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FATE

Newsletter of Foundation Aiding The Elderly

President's Message

UNDER FIRE.....CA Department of Public Health and the Federal MediCare Rating System for U.S. Nursing Homes

By Carole Herman

On October 30, 2013, **FATE** filed a public interest civil suit against the California Department of Health Services (CDPH) for its failure to investigate complaints filed by **FATE**, as well as other consumers, in a timely manner. Some are critical of law suits; however, after 32 years of watching CDPH continue to fail its mandated duties to protect our most vulnerable citizens, it was time that CDPH's negligent behavior come to a stop.

FATE along with its counsel, the Lexington Law Group in San Francisco, spent many tedious hours researching complaints prior to the filing of this lawsuit for the benefit of the public. On January 21, 2014, the California Legislature held an oversight hearing at the state capitol to ask questions of those heading the department and those in charge of the Licensing and Certification Program for CDPH. Unfortunately, the Friday before the scheduled oversight hearing, the Deputy Director of the Program resigned and was not available to testify in front of the hearing, which was lead by Assemblywoman Mariko Yamada and Assemblyman Richard Pan. Those who were there to answer questions, including the Director of the Department of Public Health, Dr. Ronald Chapman, could not answer the majority of the questions posed by the Committee Members. The hearing resulted in both Assembly Members Yamada and Pan requesting an audit of the Department by the California Auditor General. The report was released on October 31, 2014 and clearly details how CDPH has not effectively managed investigations of complaints related to long-term health care facilities. The report outlines how CDPH's oversight process is inadequate and has contributed to the large number of open complaints, how the department did not always follow procedures to ensure consistent quality of complaint investigations, and how the department did

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INSIDE THIS ISSUE:

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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

Who Owns California Nursing Homes?

Marjie Lundstrom, a Pulitzer Prize-winning Investigative Reporter with the Sacramento Bee, in a three-part series has reported that California consumers lack information about the ownership and performance of many California nursing homes. Some large corporations have such complex business structures that it makes it difficult, if not impossible, for consumers and even government agencies to identify who is running the organizations and who should be held accountable when things go wrong.

The Bee report found that 10 of the 24 largest nursing home chains operating in California did not have a website or only had a site with few details about their facilities or locations. The Bee's investigation also shows that nursing home ownership ranges from family trusts to pension funds to big Wall Street investors. As well, most of the top executives at the largest for-profit nursing home chains have backgrounds in real estate, investment banking, finance and law, rather than in health care.

Advocates claim that this is deliberately done to avoid legal claims against the corporation at the top of the structure, which is hard to discover until all the layers of limited liability corporations are peeled down in order to identify the real operators.

In 1997, the California Legislature began requiring the CA Department of Health Services to collect accurate and up-to-date information on nursing home ownerships and make that information readily available to consumers. State officials signed an agreement stating they would comply with the law and agreed to list the names and addresses of all individuals with a nursing home ownership stake of at least 5%. The State officials also agreed to provide the names and addresses of parent groups if the nursing home was a subsidiary. The Bee reported that the data included on the State's information system is incomplete and often misleading thus leaving the consumer unaware of the real owners.

To read the entire exposé, which is in three parts, go to the **FATE** web site www.4fate.org.

Never, never be afraid to do what's right, especially if the well-being of a person or animal is at stake. Society's punishments are small compared to the wounds we inflict on our soul when we look the other way.

— Martin Luther King, Jr.

President's Message

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not consistently ensure timely receipt of corrective action plans when facilities were required to submit them. Federal and state laws, federal and state regulations and department policies require CDPH to investigate allegations of poor care and abuse of our most vulnerable citizens. Yet, over the past two decades, CDPH has not met their mandated duties even though in the past there have been at least three other audits claiming the department was negligent in its duties to the consumer. It's really a shame that **FATE** had to bring this suit against the Department. It should not be necessary for anyone to have to file legal action against the government to force it to do its job. This is especially true here where the majority of nursing home patients are under MediCare or MediCaid (MediCal in California) and we as the tax payer are basically paying for poor care and neglect in the nation's nursing homes. To read the full audit, go to www.auditor.ca.gov/reports/summary/2014-111.

