



# FATE

Newsletter of Foundation Aiding The Elderly

## President's Message

### “INSUFFICIENT STAFFING LEADS TO INSUFFICIENT CARE” “UPDATE ON CONSERVATORSHIPS IN CALIFORNIA”

by Carole Herman

One of the most important measures to ensure good quality of care is sufficient staffing. It has been proven time after time that if a health facility does not have a sufficient number of nursing staff to meet the needs of the patients, there can not be good care. The hands-on care of patients, especially in nursing homes, comes from the certified nurse

assistant, referred to as a CNA. I have found that a great majority of CNA's are dedicated individuals who really care about the patient and work hard to ensure proper care. However, insufficient staffing prevents them from meeting the needs of the patients. Personally, I believe it is not because the industry has so little money that it can not afford to pay for sufficient staffing, it's because cutting staffing creates better bottom line

profits for the operator. However, there are resources for facilities so that outside staff can be hired on an as-need basis when regular employees are sick or don't show up for work. The industry will say that it's too costly to bring in independent nursing care. But, the industry is being paid for sufficient staffing even when they don't meet the minimum requirements for reimbursement. Under penalty of perjury, a potential operator executes the



CAROLE HERMAN

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FOUNDATION AIDING THE ELDERLY  
Post Office Box 254849  
Sacramento, CA 95865

(916) 481-8558  
www.4fate.org



Agreement with the State that the facility will operate in compliance with all federal and state nursing home regulations. When the facility is not staffed as mandated, which leads to other violations, the operator is placing not only the patients in jeopardy, but himself/herself as well.

Staffing has also been an issue with advocates when it comes to the state regulators. Far too many regulators do not check staffing hours against payroll records, the only true way of determining who worked

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

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- Elderly Service Referrals
- Long Term Care Facility Evaluation

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## Inspector General Reports on Hospice Care in Nursing Homes

The Department of Health and Human Services Office of the Inspector General recently released two reports on Medicare hospice services.

The first report, **MediCare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements**, found that 82 percent of hospice claims for beneficiaries amounting to over \$1 billion did not meet at least one Medicare requirement; 33 percent did not meet election requirements and 63 percent did not comply with care plan requirements.

The second report, **Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities**, found that in 2006, 31 percent of Medicare hospice beneficiaries were in nursing facilities. Medicare paid over \$2 billion for this hospice care, averaging \$960 per week for each beneficiary. To view the full reports online, go to [www.oig.hhs.gov](http://www.oig.hhs.gov).

## GAO Releases Study of CMS's Special Focus Facility Program

According to the Government Accountability Office (GAO) almost 4 percent of the country's 16,000 nursing homes could be considered "the most poorly performing" under the CMS's Special focus Facility Program. States currently identify some 755 nursing homes (15 of the worst in each state) as "candidates" for the program. The most poorly performing homes tended to be chain-affiliated and for-profit and have more beds and residents. GAO also found that the most poorly performing nursing homes had notably more deficiencies with the potential for more than minimal harm or higher and more re-visits than all other nursing homes.

To view the full report, to go [www.gao.gov](http://www.gao.gov), reports and testimonies.

## PRESIDENT'S MESSAGE

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on what day and for how many hours. Instead, regulators are depending on staffing sheets that do not validate if the worker on the sheet actually came to work that day. Several years ago, **FATE** filed numerous lawsuits against nursing home operators for insufficient staffing. Along with winning those cases, **FATE** was entitled to hire an independent auditor that would review payroll records, which **FATE** believed was the only accurate way to check staffing ratios. As reported in the last newsletter, **FATE** also won a public interest law suit against the Licensing and Certification Department forcing the department to issue regulations setting minimum staff-to-patient ratio that the department failed to do for over 6 years as mandated by the California Legislature. Recently, the California Licensing & Certification Department put into policy that to validate staffing ratios, state inspectors have to review payroll records. And, if

the facility failed to have sufficient staffing ratios to meet the needs of the patients the facility will be issued a Class B citation with a \$1,000 penalty assessment.

U. S. Senator Grassley has co-authored Federal legislation to improve the quality of care in nursing homes which is to include improved reporting of real-time nurse staffing information so that accurate comparisons can be made across nursing homes. **FATE** would like to see this include staffing verification by payroll records. In either case, whatever legislation is passed, staffing or otherwise, unless the government follows through with the proper monitoring and enforcement of the regulations passed, it really won't even matter.

