FATE

Vol. 22 No 1
Winter 2022

Newsletter of Foundation Aiding The Elderly

President's Message 2022

40 YEARS OF SERVICE

By Carole Herman

Carole Herman

This year, **FATE** enters its 40th year of advocacy providing free services to the public in order to prevent elder abuse, specifically in long-term care facilities throughout the country. Back in 1982 when my aunt was neglected and died in a California nursing home, I had no idea what I was getting into by starting a non-profit to help other families who may have to place their loved ones in nursing homes. Her death was a tragic event for my family as it has been for thousands and thousands of other families who have also been subjected to poor care and neglect in long-term care facilities. Her death was caused by being drugged with antipsychotics which caused her to become immobile resulting in her developing infected bed sores that we had no idea she had. However, this horrific event was the catalyst for me to start the organization and since then **FATE** has had the privilege to assist over 9,000 families all over the country.

Foundation Aiding The Elderly
American River Professional Centre
3430 American River Drive, Suite 105
Sacramento, CA 95864

Mailing Address
P.O. Box 254849
Sacramento, CA 95865-4849

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

Unfortunately, the world has not yet learned how to accommodate the longer life spans and greater proportion of old people in society. **Old lives do matter** and we can all learn from their past experiences. Approximately 90% of funds going to the long-term care industry are government funds and the industry has become a huge profit maker with little to no accountability from the government to ensure that tax-payer dollars are indeed going directly to the care of the patients. The on-going poor care in these facilities, coupled with the lack of accountability by the government regulators never ceases to amaze and sadden me.

The long-term care industry continues to grow at a rapid pace. The growth has a lot to do with the baby boomers reaching social security age. Skilled nursing facilities, assisted living and residential care facilities are licensed by state government. Boarding houses typically are not licensed facilities and thus there is no agency monitoring these facilities where one can file a complaint regarding events that harm the residents in boarding houses.

This past year was no different than the past 39 years. We received hundreds of phone calls from all over the United States for help when the family experiences poor care for their loved ones, receives no responses regarding complaints they have filed themselves with the government regulators whose purpose is to be the oversight of the industry and the protection of the patients. The consumer becomes so frustrated that they sought help outside of the system and found **FATE**. We were able to help the majority of those who have reached out for assistance.

FATE continues to be a voice and stays involved with the government regulators by participating in stakeholder meetings with state agencies regarding long-term care issues. Several years ago, we fought hard to not allow the CA nursing home industry to have a staffing waiver put into place which allowed facilities to be short staffed because of the lack of an available workforce

Continued on page 3

JUSTICE MATTERS:
FATE CONCLUDES ANOTHER PUBLIC INTEREST LAWSUIT AGAINST THE CA DEPARTMENT OF PUBLIC HEALTH

In July of 2022, for the second time in almost 10 years, **FATE** was successful in the court's ruling against the California Department of Public Health (CDPH) to compel the agency to perform its obligation to completed timely investigations and resolve pending appeals lodged against skilled nursing facilities. Initially filed in November of 2020, by the Lexington Law Group in San Francisco on behalf of **FATE**, the complaint sought to remedy CDPH's widespread delay in completing investigations within the timeframes set by California law. The case secured long-overdue relief not only for numerous **FATE** clients who have waited years for CDPH to finalize the complaint issued on their behalf by **FATE**, but also complaints filed by family members for the neglect and poor care, which in some cases caused the death of their loved ones. **FATE** filed the first court case back in 2013, which was based on the same allegations of CDPH not investigating complaints according to the law. After the first case was won, CDPH upheld its mandated duties for a while but eventually fell back into its on-going habits of delaying completion of investigations and appeal hearings. **FATE** tracks all of its complaints and CDPH's failure just pertaining to our cases, clearly showed that CDPH was failing again to complete the complaint process. After the Writ of Mandate was signed, **FATE** received a call from a resident in the Los Angeles area to report that she had received a phone call from CDPH that the complaint she had filed six years previously was now

being investigated. The client filed the complaint herself prior to her mother's death, which may have been prevented had CDPH investigated her complaint according to the regulations. **FATE** deeply appreciates and thanks Howard Hirsch and Joseph Mann of the Lexington Law Group in San Francisco for their excellent legal representation and dedication to ensuring that CDPH serves the public according to its mandate. **FATE** hopes that CDPH does a better job in the future…**time will tell.**

FATE'S MISSION

"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

FATE'S GOALS

- Protect the elderly in their remaining years.
- Enhance national awareness of abuse in elderly care institutions.
- Initiate action to improve care.
- Report violations, malpractice and criminal actions to appropriate federal and state authorities.
- Follow-up to see that corrections and redress occur.
- Educate the public of their rights.

