Vol 21 No 1
Winter 2021

FATE

Newsletter of Foundation Aiding The Elderly

President's Message

THE BEAT GOES ON…. ANOTHER YEAR OF COVID… ANOTHER YEAR OF ABUSES

By Carole Herman

CAROLE HERMAN

Another year of COVID has passed along with another year of continued abuses going on all over the country in long-term care facilities. Restrictions going into long-term care facilities have eased up somewhat, but the industry is still making it difficult for families to visit 24/7, even though there are mandates from the Center for MediCare Services (CMS) to ease up on the restrictions. Facilities have been demanding that family members, even if vaccinated, be tested every week prior to making a visit to their loved ones. Some of our families have called complaining because the testing has become quite expensive and they can't afford to pay the fee and are being denied visits. We continue to work on a case-by-case basis to help families get into facilities to check on their loved ones. It has been a difficult task as the industry wants to keep us out because the facilities are chronically understaffed, which relates to automatic neglect. Our experience is that the industry is using the COVID excuse and stating that many patients have tested positive for the virus when we know differently. Facilities receive a larger reimbursement to care for patients that have tested positive for COVID. Some of our clients have had their family members, who they were told had the virus, call 9-1-1 and have the patient sent to an acute hospital where they have been tested negative for the virus. As well, we continue to file allegations of abuses with the State regulators for malnutrition, dehydration, bedsores, falls with injuries, etc. This past year, I have personally focused on getting media attention to these on-going abuses. We brought incidences of abuse to the major Networks, i.e., ABC , NBC, CBS, Fox News, which were aired and as well, to the NY Times, Wall Street Journal Market Watch, Sacramento Bee, Cal Matters, USA Today to name a few.

We rely on the news media to expose this national disgrace so that other families will come forward if they suspect any type of harm to their loved ones. It has become more and more difficult to get facilities sanctioned for poor care, neglect and abuse by the regulators. The reason? Investigations are sloppy, investigators are working at their homes under no supervision and allegations are being unsubstantiated on a regular basis. No matter what the facility documents in their records, the regulators believe them and turn their heads on what the family tells them and discount the condition of the patient after being in the facility. I believe in "outcome"... If a consumer enters a long-term care facility with clear skin and not dehydrated, was not under nourished, had no broken bones, had no sustained injuries due to falls, etc. then surely it's pretty clear that the patient suffered from poor care and neglect while in the facility. Not according to the regulators who tell us that "falls happen when you get old" or "the injury may have occurred in the ambulance on the way to the emergency room" and these regulators unsubstantiated approximately 90% of the egregious abuse complaints we file. These are very offensive excuses from the regulators who are mandated to investigate abuses, violations of state

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

JUSTICE MATTERS... FATE FILES ANOTHER PUBLIC INTEREST LAWSUIT AGAINST THE CA DEPARTMENT OF PUBLIC HEALTH

FATE has filed yet another public interest lawsuit against the California Department of Public Health (DPH) for its failure to promptly investigate allegations of neglect and abuse of patients in California nursing homes. In 2013, the Lexington Law Group filed the first lawsuit on behalf of **FATE** seeking to remedy DPH's widespread delay in concluding complaint investigations within the time frames set by California law and promptly reviewing those findings once rendered. The lawsuit secured long-over-due relief for a number of **FATE** clients who had been waiting for years for the complaint process to resolve. This lawsuit helped **FATE** spur the 2015 passage of Senate Bill 75, which amended California law to reduce the time in which DPH must complete such investigations. At the time, **FATE** was hopeful that DPH would do a better job in the future. However, as time would tell, this was not the case and DPH fell back into their mode of operandi and complaint investigations were not being completed in a timely manner per the law. Thus, at the later part of 2020, the Lexington Law Group on behalf of **FATE** again had to file another public interest lawsuit to compel DPH to adhere to their mandate for the completion of complaint investigations and the appeal process. The current lawsuit is still pending resolution. **FATE** continues to be hopeful that DPH will live up to its responsibility and purpose to protect the health and safety of our most vulnerable citizens in long-term care facilities… Time will tell.

