite a few nursing home employees have contacted **FATE** to report neglect and poor care knowing that **FATE** will keep their names anonymous and will file the necessary complaints with the state regulators and oversee the outcome. As well, the general public is getting smarter and more concerned about this type of abuse and is demanding that the perpetrators be held responsible. The nursing home operators have declared that their industry is the most regulated in the country. That may be true because of all the billions of our tax dollars they receive; however, if there is no oversight, it doesn't really matter how many laws they are required to follow. **FATE** works hard to education the public to know their rights and to do something about the violations against their loved ones. Facilities operating in a "business as usual" status should hear it loud and clear that taking advantage of our most vulnerable citizens is not acceptable.

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. Over the past several years, FATE has averaged three to five complaints a month. Although a prompt response is required from these agencies, resource limitations can extend the process for years. Some of these complaints that FATE has filed do 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:

ARBOR HILLS NURSING CENTER, LA MESA, CA….CLASS WMF CITATION….PENALTY ASSESSMENT $1,000….a willful material omission/falsification in the medical record of the patient pertaining to informed consent for medications. Family submitted a copy of a consent form and signed a declaration that the signature was forged as the family member was not in town on the date on the consent form and it was not his signature. Deficiencies also issued for failure to ensure a geriatric dosage of Ambien was considered prior to initiating a physician order for a stronger dosage which this failure had the potential for increased risk of confusion prolonged sedation and falls. There was no document to show the necessity for administering a dosage of Ambien CR 112.5 which was two times the recommended dose for an elderly patient.

ASBURY PARK NURSING AND REHABILITATION, SACRAMENTO, CA….DEFICIENCIES….failure to ensure the patient's clinical record was accurate and complete when medications were given to the patient but were not completely and accurately documented on the clinical record; failure to ensure that all health records were kept confidential and that the records only be disclosed to authorized persons in accordance with federal, state and local laws when a copy of the patient's health record was given to another patient's family member.

AUBURN OAKS (PREVIOUSLY KNOWN AS FOOTHILL OAKS), AUBURN, CA….DEFICIENCIES…. failure to ensure that prescribed psychiatry services were provided to patient; failure to implement physician orders for medications and treatments; failure to maintain a complete medical record for patient.

BRUCEVILLE TERRACE, SNF OF METHODIST HOSPITAL, SACRAMENTO, CA….DEFICIENCIES….failure to ensure that patient had a nursing care plan in place for anti-coagulant therapy; failure to ensure that policy and procedures regarding neurological checks after falls were carried out when patient did not receive neurological checks for up to 72 hours; failure to ensure that the information material to a decision to accept or refuse treatment was disclosed to patient's responsible party and an informed consent was not obtained by the physician for the administration of antipsychotic medications; failure to provide requested copies of medical records to the responsible party within two (2) business days of the request.

CARMICHAEL CARE & REHABILITATION CENTER, CARMICHAEL, CA….CLASS B CITATION…. PENALTY ASSESSMENT $1,000….failure to ensure a continuing assessment of patient; failure to ensure patient was treated with dignity and respect; failure to provide pain medication promptly when needed. These violations had a direct or immediate relationship to the health, safety or security of the patients.

EMERITUS AT CITRUS HEIGHTS ASSISTED LIVING, CITRUS HEIGHTS, CA….CITATION…. PENALTY ASSESSMENT $200….failure to care plan when patient's needs changed and failure to update appropriate interventions for fall risks resulting in patient suffering several falls; failure to protect resident from harm when patient sustained injuries to the forehead and skin tears to elbows and arms after a fall; failure to provide sufficient staffing to meet the needs of the patients and failure to increase need for supervision, reassessment and intervention.

THE FOUNTAINS, YUBA CITY, CA….DEFICIENCIES…Facility failed to document physician ordered weights and follow-up of a diet which failure to implement lead to the potential for a delay in treatment of patient's weight loss.

INLAND VALLEY CARE & REHABILITATION CENTER, POMONA, CA….DEFICIENCIES….failure to ensure patient was free from unnecessary drugs; failure to implement patient's care plans according to the methods indicated; failure to notify the physician of patient's weight loss; failure to provide patient with a therapeutic diet as ordered by the physician; failure to ensure patient's food allergies were accurately recorded on the patient's health record.

NORWOOD PINES, SACRAMENTO, CA…..4 CLASS B CITATIONS, WITH PENALTY ASSESSMENT OF $1,000 EACH…. Failure to meet minimum nurse staffing requirements with one day resulting in an injury of a patient; Failure to provide quality patient care based on patient needs; failure to investigate an injury of unknown origin; failure to report an injury to the State licensing office; failure to provide adequate supervision to prevent accidents; failure to revise the patient's plan of care; failure to ensure patient maintained acceptable body weight; failure to ensure plan of care was revised based on assessed needs.

PIONEER HOUSE, SACRAMENTO, CA….DEFICIENCIES…facility failed to ensure patient's medication was administered as prescribed by the physician.

RESIDENTIAL CARE FACILITY ON BEAUMONT STREET, SACRAMENTO….FATE's complaint on behalf of a client resulted in the closure of this home that was unlicensed and accepting residents who needed care when the operators were not capable of caring for them.

ROSEWOOD POST-ACUTE REHABILITATION (PREVIOUSLY KNOWN AS ROSEWOOD TERRACE), CARMICHAEL, CA….CLASS B CITATION, $1,000 PENALTY….facility transferred patient to an unlicensed facility without the approval of the responsible party thus failed to ensure that the patient was not discharged to a lower level of care when his condition had not improved sufficiently and that he no longer needed the services provided by this facility; failure to ensure the clinical record contained documented evidence by the attending physician that the patient's condition had improved sufficiently that he no longer needed the services of this facility; failure to ensure patient received sufficient preparation and orientation for a safe transfer from the facility.

SIERRA POINTE ASSISTED LIVING, ROSEVILLE, CA….CITATION AND DEFICIENCIES ISSUED…. Facility retained a patient who had a decubitus ulcer (bed sore) that was beyond a stage 2; facility failed to have a skilled professional to care for the decubitus ulcer; administrator failed to demonstrate having the knowledge or the requirements for providing care and supervision appropriate to the patient as evidenced by the fact that the facility continued to retain a patient who had a prohibited health condition.

TWIN OAKS POST- ACUTE REHABILITATION, CHICO, CA….CLASS B CITATION, $1000 PENALTY…. Failure to review, update and implement the interventions identified on patient's care plan to avoid injuries as a result of falls. This failure resulted in six falls, five with injuries which included a laceration requiring eight stitches to the forehead, a cervical spine fracture requiring hospitalization; failure to notify the physician of the patient's 16.5 pound weight loss within a thirty-day period.

WALNUT WHITNEY CARE CENTER, CARMICHAEL, CA….DEFICIENCIES ISSUED…. Facility failed to develop a policy and procedure for the inventory of patient's valuables and took no action when the patient's valuables were missing; failure to get informed consent from the patient's responsible party prior to the administration of antipsychotic medications.

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