



FATE

Newsletter of Foundation Aiding The Elderly

President's Message

THE NEED FOR ADVOCACY CONTINUES TO INCREASE

By Carole Herman

Now in existence for over 30 years, **FATE** continues to strive in preventing elder abuse and has assisted over 4,000 families needing advocacy for a loved one or friend. **FATE** has helped families in every State in the Country

at no charge. **FATE** accepts no government monies and has been able to help our most vulnerable citizens and their families because of donations from the public. We are quickly migrating to a senior society. Baby Boomers are entering their senior years and many are caring for their parents. Our mission statement is to assure our elders are treated with care, dignity and the utmost respect during their final years. In order to continue our mission and to aspire to cloning the **FATE** operation into other

major cities, we rely on the generosity of individuals and businesses to support our mission. Thus, we ask that you become a part of this mission by donating to our worthy cause. We ask that you make a commitment to support our annual appeal with a tax deductible cash donation as your generosity will enable **FATE** to continue our advocacy. Every donation makes a difference, regardless of size. You may send your donations directly to our office or go to our web site www.4fate.org and donate



CAROLE HERMAN

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*Warm Wishes for
a Very Happy and
Joyous Holiday Season
with a Safe and
Healthy New Year.*

via PayPal. Your consideration is most appreciated.

THE VOICE OF THE BABY BOOMERS

As far back as the early '80's, I spoke of what was going to happen when the Baby Boomers reach retirement age. Not only will they be concerned about their healthcare needs, but many would still have parents alive who would be worrying about the same thing. Who would have thought at the turn of the 20th century that people would be living as long as they are today. In the early 1900's, life expectancy for women was 46 years and men 48 years. Today, life expectancy for

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FATE'S MISSION IS:

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

SERVICES FATE PROVIDES

- Direct & On Site Advocacy
- Patient & Family Rights Advice
- Elderly Service Referrals
- Long Term Care Facility Evaluation

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FATE Files Lawsuit against State of California/Department of Public Health

California citizens who have filed complaints against nursing homes are being denied their rights by the California Department of Public Health (DPH) due to the Department not complying with their statutory obligations to complete investigations of complaints lodge against skilled nursing homes and other long-term care facilities in a timely manner according to a law suit filed against the Department in Northern California. FATE brought the suit alleging that DPH and its personnel have been delinquent in carrying out their duties required of them pursuant to State statutes. DPH takes months or even years to complete investigations exposing elderly and infirmed patients of skilled nursing homes and other long-term care facilities to real and substantial harm, including neglect, suffering and avoidable death. "The failure of DPH to adhere to State regulations when investigating allegations of nursing home abuse is detrimental to all nursing home and long-term care patients" according to attorney, Howard Hirsch. Hirsch of the Lexington Law Group, a San Francisco public interest law firm, is lead counsel for FATE. "It is unfortunate that it takes the intervention of the courts to force DPH into compliance with the laws it is charged with carrying out," stated Hirsch. "Nursing home patients are among the most fragile and vulnerable members of our society", stated Carole Herman, President of FATE in a news release after the filing. "When complaints for negligence and poor care are reported to the State regulators it puts them on notice that the alleged infractions have a negative effect on all patients in the facility and should be investigated promptly not only because it is DPH's duty, but because it will prevent other patients from suffering", stated Herman.

The California Department of Public Health is a division of the California Health and Human Services Agency. Also named as defendants are Dr. Ronald W. Chapman, M.D., director of the Department and Debby Rogers, R.N., the Deputy Director of Licensing and Certification, the department that licenses and monitors nursing homes, long-term care facilities, acute hospitals, psychiatric hospital and hospice care companies.