CONSERVATORSHIP ABUSE

FATE became aware of conservatorship abuses in 1986 when we attempted to advocate for an elderly patient in a nursing home who was under conservatorship of the Placer County Public Guardian's Office in Auburn, CA. This case led to an appearance on the Geraldo Rivera Show, which exposed not only conservatorship abuse, but elder abuse in long-term care facilities. The number of elders being conserved has risen drastically since then. Undoubtedly, there are many ethical conservators; however, there are also too many who are not. In May of 2022, Calvin Curtis, an attorney in Salt Lake City, Utah, was sentenced to serve 97 months in federal prison by a U. S. District Court Judge after being found guilty of embezzling money from his clients who were elderly, incapacitated or disabled individuals. He was also ordered to pay $12,779,496.00 in restitution to the 26 victims of his crimes and sentenced to an additional three years of supervision upon his release from federal prison. Curtis pleaded guilty to embezzling millions of dollars from clients of his estate planning law firm based in Salt Lake City, known as Calvin Curtis Attorney at Law PPLC and Curtiselderlaw.com. Curtis admitted being an attorney

Continued on page 3

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

– American Journalist, Brett Arends.

Conservatorship Abuse

Continued from page 2

who specialized in special needs trusts and that beginning in January of 2008, he began a fraudulent scheme to defraud a client known as "GM" out of money. Curtis had access to millions of dollars in two different trust accounts belonging to the "GM" and that he transferred at least $9,500,000 intended for the care of "GM" into his own accounts and then used this money for his own personal use. Curtis created fake financial statements to conceal the fraud and submitted them to the court. Curtis admitted that he used the money to support a lavish lifestyle with frequent travel, to purchase tickets to basketball and football games, to give lavish gifts to others and to support the operations of his law firm. He plead guilty to money laundering and admitted that he knew these transactions were illegal. Special Agents from the FBI and IRS conducted the investigation that resulted in Curtis' arrest.
FATE has documented hundreds of similar cases all over the country and this year participated in an expose' produced by ABC News Channel 10 in Sacramento regarding conservatorship abuse. **FATE** carries the 5-part series on its web site www.4fate.org. It's worth the watch.

President's Message

Continued from page 1

in their area. Most poor care and neglect occurs when there is not enough staff to meet the needs of the patients. **FATE** was not successful in stopping the industry from being insufficiently staffed and lost the argument that if there were not enough staff to meet the needs of the patient, then the nursing home should stop admissions.

FATE was again successful with another public interest lawsuit against the California Department of Public Health for its failure to respond and investigate almost 10,000 complaints against nursing homes, acute hospitals, hospice companies filed by consumers and **FATE**. Unfortunately, the general public does not know the process when filing a complaint and they think the regulators will investigate and issue sanctions when need be. Regretfully, in many cases, this is not what happens. The complaint falls into a black hole and does not get investigated and consumers are left in the dark thinking the State took care of the complaint. Without the facilities being held accountable, their behavior will not change. It's like getting a speeding ticket for doing 100 mph in a 30 mph zone and then not having to pay the fine. These state regulators need to be held accountable as well since their responsibility is to protect the health and safety of all patients. Although **FATE** has clients in every state and we have filed complaints in other states, California is the only state where **FATE** has filed official civil public interest cases because most of our work is in California and we have an extensive tracking system to monitor the hundreds of complaints we file (see article on page 2).

"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

FATE's services are critical and much needed. We have found no other organization in the country that does the work we do. We continue to be very aggressive in our advocacy work and do what is necessary to ensure the health and safety of our mothers, fathers and loved ones in long-term care facilities.

We look forward to another year of advocacy. It is a difficult task but we are always up for the fight. We have been able to provide our free services for all these years because of the support from our donors.

I'd also like to thank our wonderful staff for their continued dedication. We will certainly appreciate your tax-deductible donation to enable us to continue this much needed work. Please donate either via PayPal on our web site or send a tax-deductible donation to our office in the enclosed envelope. Thank you for your support and know that every little bit helps us to achieve our mission to protect our most vulnerable citizens.

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.

NURSING HOMES' WORST OFFENSES HIDDEN FROM THE PUBLIC

In December of 2021, ***The New York Times*** published an in-depth report on how the country's worst nursing home violations are being hidden from the public. Some of the violations that harmed nursing home patients included an Arizona patient who was sexually assaulted and a Texas patient with dementia found in the nursing home's parking lot lying in a pool of blood. State inspectors determined that the two nursing homes endangered the patients and violated federal regulations. Yet the government didn't report the incidents to the public or factor them into its ratings system. Many incidents of harm to the patients were uncovered by state inspectors, but quashed during a secretive appeals process, which ***The Times*** obtained via public-records requests. On rare occasions when inspectors issue severe citations, nursing homes can fight them through an appeals process that operates almost entirely in secret. If nursing homes do not get the desired outcome, they can appeal to a special federal court inside the executive branch. That process is also hidden from the public. Representatives of the strong and powerful nursing home industry say it is only fair that they be allowed to appeal citations before they are made public; however, ***The Times*** investigation found that the appeals process can be one-sided, excluding patients and their families. The consumer who files the complaint is not made aware that the facility can appeal the outcome and is not even told about the appeal process. However, if the complainant appeals the findings, or the lack of findings, the system alerts the nursing home and their representatives, including their legal counsel, of the appeal hearing and they are invited to attend. Certainly not a fair business practice. Years ago, the Center for Medicare and Medicaid Services (CMS) developed a rating system for all nursing homes in the country. However, this rating system is based almost entirely on self-reporting incidences by the nursing home industry itself. Several years ago, **FATE** participated in a similar exposé by ***The New York Times*** clearly showing that the public should not use the rating system prior to placing a loved one in a facility. Best to visit the facility, get a copy of the State's annual inspection report and get citation information from the state agency monitoring the nursing homes in your state.