FATE also participated in a front-page article, along with a video, that appeared in the New York Times on September 25, 2014. This report focused on the MediCare Rating system for nursing homes, entitled, "Nursing Home Compare." This system is being used by consumers all over the country when they are faced with placing a loved one in a nursing home. **FATE** has strongly objected to this rating system since its inception claiming that the data may not be accurate as the majority of information is based on self-reporting by the nursing home industry. The New York Times agreed and reported this misconception to its readership. In California alone, all deficiencies and citations issued under the California nursing home regulations are not listed in the MediCare Rating System because the violations are based on state regulations, not federal regulations. This alone gives the consumers the wrong information for them to make a decision on where to place a loved one.

On October 6, 2014, as a result of this nation-wide story, the federal government announced substantial changes to the five-star rating program for nursing homes, which has been criticized for its reliance on self-reported, unverified data. The rating system had become the gold standard for evaluating the nation's more than 15,000 nursing homes since it was put in place five years ago even though two of the major criteria used to rate the facilities…staffing levels and quality statistics…are reported by the nursing homes themselves and generally are not audited by the federal government. The changes will start in January 2015 and will be aimed at addressing some of these concerns. Staffing ratios are critical to ensuring good care and the nursing home industry will have to begin reporting their staffing levels quarterly using an electronic system that can verify payroll data. Also beginning in January 2015, nursing homes' ratings will also be based partly on the percentage of its residents being given antipsychotic drugs. To read the New York Times and view the video, go to the **FATE** web site at www.4fate.org and click on the story.

FATE's on-going advocacy played a role in these two major outcomes and we continue to aggressively advocate on behalf of our most vulnerable citizens in long-term care facilities all over the country. We are currently doing research on whether the consumer has the right to appeal a complaint filed against a facility that results in an "unsubstantiated" allegation. We are finding that most states do not have an appeal process for the complainant; however, all states that we have current information on do allow an appeal process for the industry if a deficient practice is found. **FATE** will attempt to bring reform that will allow the consumer the same "due process" as the industry. Unfortunately, our work load increased drastically again this past year. We are always hopeful that poor care, neglect and abuse will subside or better yet, come to an end so that there would be no need for the advocacy work we do. In the meantime, we will do our best to serve those in need.

BOOKS OF INTEREST

"Another Country", navigating the emotional terrain of our elders….by Mary Pipher, Ph.D. A book about us and our parents. The landscape of age is that of "Another Country". The author turns her keen eye to a troubled passage….the journey into old age. As we grow older, the relationships among us become more complex and difficult just when they need to be the closest and strongest. The gradual turning of life's tide can take us by surprise as we find ourselves unprepared to begin caring for those who have always cared for us. Order via Amazon.com/Mary Pipher, Ph.D., Another Country….cost $17.00

"Dementia Reconsidered: the Person Comes First"…by Author Tom Kirwood. A book on dementia care that has stood out as the an important, innovating and creative development in the field that has for too long been neglected. This book is a landmark in dementia care and it brings together and elaborates on Kirwood's theory of dementia and of person-centered care in an accessible fashion. Order via Amazon.com/Dementia-Reconsidered-Person-Comes-First…cost $41.00.

Inspector General Criticizes CA Nursing Home Inspections

In June of 2014, the U.S. Department of Health and Human Services, Office of the Inspector General, released its report that Medicare's reliance on California licensing surveys of nursing homes could not ensure that quality of care provided to Medicare and Medicaid (MediCal in California) beneficiaries is taking place. The Centers for Medicare and Medicaid Services (CMS) relies on State licensure, including licensing surveys, as one way to ensure the quality of care provided in nursing homes. The objective of this report was to determine whether CMS's reliance on the California Department of Public Health, Licensing and Certification Division's licensing surveys of nursing homes ensure quality of care and that adequate protection was provided to Medicare and Medicaid beneficiaries.

The CMS study reported that California nursing homes do not always meet certain State requirements for employee health examinations and optional service units. The State surveys do not always identify certain issues; thus, CMS's reliance on these surveys could not ensure quality of care and that adequate protection was provided to Medicare and Medicaid beneficiaries. The study found that nursing homes did not always meet certain State requirements for employee health examination and optional service units. The report number is June 2014 A-09-12-02037can be read on line by going to https://oig.hhs.gov.

