



# FATE

Newsletter of Foundation Aiding The Elderly

## President's Message

# PRISON OR A NURSING HOME...WHAT'S YOUR CHOICE

By Carole Herman

**Y**ears ago, after I formed **FATE** and became an advocate for the prevention of elder abuse, especially in nursing homes, I would tell my mother (**hypothetically, of course**) that if I should die before her and there was no one to care for her

that she should rob a bank. That way, she would go to jail rather than a nursing home. She would get better care, better food, television, a computer, schooling, cell phones and if she didn't like any of the care, food, etc., she could file a lawsuit against the government. Sound ridiculous? Not really. Luckily my mother at almost 90 years old and still dancing and playing cards, died in her sleep never having to face either a nursing home or a prison cell.

Back on August 23, 2012, I read an article from the Associated Press/Los Angeles with a headline that read...**"Inmate wins \$425,000 settlement with feds"**... Even though it was a small article, it caught my attention because of what I had always told my mother. The verbiage read..."An inmate who sued the federal government after contracting "Valley Fever" in a Central California prison has been awarded \$425,000 in a settlement. The govern-



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ment admitted no fault in the settlement, Judge Gary Allen Feess signed Tuesday. "Convicted methamphetamine dealer, Arjang Panah, sued after he contracted the fever at the Taft Correctional Institution after being transferred there from a federal institution in New York in 2005. Panah has since been released."

Then on September 5, 2012, the Associated Press/Boston again published an article entitled..."**Judge rules Massachusetts must pay for killer's sex-change surgery**". The article stated that state prison officials must provide **taxpayer-funded sex-re-**

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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

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## Inappropriate Medicare Payments To Nursing Homes Costs Billions of Dollars

In its November 2012 report (OEI-02-09-00200), the **Office of the Inspector General (OIG) at the U. S. Department of Health and Human Services (HHS)** states that OIG identified a number of problems with billing by skilled nursing facilities (SNF's), including the submission of inaccurate, medically unnecessary and fraudulent claims. Further, the Medicare Payment Advisory Commission (MedPAC) has raised concerns about SNF's' improperly billing for therapy to obtain additional Medicare payments. Specifically, MedPAC noted that the payment system "encourages SNFs to furnish therapy, even when it is of little or no benefit. The study found that SNF's billed one-quarter of all claims in error in 2009, resulting in \$1.5 billion in inappropriate Medicare payments. Of the \$27 billion paid to SNFs in 2009, **inappropriate payments amounted to about 5.6 percent of all Medicare payments made to skilled nursing facilities.** SNFs provide skilled nursing care, rehabilitation services and other services to Medicare beneficiaries who meet certain conditions. In fiscal year (FY) 2012, Medicare paid \$32.2 billion for SNF services. The OIG identified a number of problems with SNF billings. Notably, OIG found that 26 percent of claims submitted by SNF's in FY2002 were not supported by the medical record. Also misreported were items related to oral and nutritional status and items related to skin conditions and treatments. Notably, for the items related to skin conditions and treatments, SNF's did not always report the correct number or stage of skin ulcers (bedsores) or they reported the presence of burns or open lesions inaccurately. The report suggests that the Centers for Medicare and Medicaid Services (CMS) should use its Fraud Prevention System to identify and target SNFs that have a high percentage of claims. As well, FATE would recommend that family members of SNFs patients should review all Medicare billings for accuracy. To read the entire report go to <http://oig.hhs.gov> and enter the report number of OEI-02-09-00200.

## Johnson & Johnson Pays \$181 Million to Settle Fraud Cases

Johnson & Johnson has agreed to pay \$181 Million to settle consumer fraud claims by 36 U.S. States and the District of Columbia that it improperly marketed its Risperdal antipsychotic drug for unapproved uses. The diversified healthcare company has also been targeted by federal authorities for separate but related allegations including improperly promoting the drug for use in nursing homes. The funds will be divided among the states participating in the settlement. Michael Yang, the President of J&J's Janssen Pharmaceuticals, said in a statement that J&J chose this path to achieve a prompt and full resolution of the state's claims. Annual sales of Risperdal, which topped \$4 billion at their peak,

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## PRESIDENT'S MESSAGE

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**assignment surgery** to a transgender inmate serving life in prison for murder because it is the only way to treat her "serious medical need," a federal judge ruled.