### Update on Conservatorships

Back in 2005, I gave testimony in front of the California Legislature concerning

the numerous conservatorship cases that **FATE** had documented over a 20+ year period showing many conservatees who had their rights violated and in some cases their assets stolen by unscrupulous conservators, both private and public. The hearing was prompted by the Los Angeles Times expose' on conservatorships in California detailing how there was no oversight for conservatorships and abuses were on the rise. As a result, in 2007, the California Legislature enacted a law that private conservators/fiduciaries now have to be licensed in California, which I believe is the only state to enact an oversight bureau for conservators/fiduciaries. The Fiduciary Bureau under the California Department of Consumer Affairs has the responsibility to regulate non-family members, professional fiduciaries, including conservators, guardian, trustees and agents under durable powers of attorney and to investigate complaints filed

against any private fiduciary. Unfortunately, with the on-going fiscal problems in California, this bureau is not sufficiently staffed or financed and people who file complaints should be aware of this problem and know that one must monitor the complaint process to ensure accountability. To find out more information about the Bureau go to [www.fiduciary.ca.gov](http://www.fiduciary.ca.gov). Hopefully, other states will follow California's lead and pass similar legislation as this is a national problem.

There are many more issues about the elderly that need attention.....way too many to include in this newsletter. For information or help, go to the **FATE** web site [www.4fate.org](http://www.4fate.org) and send us an e-mail or call our office on our toll-free number (877) 481-8558.

**“Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.”**

*— Margaret Mead*

# Nursing Home Arbitration

## “Elder Victims of Abuse and Neglect Deserve Justice”

Clauses buried in nursing home admissions agreement are depriving nursing home residents and their families of their constitutional rights. During one of the most stressful times in their lives... an admission to a nursing home....residents and their families are unknowingly signing away their right to sue if the nursing home causes the resident serious injury or even death. Nursing home corporations insert binding mandatory arbitration clauses in their contracts to ensure that they will never be held publicly accountable for their actions, no matter how egregious their conduct. The Federal Fairness in Nursing Home Arbitration Act (S. 512 & H.R. 1237) would invalidate mandatory arbitration clauses in nursing home, assisted living and other long-term care facility contracts. This bill does not prohibit arbitration. Rather, it would ensure that the resident or his/her representative could voluntarily choose arbitration after a dispute arose. The bill would amend the Federal Arbitration Act (FAA) to eliminate binding mandatory arbitration contracts that are unfair to the elderly because they take away their right to be

heard in a court of law and increase their vulnerability to neglect and abuse in a care facility. Some have argued that if arbitration is truly fair and efficient, both sides should be able to voluntarily choose arbitration after, not before, a dispute arises.

Nursing home neglect and abuse are well documented, but not adequately prevented or penalized by the state and federal regulators. Incidents of actual harm to residents are documented in 20 percent of all nursing homes in the country every year. According to a 2008 GAO report, 18 states cited more than 20% of their nursing homes for harming the patient or placing them at risk. As alarming as these statistics are, the GAO report and other government studies have found that many states cite fewer serious deficiencies than actually occur and do not impose appropriate or effective remedies.

Mandatory arbitration clauses bar any claims against a facility, even those for severe neglect and serious injuries. These mandatory arbitration agreements are part of a nursing home industry trend that includes restructuring to increase profits and limit liability for bad care. Medicare

and Medicaid (Medical in California) spend approximately \$100 billion a year on nursing home care while many nursing home owner profit while remaining virtually unaccountable for the incidents that occur in their facilities.

All citizens have the right to seek justice in a court of law once they have been admitted to a long-

term care facility. Forced arbitration strips this most basic right. FATE along with many other advocates across the country support the Fairness in Nursing Home Arbitration Act.

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## Antipsychotic Medications in Nursing Homes

The state of California attempted to pass legislation during its last session placing stronger regulations on nursing homes administering antipsychotic medications. That legislation was vetoed by Governor Schwarzenegger. However, not all was lost.

Federal regulations state that informed consent must be obtained prior to the administration of any antipsychotic medication to a nursing home patient. Informed consent comes from the patient themselves or the person who is responsible for decision making for that patient when the patient is incapacitated. These antipsychotic drugs considered to be “chemical restraints” include Thorazine, Mellaril, Prolixin, Haldol, Risperal and Zyprexa. All of these drugs have horrific adverse side effects including falls and hip fractures, nerve problems, such as involuntary movements of the lips, tongue and fingers, known as tardive dyskinesia; drug-induced parkinsonism; weakness and muscle fatigue; sedation and lowering of blood pressure to levels that are too low, especially in patients that are taking

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## ANTIPSYCHOTIC MEDICATIONS

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other drugs to treat high blood pressure. As a result of a drug-induced drop in blood pressure, falls result in injury, heart attacks and strokes may also occur. The drug reference book, "Worst Pills/Best Pills", states that antipsychotic medications should not be administered to dementia patients and especially the elderly.