Doctors' Ties to Drugmakers

A federal website made public in September of 2014, sheds new light on the medical world's financial ties to the health care industry by providing a detailed look at doctor's payments from drug and medical device makers as reported by the New York Times. The website was required by federal health care law and is being hailed by consumer advocates for showing that doctors' financial relationships to drug companies affect their prescribing practices. Data gathered included 4.4 million payments to more than half a million doctors from August to December of 2013, which added up to about $3.5 billion. The data includes payments from virtually every pharmaceutical and medical device maker, as well as information about doctors' ownership interests in companies. The data base is being questioned by the drug and device industry, as well as doctors, who say that technical problems and data inaccuracies limit its value. Under new federal requirements, all manufacturers of drugs, medical devices and medical supplies that have at least one product covered by Medicare or Medicaid (MediCal in California) must report payments or gifts they make to doctors and teaching hospitals. Dr. Michael Carome, Director of Public Citizen's Health Research Group stated "the interest of those companies is to improve their financial bottom line, and not necessarily represent the best interest of the patients". **FATE**'s position is that doctors should refer to their PDR (Physician's Desk Reference) before prescribing medications instead of just listening to the 60,000 drug salespeople in the country.

Florida's Ombudsman Too Cozy with the Nursing Home Industry?

The Palm Beach Post recently published an article by its Opinion Staff claiming that frail nursing home residents in Florida need strong advocates as an estimated 60 percent of long-term-care residents do not routinely get visitors. As a result, the need for Florida for a robust long-term care ombudsman program is immense. Ombudsmen are trained citizen volunteers who are to ensure that residents are treated with dignity and advocate on their behalf when they are mistreated, neglected or abused. Over the past four years, Florida's Long-Term Care Ombudsman Program has been the subject of controversy. The Florida Department of Elder Affairs ousted its top ombudsman Brian Lee on orders from Florida's Governor Rick Scott's administration after Lee demanded ownership of Florida nursing homes be transparent. Federal investigators were called in and found that the state acted improperly in multiple ways. The state politicized the office by overseeing "hiring" and "firing" of volunteers despite federal requirements that the state ombudsman be independent. The agency now refers about half as many elder care complaints to the Florida Agency for Health Care as it did under Lee. The agency's spin is that this is a good thing because it means the volunteers are resolving complaints on behalf of elders immediately. Advocates see it differently…an agency too cozy with industry. Lee stated publically that the ombudsman program in Florida has been weakened and the regulators are not imposing sanctions as it should. This is not just happening in Florida, either. **FATE** has received many complaints from all over the country about how the public is not getting served by this government-funded program, so it's not just Florida that has this problem. The program has no clout and mandates that volunteers settle complaints at the lowest level thus avoiding the involvement of the state regulators who are the ones that can sanction a facility for violations of state and federal nursing home regulations. Hardly seems like the program really serves the needs of our most vulnerable citizens.

Psychiatric Drugs Send 90,000 to Emergency Rooms Each Year

The Journal of the American Medical Association (JAMA)reported in July of 2014 that between 2009 and 2011, there were an estimated 267,000 emergency room visits because of adverse drug events from psychiatric drugs such as overdoes, excessive sleepiness and head injuries. Over 19% of these emergency room visits resulted in patient hospitalization. The lead author of the JAMA study suggested the need for caution, increased surveillance and reduced use of psychiatric drugs. The data in this report should be of no surprise given the ever-increasing use of psychiatric drugs, which now includes even the youngest of the nation's population. One in four Americans are currently prescribed psychiatric medications. While many of the psychiatric drugs long have been branded with the FDA "black box" warning, too often the adverse reactions associated with these drugs are down played and physician follow-up is spotty, leaving those taking psychiatric drugs to find accurate information on their own. The JAMA study reinforces the need for full disclosure and the study's limited data at least provides an honest appraisal of the growing problem of adverse events associated with psychiatric drugs. Federal nursing home regulations require that informed consent be obtained prior to the administration of any antipsychotic medications. The consent must be obtained by the physician and given by either the patient or the patient's decision maker in the event the patient has no capacity.

For further information on the report, go to the JAMA web site at www.JAMAnetwork.com

How To Obtain Copies Of Medical Records

FATE continues to receive calls from consumers asking how one might get copies of medical records. Sometimes the call comes directly from a person who wants copies of their own records from when they were a patient in a nursing home. Sometimes the call comes from the holder of the durable power of attorney for someone who is incapable of obtaining the records. The Federal Code of Regulations, namely, 42 CFR 483.10 (b)(ii), allows the consumer or the holder of the durable power of attorney to obtain copies of medical records from a nursing home. The regulations states that the facility must give the copies within two (2) business days of receipt of the request.

