FATE

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Newsletter of Foundation Aiding The Elderly

President's Message 2023

KNOWLEDGE IS POWER

By Carole Herman

Carole Herman

As usual, **FATE** experienced another very busy year advocating for our most vulnerable citizens and their family members. Our outreach resulted in educating hundreds of new clients this year empowering them with knowledge of patient rights and how to advocate for their loved ones. The old saying "knowledge is power" … certainly is the case. Most calls we received were from family members frustrated with the system and their lack of knowledge of nursing homes, assisted living and residential care homes and even acute hospitals that operate under state and federal regulations. We also served many young adults who had the misfortune of being accident or crime victims and some who have health issues that have unfortunately landed them in facilities probably for the rest of their lives.

Most people do not want to think of long-term care facilities. Then something happens to them or a family member and they are thrown into the dark about what to do or what to look for to prevent neglect and poor care. News articles appear frequently about poor care and neglect in facilities; however, no one wants to read about this happening to them at the end of life. So, they skip over these articles. It's difficult enough to wade through the maze of healthcare much less not knowing your rights and ending up in one of these places wondering what is going on and what one can do. Knowing our rights as patients in the healthcare arena is a powerful tool to lean on when need be.

FATE continues to offer information to the public regarding our rights when entering the world of health care in general and how to be there as an advocate for the family when problems arise. In particular, this year we had a substantial increase in filing complaints with state regulators, as well as responding to hundreds of calls for help from all over the country. It is totally unacceptable that the beat goes on with abuse, neglect and poor care in facilities housing our most vulnerable citizens while the operators continue to line their pockets and not be held accountable for poor care. **FATE's** research into complaints filed with the regulators and what the outcomes have been, clearly showed us that the majority of complaints filed were all unsubstantiated with facilities not held accountable for causing harm. **FATE** files very serious allegations that cause great harm to our clients and without the facility being held accountable, there is no reason for the operator to change.

The number one problem resulting in poor care and abuse is not having enough staff to meet the needs of the patients. Several years ago, at the request of the nursing home lobbyist, California allowed nursing homes to submit requests to waive standard nursing staff when the facility could prove that there was a shortage of qualified workers in the area of the nursing home. **FATE** was on that committee and suggested

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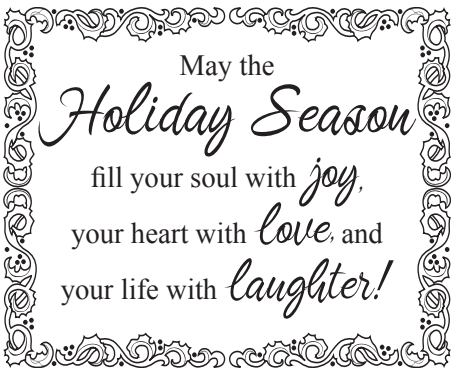

JUSTICE MATTERS

Back in 2010, **FATE** was contacted by a family in distress. Their mother had been in an acute hospital in the Chico, CA area and the hospital was attempting to have her conserved because the hospital was accusing the family of interfering in her care. The mother who suffered with dementia had been cared for by her husband and daughters for about four years prior to being sent to the acute hospital due to pneumonia. She also had a small bed sore on her back side that the family was treating. The hospital began caring for her; however, according to the family, that care turned into a nightmare. The hospital began a series of procedures on her, which one daughter, who is a Registered Nurse, claimed were unnecessary after she read the medical records. The hospital called in a wound doctor who started a series of debriding the bedsore. Debridement is the removal of the dead tissue from the wound, which can be very painful. That initial debridement of one small wound turned into multiple stage 4 wounds and many surgeries including 18 debridements and the removal of her colon. When the family started to question the numerous procedures and were attempting to make arrangements to send her to another hospital, they were accused of interfering in her care and the hospital filed a petition in the Butte County Probate Court to have her conserved.

From that day on, the family lost all control and a public entity was now making all life and death decisions for their mother. The family was barred from obtaining any information on her condition, lost all decision making for her care and was not allowed in patient care meetings regarding their mother's condition and treatment. At that point, the hospital had billed MediCare for almost $2 million dollars for her stay in the acute hospital for care that the family was alleging was created for billing purposes. After running up MediCare billings and having the patient conserved, the hospital then wanted to discharge her somewhere else. The family accused the hospital of using up her MediCare dollars and now wanted her out of their hospital. The Public Guardian of Butte County, who now had control over her, transferred her to another hospital in Folsom, CA about 100 miles away from her home and family, which created another hardship on the family by making it difficult to see her.