FLORIDA LAW ON PUNITIVE DAMAGES BEING CONTESTED AGAIN

Debbie Dahmer of Florida never gives up. Her father, professional wrestler George "Chief White Owl" died from poor care and neglect in a Florida nursing home back in 2012. After years of litigation, the Dahmer family won a civil lawsuit that included punitive damages. However, they discovered that there was a law in Florida that allowed the State of Florida to get 50% of any punitive damage award in a civil lawsuit. This means that the department that is to oversee nursing homes in Florida gets a reward for not protecting Mr. Dahmer while he was abused in a Florida nursing home. This did not seem ethically right, and possibly unconstitutional, to Debbie so she began her quest to have the law repealed. Debbie reached out to **FATE** to assist her in her mission, which we gladly did and have worked with her each year since then to have this law repealed. That was six years ago and the bill was voted down each year. Debbie did not give up and neither did **FATE** or Representative Amber Mariano, who has authored the bill each year. During this process, **FATE** learned that there are other states that have the same law on the books. The Florida Department that receives the funds is not in favor of having this law repealed. We will continue with this mission to get the law ousted in Florida and then attempt to have the other states repeal the same type of legislation.

"Elder abuse is like child abuse, except the victims never grow up to testify."

– American Journalist, Brett Arends.

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

Again, this year the virus had a negative effect on our finances. People were still out of work and struggling to make ends meet. Problems in long-term care facilities were on-going and our work load continued to increase yet we stayed on our path to serve the most vulnerable and their families. We hope that you will consider donating to our most-worthy and much needed cause. **FATE** takes no government money and relies solely 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 Pay Pal. Your tax-deductible contribution will certainly be appreciated.

President's Message

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and federal nursing home regulations and whose main purpose is to protect our most vulnerable citizens.

In all reality, **FATE** should not be doing this advocacy work. The regulators should do their job of enforcement of regulations and the industry should not be so greedy by putting profits before patients. The health care industry in this country is among the top companies reaping the large amounts of tax-payer dollars through the MediCare, MediCaid and MediCal systems. But where is the over-sight? We are paying for substandard care and I have yet to find the politician who will take on this national problem to make it right for us citizens. Recently, I sat in on a California Assembly hearing regarding the State of California, Department of Public Health, not meeting its mandate to investigate nursing home abuse complaints in a timely manner. **FATE** filed a Public Interest lawsuit several years ago that resulted in time periods for the department to complete investigations. It worked for a while, but the State fell back into its old habits and in November of 2020, **FATE** had to file yet another public interest lawsuit against the CA Department of Public Health for its failures. ***(See the article on page 2)***.

During this past year, we had the honor of assisting over 300 more families from all over the country concerning many issues. Some were abuse complaints that **FATE** could help with, some calls were not regarding long-term care neglect or abuses or elder health care issues at all. Some calls were from consumers who had money stolen from them, neighbors harassing them, landlords attempting to evict them from their rentals, children trying to find a parent who was being hidden from family members by another sibling and a slew of calls regarding conservatorship abuses. **FATE** has been on the forefront of conservatorship abuse since the mid 1980's when we had our first call regarding a conservatorship abuse. Her name was Isabel Miller and she had been conserved by the Placer County Public Guardian's Office. Her story received media attention when I appeared on the Geraldo Rivera talk show in October of 1986 and exposed how she died in a nursing home from being drugged and developed stage 4 bed sores that caused her death. Since then, **FATE** has received hundreds of calls regarding the abuse of power by court appointed conservators and public guardians all over the country resulting in nine banker boxes of documented conservatorship abuse cases. The video of the Geraldo show can be viewed on the **FATE** web page. The issue of conservatorship gained national attention this year with the media exposure of the Brittany Spears conservatorship case. As well, **FATE** and numerous victims of conservatorship abuses appeared on ABC Channel 10 Sacramento expose' on abuse of conservatorships entitled "Abuse of Care". It is a 5-part series and can be viewed on the **FATE** web page or on the ABC/10 Sacramento web page. We continue to count on the news media to expose wrongdoings toward the elderly. As **FATE** enters its 40th year of advocacy and having served over 8,400+ families all over the country, we continue to keep a positive attitude in our attempts to help the public maneuver through the nightmares of long-term care. It's not an easy task, as we unfortunately never receive calls about good experiences in long-term care facilities. Quite the opposite. However difficult, we continue our dedication to making a difference in the lives of our most vulnerable citizens and their families. And we will continue to count of the news media to expose wrong doings toward our elders.