Attorney Eric Ratinoff's "Network for Cause" sponsored a fund raiser for **FATE** in August of 2014. A silent auction was held with gifts donated from numerous companies and individuals,Pictured are Angela Rosas, Event Coordinator, Harris Herman, **FATE**, Director of Volunteer Services, Eileen Dancause, **FATE** volunteer and her husband Dennis Dancause.

Visitation Rights…

Many nursing homes post visiting hours. Sometimes, family members assume, or the facility states, that those visiting hours apply to all visitors in the facility. Not so. Under the Code of Federal Regulations, 42 CFR 483.10 (j)(1)(vii), a nursing home must permit immediate access to a patient by a family member at any hour of the day or night, without regard to any visiting hours posted in the facility. Visiting hours are for non-family members only. In fact, it may be a good idea for family members to make some visits during off hours to monitor the care given to their loved one.

MAKE A DIFFERENCE…. MAKE A DONATION

During 2014, FATE helped over 300 new clients all over the country. To assist FATE in continuing to serve our most vulnerable citizens and their families, please make a tax deductible donation via our web site…Go to www.4fate.org and click on MAKE A DONATION. Your contribution will make a big difference.

LONG-TERM CARE FACILITY 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, these state agencies 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:

AIR FORCE VILLAGE WEST, RIVERSIDE, CA….. CLASS A CITATION…$5,000 PENALTY ASSESSMENT…..Failure to individualize the patient's care plan to incorporate input from the therapy services for the patient's broken hip; failure resulted in patient being left unattended in the bathroom, falling and sustaining another fracture to her right hip; failure to monitor the patient who was a high risk for falls. **Note:** complaint was filed by the patient's daughter in July of 2008; however, the San Bernardino licensing office never completed the investigation even though the daughter continually called for a status. **FATE** was contacted on 11/6/13, by the daughter after she read about **FATE** filing a public interest law suit against the CA Department of Public Health for its failure to investigate complaints in a timely manner. **FATE** took over on behalf of the daughter and on 11/14/13 the citation was issued. This complaint took the San Bernardino office 64 months to complete.

ALTA MANOR RESIDENTIAL CARE…..ROSEVILLE, CA…CITATION AND DEFICIENCIES….failure to ensure that incontinent residents are kept clean and dry and that the facility remains free of odors; failure to ensure that condition of the skin exposed to urine and stool is evaluated regularly to ensure that skin breakdown is not occurring and as a result, the resident suffered from skin breakdown; failure to provide basic services to which resulted in severe dehydration (civil penalty of $150.00); failure to notice resident's change of condition and to notify the resident's physician of the change.

ARBOR NURSING & REHABILITATION, LODI, CA…..DEFICIENCIES….failure to provide copies of medical records according to the federal regulations. **FATE** filed an appeal as not all allegations in the original complaint were addressed, i.e., failure to treat; failure to notify physician of a change of condition, lack of dignity and insufficient staffing.

ASISTENCIA VILLA REHABILITATION AND CARE CENTER, REDLANDS, CA…DEFICIENCIES…. failure to perform a complete assessment to include a neurological assessment of the patient after she sustained a fall with a nasal fracture. This had the potential for changes in her mental or physical status to be missed on assessment, which affected the course of treatment the physician might prescribe. The original complaint was filed by the **FATE** client. **FATE** filed an appeal to have the complaint reheard.

ASISTENCIA VILLA REHABILITATION AND CARE CENTER, REDLANDS, CA..DEFICIENCIES…facility failed to provide the family of a deceased patient with copies of the patient's medical records in a timely manner , which resulted in a violation of the federal law.

BELHAVEN NURSING AND REHAB CENTER, CHICAGO, IL….DEFICIENCIES…facility failed to maintain an effective pest control program resulting in an infestation of bed bugs that resulted in the closure of 9 resident rooms on the second floor of the facility and 2 rooms on the third floor.

BRISTOL HOSPICE CARE, SACRAMENTO, CA… DEFICIENCIES….failure to ensure patient's right leg was assessed when she complained of new pain and appeared confused. This failure placed the patient at risk of unidentified care needs; failure to ensure the plan of care included the treatment of the wounds on her legs; failure to revise the care plan to include the care and monitoring of an external bone stabilization device, which placed patient at risk of inadequate wound care and a lack of monitoring of the bone stabilizer; failure to report unusual changes in the patient's physical condition to the attending physician and the interdisciplinary team when evident that the patient had a change of condition in her right leg which resulted in the amputation of the right leg.