Before the mother died, the family filed an official complaint with the CA Department of Public Health, which the department deemed unsubstantiated. The family then attempted to find an attorney to file a civil suit against the hospital for harming their mother. However, after months and months of seeking representation, no attorney was willing to take the case. In an attempt to not lose their right to bring an action, the Registered Nurse daughter filed a Federal case in pro per, which means without an attorney. Over ten years later and many motions filed by the hospital's and doctor's attorneys to dismiss the case, the trail started in October of 2023. Since I was a witness to some of the events, I was called to testify at trial. The defense opposed my testimony as being prejudicial and the Judge ruled that I could only give my name and could not mention **FATE** and its work to prevent elder abuse. In other words, I could not testify, especially about the conservatorship. I could only give my name, how I met the plaintiff, if I ever saw her mother in the hospital and in what condition she was in when I did see her. When I started to tell the jury that the family contacted **FATE** at the request of an attorney after the petition for conservatorship was filed, the defense objected and I was not permitted to testify to that event. I was then dismissed from testifying. I did sit in on the trial a couple of times. Due to the daughter not being an attorney and the defense objecting to her questions 90% of the time, the trial ended with the Judge ruling in favor of the defense's Rule 50 motion. Rule 50 means that the Judge would rule whether the plaintiff had met her burden of proof, which he ruled, she did not. The trial was then over.

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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.

Justice Matters

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Over the years, **FATE** has gathered information from consumers all over the country who have been adversely affected by conservatorship abuse and has been involved with working with families starting with the 1986 horrific death of Isabel Miller in Auburn, CA. Her case was so egregious that it was featured on the Geraldo Rivera Show in New York and can be viewed on the **FATE** web page. Years later, **FATE** worked with Robin Fields, an investigative reporter with the Los Angeles Times, who wrote a three-part series on conservatorship abuse. At that time, there was no oversight on conservatorships and very little reporting was taking place by the news media. That all changed after the Los Angeles Times article, which was instrumental in establishing the CA Fiduciary Board that requires private fiduciaries to be licensed.

Unfortunately, conservatorship abuse continues to be an issue all over the country with the stamp of approval by the courts. **FATE** alone has nine banker boxes full of cases that have been reported to our office by consumers all over the country. There are probably many vulnerable citizens that do need to be conserved and undoubtedly, there are fiduciaries who really do care about the person and their needs. However, with all the calls that **FATE** continues to receive on a weekly basis, we still maintain that there are unscrupulous conservators, both private and public guardians, who do not have the conservatees' best interest at heart, are seizing family members and their assets and abusing their authority. Go to the **FATE** site at **www.4fate.org** and watch the 5-part series on Conservatorship abuse produced by ABC News Channel 10 in Sacramento. It's an eye opener!

President's Message

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that if that were the case and the nursing home got the workforce shortage waiver, then that nursing home should also stop admissions if they couldn't staff it to meet patient needs, which made sense. **FATE** lost that battle and now there are over 200 facilities in California that have been approved to participate in this program that allows them to not meet the direct care nursing hours per patient. The nursing homes under this program are also mandated to post a sign at the entrance that the facility is currently understaffed. **FATE** has had numerous complaints that the facilities under this program are not posting the mandated sign to alert the public of the understaffing.

As we enter our 41st year of advocacy, we strive to continue to be a voice for those that can't speak for themselves and to assist the families who are overwhelmed and uninformed to bring about better care for all patients. Over the years, our advocacy work has become more difficult as we not only battle for our client's rights, but we also battle the health care industry and the state regulators who have been lackadaisical in their duties to protect us consumers. It has been most alarming that since COVID most government offices who monitor health care facilities are still working from home and it has become more difficult to get responses from those that have the authority and responsibility to monitor facilities. As we have stated for years, the long-term care and medical industry has all the power and money along with lobbyists who influence legislators to do what's right for them and not us. We will continue to be the voice for those who cannot speak for themselves. We will work continuously to bring about better care for all consumers and provide important information to those who call **FATE** for help.