**Far and away the best prize that life has
to offer is the chance to work hard at
work worth doing.**

— Theodore Roosevelt

PRESIDENT'S MESSAGE

Continued from page 1

women is 81 years and men 76 years. Quite a difference. Certain medicines, healthy life styles, good eating habits, exercise and good genes have contributed to our extended life expectancy in the 21st century. We all want to live a long life as long as the quality is good. And that is the big question...Over the past 10 years, the number of Baby Boomers calling **FATE** for assistance with parents has increased dramatically. The Baby Boomers seem to be taking a position to stand up to the medical profession when it comes to care for their parents. Unlike the older generation, Baby Boomers are not afraid to speak out and question doctors and care providers about treat-

ment and quality of care. As the Baby Boomers age there will be a sharp decline in who will take care of them. According to AARP, there are about 7 people aged 45-64 to care for each person 80 or older. By 2030, there will only be 4 people and by 2050 fewer than 3. The percentage of people staying home is likely to increase as people do not want to go into an institutionalized facility, such as a nursing home. This will cause a massive shortage of paid aides and the availability of potential family caregivers will increase. Baby Boomers will be the huge population of elders that need caregiving. This raises a loud alarm as fewer family members will be

there to deliver caregiving for this large population. Baby Boomers who have been caring for their parents have begun the slide from middle-aged to old age and by 2025, the first of the Baby Boomers will reach 80, an age they are likely to need some level of assistance. As medical care changes, so does the profile of the consumer and hopefully with the Baby Boomers reaching retirement age, they will be the voice to reckon with when it comes to long-term care needs and our treatment by the medical profession and the long-term care industry.

FATE's Automated Computerized Tracking System Now On-line

After a two-year conversion effort, **FATE** has implemented an automated system specifically designed for its use. Headed by Paul Lazio, a systems design consultant with over 30 years of experience, and with the dedicated assistance of our volunteers Jamie Lamborn, Terry Fickies, Eileen Dancause and staff

members Jane DeSoiza, Harris Herman and Consultant Jesse Esquivel, literally thousands of case files and documents have been converted to a searchable database. All clients, patients, complaints are now at our fingertips. Productivity has leaped forward by 300% over the last few months. The old adage "information is

power" will prove itself in our ability to do more for our clients and to provide more information. With over 4,000 families served, we pride ourselves as a pure advocacy group providing services and much-needed information to the consumer and this tracking system will enable us to be more efficient in providing our services.

Emeritus Found Guilty in Elder Abuse Case

After a two-month trial, Emeritus Corporation, a Seattle-based residential care giant was found guilty of malice, oppression and fraud in a Sacramento Superior Court case in which the jury awarded \$23 million in punitive damages to the family of Joyce Boice who died in 2009 from negligence and poor care in Emeritus' Emerald Hills facility in Auburn, CA. The jury also awarded the family \$4.1 million in compensatory damages, which was reduced under California law to \$500,000, as well as awarding attorney fees. Lesley Clement, the

plaintiff's attorney and FATE board member, brought this case to trial and argued to the jury that Emeritus cut staffing to the point where there were nights during Ms. Boice's stay in the memory care unit when nobody was on duty. Before trial, Emeritus offered to settle the case for \$3.5 million; however, the Boice family declined the settlement offer stating that under a settlement agreement they would have to sign a confidentiality agreement and then nobody would have ever known what Emeritus was doing. During the trial, it became evident that

along with systemic understaffing and lack of training, Emeritus' retention policies designed to keep "heads on the beds" resulted from a corporate drive for profits that put the bottom line above resident's care. PBS Frontline was present and filmed during parts of the trial and aired its program "Death in Assisted Living" in conjunction with ProPublica focusing in on the Emeritus Corporation. To view the Frontline Program, go to our web site www.4fate.org or go to <http://www.pbs.org/wgbh/pages/frontline/life-and-death-in-assisted-living>.