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:

ASIAN COMMUNITY CENTER CARE CENTER, Sacramento, CA…Deficiencies…facility failed to implement measures for the prevention of pressure ulcers (bed sores) when the patient developed an ulcer to the skin which resulted from prolonged pressure on her coccyx resulting in the development of an avoidable pressure sore; facility failed to ensure an accurate medical record when they did not monitor a standard intervention in the plan of care; inaccurately documented the patient's level of bed mobility; failure to document that the patient was refusing to cooperate in order to prevent pressure sores and did not document notification of a pressure injury to the patient's responsible party.

BROOKDALE STERLING COURT, Roseville, CA… Enhanced Remedy Fine $15,000.00…facility failed to seek timely medical attention for resident while in care, questionable death and failure to meet resident's needs. Resident suffered multiple falls with no intervention; failure to seek immediately care when resident suffered from a left femoral neck fracture. Death certificate states cause of death as femoral neck fracture and accidental fall. A $15,000.00 civil penalty was assessed against the facility for this death.

BROOKDALE/FOLSOM…Folsom, CA…Enhanced Remedy fine of $9,500.00….facility was previously fined $500.00 for failing to ensure that residents are free from punishment, humiliation, intimidation, abuse or other actions of a punitive nature, which posed an immediate health and safety risk to the residents in care, failure to receive an approved criminal record exemption for a staff member and failure to report physical abuse, which all resulted after **FATE** filed an official elder abuse complaint after the assault of an elderly resident, which was caught on video, caused her harm and eventual death. **FATE** published the first findings in its December 2021 Newsletter.

BRUCEVILLE TERRACE, D/P OF METHODIST HOSPITAL, Sacramento, CA…Deficiencies… facility failed to ensure the total number and the actual hours worked by licensed and unlicensed nursing staff, along with the patient census, was posted daily. This failure had the potential to give incomplete staffing information to patients and visitors; failure to ensure handrails were firmly secured to the walls when two railings were observed loose from the walls; and failure to ensure the safety of patients who smoke when a safety cart was not maintained within a close proximity of the smoking area and patient's smoking assessment was not completed quarterly. All of these failures had the potential to jeopardize the safety of the residents while smoking. **FATE** filed an appeal as the allegation that the facility was in violation of ADA requirements pertaining to the ingress and egress to the patio was not addressed.

Continued on page 5

Long-Term Care Facility Complaints

Continued from page 4

DOUBLE TREE POST ACUTE CARE CENTER… Sacramento, CA…Deficiencies…facility failed to ensure resident was free from neglect by not placing the call light within reach of the patient; facility failed to ensure a homelike environment was provided when the patient's room was bare and not homelike. These failures increased the potential for patients not attaining their highest practicable quality of life.

EMPIRE RANCH ALZHEIMER'S CARE CENTER… Folsom, CA…Class "A" Citation….facility cited for patient rights violations by locking patient doors from the outside preventing patients from leaving their rooms, which posed an immediate health and safety risk to the residents.

EMPIRE RANCH ALZHEIMER'S CARE CENTER… Folsom, CA…Class "A" Citations…this complaint was filed by a **FATE** client….facility was cited for resident being improperly restrained to a recliner. Staff placed a chair underneath resident's recliner footrest so that resident was unable to get up from the recliner. This posed an immediate health and safety risk to the resident. This complaint also alleged that the staff left medical cart unattended, arrangement of furniture in the room created a hazard, facility was not maintained in a clean, sanitary and odorless condition, incontinency needs not being met, call light inaccessible to residents, and staff not following physician orders for medications were all unfounded. **FATE** would have appealed these findings; however, the California Department of Community Care Licensing does not allow an appeal for complainants, only facility operators can appeal findings.

FREMONT HEALTHCARE CENTER, Fremont, CA…Class "B" Citation with a $2,000 penalty assessment…facility failed to follow regulations by not monitoring patient's bowel movements and providing prescribed medications causing the development of a fecal impaction, which caused compression of internal organs, prevented normal urination and required critical care treatment to prevent life-threatening urinary obstruction and severe constipation. The CA Department of Public Health, Licensing and Certification Division took 12 months to conclude the investigation, which is a violation of the Department's mandate to complete investigations in no more than 120 days.

GRAND VILLA ASSISTED LIVING…Grand Junction, CO…Deficiencies…facility failed to follow physician orders for the administration of medications and failed to keep sufficient medications in stock, which caused residents to go without their prescribed medications, which could have caused harm to the residents. The allegations that the facility was not sufficiently staffed was unfounded.