COAST OAK VILLA, CITRUS HEIGHTS, CA… DEFICIENCIES….facility provided prohibited wound care to resident with bedsores; facility failed to provide resident medications prescribed for pain management; facility administered medications to resident without physician's order.

CREEKSIDE HEALTHCARE CENTER, SAN PABLO, CA…DEFICIENCIES….facility failed to involve the family of the patient in the care planning process prior to initiating a new treatment. The family was notified after the facility had already started intravenous (directly into a vein) hydration. This failure placed the patient at risk for potential complications. Facility failed to ensure adequate monitoring and assessment of a pressure ulcer (bedsore). Patient's skin was not monitored by the facility's licensed staff for a change in condition. Failure resulted in patient's pressure sore worsening from a Stage 1 to a Stage 3 putting the patient at risk for infection, pain and decline in her mobility; failure to provide proper care for the patient in relation to her IV nutrition and failed to give sufficient calories to meet her needs. This failure had the potential to result in poor nutrition, weight loss and skin damage.

CREEKSIDE HEALTHCARE CENTER, SAN PABLO, CA…DEFICIENCIES… facility failed to provide medical records to responsible party under the Federal Regulations when they were requested. This failure resulted in unresolved anger and frustration for the responsible party following the death of the patient.

DRIFTWOOD HEALTHCARE CENTER/HAYWARD, CA…(MARINER CORPORATION)…DEFICIENCIES…facility failed to place arbitration agreement advisory in a prominent place at the top of the proposed arbitration agreement which resulted in misleading information.

EMERITUS AT CHATSWORTH, CHATSWORTH, CA…..TYPE B CITATION FOR ASSISTED LIVING FACILITIES...facility failed to complete an individual written admission agreement with each resident and did not specify the refund conditions. The resident died and the facility failed to refund the family within a reasonable amount of time. **FATE** obtained the refund for the family and filed this complaint.

EMERITUS AT THE PALMS….(NOW KNOWN AS THE PALMS ASSISTED LIVING AND MEMORY CARE)…ROSEVILLE, CA…TYPE B AND TYPE A CITATIONS FOR ASSISTED LIVING FACILITIES WITH A $150.00 CIVIL PENALTY….Facility failed to provide sufficient staff to meet the needs of the residents (a resident got out of the facility and had a fall which resulted in an injury); facility also failed to follow physician orders.

ESKATON CARE CENTER/GREENHAVEN….SACRAMENTO, CA…DEFICIENCIES….failure to ensure care plans were developed for patient which indicated the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care; failure to ensure written patient care policies and procedures were implemented to ensure that patient related goals and facility objectives were achieved; failure to provide copies of medical records as requested in accordance with the federal regulations.

ESKATON LODGE AT CAMERON PARK…CAMERON PARK, CA…DEFICIENCIES….failure to reassess resident and failure to follow resident care plan causing 8 falls, one of which resulted in a fractured hip and dehydration causing a hospital admittance.

GOLDEN LIVING CENTER/PORTSIDE, STOCKTON, CA….DEFICIENCIES…failure to ensure care plan for cardiovascular status was followed when no documentation indicated the intake/output of fluids and/or meals was recorded; failure to ensure patient was assessed for dehydration. **FATE** filed an appeal for a hearing as the Licensing Office did not address all the allegations, i.e. weight loss, low blood pressure, yeast infection in kidneys, failure to notify family/physician of a change of condition, failure to treat, isolation, missing personal belongings, threats of guardianship, false charting and insufficient staffing to meet the needs of the patients.

HANFORD NURSING AND REHABILITATION CENTER…FRESNO, CA…DEFICIENCIES….failure to obtain informed consent prior to the administration of Trazodone and Imipramine; failure to provide copies of all medical records after requested by the responsible party.

HAYWARD HILLS HEALTH CARE (MARINER CORPORATION)….HAYWARD, CA…DEFICIENCIES… failure to provide copies of medical records and failure to ensure that patient's had access to their medical records. The admission agreement contained language that facility may deny patient's request to inspect and copy medical information which resulted in misleading information and potential lack of access to the medical records; failure to place arbitration agreement advisory in a prominent place at the top of the proposed arbitration agreement resulting in misleading information.