The inmate, Michelle Koslik, was born male but received hormone treatment and now lives as a female. Kosilek was named Robert when married to Cherly Kosilek and was convicted of murdering her in 1990. U. S. District Judge Mark Wolf is believed to be the first federal judge to order prison officials to provide sex-reassignment surgery for a transgender inmate. Kosilek sued the Massachusetts Department of Corrections on two occasions over a 12- year period arguing that the surgery is a medical necessity. Kosilek's case has become fodder for radio talk shows and Massachusetts lawmakers who say the state should not be forced to pay for a convicted murderer's sex change operation.

Several years ago, **FATE** had a client whose wife was a patient in an upscale and very costly sub-acute hospital in the Marin area of California. Through the client, I became aware that inmates from San Quentin Prison were receiving care in this facility. At the time, there were six inmates in this facility. Each required two guards 24/7 while they were patients. These inmates were compromised patients who were not capable of even getting out of bed yet each required two guards 24/7. The **FATE** client was very upset as he felt the inmates were getting more attention and better care than his young wife who was rehabilitating from head injuries she sustained in an auto accident. I was quite appalled learning of this and attempted to get some media attention to this as the costs for just the guards alone must have been a huge amount of money and we the taxpayers paid the

medical bills for the inmate's care and the salaries of all those guards. Subsequently, I learned that the guards loved this duty and would volunteer because it was easy work and it paid double time.

The elderly, our most vulnerable citizens, who are now living in long-term care facilities are the people who helped build this country...they worked hard...paid taxes...abided by the laws of the land... some are WWII, Korea and Vietnam Vets...and now at the end of their lives are living in institutionalized care, some of which are not only substandard, but not operating according to federal and state nursing home regulations and they certainly do not have two people watching over them 24/7. Yet prison inmates, who broke the law, are not paying taxes, killed someone, caused societal problems in this country are the ones getting better care, better food, better living conditions, better medical care, etc. And, if they don't like it, they can file a federal law suit just like convicted criminals Arjang Ranah and Michelle Koslik did!

Now that the baby-boomers are entering the sunset of their lives, more and more of us will unfortunately end up in some type of institutional care. Nursing homes are chronically insufficiently staffed to meet the needs of the patients and continue to be in violation

of federal and state nursing home regulations causing harm to the patients. Seems like prisons allow convicted felons better everything along with the right to file a lawsuit against the government. Nursing home patients are not afforded the same rights. Where would you rather be?

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## JOHNSON & JOHNSON PAYS

*Continued from page 2*

have dwindled in the face of competition from cheaper generic versions of the drug. This settlement follows a number of costly court setbacks in various states related to Risperdal sales practices. **FATE** has had many clients who were given Risperdal, as well as other antipsychotics medications, while in either an acute hospital or a nursing home. Antipsychotics are considered chemical restraints and Federal law states that in nursing homes, antipsychotic medications may not be administered without the consent of the patient or the patient's decision maker. The attending physician is required to get the consent before the drug can be given. Even though the patient's bill of rights clearly states that the patient has the right to agree or not agree to treatment, the issue of informed consent in acute hospitals is still a gray area.

## Huffington Post Blog

The Huffington Post now has Carole Herman's blogs posted. Several articles have already been written and can be read on the Huffington Post site at

[www.huffingtonpost.com/carole-herman](http://www.huffingtonpost.com/carole-herman)

or go to **FATE's** web site

[www.4fate.org](http://www.4fate.org) and click on the icon and read the articles directly from the **FATE** site.



## A New President for the Nursing Home Industry

When Mark Parkinson left the Governor's mansion in Kansas, he figured he would go back to a successful business career operating nursing homes. Not so... He now represents the entire nursing home industry on a national stage as the new president of the American Health Care Association (AHCA), the trade association for nursing homes and assisted living facilities. Parkinson and his wife began opening assisted living facilities in Kansas and Missouri years ago. The couple sold their company in 2006 with the intent of retiring; however, Kathleen Sebelius, at that time Governor of Kansas, asked Parkinson to become her lieutenant governor. Sebelius chose Parkinson for his busi-

ness acumen and ability to work with people on both sides of the aisle. Sebelius was eventually tapped to lead the U.S. Health and Human Services Department (HHS) and Parkinson took over as Governor. Parkinson said he still keeps in touch with Sebelius now that he too has come to Washington. Parkinson also states that his industry doesn't expect, or receive, any preferential treatment. However, as a past governor with personal ties to HHS questions may arise as to how forceful the regulators will be in making sure nursing home patients get their fair share of monies allocated to nursing home operators who, like the ex-governor, made lucrative livings from nursing home operations.