JURUPA HILLS POST ACUTE Riverside, CA… Federal Deficiencies…facility failed to ensure proper bowel management was provided to address constipation when staff did not follow physician's orders on multiple occasions. This failure had the potential to result in complications related to constipation; the facility also failed to administer a consistent dose of regular insulin which had the potential to result in uncontrolled blood sugar and increased the risk for the patient to experience further complications related to abnormal blood sugar; failure to administer sufficient fluid intake to maintain proper hydration and health; failure to ensure nutritional care and services were provided in a timely manner when patient had severe and progressive weight loss. These findings occurred after **FATE** filed an appeal from the original findings that unsubstantiated the complaint. For the second time, **FATE** filed another appeal to these findings as the State again did not address the fact that the patient sustained a broken neck while a patient in this facility. The family had an autopsy that clearly stated cause of death as complications due to a blunt force cervical vertebral fractures (a broken neck). As well, because of the severity of the death, **FATE** believes the State regulators should issue a Class AA citation with a $100,000 fine, based on California's Title 22 regulations for nursing home care.

MAINPLACE POST ACUTE, Orange, CA… Deficiencies…facility failed to ensure oral care was performed more than once per day. This failure had the potential to negatively affect the patient's well-being and comfort; failure to conduct the initial and weekly assessments of pressure ulcers (bed sores) on the tailbone and heels of feet of the patient; failure to conduct the initial and weekly assessments of the pressure sores (bed sores) and failure to assess the pressure ulcers (bed sores) during a 12-day period, which had the potential of patient not receiving the appropriate care and services to promote healing of the sores and the potential for not identifying the worsening of the pressure sores should they deteriorate. **FATE** filed an appeal as the allegation that the patient was dehydrated was not addressed by the department.

NORTHGATE POST-ACUTE CARE, San Rafael, CA…Deficiencies…facility failed to provide access and copies of medical records in a timely manner according to the Federal policy. This failure resulted in unnecessary frustration of the responsible party in his ability to seek information about his family member.

OAK COTTAGE OF SANTA BARBARA, Santa Barbara, CA…Three "A" Citations and three "B" Citations…Immediate $500.00 Penalty… Enhanced Remedy of $10,000.00 under review… facility failed to ensure that the resident was accorded safe, healthful and comfortable accommodations resulting in the resident sustaining 16 falls with injuries and subsequent death; facility failed to ensure the resident received care, supervision and services to meet the resident's needs; facility failed to ensure resident was observed for changes in conditions and did not notify resident's physician of such changes; facility failed to provide clean rooms and bathrooms; facility failed to provide toilet paper; facility failed to ensure resident's medical appraisals were updated to reflect significant changes and facility failed to ensure residents with dementia did not have access to an electric tea kettle. By not meeting these requirements, the facility posed a potential health and safety risk to residents in their care.

OAKMONT OF CARMICHAEL, Carmichael, CA…Citations. Three "A" Citations and one "B" Citation…$500.00 Penalty…facility failed to ensure that there were sufficient staffing so that the resident who has dementia was not able to purchase alcohol during a facility outing and became intoxicated and was sent to the emergency room; failure to ensure that resident was prohibited from buying, storing and drinking alcohol; failure to ensure to prevent access to alcohol during or following the excursion and staff did not follow the alert on resident's information sheet; failure to ensure that resident did not have any access to alcohol and failure to obtain an annual updated physician's report that was signed by a physician and responsible party. All of these violations posed an immediate health and safety risk to the resident.

OAKMONT OF FAIR OAKS, Fair Oaks, CA…"A" Citation and "B" Citation…$500.00 penalty…"A" Citation was issued based on the facility's failure to ensure that the resident received assistance in changing contact lenses in both eyes, which posed an immediate health and safety risk to the residents in care. When seen by the optometrist it was determined that one contact lens was missing and the other lens was "heavily stained with significant deposits and buildup causing resident to have an eye sight worse than 20/400; "B" Citation was issued based on the facility's failure to make reasonable efforts to safeguard resident's property and the resident is to be reimbursed for the replacement of the stolen property and did not record the lost property in the Theft and Loss Log and did not report the theft to local law enforcement.

PARKVIEW POST ACUTE, Santa Rosa, CA… Deficiencies…facility failed to ensure the responsible party was informed of a medical service provided or had verified consent for the service prior to providing a psychiatric evaluation without notifying the responsible party. This failure did not provide the responsible party with advance information about the doctor visit or afford the responsible party the opportunity to accept or decline care and did not ensure appropriate consent for the care rendered; facility failed to ensure the resident's rights to receive visits from immediate family when the facility imposed restrictions on the manner and time responsible party, an immediate family member, could visit the patient and the policy governing facility processes affecting patient rights for visitation did not indicate all written provisions required by the regulations.

PARKVIEW POST ACUTE, Santa Rosa, CA… Two (2) B Citations with two (2) $2,000.00 penalty assessments for each Citation… the facility failed to comply with the federal requirements regarding patient rights for

Continued on page 6

Long-Term Care Facility Complaints

Continued from page 5

visitation with immediate family members when it imposed restrictions on the manner and time the patient's responsible party could visit the patient. This violation had a direct or immediate relationship to the health, safety and security of the patient; failure to comply with the federal requirements regarding resident rights for planning and implementing care when it coordinated and facilitated a doctor visit for psychological evaluation without approval or notification of the responsible party. This violation had a direct or immediate relationship to the health, safety or security of the patient.