Special thanks to the Lexington Law Group in San Francisco who filed the recent civil lawsuit for the benefit of the public, the elder abuse attorneys across the country who file civil cases against the industry abusers and our dedicated staff… Jane DeSoiza, Eileen Dancause, Chris Huskey and Harris Herman for all of their hard work and dedication. And, a very special thank you to all of our donors for continuing to support our work. We couldn't do it without any of you.

RESIDENTIAL CARE OPERATOR CITED FOR IMPERSONATING A DOCTOR

After several consumers contacted **FATE** regarding concerns about a residential care facility operator in Orange County and San Diego County impersonating a doctor, **FATE** filed an official complaint with the California Medical Board. After a three year investigation, the Board issued its findings that the facility operator who continually wore a doctor's coat, referred to herself as a Doctor, and had numerous pictures on the internet with a stethoscope around her neck, was indeed not a doctor or a Ph.D. and had purchased a fake Ph.D. degree from a diploma mill headquartered in London. She was cited for violating the CA Business and Professional Code and Title 16, of the CA Code of Regulations by impersonating a doctor. She was issued a fine and ordered to cease and desist from using "Dr." and/or doctor and to remove all references of being a doctor or MD from all of her postings. The CA Medical Board turned the case over to the Orange County District Attorney for prosecution; however, for some reason, the District Attorney of Orange County refused to prosecute her. The Rule of Law is Enforcement and without justice, there is no law.

Surveillance Cameras in Long-Term Care Facilities

Many years ago, **FATE** worked with Violette King, the founder of Nursing Home Monitors located in Godfrey, IL. Violette was considered the grandmother of cameras in long-term care facilities. She worked for years attempting to get cameras to be mandated in nursing homes. Unfortunately¸ Violette passed away several years ago. Surveillance cameras and other devices can offer information about the type of care patients are, or are not, receiving and how patients are being treated by nursing home staff. However, they can be invasive and may violate resident privacy. They are also no substitute for personal involvement and monitoring. **FATE**'s position on cameras is to start off with mandated cameras in the halls so that those entering the patient's room can be seen, which would determine how often a staff members goes into the room to tend to the patient's needs, timing of when medications are administered to make sure its according to physician orders, identification of who entered the patient's room and at what time they entered. This could be a means of ensuring proper care. There is no reason why the industry would object to this other than it would expose the facility to poor care, lack of staffing and other issues detrimental to the patient. Recently, a camera in the room of a 90 year old woman became the key factor when she was assaulted by two care givers. The video clearly shows the abuse and the perpetrator was arrested for elder abuse. **FATE** reported this abuse to the state regulators and the results are listed in this newsletter under Brookdale/Folsom. The staff person who stood by and did nothing has yet to be arrested. Hopefully, regulations can be enacted to include mandated cameras in at least the hallways of the facilities.

ANTIPSYCHOTIC MEDICATIONS ARE MISUSED IN NURSING HOMES

In August of 2021, the New York Times published a report detailing the disturbing rise of patients with schizophrenia diagnoses in nursing homes and an accompanying rise in the use of antipsychotic medications. The Times investigation concluded that at least 21 percent of nursing home patients are on antipsychotic drugs. The report also found that "the government and the nursing home industry are obscuring the true rate of antipsychotic drug use on vulnerable patients." Although the federal government tracks antipsychotic drugging in nursing homes, patients with schizophrenia diagnoses are not included. As a result, a facility's illegal use of antipsychotics is hidden by falsely diagnosing residents with schizophrenia. Many patients, particularly those living with dementia, are being given off-label antipsychotic drugs to control their behavior. These antipsychotics for older people are not approved for the treatment of dementia. Nursing homes are chronically understaffed and do not pay enough to retain employees, especially the nursing assistants who provide the bulk of the patients' daily care. Studies have found that the worse a nursing home's staffing situation is, the greater its use of antipsychotic medications. **FATE** was a participant in the California group that worked on the reduction of antipsychotic uses in nursing homes. However, it became very frustrating that there appeared to be no improvement in the drugging of nursing home patients. Families with loved ones in nursing homes should be aware of the fact that nursing homes are insufficiently staffed and that there is a high probability that these drugs will be used in place hands-on care.