## Health Departments Put Inspection Reports of Nursing Homes Online

Under the new Federal Health Care Reform Law, formerly known as the Affordable Care Act, all states have to list federal inspection reports on licensed nursing homes in the state. The law set January 1, 2012 for all states to come into compliance. While state inspection reports for nursing homes, hospitals and other licensed facilities are considered public records, obtaining copies of these reports was previously difficult. Advocacy groups across the country say that the online postings are a major step forward for anyone faced with a decision about placing a loved one in a nursing home. **FATE** agrees that this information will benefit everyone who

is considering a nursing home. However, additional information should be gathered by visiting the nursing home, having quick access to the facility, talking with family members with loved ones in the facility, as well as personally going to the health department office and reviewing the physical file to ensure that all information is contained on line, such as, name of the operator of the facility, how many citations and/or deficiencies have been issued, review the latest annual certification inspection report, etc. One must obtain as much information as possible about the facility where a loved one will be placed.

## Conservatorship Update

Last October, *ABC News* in San Francisco aired a two-part segment regarding two elderly people who were conserved the Santa Clara County Public Guardian over the loud objections of family members. One case focused on a 90-year old woman, who had been living in her own home being cared for by her 85-year old brother for over 16 years. The public guardian accused the brother of financially exploiting his sister because he never paid her rent. The court gave control of her finances and her person to the public guardian, who almost immediately evicted the brother from the house, took over all of her assets, placed her in a nursing home and took out a reverse mortgage on her home. The brother and his daughter attempted for two years to get the attention of the media, law enforcement, the courts and whoever would listen to their story. When the representative of the public guardian's office was asked by the *ABC* reporter how they were able to secure such financing since the owner had to be living in the house in order to qualify for a reverse mortgage, the answer was... "I think one needs to live in the home". On

11/21/12, *ABC* aired another segment of this story and it was reported that the woman was moved back into her home after the October broadcast and that the public guardian was in violation of Federal lending laws. This case is on-going. The other case is similar..elderly woman's son lived with her and when she began wandering, adult protective services was called and the public guardian accused him of taking advantage of her by living in her house without paying rent, a repeat of the other case. Another case that has yet to be exposed is that of a 50 year old **FATE** client who also lived with his parents all his life who is now homeless because the San Joaquin Public Guardian got conservatorship of both parents, placed them in care homes and the illegal eviction of the son was sanctioned by the court. This case is also on-going. **FATE** has documented over 300 cases of guardian ship abuse around the country by both private and public guardians. These abuses are starting to get attention from the media, which is long overdue. Hopefully, some justice will result from these expose's by the press.

## In Memory of Don Esco

(1930-2012)

Don Esco, a beloved Board Member of **FATE**, passed away on October 8, 2012. Don was born on September 6, 1930 in Marbury, AL. In 1946, at the tender age of 15, Don enlisted in the U.S. Army Air Corp by faking his age through the draft board and took his draft card to the Army Recruiter to enlist. By age 17, Don's Commander somehow had a copy of Don's birth certificate and confronted him, saying "you're only 17. What are you going to do about that?" Don replied, "I'm going back to work." Don was able to get his mother to sign off to stay in the Army Air Corp. Don was stationed at several bases in the U.S. until he was transferred to Japan in 1949. He was in Japan when the Korean War broke out.

After the Korean War, he returned to the U.S. and was assigned to the Air Force Reserve Officer Training Corp Headquarters in Montgomery Alabama. He later entered Officer Candidate School and graduated and was commissioned a 2nd Lieutenant. Don retired from the Air Force as a Captain with 22 years of service. Don was a decorative soldier with the following military awards: Japanese Occupational Medal, WWII Victory Medal, Korean Service Medal, Korean Presidential Unit Citation, U.S. Service Medal, Air Force Outstanding Unit Award, Air Force Longevity Service Medal, National Defense Medal with 1 Bronze Star. He then went to work for Brunswick Corporation and developed a device that could detect, compute and print bowling scores. Don later went to work

for the Sacramento Army Depot and made a trip to Kuwait to support Desert Storm. Don finally retired and settled in Cameron Park, CA. Don met his future bride, Johnnie, when they were both 14 years old and they married at age 16. They had three children, Judy, John and Michael, six grand-children and seven great-grand-children. Don's relationship with **FATE** began



after he contacted the office to help him after the untimely death of his wife in a local nursing home. As a result, Don became a very strong advocate for the prevention of elder abuse, became a **FATE** Board Member and worked closely with the **FATE** staff to bring about the awareness of elder abuse in nursing homes. Don was relentless in his mission to hold accountable those responsible for the death of his wife and, finally, after four years of effort, the Director of Nursing at the nursing home was arrested by the California Attorney General and charged with elder abuse in the death of his wife, Johnnie.