While you or a loved one is in a nursing home or an acute hospital, be sure to continually check medication orders to ensure that the proper medications are being administered and that there has been informed consent giving prior to the administration of any antipsychotic drug. If the nursing home or acute hospital is not adhering to this regulation, a complaint should be filed with the state regulatory agency mandated to ensure that the nursing home is abiding by both federal and state nursing home regulations in order to ensure the health and safety of all patients. We all fear losing our minds as we age. So mind altering drugs should be our enemy and add to that a lack of drinking sufficient water to stay hydrated could be lethal.

## Rights to Visits From Family Members

Under the Federal law, all nursing home patients have the right to unrestricted visits by family members 24 hours a day while in a nursing home. Most nursing homes in the country post visiting hours; however, the posted notices fail to state that the visiting hours are for non-family members only. Individual states may also have regulations on visiting hours; however, the federal law states 24/7 and always takes precedence over state law.

## Resident Bill of Rights

As a resident of a skilled nursing or intermediate care facility, you have the right to:

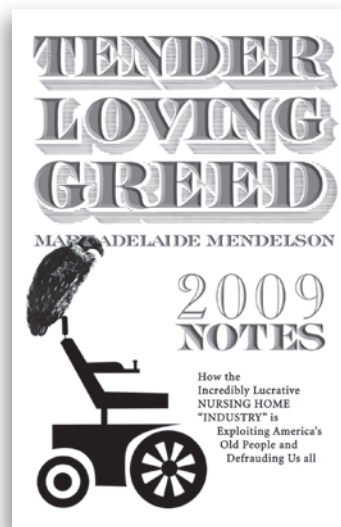
- be fully informed of your rights and all rules adopted by the facility that you must follow.
- freely exercise all your rights and to get help from the facility in doing so.
- be treated with consideration, respect and dignity.

- suggest changes and to file complaints you have about the facility and to be free of any reprisal.
- organize and participate in resident/family groups to discuss facility operations and quality of care/life.
- get information from the facility about how to apply for and use Medicare and MediCaid benefits.
- be fully informed by a doctor about your health status.
- review your medical records and get copies of them.
- participate in developing a plan of care to meet your health needs
- choose your own doctor and to know how to contact him/her.
- consent to, or to refuse, any treatment or medical procedure and the right to revoke your consent at any time.
- get all the information you need to make a decision whether to accept or refuse any treatment.
- know whether the facility owns or has an interest in any other health care provider.
- confidential treatment of your medical and financial records and to approve/deny the release of the information.
- care in the facility that is clean, sanitary and in good repair.
- care that is provided by an adequate number of qualified staff, promotes good personal hygiene and prevent bedsores.
- enough good food to meet your needs based on your doctor's orders.
- be free of any mental or physical abuse.
- to be free from drugs or devices used to restrain you, if not medically needed or are used for staff convenience.
- have daily visits with your family, friends, clergy or anyone you choose to meet privately.
- access to a telephone and to talk privately on the telephone.
- Review the results of the most recent government inspection of the facility and the plan of correction to any problems.

## BOOKS OF INTEREST

**“TENDER LOVING GREED”**  
 ....written by Mary Adelaide Mendelson (1917-1997)  
 (The book includes excerpts from “Conspiracy of Silence”, written by Mary Adelaide Mendelson and Walton Mendelson)

Back in the early 1980's, about the time I started FATE, I had a friend who was a reporter for the Dallas Sun. He knew of the advocacy work I was doing and sent me a book he had read when he was going to write some stories on the nursing home industry. He thought this book would be very helpful to me. The book, entitled “Tender Loving Greed” was indeed very helpful and provided me with a great deal of information on how the nursing home industry operates. Better yet, several years later, I received a phone call from the author, Mary Adelaide Mendelson, after she had seen me on a national talk show about abuse in nursing homes. She and I became very close colleagues and she was my mentor and good friend until her untimely death in 1997. Ms. Mendelson got her bachelor's degree from Radcliffe College and her master's from the University of Michigan. She taught government and history for five years before joining the Federation for Community Planning of Cleveland in 1964, where she was assigned the task to see if there was a way to improve nursing homes. This experience led her to write “Tender Loving Greed” for which she received the George C. Polk Award in 1974. “Tender Loving Greed” is a reissue of the 1974 edition from Alfred A. Knopf and the 2009 Notes give something of the history of publishing “Tender Loving Greed” despite the efforts to kill the book by the Chairman of the Senate Subcommittee on Long-Term Care. This book will discuss how the incredibly lucrative nursing home industry is exploiting America's old people and defrauding us all. The book can be ordered through Amazon.com or from [wwwcreatespace.com/customer/EStore.do?is=3401413](http://wwwcreatespace.com/customer/EStore.do?is=3401413) at a cost of \$6.95.



