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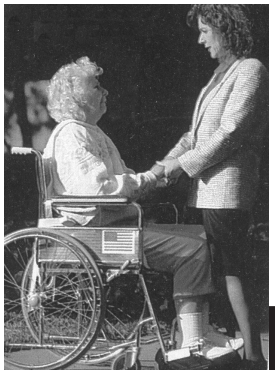

FATE

Newsletter of Foundation Aiding The Elderly

President's Message

2020… THE GOOD, THE BAD AND THE UGLY

By Carole Herman

CAROLE HERMAN

As with everyone, 2020 was a most memorable year… good, bad and ugly. The good had to be searched for, the bad was clearly visible and the ugly hopefully will never happen again.

The COVID-19 virus will be known as the most difficult event in most of our lifetimes. The ramifications of this virus will have an effect on all of us for years to come. **FATE** had to lay off staff at the most difficult time for patients in the history of nursing homes. It has been difficult over the past 35 years to advocate for our most vulnerable citizens, but this year was the worst of all. Not only have we had to fight the nursing home industry to bring about better care, but too often, we had to do more battle with state regulators to enforce state and federal nursing home regulations. With this unprecedented virus crippling the world and preventing families visits to ensure the health and safety of their loved ones, poor care and neglect went rampant in the country's nursing homes. Yes, there was a virus….yes, it hit those that had underlying physical problems, especially those with pulmonary problems and yes, many nursing home patients were dying. However, did this virus really cause all those reported deaths in nursing homes?

One good thing about the virus hitting nursing homes is that it exposed the on-going lack of infection control in most nursing homes in the United States and the lack of enforcement by state regulators whose sole purpose is to protect the health and safety of nursing home patients. In the past, **FATE** filed many complaints after seeing firsthand unsanitary conditions, such as urinals on dinner trays, soiled diapers under beds, soiled wash rags on dinner trays, mold in bathrooms, to name a few. We even presented pictures of the violations. Yet state inspectors unsubstantiated these complaints stating "if we don't see it and we didn't take the picture, it didn't happen".

Since **FATE** has clients in every state, we heard from many families all over the country whose loved ones' health had deteriorated in long-term care facilities not because they had the virus, but because they were not getting the proper care. Staff members were not showing up for work because they didn't want to catch the virus, the state inspectors were not going into facilities to monitor the care, complaints that were being filed were not being investigated and infection controls measures were not in place to prevent any infections much less the COVID-19 virus. Surely, there were many nursing home patients that actually caught the virus, mostly because the facilities probable lack of following infection control policies. In some cases, facilities didn't even have an infection control policy, which placed the patient's health in jeopardy. It's questionable why so many deaths occur after the facilities were told that MediCare would reimburse them with more dollars if the facility had patients with the COVID virus. This not only occurred in nursing homes, but also in acute hospitals with patients testing positive were also reimbursed more money. In fact, we had several calls from nursing staff in acute hospitals that the staff was told to put down the virus in medical records when

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May the Holiday season fill your soul with joy, your heart with love, and your life with laughter!

JUSTICE MATTERS… CA DEPARTMENT OF PUBLIC HEALTH TAKES 5 YEARS TO COMPLETE FATE'S COMPLAINT REGARDING A DROWNING DEATH IN A NURSING HOME