Don was buried with Military Honors in Arlington National Cemetery next to his wife, Johnnie. Don was a kind and loving man, dedicated to his wife, his family and his country. He will be missed by all who knew him.

## Consumer Rights to Due Process in California

When a consumer files a complaint against a nursing home with the California Department of Public Health, Licensing & Certification Program, because of poor care, negligence or abuse of a patient, one should expect a prompt investigation from the State. A complaint should place the regulators "on notice" that there are problems in the facility that could compromise the health and safety of all patients in that facility. That is not what is going on in California. **FATE** alone has over 65 pending complaints with state regulators some of which over two years old. As well, the complaint process allows the complainant an appeal if not pleased with the agency's outcome of the investigation. The nursing home also has appeal rights if a deficiency or a citation is issued against the facility. Over the past 30 years, **FATE** has filed hundreds of complaints on behalf of the public and has also exercised the right to appeal many times. This past year, however, the appeal process in California has dragged out for such long

periods of time that the public's right to "due process" is being violated. As of the date of this publication, **FATE** has over 20 appeals waiting to be heard, several of which have been pending for over 14 months. When the regulators are questioned as to why these long delays, **FATE** is told it is because of budget cuts and staff shortages. **FATE's** position on this matter is that "**justice delayed is justice denied**" and the State of California regulators should be held accountable for its failure to act on these complaints in a timely manner to ensure the health and safety of our most vulnerable citizens, those in nursing homes.

I have found that among its other benefits  
giving liberates the soul of the giver.

— *Maya Angelou*

## Covenant Care Staffing Lawsuit Reinstated

In August of 2012, a California Appeals Court reinstated a lawsuit against the owner of 16 nursing homes in Alameda County stating that patients can sue long-term care facilities for failing to meet California's nurse-staffing standards. The owner, Covenant Care, argued that only state regulators had the authority to enforce the requirement that skilled-nursing homes provide each patient with 3.2 hours of nursing care per day. A Superior Court judge agreed and dismissed the suit, but the First District Court of Appeals in San Francisco overruled the decision. State law authorizes residents of the facilities "to bring actions themselves to remedy violations of their rights," including the "right to reside in an adequately staffed facility," said Presiding Justice Ignazio Ruvolo in the 3-0 ruling. A group of patients is seeking to prove that the 16 homes violated staffing standards at least 35 percent of the time over a four-year period that started in December of 2006. The law provides damages of up to \$500 for each violation of a patient's rights, but the plaintiff's main goal is an order requiring compliance with the rules, stated attorney Aaron Winn. The ruling is important because the California

Department of Public Health has a record of lax enforcement and has been criticized by federal inspectors in two reports in the last year. Officials at the Department of Public Health has cited state funding shortages and said it was working to improve staff training. The Department has also proposed reducing its obligations to inspect nursing homes and investigate complaints, but state lawmakers rejected the proposal in May of 2012. Several years ago, **FATE** filed a public interest law suit against the department after discovering the Department failed to implement the staffing ratios for a period of six years after the Legislature passed the staffing regulations. State inspectors were reviewing daily staffing sheets, rather than payroll records, which are the only reliable source to show staffing. Since then, the Department has mandated that payroll records be reviewed for staffing ratios. Insufficient staffing to meet the needs of the patients is considered the number one cause of neglect and poor care and nursing home operators should be held accountable for violating staffing regulations causing harm to the patients.