KAISER FOUNDATION HOSPITAL/SACRAMENTO/ MORSE AVENUE…DEFICIENCIES…failure to implement its policy and procedure by failing to obtain informed consent prior to the administration

Long-Term Care Facility Complaints

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of antipsychotic medications. Neither the patient or his responsible party were given the opportunity to consent to, or to refuse, the course of treatment.

MARK TWAIN CONVALESCENT HOSPITAL, SAN ANDREAS, CA…DEFICIENCIES….failure to protect patient from repeated sexual harassment (molestation) and for failure to protect family members from inappropriate body exposure by the same patient; failure to follow policy and procedure on reporting abuse within 24 hours when patient told facility staff of the sexual abuse and the incident was not reported to the Department of Public Health within 24 hours; failure to adequately assess patient and develop and implement a comprehensive care plan specific to other patient's inappropriate behaviors.

MERCY GENERAL HOSPITAL, SACRAMENTO, CA….DEFICIENCY….failure to deliver care that reflected all the elements of the nursing process including assessment, intervention, evaluation and patient advocacy. The hospital administered multiple doses of two different anti-anxiety medications and multiple doses of three different antipsychotic drugs without adequate knowledge of indication for use and side effects. The facility failed to get informed consent prior to the administration of these medications.

NAZARETH PARK PLACE ASSISTED LIVING, SACRAMENTO, CA…DEFICIENCY…failure to follow care plan; failure to provide assistance with the administration of oxygen.

NEWPORT BAY HOSPITAL, NEWPORT BEACH, CA…..DEFICIENCY….hospital failed to ensure informed consent was obtained prior to the administration of an anti-depressant medication as required by the hospital's policy and procedures. Review of the hospital's drug list for medications requiring signed consents included the drug administered to the patient when the consent was not obtained.

NORWOOD PINES ALZHEIMERS CENTER, SACRAMENTO, CA…CLASS B CITATION….$1,000 ASSESSED PENALTY. Failure to implement its policy to report and investigate the cause of seven significant injuries of unknown origin to determine if abuse had occurred and to determine the underlying cause of the injuries. Deficiencies for failure to assess the patient's needs and failure to develop a written patient care plan which indicates the care to be given; failure to establish a care plan for patient communication deficit which the Spanish speaking patient was assessed to require a Spanish language translator to enhance the patient's understanding of staff which contributed to the patient's resistance to staff providing care. This complaint investigation took the Department of Health 21 months to complete. **FATE** appealed the citation as not all of the allegations were investigated by the State licensing office.

NORWOOD PINES ALZHEIMERS CENTER, SACRAMENTO, CA..CLASS A CITATION…$18,000.00 ASSESSED PENALTY. Failure to notify physician and/or family of a fall which resulted in an injury resulting in the patient's physical, mental or psychosocial status in a life threatening condition; failure to develop an appropriate care plan; failure to provide qualified persons to treat patient; failure to ensure prevention of bed sores; failure to ensure that the patient received the necessary treatment to promote healing, prevent infection and prevent new sores from developing; failure to identify C-diff, a contagious bacterial infection; failure to identify and monitor individual risks for pressure sores and implement preventive measure to relieve pressure from vulnerable areas; failure to ensure the plan of care to monitor skin condition following diarrhea; failure to prevent dehydration; these violations presented either imminent danger that death or serious harm to the patient would result therefrom, or substantial probability that death or serious physical harm to patient would result therefrom. This complaint investigation took the CA Department of Health 2 years and 5 months to complete.

NORWOOD PINES ALZHEIMERS CENTER, SACRAMENTO, CA..DEFICIENCIES…facility failed to maintain accurate clinical records in accordance with accepted professional standards and practices.

PARKVIEW HEALTHCARE CENTER (MARINER CORPORATION)…HAYWARD, CA…DEFICIENCY… facility failed to place arbitration agreement advisory in a prominent place at the top of the proposed arbitration agreement that resulted in misleading information. This was a violation of the California Standard Admission Agreement for Skilled Nursing and Intermediate Care Facilities.