PROMEDICA SKILLED NURSING & REHABILITATION (formerly known as Manor Care – Tice Valley), Walnut Creek, CA… Deficiencies…facility failed to provide copies of medical records according to Federal statute; facility failed to revise the patient's care plan after a change of condition; facility failed to prevent weight loss; facility failed to maintain infection control. **FATE** filed an appeal. This particular complaint took the CA Department of Public Health almost two (2) years to complete, which is a violation of the department's mandate to complete investigations within 120 days.

RIVER POINTE POST ACUTE, Carmichael, CA… Two (2) deficiencies…facility failed to obtain a new medication order for a new dosing schedule when a medication given every 14 days was given 7 days later than scheduled; facility failed to obtain informed consent for the administration of a psychotropic medication from the patient's responsible party. These failures had the potential to deny patient's responsible party the right to make informed decisions and to choose alternative options for care. These failures had the potential to cause harm to the patient.

RIVERSIDE VILLAGE HEALTHCARE CENTER, Riverside CA…five (5)Federal Deficiencies… failure to follow professional standards of practice when physical therapy was stopped; failure to ensure assessments were done and accurately documented redness and edema; failure to ensure patient received proper services to prevent pressure ulcers when patient developed a traumatic wound to the ankle; and, failure to ensure that pain medications were offered or provided; failure to ensure that the physician's orders for wound culture test was completed. These deficient practices had the potential to result in the resident's decline in mobility and deterioration in the ability to perform daily activities.

STOCKTON NURSING CENTER, Stockton, CA…deficiencies…facility failed to maintain proper infection controls; failed to maintain sanitary conditions to prevent cockroaches and vermin from entering the facility and failed to provide sufficient staffing.

UNIVERSITY PARK HEALTHCARE CENTER, Los Angeles, CA…Federal Deficiencies…facility failed to ensure patients received treatment and care in accordance with professional standards of practice when the patient had a rash on the arm which was not reported or treated, which had the potential for increased pain and discomfort; facility failed to maintain sufficient staffing for licensed nurse staff and Certified Nursing Assistants. This deficient practice had the potential to negatively affect patient's quality of life, care and treatment; the facility had been issued a $15,000.00 fine for being understaffed in 2019; facility Administrator failed to manage the facility effectively and efficiently by failing to ensure the facility did not repeat the same deficiency during a prior survey during the months of May, June and July of 2021. These deficient practices caused an increased risk in the health and safety of the patients effecting their quality of life; the facility failed to maintain clinical records in accordance with accepted professional standards and practices by failing to accurately document the administration of wound care, which deficient practice caused an increased risk in the accurate evaluation of the patient's progression or regression of the delivery of care services.

VISTA GARDENS, Vista, CA…Two "B" Citations… facility failed to ensure that a resident was reappraised for a change in condition after hospitalization. This posed a potential safety risk to the resident; facility failed to ensure that the resident's replacement appraisal information was documented or completed prior to admission. Other allegations, such as development of bed sores, not discharging a resident to a medical facility in a timely manner, not providing resident with necessary assistance, false claims, not obtaining a physician's report prior to admission, false advertising and previous licensed operator impersonating a doctor were unsubstantiated. **FATE** could not appeal the State's decision on these unsubstantiated allegations because the department does not allow the complainant to file appeals. Appeals are granted to the operators, which FATE believes to be an unfair business practice to give one party a right and not the other.

WESTWIND MEMORY CARE, Santa Cruz, CA.. Two "A" Citations and two "B" Citations… facility failed to report changes of condition to resident's responsible party; facility failed to follow resident's care plan resulting in development of multiple physical ailments; facility failed to assist resident with clipping of toe nails when needed; facility failed to protect confidential resident information which was provided to an outside party. These failures by the facility posed a potential risk to the health and safety of residents in care.

WESTWIND MEMORY CARE, Santa Cruz, CA…Class B Citation…HIPAA violation… facility provided confidential resident information to outside party, which posed a potential risk to resident health and safety.

WILLOWS POST ACUTE, Willows, CA…two Federal violations…failure to ensure patients were safe from accidents when a patient was found unresponsive on the patio and died from heat exposure; failure to ensure that patient was free of significant medication errors when medications were administered outside of physician orders. This failure had the potential to lead to a decline in the health status of the patient. **FATE** appealed the findings as we believe a California statute violation with a fine should have been issued to the facility.

WINDSOR CARE CENTER OF CHEVIOT HILLS, Los Angeles, CA…Federal Deficiencies… facility failed to ensure patient was free from significant medication errors by administering antihypertensive medications outside of the physician's order parameters. **FATE** filed an appeal as all allegations were not addressed and the appeal resulted in additional violations, i.e., facility failed to ensure skin integrity was accurately assessed, failed to provide a mattress designed for pressure reducing, which is used to prevent pressure ulcers, failed to accurately monitor and document patient's fluid and nutritional intake, failed to evaluate hydration or management of patient's fluid needs and failed to chart for three months. These deficient practices had the potential to result in the formation of pressure ulcers, dehydration and malnutrition all of which harmed the patient.