### BOOKS OF INTEREST

#### **Maltreatment of Patients in Nursing Homes ...by Diana K. Harris and Michael L. Benson**

This book is unique in that it contains the first and only nationwide study of theft from patients in nursing homes. The book is divided into four parts. Part I provides information about nursing homes and discusses some theories regarding abuse. Part II deals with the thieves in nursing homes and the victims' families. Part III focuses on physical and psychological abuse and Part IV discusses additional ways in which patients are maltreated, including financial abuse and violations of rights. The book is published by The Haworth Pastoral Press and may be ordered at [www.HaworthPress.com](http://www.HaworthPress.com)

#### **Ending Elder Abuse ...by Diane S. Sandell and Lois Hudson**

This book is in its second printing and was created to provide information on safeguarding elders from abuse. Its purpose is to educate, comfort and inspire. It is an accounting of what Diane Sandell experienced when her ninety-one-year-old mother was severely beaten in a nursing home in Orange County, California. Published by QED Press in Fort Bragg, California it may be ordered through Amazon.com

#### **Alone and Invisible No More ...by Allan S. Teel, M.D.**

Dr. Teel discusses how grassroots community action and 21st century technologies can empower elders to stay in their homes and lead healthier, happier lives. This book also empowers older adults to serve as resources for one another. The book is published by Chelsea Green Publishing and may be ordered at [www.media.chelseagreen.com/alone-and-invisible-no-more](http://www.media.chelseagreen.com/alone-and-invisible-no-more).

#### **Granny Snatching ...by Ron Winter**

How a 92-year-old widow fought the courts and her family to win her freedom. Granny Snatching refers to efforts by family members and, in some cases, mere acquaintances, to gain control of an elderly person's financial affairs, by convincing the courts to place the person into an elder care facility while the "guardian" has complete control over their life and finances. The book includes helpful definitions and guidelines providing security from elder abuse. The book is published by Nightengale Press and may be ordered at [www.nightengalepress.com](http://www.nightengalepress.com).

# 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:*

**AMERICAN RIVER CARE CENTER (SUNBRIDGE BRITANNY REHABILITATION), CARMICHAEL, CA...CLASS B CITATION...\$1,000 PENALTY ASSESSMENT...**failure to ensure that each resident receives adequate supervision and assistance devices to prevent accidents, which resulted in a 95 year old patient with a history of falls being left unattended and unobserved in his wheelchair. He was found on the floor after a fall from the wheelchair and was hospitalized and treated for a subdural hematoma.

**ARDEN REHAB AND HEALTH CENTER, SACRAMENTO, CA...DEFICIENCIES...**failure to provide minimum staffing to meet the needs of the patients.

**ASBURY PARK NURSING & REHABILITATION, SACRAMENTO, CA...DEFICIENCIES...**failure to evaluate and update patient's plan of care after the patient sustained a fall which resulted in a left shoulder injury. This failure potentially impacted the patient's recovery secondary to delays in providing appropriate follow up interventions to address pain issues, which potentially impacted the patient's mobility and rehabilitation progress.

**BURBANK HEALTHCARE & REHAB CENTER, BURBANK, CA...CLASS A CITATION...\$20,000 PENALTY ASSESSMENT...**failure to effectively manage patient's bowel hygiene and dietary needs to prevent constipation or its progression to a fecal impaction that resulted in complications and death of the patient; failure to accurately assess and document the patient's bowel habits; failure to provide and ensure the consumption of adequate fluids; failure to implement the care plans that identified alteration in bowel patterns; failure to implement and monitor effectiveness of the physicians orders that lead to fecal impaction. These violations presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would and did result to the patient.

**CHATEAU AT CARMICHAEL PARK, CARMICHAEL, CA...DEFICIENCIES...**failure to keep facility clean, safe, sanitary and in good repair at all times; failure to have sufficient staff to meet the needs of the residents.

**COURTYARD HEALTH CARE CENTER, DAVIS, CA...CLASS B CITATION, \$1,000 PENALTY ASSESSMENT...**failure to get consent from the patient's responsible party prior to the extraction of eleven (11) teeth; failure to adequately plan for patient's care following the extraction of the teeth; insufficient staffing. These failures contributed to weight loss and dehydration which further compounded patient's medical condition. FATE filed for an appeal as citation levied by the department does not fit the failures.

**EMERALD GARDENS NURSING CENTER, SACRAMENTO, CA...DEFICIENCY...**failure to ensure clinical records were complete and accurately documented.

This failure resulted in inaccurately documented skin condition reports and incomplete intake/output records, which increased the risk of unrecognized changes in the condition of the patient.