Five years ago, **FATE** filed an extensive complaint against Windsor of El Camino Care Center, a nursing home located in Sacramento, CA for the drowning death of a patient. The patient was compromised and was to have 24/7 supervision especially in a bathtub. This Windsor facility is the only one that **FATE** has ever known of that provides a whirlpool bath for the patients. According to the patient's care plan, he was never to be left alone in a shower, much less a bathtub. We will never know the true story of his drowning; however, we do know that he was alone in the tub, removed from the tub after being found unresponsive with no vitals, dried off and placed back in his bed. The facility called 9-1-1 and the responders were puzzled as to why they were called when he was already deceased and the coroner should have been called, not 9-1-1. **FATE** filed an official complaint with the CA Department of Public Health on behalf of the family on 11/24/15. On 4/18/16, the original complaint was unsubstantiated by the Sacramento District Office of Licensing and Certification, the office that monitors and investigates allegations of abuse and poor care in the region where Windsor El Camino is located. **FATE** immediately appealed this outcome and an Informal Conference (IC) was held on 4/10/17 (16 months later). **FATE** received the results of the IC on 11/6/17 (7 months later) that the complaint was again unsubstantiated. A very disturbing outcome by the State of California regulators. We immediately requested a Headquarter Appeal and that hearing was held on 10/28/2019 (2 years later). Almost one year to the day of the Headquarter Appeal Hearing and 5 years since the original complaint filing, **FATE** received notification that a Class A Citation with a $20,000 penalty was issued to Windsor of El Camino for the death of this patient. Class A Citations are based on a violation at the time of the occurrence presents an imminent danger to the patient or a substantial probability that death or serious physical harm would result therefrom, which in this case, a death did occur. A class AA violations meets the definition of a Class A Citation AND was a direct proximate cause of patient harm and/or death resulting from the occurrence. The drowning clearly warranted a Class AA Citation and a civil penalty up to $100,000.00. **FATE** exhausted the entire due process afforded the consumers, which took 5 years to accomplish. What is most concerning is that **FATE** knows the process and yet the Department continued to violate its duties to complete compliant investigations in a timely manner and to also enforce both state and federal nursing homes regulations. In this case, they did neither until we pushed them to follow regulations and cite the facility for harming this patient.

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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

DONATE TO OUR CAUSE

As with most non-profits, the virus had a very negative affect on our finances. Our donations took a tumble as people were out of work and struggling to make ends meet for their own survival. However, problems in nursing homes escalated and our work load increased. As the months lingered on, we continued to serve the public each and every day..we never missed a beat. Our commitment has always been to serve the most vulnerable no matter what and that is exactly what **FATE** did during this horrific world-wide pandemic. That being said, we sincerely hope that you will consider donating to our most-worthy and much-needed cause. **FATE** takes no government money and relies totally on the public for tax deductible donations. Our services are free and in great demand and we need your support to continue to serve. Make a donation by using the enclosed **FATE** envelope or go to www.4fate.org and donate via PayPal. Your tax-deductible donation will certainly be appreciated.

Justice Matters...

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So how does the State of California regulators handle complaints filed by the ordinary public who do not know the process? This is not the only complaint **FATE** has filed that shows the lack of enforcement by the Department, but this complaint took the longest time and clearly shows that the CA Department of Public Health did not enforce California Title22 regulations put in place by the Legislature to protect our most vulnerable citizens. Not until **FATE** exercised its due process to appeal did the State issue the citation. Shame on the California regulators for their mishandling of this egregious complaint of a dependent adult whose untimely death by drowning occurred in a California nursing home.

President's Message

Continued from page 1

the patients did not have the virus. And, who was checking with the facilities to see if the patients did have the virus? Facilities and hospitals were closed to the public and family members were not allowed in to check on their loved ones to ensure that they were being cared for. Dementia patients were not only at risk for physical suffering, but emotionally as well since they are most effected by change and could not understand why family was not around, much less why are these people all wearing masks.

Even though the **FATE** staff had to be sent home, the office was kept open to field calls from frantic family members worried about their loved ones not getting the care they needed and family members not able to go into the facilities to ensure their safety. We helped families by getting their very ill loved ones out of the facilities and into acute hospitals for treatment not for the virus, but for bed sores, malnutrition, dehydration and falls with injuries. Prior to the virus, many nursing home patients were dying from poor care and neglect so it is highly suspicious why all of those causes of death in the past all of a sudden disappeared and nursing home deaths were only caused by the virus. **FATE** initiated a lot of questions pertaining to this matter, but never received a straight answer from the state or federal regulators as to the authenticity of the industry's claim that all these patients died from the COVID-19 virus.