Many thanks to the **FATE** staff, Eileen, Jane, Harris and our volunteers, for all their hard work and dedication assisting all our clients no matter what their issues are. Without their support, **FATE** would not have been able to accomplish our goals and help the over 9,500 families all over the country that we have had the honor to serve. A very special thank you to our donors who continue to believe in and support the work we do and to the many elder abuse attorneys and litigators all over the country who file civil actions. Unfortunately, it has become very apparent to **FATE** that civil actions are the only means of holding the industry accountable for harming our loved ones.

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, acute hospitals, assisted living facilities, and residential care homes 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.

MEDICARE APPEAL RIGHTS

A growing number of calls to FATE have been centered on patients being discharged from acute hospitals. Families of patients are being told that Medicare has ceased to pay for the patient's hospital stay and that the patient will be discharged. In the event the patient needs rehabilitation, the hospital discharge staff is to assist in placement into a rehabilitation center. However, what the public is not being told is that consumers have the right to approve placement and the right to visit the intended facility to approve it before placement. The hospital may not discharge a patient to a facility that has not been approved by either the patient, if competent, or if not competent, the patient's decision maker.

Another right that the consumer has is the right to appeal a discharge. Under Medicare, there are five (5) levels of appeal:

Level 1 - Redetermination by Medicare Administrative Contractor;

Level 2 - Reconsideration by a qualified Independent Contractor;

Level 3 - Hearing before an Administrative Law Judge;

Level 4 - Review by the Medicare Appeals Council; and

Level 5 - Judicial review by a Federal District Court.

Appeals can be made to the Quality Improvement Organization, Livanta, at their helpline number 1-877-588-1123. **FATE's** experience on this matter is that the acute hospital case managers are not telling the patients and their families of these five (5) appeals. If the hospital staff does address the appeal, they are only stating one appeal right and not all five.

FEDS TO INVESTIGATE NURSING HOME ABUSE OF ANTIPSYCHOTICS

Earlier this year, the federal government began a targeted crackdown on nursing homes' abuse of antipsychotic drugs and misdiagnoses of schizophrenia in patients. The government launched the investigation into select nursing homes, aimed at verifying whether patients have been properly diagnosed with the psychiatric disorder. Evidence has mounted over decades that some facilities wrongly diagnose patients or administer antipsychotic drugs to sedate them, despite dangerous side effects that could include death. Health and Human Services (HHS) Secretary Xavier Becerra stated "the steps we are taking today will help prevent these errors and give families peace of mind." In 2012, the federal government began tracking when nursing homes use antipsychotics on patients. For over 10 years, **FATE** participated as a member of the task force in California working on the reduction of antipsychotics in nursing homes, as well as the development of an Informed Consent form, which must be executed by the patient, if capable, or the patient's decision maker prior to the administration of any antipsychotic or black-box drug. However, the use of antipsychotics has not decreased and the industry continues to not be held accountable for the administration of these drugs which have numerous serious adverse side effects. Xavier Becerra, who was the Attorney General of California prior to his appointment as the Secretary of HHS and oversaw the Bureau of MediCal Fraud and Patient Abuse, did little to nothing to ensure the unauthorized use of antipsychotics or any other problems in CA nursing homes that hindered the health and safety of California's most vulnerable citizens.

GAO REPORT ON TRANSPARENCY IN NURSING HOME OWNERSHIP

The Government Accountability Office (GAO) released a report this year finding fault with how the Centers for Medicare and Medicaid (Medical in California) (CMS) currently provides information to consumers regarding nursing home ownership. The report noted that ample evidence demonstrated that different ownership types often lead to disparate health outcomes for nursing home patients. For instance, non-profit homes generally perform better on measure of quality than for-profit homes. The report acknowledged these differences in care quality and emphasized the importance of accurate and accessible ownership interest to consumers. The report focused on how CMS provides ownership information with terms that are vague and undefined and not easily understandable to consumers. It also noted that the presentation of ownership information does not allow consumers to easily identify relationships and patterns related to quality across nursing homes under common ownership. When deciding on a nursing home, patient and their families must have access to ownership data that is reliable and accurate. It is currently impossible to easily access care quality information. If possible, before placing a family member in a facility, consumers should go the state office that licenses the facility and take a look at the public record outlining who the operator actual is or call **FATE** and we can provide that information. Until CMS ensures that ownership information for all nursing homes is accurate, the system's utility as a whole will be undermined.