Erroneous Death Certificates

Death certificates for patients dying in long-term care facilities don't always list the actual cause of death. **FATE** has had numerous clients over the years whereby physicians have listed erroneous illnesses as the cause of death. In one case, the cause was listed as "heart attack". The family could not understand how that caused their loved one's death when the patient had never been treated for heart problems. The family requested an autopsy and the coroner discovered she had actually choked to death as her throat was full of food which prevented her from breathing. In another case when the patient died, the physician wrote her cause of death was

due to Alzheimer's disease. The patient had never had a diagnoses of Alzheimer's disease and the physician was on vacation when the patient died. The coroner was contacted to do an autopsy and the actual cause of death was due to complications from a fractured hip caused by a fall in the facility where she resided. **FATE** strongly urges family members to challenge the cause of death on their loved one's death certificate if they feel the cause listed is inaccurate. Physician's listing erroneous causes of death should also be reported to the Medical Board in the state where the death occurs.

China Requiring People to Visit their Aged Parents...

Earlier this year, China's National Legislature amended its law on the elderly to require that adult children visit their aged parents "often" or risk being sued by them according to the Associated Press in Beijing. The requirement will allow elderly parents who feel neglected by their children to take them to court. The move comes as reports abound of elderly parents being abandoned or ignored by their children. China is facing increasing difficulties in caring for its aging population. Three decades of market reforms have accelerated the breakup of the traditional extended family in China and there are few af-

fordable alternatives, such as retirement or care homes, for the elderly or others unable to live on their own. The expansion of China's elderly population is being fueled both by an increase in life expectancy... from 41 to 73 over five decades... and by family planning policies that limit most families to a single child. Like everywhere, rapid aging poses serious threats to the country's social and economic stability as supporting the growing number of elderly passes on to a shrinking working population and the social safety net remains weak. How the legislature will monitor its new law is unknown.

Thefts from Nursing Home Trust Funds

AUSA TODAY investigative reported published on 10/21/13 uncovered data that long-term care patients in nursing homes have had their personal savings raided or mismanaged after relying on facilities to safeguard their money in special trust fund accounts. These trust funds, which most long-term care providers are required to maintain for residents who request that the facility handle their money, are supposed to work like conventional bank accounts, but USA TODAY found more than 1,500 recent cases in which nursing homes have been cited by state and federal regulators for mishandling the funds. In scores of cases, employees siphoned

huge sums of money from patient's trust accounts from everything from shopping and gambling sprees to routine household expenses. Medicaid (MediCal in California) patients who have a share of costs are allowed \$30/month for personal expenses. These funds are usually maintained in the patient's trust account for the patient's use. Some family members watching over their loved ones in the facilities do not even know about the trust funds.

For tips on how to protect your loved one's trust fund go to <http://www.usatoday.com/story/news/nation/2013/10/16tips-protecting-nursing-home-residents-funds/2990537>

BOOK OF INTEREST

Feet First, Riding the Elder Care Rollercoaster with My Father ...By Jamie Legon

Jamie Legon began his career in the entertainment business producing concerts in South America. He then moved to Hollywood, where he produced and directed commercials and videos of all kinds during a twenty-five year span. His father's long life forced him into a situation about which he knew nothing. His story provides a few comforting laughs, but perhaps will also call attention to a few of the many issues of elder care. This book will hopefully reassure those of you already caring for your parents that you are not alone. This book may be ordered through www.Amazon.com or www.barnesandnoble.com

Efforts to Reduce Use of Antipsychotic Drugs in Nursing Homes Falls Short of Goal...

A two-year effort by the federal government and the nursing home industry has reduced the use of powerful antipsychotic drugs among elderly nursing home residents, but the decline fell short of the program's goal, according to the Center for Medicare and Medicaid Services (CMS).

CMS, which oversees spending on the big federal health-care programs for the elderly and poor, embarked on its effort to cut the use of such drugs, the agency's goals was for nursing homes to achieve a 15% reduction in the usage of these drugs by the end of 2012.

Antipsychotics are costly to Medicare. In 2011, Medicare spent \$7.6 billion on antipsychotic medications, namely, Abilify, Haldol, Risperdal, Seroquel, Zyprexa, to name a few. In 2011, the Inspector General issued a report about the use of antipsychotics in the elderly and found that 88% of the time, the drugs had been prescribed to patients suffering from dementia...a situation he later said was "potentially most alarming".