In California, Governor Gavin Newsom, went public and announced that the Sacramento Kings basketball team was offering up the empty old Arco Arena where the Kings played prior to building the new arena in downtown Sacramento. What Governor Newsom alluded to was that the Kings were donating the empty arena for COVID-19 patients. However, they were actually charging the State of California $1Million a month to rent the vacant arena. The irony of this is that only 6 COVID patients were ever placed in the arena which had been converted to a hospital-like environment. When it went public that the State of California was paying the monthly rental with taxpayers dollars, the Governor had egg on his face and the Kings owners decided not to charge the $1 Million for the third month. Instead of using the Arco Arena, which was set up like a hospital, Governor Newsom allowed COVID patients to be placed in nursing homes, which made no sense at all. New York Governor Cuomo did a similar thing in New York City when no patients were being placed in the Military Hospital ship and were still being placed in New York nursing homes instead.

This past year **FATE** responded to over 400 calls for help. We were able to address and resolve each and every problem for all the families that contacted our office. We filed many complaints against nursing homes, assisted living facilities and residential care homes during the pandemic. Staffing in these facilities fell short, care diminished, state regulators were not going into facilities to ensure proper care, families were denied visits, patients were suffering from dehydrations, malnutrition, falls with injuries, bed sores and depression, especially those that suffer with dementia. During the year, **FATE** provided important information on patient rights, how to advocate for your loved ones, where to obtain information and services beyond what **FATE** could provide and hand held many distraught consumers who had nowhere to turn to get help.

As we head into our 38th year of advocacy, our commitment to prevent elder abuse and make a difference for families and patients is as strong as ever. **FATE** continues to be a "force to be reckoned with" and we are very proud to have had the opportunity to help so many people. **FATE** would not be successful without the continuing dedication and hard work by staff members Eileen Dancause, Jane DeSoiza, Nancy Haycock, Chris Huskey, Harris Herman and the on-going tax-deductible contributions from our donors who are listed in this Newsletter. Our deepest gratitude to each and every one of you.

Carole Herman/President

LONG-TERM CARE FACILITY COMPLAINTS

One of FATE's services is filing complaints with the state regulator agencies on behalf of patients and residents in a nursing home, assisted living facility, residential care home or acute care hospital. Although we get complaints on a daily basis, some do not result in an actual filing with the state regulators. Over the past several years, FATE has averaged four to six complaints a month. Although a prompt response is required, state agencies can extend the process for years. Some complaints FATE files do result in the appropriate state department citing these facilities for violations of federal and state regulations. The following are results from some of those complaints:

APPLEWOOD POST ACUTE, Sacramento, CA... Federal violation… facility failed to provide copies of medical records under the federal law in a timely manner. Previously, this facility was issued a federal violation for not returning personal funds of the deceased patient to the responsible party. The violation for failure to provide the medical records was never given to FATE until it was discovered by FATE that the original findings had been changed without notifying FATE. This particular complaint also included bedsores, anemia, malnutrition, lost dentures, sending the deceased to a crematory without authorization from the responsible party, failure to notify responsible party of the death and insufficient staffing. After several years of appeals, FATE used the due process for this complaint; however, a reconsideration of the complaint has been formally requested by FATE to the CA Deputy Director of the Licensing and Certification Office.

AUBURN OAKS CARE CENTER, Auburn, CA… Federal violation... facility failed to report the reasonable suspicion of a crime to the State Agency and law enforcement within 24 hours per regulations. This failure had the potential to impede the gathering of time-sensitive information for completing a thorough investigation and protecting additional patients from abuse.

AUBURN OAKS CARE CENTER, Auburn, CA… Federal violations… facility failed to protect patient from misappropriation of property when a certified nursing assistant (CNA) took the patient's credit cards and charged items on the card. This failure resulted in the loss of a substantial amount of money with the potential risk for financial and/or psychosocial distress; failure to report the reasonable suspicion of a crime to the State Agency and law enforcement within 24 hours per regulation which failure had the potential to conceal abuse allegations, diminish the quality of the investigation and omit safeguards for the protection of patients from further abuse; failure to investigate allegations of misappropriation of property and report the results, which failure had the potential to impede the gathering of time-sensitive information for completing a thorough investigation and protecting additional patients from abuse. NOTE: the alleged perpetrator was arrested and is facing several counts of fraud and identity theft.