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:

BROOKDALE/FOLSOM….Folsom, CA… Three Type A Citations….$500.00 penalty assessed……facility failed to ensure that residents are free from punishment, humiliation, intimidation, abuse or other actions of a punitive nature, which poses an immediate health and safety risk to the resident in care; failure to ensure residents were treated with dignity; failure to receive an approved criminal record exemption for a staff member, which posed an immediate health and safety risk to the residents in care; failure of the licensee staff member to report physical abuse, which posed an immediate health and safety risk to residents in care. These citations were issued after **FATE** filed an official elder abuse complaint after the assault on this elderly resident causing her great harm. During **FATE**'s gathering of information, it was discovered that the other staff member in the room who did nothing to prevent the assault had been on probation for another crime and Brookdale was not cleared to hire her. There may be additional penalties assessed on this complaint.

CAPITAL TRANSITIONAL CARE, Sacramento, CA…Deficiencies….facility failed to follow their policy related to ensuring accuracy of a patient's admission record when the record contained an inaccurate social security number and the facility failed to release medical records within the facility directed time frame upon request of a family member. **FATE** will appeal the outcome of the investigation as the Department of Health investigator did not address bedsores, malnutrition, weight loss, falls and insufficient

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Long-Term Care Facility Complaints

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staffing. As well, the findings for the failure to provide copies of the medical records is a failure of the federal law and should have been cited as such.

COMPASS ROSE MEMORY CARE, THE TERRACES, Chico, CA…..Class A Citation….facility failed to fill the resident's prescription for pain medication upon discharge from the hospital, which posed an immediate health and safety risk to the resident. Other allegations, such as insufficient staffing, failure to provide basic needs for the residents, failure to notify family of change of condition, failure to prevent hematoma and resulting bleeding, failure to develop care plan for a COVID positive resident for over a week, failure to send COVID positive employee home from work were all unsubstantiated. This complaint was investigated by the State of California, Community Care Licensing, Investigative Branch. Under statute, the care home may contest the Class A citation; however, under current statute, the complainant does not have the same right to appeal the lack of findings by the department. **FATE** will attempt to have the department re-look at this complaint.

COTTONWOOD HEALTHCARE CENTER, Woodland, CA….Deficiency…..facility failed to develop care plan for care needs for diabetes and antipsychotic medication use. **FATE** filed for an appeal based on the state's failure to address the other allegations, i.e., development of bedsores, non-working call bells, insufficient staffing, failure to provide all the medical records, failure to obtain consent before administering an antipsychotic medication, failure to maintain patient hygiene and failure to provide adequate care.

GRANT CUESTA SUB-ACUTE AND REHABILITAITON CENTER….Mountain View, CA…Deficiencies….facility failed to notify the responsible party of physician orders for an X-ray and narcotic drugs used to treat moderate to severe pain. This failure resulted in the patient's responsible party to be unaware of changes to the patient's healthcare and the potential to not be involved in the provision of care. The facility failed to implement interventions to maintain a safe environment and reduce risk hazards when resident eloped from the facility unnoticed and unsupervised and resident had a reported fall with no post fall assessments. These failure had the potential to result in significant harm and injury to the patient. **FATE** filed an appeal hearing based on the department ignoring the allegation that the patient suffered a broken hip from the fall that went unnoticed for almost a week, was dehydrated, was a fall risk and escaped the facility on two occasions. The patient was harmed in this facility, which warrants a State Citation with a civil penalty.

JURUPA HILLS POST-ACUTE, Riverside, CA…. Original complaint filed by the family for dehydration, weight loss, lack of personal hygiene, excessive medications and a broken neck. **FATE** filed an appeal at the request of the family due to the Department of Public Health not properly investigate all allegations.

LATER YEARS SENIOR CARE HOME, Sacramento, CA…Several citations…. Class A…facility staff used an over the counter medication on a resident without a prescription order from a licensed professional. This violation posed an immediate health and safety risk to residents; Class A…facility staff stored medication in a drawer in the resident's room that was not locked, which also posed an immediate health and safety risk to the resident; Class B…screen was missing from the window prior to the admittance of a resident and was not immediately repaired which posed a potential health and safety risk to the resident. The other allegations regarding this facility were that the facility did not meet the hygiene needs of resident, development of bedsores, did not observe resident's change of condition, was left unattended for extended periods of time, not providing activities and restricting resident's water intake were all unfounded.