Dr. Patrick Conway, chief medical officer for CMS, stated that CMS set a national goal to decrease antipsychotics and we have made really dramatic progress working with stakeholders. **FATE** was one of the stake-

holders in California and agrees with other stakeholders that the effort fell short of the goals set by CMS. **FATE's** position as a stakeholder was to not reduce the usage of antipsychotics for elderly nursing home patients, but to ban the use of antipsychotics in nursing homes based on the horrific side effects of these drugs in the elderly. In 2005, the federal Food and Drug Administration imposed its strongest warning label, a "black box warning", on all atypicals stating that elderly patients with dementia face an increased risk of death from the drugs. According to Stephen Crystal, a health researcher at Rutgers University, "these drugs are estimated to increase risk of death by 60%-70% in elderly patients with dementia."

Back as far as the 1990's, federal law has required nursing homes to obtain consent of the patient or, if the patient is not competent, the patient's decision maker prior to the administration of any antipsychotic medication. Consent must be obtained by the patient's physician and in writing and must state why the medication is needed and what steps had been taken prior to any consideration of antipsychotic medications being given to an elderly nursing home patient.

Drug Giant Settles Case

Johnson & Johnson has agreed to pay more than \$2.2 billion to resolve criminal and civil allegations that the company promoted powerful psychiatric drugs for unapproved uses in children, seniors and disabled patients according to the U. S. Department of Justice. The agreement is the third-largest settlement with a drug maker in U.S. history and the latest in a string of accusations against drug companies allegedly putting profits ahead of patients. The Justice Department alleged that J&J used illegal marketing tactics and kickbacks to persuade physicians and pharmacists to prescribe Risperdal and Invegal, both antipsychotic drugs. Attorney General Eric Holder stated that "every time pharmaceutical companies engage in this type of conduct, they corrupt medical decisions by health

care providers which jeopardizes the public health and takes money out of taxpayers' pockets". J&J subsidiary Janssen Pharmaceuticals admitted promoting Risperdal as a way to control behaviors in seniors with dementia. Janssen marketing materials stated that Risperdal had been determined to be safe for the elderly, which the Justice Department stated is "misleading". **FATE** has advocated for years that the elderly population should never be given these types of drugs and continues to warn clients who have loved ones in nursing homes to know that antipsychotic medications cannot be administered without consent from the patient or the patient's decision maker if the patient is not capable of decision making.

BOOK OF INTEREST

67 Ways to Protect Seniors from Crime ...By J. L. Simmons, Ph.D.

J. L. Simmons, Ph.D., has taught in four major universities, co-founded two counseling centers and lectured extensively across the country on crime issues. The Federal Bureau of Investigation's statistics report that older Americans are increasingly the victims of personal and property theft, swindles and con games and financial and medical fraud. By learning certain habits and taking certain protective measures, one can reduce the risk of being a victim of crime. This book may be ordered through www.Amazon.com or on E-Bay.

LONG-TERM CARE FACILITY COMPLAINTS

One of FATE's services is filing complaints with the state regulatory agencies on behalf of nursing home, assisted living, residential care and acute care hospital patients and residents. Over the past several years, FATE has averaged three to five complaints a month. Although a prompt response is required, these state agencies can extend the process for years. Some of these complaints that FATE has filed do result in the appropriate state department citing these facilities for violations of Federal and State regulations. The following are the results of some of those complaints:

ALTA MANOR ASSISTED LIVING, ROSEVILLE, CA...TYPE A CITATION...\$150.00 PENALTY ASSESSMENT...facility failed to report a change of patient's condition or document patient's falls; failure to document or monitor significant weight loss and dehydration; failed to notify physician or the family of the weight loss or dehydration and failure to document care notes.

ALTA MANOR ASSISTED LIVING, ROSEVILLE, CA...TYPE B CITATION...facility failed to notify the physician and family of a change of condition; facility failed to document or notify family of weight loss; facility was using a faulty scale; facility retained a resident who needed total care that facility could not provide; facility failed to report to the licensing agency of an incident which threatened the welfare, safety or health of the resident.