*Mary Adelaide Mendelson*

### Other Books of Interest are:

**“How Old Would You Be If You Didn't Know How Old You Were?”**...Entertaining and informative book on the topic on aging in America.

The above book can be ordered from:  
 Todd Publications, P. O. Box 1752,  
 Boca Raton, FL 33429...\$9.95 plus shipping.

**“The Real Truth About Aging”**...A survival guide for older adults and caregivers...\$21.98

**“An Insider's Guide to Better Nursing Home Care”**...Tips you should know...\$17.88

**“What if it's Not Alzheimer's?”**...A caregiver's guide to dementia....\$22.98

**“Forgetting”**...When to Worry, what to Do...\$19.98.

**“Eldercare 911”**...The Caregiver's complete handbook for making decisions....\$26.98

The five books listed above can be ordered from:  
 Prometheus Books  
 59 John Glenn Drive  
 Amherst, NY 14229  
 (800)421-0351

# NURSING HOME COMPLAINTS

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

**EL DORADO CARE CENTER (HORIZON, INC.), PLACERVILLE, CA...CLASS B CITATION...\$1,000.00 PENALTY.** Failure to report an allegation of suspected abuse to the Department of Public Health; failure to investigate the allegation of abuse for over a month; and, failure to implement their abuse policy when they did not interview the patient's husband about her injuries. These violations had a direct or immediate relationship to the health, safety and security of long-term care facility patients.

**FLORIN HEALTH CARE, SACRAMENTO, CA...DEFICIENCIES...**Failure to provide copies of medical records; failure to provide assistance to the patient when requested use of a telephone; failure to follow policy to safeguard personal effects of patient; failure to obtain family contact information; failure to notify family of change in patient's condition; failure to notify family of transfer to an acute hospital; failure to provide family contact information to the acute hospital.

**FOOTHILL OAKS CARE CENTER (HORIZON, INC.)...AUBURN, CA...CLASS B CITATION...\$600.00 PENALTY ASSESSMENT.** Failure to meet the required minimum number of actual nursing hours per patient per day. This violation of staffing requirements had a direct relationship to the health, safety and security of the patients.

**IVY RIDGE RETIREMENT HOME, SACRAMENTO, CA...DEFICIENCIES...**Failure to ensure that patient did not have falls with sustained injuries; failure to report falls and injuries to the licensing agency; failure to provide proper 30-day eviction notice and failure to refund monies due the resident.

**LA MARIPOSA CARE & REHAB CENTER, FAIRFIELD, CA...CLASS B CITATION...\$1,000.00 PENALTY ASSESSMENT...**Failure to provide sufficient staffing which had a direct relationship to the health, safety or security of the patients.

**MISSION CARMICHAEL HEALTHCARE, CARMICHAEL, CA...DEFICIENCIES...**Failure to accurately maintain records of controlled drugs dispensed and administered; failure to implement their physical restraint consent policy and procedure when patient consented to side rails for mobility; failure to ensure accurate documentation of routine and as needed medications.

**RIDEOUT MEMORIAL HOSPITAL, MARYSVILLE, CA...DEFICIENCIES...**Failure to ensure policies and procedures were followed when staff failed to obtain a physician's order for a restraint; failure to ensure that the staff acted as an advocate for the patient when they failed to ensure the patient's needs were met while in a cervical collar; and failure to provide information to and obtain consent prior to the administration of a psychotropic medication.

**PETALUMA CARE AND REHAB, PETALUMA, CA...DEFICIENCIES...**Failure to ensure that the required

wording was included in the facility arbitration agreement; failure to identify care needs of patient with a continuing assessment when patient complained of shortness of breath and not being able to swallow; failure to obtain a physician's order to administer oxygen therapy to patient; failure to establish written patient care policies and procedures for emergency versus non-emergency ambulance transportation which resulted in patient experiencing a delay in gaining access to emergency medical care; failure to retain medication administration records for patient; and failure to ensure that medical records were disclosed to authorized person in accordance with the law.