LEGACY OAKS OF SACRAMENTO, Sacramento, CA…Class A and Class B Citations…The A citation was for the facility's failure to have signal system which shall meet the following criteria: all facilities licensed for 16 or more and all residential facilities having separate floors or buildings shall have a signal system which shall operate from each resident's living unit and shall transmit to a central staffed location. Inspectors found that the memory care pull cords in residents' rooms were deactivated or not functioning which posed an immediate health, safety or personal rights risk to residents' care. The B citation was regarding the facility's failure to meet requirements to comply with all applicable terms and conditions set forth in the admission agreement, which states there is a signal system in each residents' bedroom. The violation posed a potential health, safety and personal rights risk to residents in care.

MAIN PLACE POST-ACUTE, Orange, CA…. Original complaint filed by family…FATE filed an appeal based on the Licensing Offices failure to investigate all allegations, which led to the death of the patient.

ORCHARD POST ACUTE CARE, Vacaville, CA…Deficiency…facility failed to follow physician orders to notify the physician of weight changes of 2 pounds or more a day. This failure resulted in the resident not being treated timely for exacerbation of his condition, which resulted in declining health. **FATE** will file an appeal on these findings as other reported violations were not reported on by the state regulators.

ORCHARD POST ACUTE CARE, Vacaville, CA…Class B citation, Assessed Penalty $2,000.00….as a result of **FATE**'s appeal to the original findings of a deficiency, the Santa Rosa Office re-opened the complaint and issued a Class B Citation for the facility's failure to assess, treat, document or follow the nursing care plan and provide necessary nursing services to prevent, identity and promote healing of a pressure sore. As a result, the patient developed a pressure wound which progressed to a Stage 3 wound within a week, which had a direct relationship to the health and safety of the patient and caused physical harm to the patient.

ROSELEAF/OROVILLE, Oroville, CA…. ENHANCED REMEDY CITATION WITH AN ASSESSED PENALTY OF $10,000.00….. Previously reported in our last newsletter was that the facility was issued a Class A Citation for failure to provide care and supervision to a resident when the resident was admitted to an acute hospital with left lower extremity burns when the resident's clothing was set

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Long-Term Care Facility Complaints

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on fire while smoking a cigarette unattended. Because of the nature and severity of this harm, the facility was also issued an Enhanced Remedy in the amount of $10,000.00 for causing serious bodily injury to the resident.

TEMESCAL RESIDENTIAL CARE HOME, Antioch, CA….Deficiencies….facility failed to prevent pressure sores from developing on resident; failed to ensure that resident maintained mobility; failed to notify responsible party of a change of condition; failed to adequately feed the resident; failure to allow resident to have visitors; and failure to have sufficient staff to meet the residents' needs.

WINDSOR CHICO CREEK CARE AND REHAB CENTER, Chico, CA.... Deficiencies….facility failed to provide an accurate and complete assessment when patient's health history was not adequately acquired in order to manage patient's health conditions and verifiable risk for falling; failure to ensure interventions for treatment of skin breakdown and/or pressure ulcer were ordered or the wound order reinstated upon patient's return from an acute hospitalization. This failure had the potential to result in the reduction of wound healing, increased infection, increased tissue loss and wound severity. **FATE** filed for an appeal on this decision as the patient sustained a fall, suffered altered level of consciousness and a femur fracture, which contributed to the patient's death. The State of California did not address these issues during the investigation, which was a failure to thoroughly investigate the complaint allegations.

VIENNA NURSING AND REHABILITATION CENTER, Lodi, CA...Deficiencies... facility failed to provide bowel care to treat constipation, which had the potential to cause the patient to experience abdominal discomfort or fecal impaction; failure to prevent the development of bed sores, which had the potential to cause the patient to experience pain and infection. **FATE** filed an appeal on this decision as the patient sustained a fall, a broken leg and severe malnutrition, which contributed to his death. The State of California did not address these issues during the investigation, which was a failure to thoroughly investigate the complaint allegations.

"Our prime purpose in this life is to help others. And, if you can't help them, at least don't hurt them."

- Dalai Lama

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