AUBURN OAKS CARE CENTER, Auburn, CA… Federal violations... facility failed to develop a plan of care for call light response concerns which precluded the patients from receiving staff assistance in resolving a care issue important to the patient and may have contributed to a continuing delay in meeting the patient's care needs.

CITY VIEW, Los Angeles, CA... Four "B" citations for violations of state regulations... failure to provide evidence of a reappraisal and new medical assessment and did not have documentation for providing medical attention, which posed an immediate health and safety risk to the residents in care; failure to administer medications…either missed or administered incorrectly also posed an immediate health and safety risk to the resident; failure to provide sufficient staffing to meet the needs of the residents and failure to protect residents from physical altercations with other residents.

COMFORT CARE FOR THE ELDERLY, Marysville, CA... Two "A" Citations with a $500 fine... the facility failed to ensure that more than one staff was on shift when a resident eloped resulting in resident's injuries; $500 fine was issued for not insuring resident was unable to elope from the facility causing injury and hospitalization.

EMERALD OAKS, Yuba City, CA... violations of state regulations... Three "A" Citations with a $500.00 fine… facility failed to ensure that more than one staff person was on shift when a resident eloped resulting in the resident sustaining injuries; failure to ensure resident was unable to elope from the facility causing injuries and hospitalization (an immediate $500 per day for any of the following: 1) sickness, injury or death occurred as a result of the deficient practice and the licensee did not ensure that any auditory devices were in place when the facility accepts dementia residents. An additional enhanced remedy of up to $15,000 may also be levied after a higher-level review.

HEALTHY LIFE CONGREGATE CARE, INC., Simi Valley, CA… Deficiencies… facility failed to ensure the Director of Nursing was available to come to the facility within 30 minutes. This failure had the potential for lack of nursing care and oversite as indicated in the plan of care for numerous patients; failure to ensure that no nursing personnel assigned to housekeeping or dietary duties; failure to administer multiple medications as ordered by the physician for numerous patients resulting in medication errors, which placed patients at risk for adverse effects of not receiving ordered medications; failure to implement the facility's infection control policies and procedures by not keeping an isolation cart storing personal protection equipment (gloves, masks, gowns and other supplies as needed) outside an isolation room; failure to appropriately dispose of personal protective equipment (PPE's), which had the potential for cross contaminations and spread of infections to patients, visitors and staff; failure to ensure annual review and approval in writing by the governing board of the infection control policies and procedures, which had the potential for outdated policies thereby not keeping up to date with current regulations, technology and best practices; failure to ensure annual review of the administrative policy and procedure manuals; failure to ensure the administrative policy and procedures approved in writing by the governing board; failure to ensure daily and weekly nurses' progress notes were meaningful, informative and reflective for the patient when notes indicated inaccurate information regarding internal feeding and skin status issues, which failure had the potential to result in patient care needs going unmet; failure to provide convenient handwashing and toilet facilities for laundry personnel, which had the potential to result in unsanitary linen processing, which could lead to the development and transmission of communicable diseases and failure to ensue soiled linen was handled in a manner that would prevent the spread of infection, which had the potential to result in dissemination micro-organisms which could lead to the development and transmission of communicable diseases.