**PETALUMA CARE AND REHAB, PETALUMA, CA...DEFICIENCIES...**Failure to inform the responsible party of the patient's change of condition on two occasions; failure to inform the responsible party of results of a chest x-ray; failure to obtain informed consent from the responsible party prior to the use of a psychoactive medication, Zyprexa.

**SANTA CRUZ HEALTHCARE CENTER, SANTA CRUZ, CA...CLASS B CITATION...\$900.00 PENALTY ASSESSMENT...**Failure to protect resident from physical abuse when another resident repeatedly slapped patient on the face causing an injury. The above violation had a direct or immediate relationship to the health, safety or security of patients.

**SANTA CRUZ HEALTHCARE CENTER, SANTA CRUZ, CA...DEFICIENCIES...**Failure to report to the Department of Public Health within 24 hours of an unusual occurrence which threatened the welfare, safety and health of a resident; failure to maintain a patient health record in accordance with accepted professional standards and practices.

**SANTA CRUZ HEALTHCARE CENTER, SANTA CRUZ, CA...CLASS B CITATION \$700.00 PENALTY ASSESSMENT...**Failure to report to the State Ombudsman immediately or as soon as practicably possible and followed by a written report sent within two (2) working days, when a patient reported to the facility that a certified nurse assistant was verbally abusive. The above violation had a direct or immediate relationship to the health, safety or security of patients.

**SANTA CRUZ HEALTHCARE CENTER, SANTA CRUZ, CA...CLASS B CITATION \$700.00 PENALTY ASSESSMENT...**Failure to ensure the alleged patient abuse was reported to the Department of Public Health immediately or within 24 hours. The above violation had a direct or immediate relationship to the health, safety or security of patients.

**SHERMAN OAKS HEALTH & REHAB, SHERMAN OAKS, CA...DEFICIENCIES...**Failure to evaluate the effectiveness of treatment and failure to identify the need for a dermatologist's assessment for a patient with scabies

and failure to prophylactically treat employees with a scabicide to prevent the spread of infection. (Complaint filed by FATE client.)

**SIERRA HILLS CARE CENTER, ROSEVILLE, CA...DEFICIENCY...**Failure to follow policy for pain management when patient was sent to physical therapy without receiving pain medication as ordered by the physician prior to physical therapy.

**SKY PARK GARDENS, SACRAMENTO, CA...DEFICIENCIES...**Failure to provide air conditioning and heating control in patient room; patient rights violation by limiting patient's visits with family members at the request of Adult Protective Services when patient was her own self conserved; allegations of facility administering mind controlling medications was inconclusive.

**VILLA MONTE VISTA, POWAY, CA...DEFICIENCIES...**Failure to develop a care plan for a PICC line (a catheter inserted through the skin into a main blood vessel to infuse fluids/medications); failure to ensure that licensed staff implemented a plan of care related to fluid restriction and failed to maintain accurate intake records to ensure compliance with the physician's orders; failure to document that the physician was notified when three pressure sore sites increased in size; failure to provide copies of policies and procedures for bedsores, bowel impaction and insufficient staffing as requested by family members and failed to review the policy and procedures on an annual basis; and failure to implement the pharmacy protocol when a PICC was removed from the patient; failure to ensure that facility staff completed meaningful weekly progress notes.

**WINDSOR EL CAMINO CARE CENTER...SACRAMENTO, CA...DEFICIENCIES...**Failure to ensure that the call light system was readily accessible for patients use in the facility.

**WINDSOR ELK GROVE CARE & REHAB CENTER, ELK GROVE, CA...DEFICIENCIES...**Failure to make readily available all medical records regarding the patient when requested by the responsible party who was lawfully authorized to access the medical records.

**WINDSOR ELK GROVE CARE & REHAB CENTER, ELK GROVE, CA...DEFICIENCIES...**Failure to provide the required minimum staffing to meet the needs of the patients; failure to ensure that patient health records contain meaningful, informative nurses' notes, accurately reflecting intake fluid status specific to the patient's needs.

**YUBA CITY CARE CENTER, YUBA CITY, CA...DEFICIENCIES...**Failure to ensure informed consent was obtained from the patient or the patient's decision makers prior to the administration of psychotropic medication, namely, Zyprexa, to the patient.

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**In Memory of Freda Vogel**

Lesley Clement, Sacramento, CA  
Cordia Wade, Sacramento, CA  
Dr. and Mrs. Melford Weiss, Sacramento, CA  
Carol and Bob Williams, Sacramento, CA  
Wendy York, Esq.

York Law Firm, Sacramento, CA

Merrily and Tom Zanze, Sacramento, CA

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Sincerely,