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:

ARBOR POST-ACUTE, Chico, CA … numerous deficiencies … (Original complaint filed by FATE client … resolved during a recertification survey) Failure to ensure that all patient care plans were accurate and updated; failure to ensure patients' medications were administered per manufacturer's instructions and professional standards; failure to provide sufficient supervision to prevent accidents when the use of and documentation for fall alarms were not consistent causing an unsafe environment; failure to ensure kitchen staff were competent to carry out the responsibilities of the food and nutrition services; failure to ensure menus were in place, prepared and followed; failure to ensure food was stored, prepared and distributed in accordance with professional food safety standards; failure to have an effective Governing Body; failure to ensure that infection control measures were followed; failure to ensure kitchen floor drains and drainpipes were kept in good repair, compromising kitchen sanitation. These violations all had the potential to contribute to an unsafe environment putting patients at risk for falls, injuries, food poisoning, etc.

ATRIA WALNUT CREEK, Walnut Creek, CA … three State B Citations and three A Citations … $1,500.00 civil penalties … failure to submit incident reports for falls; failure to comply with having an old mattress sitting in resident's room, which posed potential safety and personal rights risks to the resident; failure to provide a safe healthful and comfortable environment when resident sustained a fracture; failure to prevent a broken hip, bruising, broken wrist and hematoma, which posed immediate health and personal right risks to the resident; failure to prevent pressure sore injuries; failure to comply with a thirty-day eviction for reasons that the resident was on a pureed diet; failure to provide sufficient staffing, of which all of these violations posed immediate health and personal right risks to the resident who subsequently died. Facility under review for an additional civil enhanced remedy up to $15,000.00 for these failures.

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

– American Journalist, Brett Arends.

AURORA VISTA DEL MAR HOSPITAL (Signature Healthcare), Ventura, CA … CA Health and Safety Code Violations … facility failed to implement policies and procedures regarding assessment and safety rounds by staff failing to ensure staff performed safety rounds as ordered to prevent the patient from carrying out a suicide plan; failure to ensure mental health workers were qualified and failure to conduct evaluations to determine if staff was sufficient to meet patient care needs; failure to ensure staff followed policies and procedures for adequately monitoring patient to prevent patient from carrying out his established suicide plan, which was to hang himself and die, which he eventually did and died from hanging himself with a linen sheet tied around his neck and tied to the bathroom toilet. The facility failed to prevent this episode that caused death to the patient. **FATE** did not file this complaint; however, it was so egregious because the patient was only 17 years old that it was decided to include this complaint in our newsletter.

DOUBLE TREE POST-ACUTE CARE CENTER, Sacramento, CA … Federal Deficiencies … facility failed to maintain hydration and nutritional status when the patient was admitted to the acute hospital with critical lab values and significant weight loss which occurred over a 15-day period. This failure resulted in the patient experiencing avoidable physical harm which required transfer to a higher level of care; failure to provide patient with necessary, physician-ordered medication, when two doses of mycostatin (a medication to treat fungal infections) were not administered. This failure resulted in the patient experiencing oral discomfort during the days of the missed dose. **FATE** filed for an appeal as higher level of citations should have been issued with civil penalties under the California Statutes.

FAIRFIELD POST ACUTE REHABILITATION, Fairfield, CA … State Deficiency … facility failed to ensure safe and appropriate drug disposition when multiple packs of Seroquel were not among the physician's discharge medications orders and were given to a patient during discharge. This failure had a potential for the patient to take the wrong dose thereby increasing his risk for the medication's side effects. **FATE** filed for an appeal based on the Department of Public Health's failure to investigate the other allegations contained in the original complaint, which were failure to obtain consent to administer antipsychotic medications, weight loss, failure to follow doctor's orders, failure to prevent bed sores, failure to produce copies of medical records and insufficient staffing.