AMERICAN RIVER CARE CENTER...CARMICHAEL, CA...DEFICIENCY...facility failed to ensure a STAT (immediate) x-ray was obtained as ordered by the physician for the patient.

APPLEWOOD CARE CENTER, SACRAMENTO, CA...B CITATION WITH A \$1,000.00 PENALTY ASSESSMENT...facility failed to assess and consult with appropriate health professionals to ensure the patient could be safely transferred using an appropriate lift device based on the patient's physical condition resulting in an injury to the patient. This violation had a direct or immediate relationship to the health, safety or security of the patient.

ASIAN COMMUNITY CENTER NURSING HOME...SACRAMENTO, CA...CLASS AA CITATION \$80,000.00 PENALTY ASSESSMENT...facility failed to provide meal assistance to the patient including cutting her meat into smaller pieces during a facility sponsored outing to ensure that the patient ate foods in a form she could safely swallow. This failure resulted in the patient consuming a large piece of meat which completely blocked her airway and resulted in her death. This violation presented imminent danger that death would result and resulted as a direct proximate cause of the death of this patient.

BURBANK HEALTHCARE AND REHABILITATION...BURBANK, CA...DEFICIENCIES...facility failed to ensure adhesive strips used to close surgical incision were changed daily after the removal of surgical staples, which resulted in the potential interference and/or disturbance of the healing process of the wound and exposure to infectious

agents; facility failed to ensure that the patient with an indwelling catheter and who had recurrent urinary tract infections (UTI) was consistently monitored for signs and symptoms of another UTI; facility failed to ensure the patient, who was at risk for dehydration, received fluids based on the calculated daily fluid needs to prevent the potential for dehydration; facility failed to ensure that the patients who have not used antipsychotic medications are not given these drugs unless antipsychotic therapy is necessary to treat a specific condition. Original complaint filed by client.

CARMICHAEL CARE & REHABILITATION, CARMICHAEL, CA ...B CITATION WITH A \$1,000.00 PENALTY ASSESSMENT...facility failed to assess a patient for two days following a fall; failure to promptly notify the physician following the patient's fall.

CARMICHAEL CARE & REHABILITATION, CARMICHAEL, CA...DEFICIENCIES...facility failed to maintain nurses notes which shall be signed and dated; failed to include notification to the license nurse of changes in the patient's condition; failed to ensure nursing assistants documented the patient's fall; failure to ensure a meaningful and informative progress note documented an actual fall.

CARMICHAEL CARE & REHABILITATION, CARMICHAEL, CA...DEFICIENCIES...facility failed to ensure services provided met professional standards of quality when staff failed to perform an initial and on-going skin assessment and develop a plan to prevent the development of pressure sores; failure to perform a comprehensive assessment and provide necessary care and treatment of pressure sore.

CHATEAU AT CARMICHAEL PARK, CARMICHAEL, CA...CITATION...\$150.00 PENALTY ASSESSMENT...facility failed to monitor patient to prevent numerous falls resulting in skin tears, bruising and suffering on at least three occasions; facility failed to ensure patient's rights were not violated as there were several occasions where the family did not receive timely communications and assistance from the facility which resulted in the administration of Haldol which the family was unaware of; the allegation of insufficient staffing was inconclusive.

ESKATON CARE CENTER/MANZANITA...SACRAMENTO, CA DEFICIENCY...facility failed to follow its policy for care planning wound care when

patient did not have an individual care plan for each wound site.

ESKATON CARE CENTER/GREENHAVEN...SACRAMENTO, CA CLASS B CITATION...\$1,000.00 PENALTY ASSESSMENT...failure to continually assess and provide the necessary fluids to ensure patient's hydration needs were met; failure to follow current policy of Intake and Output criteria documentation by not ensuring patient's Inputs and Outputs were assessed; failure to provide patient with good nutrition and necessary fluids for hydration. These failures resulted in the patient being admitted to the hospital and treated for sepsis and dehydration. **DEFICIENCIES...**failure to ensure patient's treatments were administered as ordered when patient did not receive occupational therapy as ordered; failure to complete the patient's neurological assessment checklist; failure to obtain informed consent prior to the administration of the black-box drug Ativan; failure to order an appetite stimulant recommended by the registered dietician.