**EMERITUS AT HAZEL CREEK, ORANGEVALE, CA...CITATIONS...CIVIL PENALTIES OF \$150.00 PER VIOLATION...**failure to prevent falls and update care plans to address falls; failure to use preventive measures like hip protector or bedside alarms to prevent falls (resident suffered injuries requiring hospitalization); insufficient staffing to meet the needs of the residents. Also cited for same failures within a twelve month period.

**EMERITUS AT FOLSOM, FOLSOM, CA...DEFICIENCIES...**failure to follow-up care plan; failure to maintain emergency buttons; failure to respond to resident's needs in a timely fashion; failure to prevent resident from falling on four occasions; failure to meet the medical needs of the resident and failure to provide sufficient staffing.

**ESKATON FOUNTAINWOOD LODGE, ORANGEVALE, CA...DEFICIENCY...**failure to follow primary care physician medication orders.

**GOLDEN LIVING CENTER/PORTSIDE, STOCKTON, CA...DEFICIENCY...**facility failed to ensure the physician obtained informed consent from the responsible party prior to the initiation of psychotherapeutic drugs.

**GOLDEN LIVING CENTER/FRESNO, CA...DEFICIENCY...**facility failed to provide medically related social services to meet the needs of patient when patient's dentures were lost and not replaced by the facility. This failure placed the patient at potential risk of not being able to obtain highest practicable physical, mental and psychosocial well-being.

**GRAMERCY COURT, SACRAMENTO, CA...DEFICIENCIES...**facility failed to ensure an individual written patient care plan was developed for the patient which indicated care to be given; failure to notify the physician of a change of condition; failure to ensure written policy was implemented for change of condition; failure to ensure the patient's health record contained meaningful information and that nurses progress notes were written by a licensed nurse as often as the patient's condition warranted.

**NAZARETH PARK PLACE, SACRAMENTO, CA...DEFICIENCIES...**facility failed to call 9-1-1 immediately after an injury occurred which resulted in an imminent threat to a resident's health, including an apparent life-threatening medical crises and failure of staff to assess resident for bodily injuries as needed.

**NORWOOD PINES ALZHEIMERS CENTER, SACRAMENTO, CA...DEFICIENCIES...**failure to perform laboratory tests as order by the physician; failure to give adequate pain medication to patient after surgery;

failure to ensure environment remains as free of accidents hazards as possible; failure to ensure that each patient receives adequate supervision and assistance devices to prevent accidents.

**PIONEER HOUSE, SACRAMENTO, CA...DEFICIENCIES...**failure to implement a care plan to prevent elopement (escape) of a patient when she was identified as a high risk for elopement upon admission; failure to develop a care plan for fall risk as identified on admission; failure to ensure that medications were administered as prescribed by the physician which resulted in patient receiving 1/2 of the prescribed dose.

**ROSEVILLE POINT HEALTH & WELLNESS CENTER...ROSEVILLE, CA...DEFICIENCIES...**failure to continually assess and manage patient's pain resulting in the re-admission to the acute hospital for severe, unrelieved pain; failure to notify attending physician of change in condition in a timely manner; failure to obtain an order from physician before giving pain medications; failure to ensure patient's medication administration records had accurate times of administration of the drugs and no signature by the person administering the drugs.

**SACRAMENTO SUB ACUTE, SACRAMENTO, CA...DEFICIENCIES...**failure to notify patient's representative of a lung infection; failure to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development of transmission of disease and infection.

**SANTA CRUZ HEALTHCARE CENTER, SANTA CRUZ, CA...DEFICIENCIES...**failure to develop an individualized care plan for patient when a volunteer washed patient's personal clothing in his home; failure to follow facility policies and procedures when licensed nurse did not document a physician's telephone order when the patient died; failure of the social services director to follow up with a patient when a volunteer staff member informed the director that the patient was requesting the volunteer to make her financial and medical decisions; failure to ensure soiled linens were handled in a manner that prevented infection when a volunteer washed personal clothing of a patient at his home.

**SUTTER MIDTOWN, SACRAMENTO, CA...DEFICIENCIES...**failure to proactively clarify a physician's order for a seven day trial of every four hour pain medications resulting in two missed doses of ordered medications.

**WESTVIEW HEALTHCARE CENTER (PREVIOUSLY COLONIAL HEALTHCARE) AUBURN, CA...DEFICIENCIES...**failure to ensure that patients received adequate supervision to prevent accidents when the plan of care was not updated when interventions were not effective in preventing falls with injuries.



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