WINDSOR CHICO CREEK, Chico CA…Federal Deficiencies…failure to provide copies of medical records according to the federal regulations; failure to notify physician and/or responsible party of a change of condition after the patient fell; failure to assess the needs for hydration causing medical imbalance in the blood and failure to have a Director of Nursing on staff.

WINDSOR POST-ACUTE CARE CENTER OF HAYWARD, Hayward, CA…Four (4) Deficiencies… facility failed to include the responsible party (RP) in care conferences. This failure resulted in the RP not being able to participate in and make decisions about her family member's ongoing plan of care; facility failed to notify the RP of a change of condition for ten (10) weeks when an unstageable pressure ulcer was discovered on the left hip of the patient; facility failed to follow physician orders when patient's dialysis access site on the right chest was not assessed every shift by a licensed nurse , patient's wound treatments were not done once per day, which had the potential to cause infection; facility failed to provide routine medications to patient to treat seizures, which had the potential to cause patient to have break through seizures. All of these failures caused harm to the patient and **FATE** filed an appeal as there should have been citations issued with civil penalties under the California law and the State Department of Public Health only used Federal regulations with no fines imposed. Appeal is pending.

Special Thanks to our Donors

Gifts received from October 2022 to publishing date.

IN MEMORY

IN MEMORY OF JAMES ALBERTI
Diane Alberti King, Davis, CA

IN MEMORY OF ROBERT ANDERSON
Phyllis Grenzebach, Chico, CA

IN MEMORY OF MATILDA ANTICEVICH
Carole and Harris Herman/Sacramento, CA
Don and Pam Murphy Trust, Sacramento, CA
Via the Sacramento Regional Foundation

IN MEMORY OF MICHAEL ARNTZ
Penny Arntz, Montecito, CA

IN MEMORY OF JEAN BEARDSLEY
Patty Mader Beardsley, Citrus Heights, CA

IN MEMORY OF VICTOR BECERRIL
Judy Becerril, Folsom, CA

IN MEMORY OF FRANCIS BRUCE BUZBEE
Lois Buzbee, Sacramento, CA

IN MEMORY OF SUSANNA BRASSFIELD
John Brassfield, Newcastle, CA

IN MEMORY OF DEAN CHELLIS
Ann Chellis, Yuba City, CA

IN MEMORY OF ANN MARIE CHRISTIE
Susan Anderson, Reno, NV

IN MEMORY OF MERCURY-MORRIS CLAIBORNE
Theresa Claiborne, Emporia, VA

IN MEMORY OF MARY ANNE COLLIN
Rebecca Meade, Zimmerman, MN

IN MEMORY OF GEORGE DAHMER AKA PRO WRESTLER, "Chief White Owl"
Patricia Dahmer, Port St. Lucie, FL

IN MEMORY OF JOAN DE GRAEF
Mary and Jeff De Graef-Gould, Lincoln, CA

IN MEMORY OF ROBERT DAROSA
Kathleen DaRosa, Carmichael, CA

IN MEMORY OF CONSTANCE DILLEY
Eileen and Dennis Dancause, Roseville, CA

IN MEMORY OF FAROKH FAROKHZADEH
Mersedeth Farokhzadeh, Los Angeles, CA

IN MEMORY OF MANUEL AND CAROL GONZALES
Denise Gonzales, Henderson, NV

IN MEMROY OF ANNA HAMBY
Linda and Hon. Judge Michael Sweet, MeadowVista, CA

IN MEMORY OF DOROTHY HEICK
Jacqueline Victorino, Fair Oaks, CA

IN MEMORY OF SHIRLY KNIGHT HOPKINS
Kaitlin Hopkins & James Price, San Marcos, TX

IN MEMORY OF MICHAEL KOEWLER
Cecelia and Ron Angell, Sacramento, CA

IN MEMORY OF MARY AND GUSTAVE LARSON
Arcena and Alan Tocchini, Salem, OR

IN MEMORY OF JOSEPH MUNOZ, M.D.
Krystna Munoz, Orange, CA

IN MEMORY OF MARY MURPHY-SERPA
Sarah and Brian Murphy, Tigard, OR

IN MEMORY OF ALAN O. NELSON
Sharon Alexander-Nelson & Nick Alexander Sacramento, CA

IN MEMORY OF GENE PLECAS
Peggy and Jerry Bakarich, Sacramento, CA

IN MEMORY OF PATSY RALPH
Linda and Ken Giese, Sacramento, CA
Jill and Kevin Ralph, Sacramento, CA
Laurie Ramirez, Sacramento, CA

IN MEMORY OF JOSEPHINE RASMUSEN
William and Melissa Cross, Brentwood, CA

IN MEMORY OF SHARON RAZZAROLI
Judith and Michael Elston, Orangevale, CA

IN MEMORY OF BETTY ROGERS
Linda and George Cano, Davis, CA

IN MEMORY OF CLAUDE ROGERS
Sean Laird, Esq., Sacramento, CA

IN MEMORY OF JAMES ROKAS
George Rokas, Danville, CA
Maria Rokas, San Francisco, CA