FAIR OAKS ESTATES, CARMICHAEL, CA...DEFICIENCIES...facility failed to properly document any medications that were dispensed, missed or rejected by the resident in the appropriate dispensing log; facility failed to properly document/report any injuries/incidents that required some form of medical intervention on behalf of the resident, their responsible party or the licensing agency; facility failed to maintain a continuing record of any illness, injury or medical/dental care, when it impacted resident's ability to function; facility failed to continually observe the resident with any major changes to health and well-being status and failed to notify the appropriate agencies to ensure the proper level of care and supervision with the required forms.

GOLDEN LIVING CENTER-PORTSIDE, STOCKTON, CA...DEFICIENCY...facility failed to inform patient or the responsible party in writing of the right to exercise the seven day bed hold provisions afforded to patients when transferred from the facility to an acute care hospital; failure to offer the patient the next available bed in the Alzheimer's Care Unit after the expiration of the seven day bed hold. This complaint was filed in August of 2011; however, the state did not notify FATE of the findings until 10/16/13, two years later.

HIGHGATE SENIOR ASSISTED LIVING, GRASS VALLEY, CA...DEFICIENCY...facility retained a resident who was diagnosed with a Stage III bed

LONG-TERM CARE FACILITY COMPLAINTS

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sore when the facility is not licensed to care for a resident with a Stage III or Stage IV bed sore (dermal ulcer).

KAISER HOSPITAL/ROSEVILLE, CA...DEFICIENCY......failure to follow policy and procedures for patient's rights. Hospital staff failed to communicate health care decisions affecting the patient's care with the patient's decision maker when the patient was administered chemical and physical restraints without informed consent.

KAISER HOSPITAL/MORSE AVENUE, SACRAMENTO, CA...DEFICIENCY......failure to ensure that the patient or the patient's representation was explained risks, benefits and potential problems and failure to get informed consent prior to the administration of an antipsychotic medication, namely Haldol.

KAISER HOSPITAL/ROSEVILLE, CA...DEFICIENCY......failure to follow policy and procedures for patient's rights. Hospital staff failed to communicate health care decisions affecting the patient's care with the patient's decision maker when the patient was administered an antipsychotic medication without informed consent. Second deficiency issued for two separate patients.

LINCOLN MEADOWS CARE CENTER, LINCOLN, CA....DEFICIENCIES......facility failed to implement its policy to ensure the Director of Staff Development's credentials were consistent with the written job description educational requirements; failure to maintain complete and accurate personnel records for all employees.

LINCOLN MEADOWS CARE CENTER, LINCOLN, CA...CLASS AA CITATION, \$100,000.00 PENALTY ASSESSMENT......Facility failed to ensure that the patient was free from unnecessary drugs when Coumadin/warfarin was ordered and administered for 17 days without monitoring, which contributed to his death from bleeding in the brain; failure to revise a care plan for anticoagulant treatment when Coumadin was ordered. These violations presented imminent danger and substantial probability that death or serious physical harm to the patient would result therefrom and were a direct proximate cause of death of this patient.

MAGNOLIA PLACE, GREENVILLE, S.C....DEFICIENCIES......facility failed to provide a safe, clean, comfortable and homelike environment allowing the resident to use his or her personal belongings; facility failed to provide a safe, sanitary and comfortable environment and failed to help prevent the development and transmission of disease and infection; facility failed to obtain ordered laboratory services with an order for a repeat stool culture related to a contagious infection.

MAYWOOD ACRES HEALTHCARE, OXNARD, CA...DEFICIENCIES......facility failed to provide unrestricted access for patient's family members and non-relative visitors to visit patients. Facility staff were asking visitors to leave the facility after 8: p.m. in order to comply with the facility's policy to leave the facility after 8 p.m., which indicated that visiting hours were over when there are no visiting hours for family members. This failure created the potential for mental and psychosocial discomfort for residents and their visitors.