HILLDALE HABILITATION CENTER, La Mesa, CA… Federal violations… facility failed to ensure complete written patient records were maintained and made available for review. The clinical records for the patient did not have documentation to show patient's activity or health information for 11 of 21 days while patient was in this facility; failure to provide documentation the prescribing physician obtained informed consent for a psychotropic medication; physician required material information was not given to the responsible party in order to make an informed decision prior to the administration of a psychotropic medication; the form signature line had a mark made by the patient to indicate she had signed the consent form when the patient was medically compromised and could not possibly know what she was signing; failure to identify and implement treatment for the patient who developed a pressure wound and there was no assessment or intervention performed and this action influenced the patient's quality of life by producing a physical decline that influenced her sense of well being; there was no documentation or verbal information available which showed the patient had any skin abnormalities or a plan for skin care to prevent any potential skin issues from developing; patient was transferred to the hospital with no licensed nurse notes to show the type of care she had received to cover the previous 11 days prior to her transfer to the hospital. The patient died as a result of the failures of the facility. FATE is appealing the decision as several other allegations, such as severe dehydration, insufficient staff, failure to access the sores and malnutrition were not addressed by the state investigator.

KAISER FOUNDATION HOSPITAL/ ROSEVILLE, CA... Federal violations... hospital failed to monitor patient for respiratory depression and assess and document the patient's sedation level following opioid administration per hospital policy and procedure. During a 18 hour period, patient was administered too many milligrams of Dilaudid and Norco for pain and failed to monitor patient's characteristics as an elderly patient with a higher risk for over sedation and respiratory depression. Patient eventually died. Even though FATE was not satisfied with the results, which took two years and three months for the State to complete the investigation, there are no appeal rights for the complainants for complaints against acute hospitals; however, acute hospitals have the right to appeal a violation.

KIT CARSON NURSING & REHABILITATION CENTER, Jackson, CA... Federal violations... facility failed to ensure patient received a therapeutic diet as ordered by the physician; facility failed to provide the patient with a well-balanced diet that meets the patient's daily dietary needs, which was in violation of the patient's nutritional well-being; facility failed to provide patient with food that he would eat. These violation resulted from the first-time ever complaint that FATE has filed pertaining to food being given to patients. The patient received a dinner meal of 1 Oz. of potato chips, 1 peanut butter cookie, 8 Oz. of water, 4 Oz. milk and 6 Oz. of coffee. The family removed their relative from the facility after this event.

LINDA VISTA NURSING AND REHABILITATION, Ashland, Oregon… Federal and State Violations… facility failed to follow physician orders, which placed patient at risk for clinical complications as the facility failed to remove patient's staple as ordered; facility failed to have sufficient nursing staff with appropriate competencies and skills sets to provide nursing and related services; facility failed to ensure the patient's call bells were answered timely. Additional allegations of patient developing bed sores and patient given antipsychotic medications unnecessarily were unsubstantiated.

ORCHARD POST ACUTE CARE, Vacaville, CA… Federal Deficiencies... failure to develop and implement a comprehensive and resident-specific care plan that addressed the patient's wound care needs following surgery to his back; failure to store medications in a locked compartment when a medication cart with patient medications and over-the-counter medications was left unattended and unsecured in the facility hallway; failure to have records not readily available and the failure of staff needing to contact information technology to explain the documents which resulted in a delay in the investigation of patient care. These failures had the potential to cause, and did cause, harm to the patient. FATE was originally told that the complaint allegations filed had been unsubstantiated. FATE requested an Informal Conference and 30 minutes before the conference, FATE discovered that the department had in fact issued these deficiencies but told FATE that the complaint was not substantiated.

ORCHARD POST ACUTE CARE, Vacaville, CA… Federal Deficiencies… failure to follow nursing care plan precautions to prevent pressure sores from developing, which resulted in patient sustaining a Stage 3 pressure sore putting the patient at risk for an enlarged wound and infection. FATE filed an appeal as the State did not address other allegations of sepsis, urinary tract infection, not notifying responsible party of the change of condition and insufficient staffing.

RIVERSIDE CONVALESCENT HOSPITAL, Chico, CA… Federal Deficiencies… failure to produce copies of medical records in violation of federal regulations and failure to ensure that adequate supervision was provided for patient during a shower when the patient fell onto the floor. This failure resulted in the patient experiencing a fall with injury and the potential for further accidents and negative outcomes to occur to other patients.