PINE CREEK CARE CENTER, ROSEVILLE, CA… DEFICIENCIES…facility failed to provide escort services to assist the patient during an appointment to an outside doctor's appointment which resulted in the patient not receiving a medical treatment and created an unnecessary transport. The patient was left in the waiting room unattended and the doctor's office had to call the responsible party that the facility failed to accompany the patient as they were supposed to do and it was considered patient abandonment.

PROGRESSIVE HOME CARE, AUBURN, CA… DEFICIENCIES….failed to ensure a Registered Nurse performed duties consistent with the Nursing Practice Act and Standards of Competent Performance when wound care to perform debridement treatments of bedsores on patient was without a specific, signed physician order and failed to obtain consent from the resident's Durable Power of Attorney for Healthcare for the treatment and did not explain the debridement treatments to the patient per policy. These failures resulted in pain, worsening of the wound and serious infection which required the patient to be admitted to an acute hospital. Complaint was filed by a family member with **FATE** filing additional complaints.

REDLANDS COMMUNITY HOSPITAL, REDLANDS, CA…DEFICIENCIES….failure to ensure that policies and procedures were followed for the care of a patient, which had the potential to contribute to the patient experiencing an adverse outcome. The policy regarding the death of a patient was not followed by the nurse that required the nurse to report the patient's death to the coroner since the patient expired following an accident or injury, which resulted in the patient not receiving a needed examination upon death to determine the cause of patient's death. Original complaint filed by a **FATE** client.

SACRAMENTO POST-ACUTE, SACRAMENTO, CA….DEFICIENCIES…facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary/orderly environment for the patient. This failure created the potential for maggots to develop and emerge from under the bandages on patient's lower leg; failure to develop/update a comprehensive care plan for patient, which caused the patient to receive inadequate and inaccurate care; failure to ensure that patient received necessary care and services for optimal improvement in patient's cellulitis, which created the potential for unsanitary conditions and a lack of advocating for patient's intensity of treatment.

SACRAMENTO POST-ACUTE, SACRAMENTO, CA….DEFICIENCIES…facility failed to provide necessary services for pressure sores (bed sores) which had the potential to impede the healing of such pressure sore; facility failed to provide medications ordered by the physician, which had the potential to compromise the patient's condition; facility failed to maintain accurate and complete clinical records , which had the potential for the patient to receive incorrect treatment and services. **FATE** filed an appeal to these findings as the original complaint also included falls , untreated pneumonia and insufficient staffing to meet the needs of the patients.

SELECT REHABILITATION HOSPITAL OF SAN ANTONIO (PREVIOUSLY KNOWN AS GLOBAL REHABILITATION)…SAN ANTONIO, TX…..DEFICIENCIES….patient rights violation for failure to implement its grievance process as set forth in the hospital's policy and procedures when the patient's husband feared she would fall; failure to provide an air mattress and air cushion on the patient's wheelchair. Nursing services violation…the hospital must provide 24-hour nursing services that are furnished or supervised by a registered nurse and that falls were not documented in medical records appropriately and did not show details of assessments conducted; failure to care plan changes needed because of falls or near falls. Nursing care plan violations due to the failure of nursing staff not ensuring that patient's care plans are developed and kept current for each patient. Failure to document all practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports and vital signs necessary to monitor patient's condition.

WINDSOR GARDENS CARE CENTER OF FULLERTON, CA….DEFICIENCY….facility failed to verify informed consent was obtained prior to the administration of an antipsychotic medication and failed to ensure complete and accurate documentation of consent was maintained within the clinical record of the patient.

WINDSOR GARDENS OF THE VALLEY, NORTH HOLLYWOOD, CA…CLASS AA CITATION, $75,000.00 PENALTY ASSESSMENT AND FEDERAL DEFICIENCIES…facility failed to ensure that the patient who was assessed as having difficulties in swallowing was not given oral medication mixed in apple sauce, which resulted in the patient chocking. She died two days later in an acute hospital as a result of aspiration pneumonia due to the chocking episode. A deficiency was also issued for failure to notify the Department of Public Health that a serious incident took place that led to the patient's death.

ZEARING HEALTH CARE, ZEARING, IOWA…. FEDERAL CITATION…$3,000.00 ASSESSED PENALTY….facility failed to appropriately assess resident after a fall. Resident fell during a transfer and staff picked up the resident without allowing the nurse to assess the resident and the resident sustained a right ankle fracture. The nurse failed to document the fall and failed to notify the physician after the incident.

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