IN MEMORY OF ALBERT J. AND VINCENTIA SALERNO
Albert P. Salerno, Alameda, CA
Carole Salerno, Pleasonton, CA

IN MEMORY OF PETER J. SHATTUCK
Elizabeth H. Shattuck, Sacramento, CA

IN MEMORY OF MAXINE L. SHERMAN
Dr. Stephanie Sherman, Morro Bay, CA

IN MEMORY OF JOHN STASSI
Karen Stassi, Sacramento, CA

IN MEMORY OF RUTHE MAE TONEY
Christina Toney, Sacramento, CA

IN MEMORY OF ELENA VELTRY
Sheila Veltry, Sherman Oaks, CA

IN MEMORY OF ROBERT VALENTIN
Beulah Valentin, Sacramento, CA

IN MEMORY OF ROBERT L. WARREN
Nancy Plesha, Sacramento, CA

IN MEMORY OF ARTHUR WATSON
Gary and Marilyn Lewis, Shingle Springs, CA

IN MEMORY OF BETTY WIGHT
Laurie Jeandin, Phoenix, OR

IN MEMORY OF KEITH WILLIAMS
Harris and Carole Herman/Sacramento, CA
Carol Williams, Sacramento, CA

IN MEMORY OF PAULINE WILLIAMS
Rebecca and James Adams, Union, KY

IN MEMORY OF AILEEN WISEMAN
Kelli Wiseman, Elk Grove, CA

IN MEMORY OF NANCY JEAN WRIGHT
Gregory and Darcie Garcia, Carmichael, CA

IN MEMORY OF LILY YOUNG
Melanie Pedrick, TTE, El Dorado Hills, CA

IN MEMORY OF THEODORA YAZIGI
Connie A. Clemow, Sacramento, CA
Jay Lambros, Sacramento, CA
Tula Morris, Sacramento, CA