MISSION CARMICHAEL HEALTHCARE CENTER, CARMICHAEL, CA...DEFICIENCY......facility failed to provide copies of the patient's medical records according to the Federal Regulations.

NORWOOD PINES ALZHEIMERS CENTER, SACRAMENTO, CA...DEFICIENCY......facility failed to ensure that a physician obtained informed consent for the administration of psychotherapeutic medications on two separate occasions. This failure resulted in the inability of the resident/responsible party to make informed decisions related to medications that have physical, mental and emotional effects on the patient; facility also failed to ensure that the patient's health record contained documentation that the resident/responsible party had given informed consent prior to administering/increasing a psychotropic medication.

PINES AT PLACERVILLE HEALTHCARE CENTER...PLACERVILLE, CA...DEFICIENCY......facility failed to provide access or copies of clinical records of patient by the patient's legal representative within the time frame required by federal regulation.

PROGRESSIVE HOME CARE, AUBURN, CA...DEFICIENCIES......failure to ensure a registered nurse performed duties consistent with the Nursing Practice Act and Standards of Competent Performance when wound care nurse performed sharps debridement treatments without a specific, signed physician order; failure to explain sharps debridement treatments to patient per agency's policy; failure to obtain consent from patient's durable power of attorney for healthcare for the sharps debridement treatments; failure to only retain patients for who it could provide adequate care when patient developed a pressure sore on her back which progressively worsened to a Stage IV pressure sore; failure to provide a valid procedure order for wound care when patient's wound debridement order was not signed by the physician; failure to provide specific procedure orders for wound care when patient's wound debridement orders did not specify the specific type of debridement ordered and failure to make clinical records available within the required timeframe to patient's authorized representative. The complaint was filed by the patient's daughter.

ROCK CREEK CARE CENTER, AUBURN, CA....DEFICIENCIES......facility failed to notify the physician of persistent constipation and refusal of the bowel management protocol, which increased the risk of severe constipation and discomfort of the patient.

SAYLOR LANE HEALTHCARE CENTER, SACRAMENTO, CA...DEFICIENCIES......facility did not meet professional standards of quality when a licensed nurse failed to document in the medical record or fully evaluate the patient's health status following several episodes of emesis (vomiting).

SIERRA FOOTHILL RCFE II (JOY'S CARE HOME), ROSEVILLE, CA...DEFICIENCIES......facility failed to issue a 30-day eviction notice when they refused to take the resident back after being in an acute hospital.

SKY PARK GARDENS, SACRAMENTO, CA...DEFICIENCIES WITH ASSESSED PENALTY OF \$150.00......staff lacked training and failed to prevent resident from accessing alarmed door and leaving the facility; failure to ensure an adequate number of direct care staff to support each resident's needs; failure to prevent resident from leaving the facility and failure to ensure the continued safety of residents if they wander away from the facility. The resident wandered away from facility and subsequently was injured and died. This complaint was filed by Adult Protective Services.

WESTVIEW HEALTHCARE CENTER, AUBURN, CA...DEFICIENCIES......facility failed to develop a comprehensive care plan related to the care of the patient's right leg surgical site that had measurable or specific objectives and interventions to monitor for post-operative complications such as infection; failure to clarify physician's order to change surgical dressings as needed; failure to conduct thorough and accurate assessments of resident's surgical site, which resulted in the necessity to be re-admitted to an acute care hospital for surgery to treat infection and necrosis of the right leg surgical site, which resulted in the patient spending 8 days in an acute hospital receiving intravenous antibiotics and physical therapy.

WINDSOR EL CAMINO CARE CENTER, CARMICHAEL, CA...DEFICIENCIES......facility failed to revise patient's care plan for dehydration which created the potential for inadequate or inaccurate care for the patient.

SPECIAL THANKS TO OUR DONORS

Gifts received from December 2012 to publishing date.

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