HILLCREST POST ACUTE, Petaluma, CA … Federal Deficiencies … facility failed to permit full visitation rights when family was not allowed to visit patient when she was unable to get up from bed and no opportunities were provided to the family for window visits. The finding had the potential to result in feelings of loneliness, isolation and lack of advocacy; facility failed to ensure Licensed Nurses followed professional standards of practice when blood glucose readings were consistently high and staff did not notify the physician and care plans for high blood glucose were not revised despite hospitalizations and changes in the medications, which had the potential to result in serious diabetes complications, including death; facility failed to promote the prevention of pressure ulcers development due to lack of interventions such as frequent assistance with toileting, repositioning and creation and revision of care plans, which resulted in patient developing a Stage Ill pressure sore; facility failed to prevent patient falls when left alone on a bedside commode and facility failed to revise assessments for changes after falls, which had the potential to result in further falls with major injuries, including death. **FATE** filed an appeal to reevaluate findings to include issuance of State of California violations, which would result in assessed civil penalties.

IRIS GUEST HOME, Orange, CA … Class B State Violation … Class B Violation for failure to submit a written report to Community Care Licensing for an incident with a resident that posed a potential safety risk to the person in care. The allegation that the facility did not seek medical care for the resident who fell was unsubstantiated.

KINDRED HOSPITAL SOUTH BAY, Gardena, CA … Federal Deficiencies … hospital staff failed to create a care plan (provides a framework for evaluating and providing patient care needs) that addressed nutritional needs and/or aspiration concerns for patients who are receiving enteral feeding in accordance with the hospital's policy and procedure. This deficient practice resulted in aspiration. Hospital failed to weigh two patients before and receiving hemodialysis (the process of removing excess fluid and waste from the body of a person whose kidneys are not working correctly) treatment and failed to notify the physician of weight changes in accordance with the hospital's policy and procedure and physician's order. This deficient practice had the potential to result in incorrect documentation of patient's weight and had the potential for ineffective hemodialysis treatment, which may cause shortness of breath or fluid overload.

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Long-Term Care Facility Complaints

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MANORCARE HEALTH SERVICES, CITRUS HEIGHTS, CA … **Federal Deficiency** … facility failed to provide copies of medical records to the patient's responsible party within two working days of the request. NOTE: The State of California initially sent a letter to **FATE** that the complaint was unsubstantiated. When **FATE** was going to appeal the findings, a request was made for the federal document and that document showed that a deficiency had been issued to Manor Care for this Federal Violation. The state employee admitted that the document was changed the day **FATE** was about the file for an appeal.

MARLORA POST ACUTE REHABILITATION, Long Beach, CA … **Federal Deficiencies** … facility failed to ensure the licensed nurses monitored intake and output measurements of fluids to provide adequate hydration for the patient who had an indwelling urinary catheter and was receiving intravenous fluids. This failure placed the patient at risk for fluid and electrolyte imbalance and dehydration placing patient at risk; facility failed to maintain acceptable parameters of nutritional status.

OXNARD MANOR HEALTHCARE CENTER, Oxnard, CA … **Deficiency** … facility failed to ensure patient visitation rights were honored when the facility limited the amount of time patient could spend with her son. This facility violated patient's rights. Note: This patient was under conservatorship and the conservator was preventing the visits without a court order and the facility allowed the restriction, which warranted the deficiency.

PARK VIEW POST ACUTE, Santa Rosa, CA … **Federal Deficiencies** … facility failed to assess and provide necessary treatment and services when patient was not assessed and monitored for signs of Urinary Tract Infection (UTI). This failure resulted in the patient's immediate transfer to the hospital and ultimately died from sepsis secondary to bacteremia, the presence of live bacteria in the bloodstream. **FATE** filed an appeal as the incident which caused death met all the criteria for a State citation with a civil penalty assessment.

PINE CREEK CARE CENTER, Roseville, CA … **Federal Deficiency** … facility failed to ensure services provided by the facility met professional standards of practice when a physician's order for medication for Parkinson's disease was not administered causing patient to go without a dose for 11 hours. The failures had a potential to result in the patient suffering negative side effects caused by missed and late doses such as worsening of tremors, increased rigidity and pain. **FATE** filed an appeal as the other allegations including dehydration, lung issues caused by a swamp cooler, lack of physical therapy and not notifying the responsible party of a change of condition were not addressed.