INDIVIDUAL DONORS

Tony Alberico, Romulus, NY

Carolyn and Terry Albers, Sacramento, CA

Amazon Smile Foundation, Seattle, WA

Susan Anderson, Reno Nevada

Phyllis and Vincent Angell, Sacramento, CA

Maria and Charles Aranda, Sacramento, CA

Donna and Msgt. Joseph Arnold, USAF Ret., Sacramento, CA

Anthony and Karin Assenza, El Dorado, CA

Assured Life Association, Englewood, CO

James Atcheson, Rocklin, CA

Marree Babich, Sacramento, CA

Desma Beltran, Aptos, CA

Amelia Benedict, West Sacramento, CA

Gayle and James Betzing, Folsom, CA

Blackbaud Giving Fund, Your Cause, Charleston, SC

Continued on page 8

Special Thanks to Our Donors

Continued from page 7

Andrian Blanco Jewelry, Folsom, CA
Roberta Block, Whiting, NJ
James Bodenhamer, Tahoe Vista, CA
Dave and Judy Boothby, Fair Oaks, CA
Dental Hygiene Out and About
Liz and Wally Borland, Gold River, CA
Patricia Brubaker, Folsom, CA
Betty and Skip Brust, Marysville, CA
Florence Burrell , Citrus Heights, CA
Ronald R. Calvert and Candace Hill-Calvert
Cameron Park, CA
Lesley Ann Clement, Esq., Sacramento, CA
Paul Claiborne and Anna, Auburn, CA
Elizabeth Coffey, Sacramento, CA
Doris Cook, Gold River, CA
Coleen Camacho, Dixon, CA
Alice Corley, Sacramento, CA
Donna Currie, Burbank, CA
Linda Dalton, Bealeton, VA
Christine and Patrick Day, Fair Oaks, CA
Cyndi de Ford, Rohnert Park, CA
Angela De Victoria, Antioch, CA
Jane De Soiza, Folsom, CA
Thomas Domich, Sacramento, CA
Tracy Doolittle, Sacramento, CA
Norm Dunn, Windham, ME
Law Offices of Joseph Earley, Chico, CA
Dennis Eastley, Sacramento, CA
Angela Edwards-McClue, Margate, FL
Jerry Edwards, Sacramento, CA
Linda and Stanley Egger, Mountain View, CA
Maryann and Richard Elorduy, Sacramento, CA
Nancy and Michael Elorduy, Gold River, CA
Mary M. Ellis, Sacramento, CA
Emporium USA, via Pay Pal
Susan and Mel Ewald, Riverside, CA
Pam Falke, Ben Lomond, CA
Terry Fickies, Gold River, CA
Corey and Donna Fox, Fair Oaks, CA
Sandy and Herb Foster, Sacramento, CA
Diana and Michael Fredrich Trust, Livermore, CA
Frontstream Employee Giving Program, Reston, VA
Alexis Genung, No. Highlands, CA
Ellen and John Gibson, Folsom, CA
Linda and Kenneth Giese, Sacramento, CA
Susan and Douglas Gilman, Carlsbad, CA
Pete and Pat Green, Sacramento, CA
Beth Gregory, Sacramento, CA
Rachel Grossman, Gold River, CA
Michael Hackard, Esq., Hackard Law Firm, Mather, CA
Becky Halstead, Sacramento, CA
Margaret Hansen, Sacramento, CA
Carol Hardesty, Sacramento, CA
Joseph Harris, Jr., Sacramento, CA
Sheila A. Hefty, Carmichael, CA
Susan Heinz, Escalon, CA
Susan Hill, Esq., Carmichael, CA
Kathryn Hogan, Sacramento, CA
Linda Houser, Stockton, CA
Maria Husum, Lincoln, CA
Steven and Robin Hutcheson,
Indian Harbor Beach, FL
Britt Johnson and Maggie Sekul, Homewood, CA
Toni and Stephen James, El Dorado Hills, CA
Alice and Victor Jones Trust, No. Highlands, CA
Kannada Sangha of Sacramento
Sunitha Srinivasan, Sacramento, CA
Kinstler Family Trust
Elizabeth J. Brown, Reno, NV
Theresa Kautz, Lagrangeville, NY
Robert and Diane "Peach" Klemme,
Corona Del Mar, CA
Jane and Paul Lammerding, Sacramento, CA
Elizabeth and Randall Leben, Roseville, CA
Laura and Matthew Legrand, Sacramento, CA
Dan Levin, Shelburne, NH
Liferay Foundation, Diamond Bar, CA
Larry Lonski, Wilton, CA
Lucretia Lovisa, Rocklin, CA
Patricia Luce, Carmichael, CA
Luhdorff & Scalmanini Consulting Engineers
Giving Program, Woodland, CA
Marlene and David Lukenbill, Sacramento, CA
Kathryn and Richard Madsack, Sacramento, CA
Daren Maeda, Sacramento, CA
Joel Magee, Fremont, CA
Kathie and Richard Martinelli, Camino, CA
Rebecca and Rudy Martinez, Sacramento, CA
Brenda McCoy-Manfredo, Fort Collins, CO
Rebecca Meade, Zimmerman, MN
Jack Mello, Jr., Walnut Grove, CA
Lynda Middleton, Sacramento, CA
Patricia Miller, Loomis, CA
Pam and Daniel Moriarty, Santa Cruz, CA
Gregory Moss, Via PayPal
Maria and Edgar Najera, Sr., Sacramento, CA
Network for Good, Southfield, MI
Eileen Irene Nolan, Carmichael, CA
Martha and Ralph Ochoa, Sacramento, CA
Douglas and Maureen Olander, Orangevale, CA
Terrill Osborne, Carmichael, CA
Nanc Paczonay, Burleson, TX
Joyce Pappas, W. Sacramento, CA
Kathy Pasquetti, W. Sacramento, CA
Peck Law Group, Van Nuys, CA
Lee S. Pennill, Sacramento, CA
Planning for Seniors, Deborah Christensen-Short
Yuba City, CA
Neal Pollon, Sewickley, PA
Patrice M. Price, Marysville, CA
Laurie Ramirez, Sacramento, CA
Mary Ann and David Ramos, Fair Oaks, CA
Jay Renneisen, Esq., Walnut Creek, CA
Ida Remigi, Sacramento, CA
Joseph and Kathleen Rezzo, Granada Hills, CA
Dolores Rodriquez, Sacramento, CA
Elizabeth and Jerome Rose, Hayden, ID
Josh Scott, via Pay Pal
William Seabridge, Esq., Gold River, CA
Janice and Ronald Smith, Rio Linda, CA
Gordon A. Sonne, Star, ID
Jill Lynn Spriggs, Apex, NC
Martha Stringer, Esq., Easton, PA
Nancy Szakacs, Hollister, CA
Gerald Thomas, Esq., Sacramento, CA
Cathy Tsakopoulos, Sacramento, CA
United Way, Sacramento, CA
Michael L. Vaida, Davis, CA
Marie and Roger Valine, Sacramento, CA
Elizabeth Velaga, Sacramento, CA
Kathy and Steve Vickers, Gold River, CA
Denise Walker, Sacramento, CA
Richard Wareham, San Mateo, CA
Katherine Weedman-Cox, Rancho Cordova, CA
Cara Westin, Loomis, CA
Charlotte and James Westlake, Sacramento, CA
Ellen Winter/Gary Stower, Oakland, CA
Carol A. Wolfington, Sacramento, CA
Doug Wroan, Esq., El Segundo, CA
Susan and Freddie Yadao, Elk Grove, CA
YourCause Giving Program
Standard Insurance Co., Charleston, SC
Margaret Zamberlin, Carmichael, CA
Rande and Henry Zaretsky, Carmichael, CA

Our commitment to fight elder abuse is possible because of contributions from donors. Their generosity allows **FATE** to save lives, help patients reclaim dignity and their rights, and assures families that their loved ones will receive proper care.

FATE is a 501 (c) (3) nonprofit so your donation is fully tax deductible. **FATE's** EIN No. is 68-0198413

Your financial contribution allows **FATE** to continue its work. If you are able to make a donation, please send it in the enclosed **FATE** envelope or go to the **FATE** website at **www.4fate.org** and donate via PayPal. Thank you for your support to help us assist our most vulnerable citizens and their families.