ROSELEAF OROVILLE, Oroville, CA… Class A Citation….the facility failed to provide care and supervision to a resident when the resident was admitted to an acute hospital with left lower extremity burns as the resident's clothing was set on fire while smoking a cigarette unattended, which was in violation of the care plan, which clearly stated the resident was not to be left alone while smoking. The resident underwent skin grafting of the lower extremities and then placed in a skilled facility for further care. This matter is currently under further investigation by the CA Department of Social Services, Community Care Licensing, which may result in an Enhanced Remedy fine.

ST. FRANCIS HEIGHTS CONVALESCENT, Daly City, CA… Class B citation, $2,000.00 Civil Penalty Assessment... the facility failed to implement the pain management when assessments were not done before and/or after pain medication administration. This failure had the potential to administer incorrect doses and inaccurately assess the effectiveness of the pain medication which could have negatively affect the patient's quality of life; failure to notify the physician of a change of condition requiring transfer to the acute care hospital for uncontrolled pain in the right leg.. FATE has appealed this citation as numerous other allegations were not investigated by the department as the patient had a leg amputated .

SACRAMENTO POST-ACUTE, Sacramento, CA… Class B Citation, $2,000.00 Civil Penalty Assessment… facility failed to implement their policy and procedures when the facility did not notify or involve the physician about patient's worsening left gluteal fold wound (pressure

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Long-Term Care Facility Complaints

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sore). This failure had a direct relationship to the delay of the healing process of the pressure sore. The patient died from the pressure sores that was developed in this facility, which caused sepsis and osteomyelitis. This death clearly warranted a Class AA Citation with a hefty fine; however, the State of California took over 6 years to issue this small citation. FATE exhausted all of the appeal rights and has now written to the Deputy Director of the Licensing & Certification Department to re-look at this complaint as there was very clear evidence from the death certificate and medical records that warranted the most punitive citation, which the State of California failed to issue.

STEPHEN HOUSE, Clovis, CA… Class B Citation... this residential care facility failed to allow resident visits as residents in all residential care facilities for the elderly shall have the right to visitors, during reasonable hours and without prior notice, provided that the rights of other residents are not infringed upon. The complaint alleged that the Public Guardian denied resident visits with a direct relative and denied the resident visits with certain family members. It was determined that the personal rights of the resident were infringed upon in terms of permission to visit privately during reasonable hours and without prior notice.

STOCK RANCH ROAD RETIREMENT, Citrus Heights, CA… Federal Deficiencies... facility failed to provide resident's responsible party with a copy of their complete records in a timely manner. The records also did not include the incident and death report for the incident involving the resident. Prior to this deficiency, three Class A Citations were issued to this facility for failure to submit the incident report of the event in a timely manner and failure to observe the resident for at least 24 hours. Resident was found dead by an outside caregiver. The coroner determined that the resident bled out from an injury and had been dead for at least two days.

WINDSOR COUNTRY DRIVE CARE HOME, Fremont, CA… Federal Deficiencies... facility failed to inform the physician of a change in health condition when patient was sent to the acute hospital. Otherallegations of bed sores, dehydration, untreated UTI were unsubstantiated by the State. Patient left the state so no appeal was submitted.

WINDSOR ELK GROVE, Elk Grove, CA... Federal Deficiencies...facility failed to protect the patient from a physical assault when patient was hit by another patient, which placed the patient at risk for physical and psychological harm.

WINDSOR EL CAMINO CARE CENTER, Sacramento, CA… Class A Citation, $20,000.00 Civil Penalty… (NOTE: It took the State of CA Dept. of Public Health, 5 years to complete this investigation)… the facility failed to comply with regulations by not ensuring staff followed Patient Care Policies and Procedures and not providing a safety equipped bathtub with a call bell and grab bar for physically challenged patient's use when staff found the patient submerged and unresponsive in a tub full of water. These failure resulted in the patient's drowning death. (See article on this complaint in this newsletter.)

Special Thanks to our Donors

Gifts received from December 2019 to publishing date.

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