ROSEVILLE POINT HEALTH & WELLNESS CENTER, Roseville, CA … **Federal Deficiencies** … facility failed to inform patient and/or responsible party of changes in treatment when pain medications were changed without notification, which had the potential to deprive the patient of rights to make decisions regarding care; facility failed to implement the comprehensive care plan when range of motion exercises were not provided, which failure placed the patient at risk for decreased ROM and developing contractures; facility failed to ensure nursing services met professional standards when the facility failed to re-schedule a CT scan, collect a urinalysis, per physician orders; facility failed to perform a change of condition assessment all of which failures increased the potential to cause a delay in treatment that resulted in increased pain for the patient; facility failed to ensure patient received necessary treatments to promote healing and prevent infection of pressure ulcers when treatment orders were not renewed in a timely manner and were not completed as ordered, which placed the patient at risk for slowed healing and infection; and facility; failed to ensure a licensed nurse was competent for a census of 85 when no documented evidence of a competency assessment could be provided which potentially placed the patients' safety at risk when the LN competency was not assessed prior to providing patient care.

SALLY'S RESIDENTIAL CARE HOME, Camarillo, CA … **two (2) A Citations** … **.Immediate $500 civil penalty** … NOTE: This complaint was originally filed by the daughter of the deceased man who was under a conservatorship in Ventura County. His cause of death was septic shock due to bowel obstruction and fecal impaction. However, the CA regulators unsubstantiated the original complaint. **FATE** filed another complaint and it took the department 17 months to finalize the **FATE** complaint, which resulted in the following findings: facility failed to comply with monitoring the general health, safety and well-being of the resident as the licensee did not comply with physician orders, which resulted in the resident experiencing fecal impaction, bowel obstruction and sepsis, which led to death and posed an immediate health risk to residents in care; facility failed to monitor resident for any changes in condition, which also caused an immediate health and safety risk to residents in care. This case warrants an enhanced remedy fine; that happened and **the facility was fined $15,000.00 for the death of the resident**.

"All that is necessary for the triumph of evil is for good men to do nothing."

- Edmund Burke
Irish Statesman and Author

"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

SALLY'S RESIDENTIAL CARE HOME, Camarillo, CA … **Class B Citation** … Licensee failed to comply with Section 1569.191 of CA Health and Safety Code, which states the property and business shall not be transferred until the buyer qualifies for a license or provisional license within the appropriate provisions of this chapter as the licensee directed residents to pay a management company representing the buyer that had not been approved by the CA Department of Consumer Affairs, Community Care Licensing, which posed a potential personal rights risk to residents in care.

SUNRISE OF ROCKLIN, Rocklin, CA … **two {2} B Citations and (1) A Citation** … failure to ensure that resident was not able to leave the facility, which posed an immediate health and safety risk to resident's care; failure to ensure to safeguard resident's paintings that were reported missing, which posed a personal rights violation to residents in care; failure to ensure that records from resident's file were provided to the resident's responsible party within two (2) days of receiving the written request, which posed a personal rights violation to residents in care.

WILLOWS POST-ACUTE, Willows, CA … **Class A Citation with a $25,000.00 civil penalty** … facility failed to ensure that resident was safe from heat-related accident when the facility did not have policies regarding resident care during hot weather, or patio use, and patient was left unattended on an outdoor patio for an unknown length of time in hot weather resulting in the patient being found unresponsive on the patio and subsequent death. The patient was also being given Lasix, which is a diuretic, which may cause dehydration and blood volume reductions with circulatory collapse, possible vascular thrombosis and embolism particularly in elderly patients. **FATE** filed an appeal as the incident met all the criteria for a AA Citation with a higher civil penalty, which could be assessed up to $100,000.00.

WINDSOR ELK GROVE CARE AND REHABILITATION CENTER, Elk Grove, CA … **Federal Deficiencies** … facility failed to notify the responsible party when the patient developed an infection and was placed on contact precautions. This failure had the potential to spread the infection and kept the responsible party unaware of the medication condition of the patient. The results are in appeal as the entire complaint allegations were not addressed and not substantiated.

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IN MEMORY

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