DEBORAH CALVERT
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May 28, 2003

MR. CLAUDE W. VANDERWOLD
DEP. ATTORNEY GENERAL
STATE OF CALIFORNIA
ELDER ABUSE PROTECTION UNION
BUREAU OF MEDI-CAL FRAUD
1425 River Park Drive #300
Sacramento, CA 95815

RE: EVELYN M. CALVERT, PATIENT OF SUNBRIDGE CARE & REHAB OF NEWPORT BEACH, 1555 SUPERIOR AVENUE, NEWPORT BEACH, CALIFORNIA

Dear MR. Vanderwold,

I'm writing to notify you of a possible violations of the PIFJ Sun Health Care may have with you.

Specifically:

1) **UNDERSTAFFED**
On Monday, March 24, 2003, at about 11:50 a.m. my mother, Evelyn Calvert, was left unattended in the Dining Room of this facility along with numerous other residents, and had somehow fallen out of her wheelchair head first. (Her wheelchair has a "hump" between her legs so she will not slide down and out of it, yet since no one actually witnessed her fall we are at a loss as to how the accident took place.). As I was told by one of the LVN's on duty, a man named "Ray" who is extraordinarily kind to my mother, explained to me how he'd found her when he heard a loud "thump" from the employee lounge and opened the door and found her face down on the floor. The activities director, Tammy, came in the room shortly after, and then a few minutes later, ironically, I arrived. X-rays were taken and she recovered from a rather large "egg" sized contusion on her forehead within one week. A physician was also called to evaluate whether or not she had a concussion. It's my understanding that an incident report was filed within the facility. But I was not aware of the injunction at that time and did not follow through with your offices in filing my own report to notify you that proper staffing was not nearby.
Then again on Wednesday, May 28th, 2003, while visiting my mother in the Dining Room at about 9:00 am, I was asked by another resident's family member if I could help a resident to the bathroom. I told her I did not work there -she also pointed out that another resident, who happens to be a 35 yr close family friend of mine, Danny Perez, a rather large man, was falling out of his wheelchair. We looked around and realized the residents were again left alone in the Dining Room. I asked two women standing in the hallway near the entry "where is everyone" and they

said "They're all in the conference room in a meeting". So I politely knocked on the door, when a woman with strawberry blonde hair that was long and pulled up into a pony tail, of slight build, I believed to be wearing a nursing uniform rudely opened the door and said "We're in a meeting here." I said "You have some patients out here that are in need of your help and about to fall.". She said, "Look, we have to have these meetings every morning and cannot be bothered." I said, "O.k., I'll call your head offices in New Mexico and maybe they can help your patients before you can." I was shocked by her rude-ness. I was later told she was meeting with the department heads from Albuquerque New Mexico and it was "important". Maybe they were in a meeting to sell this facility? I reported this to the New Mexico office's compliance dept, a man by the name of Rene (no last name) who assured me the regional manager would be looking into the matter. I also sent an email to Susan the administrator on this date.

2) I was directly told by an R.N. by the name of Evelyn on Sunday April 12th that she did not have the staff to make my mother comfortable and there was not a physician on duty, that the nurse practitioner has suggested we transfer my mother with congestive heart failure to the local Hospital for treatment. It has been apparent to me on numerous other occasions that I have not documented that there was not the staff to provide even the water to my mother's neighbor in bed 4A, Dorothy, who has no family members visiting and we have taken on as an interest. We have also posted a sign above Dorothy's bed reminding the staff to always have a pitcher of water and a glass for her. My family and I have found the need to be certain the liquids are "saved" from the meal trays, by posting a sign in her room to remind the staff, because we notice they are removed with her meals and not drank. My concern is that dehydration will set in and she'll expire like the two patients did during the heat wave of 2000.

I understand when I take my dog to the groomers to be groomed that they don't offer him water unless it's a hot day, so he won't urinate in the cage, but I'd hope that my mother is to be treated more humanly than my dog.

3) **HAZARDOUS BUILDING / HVAC AND AIR CONDITIONING NOT IN PROPER WORKING ORDER / ROOM TEMPERATURES OUT OF CONTROL AGAIN**

Numerous nurses (two that I can name: Sherri; Janet) and other staff members, other family members and myself and my mother have all had recurring respiratory illnesses over the past few months. Upon lifting up the heating register in my mother's room I was appalled to find nothing but filth and dirt. We shut the vent off and reported this to the facility. On May 15, 2003 The Office of Statewide Health Planning & Development Facilities Development Division made a field visit and construction advisory report (attached) shutting off their HVAC and air conditioning completely, due to various violations. "A [need for] a complete removal and replacement of the duct work and registers" is noted on his report. I'm concerned the building is actually making us ill. I've asked the current acting administrator, Susan, (a few weeks ago it was Michael -hard to keep track of the employee changes there), what's being done and she has only replied they were getting bids.

This facility sits high on a bluff in Newport Beach, not far from Hoag Hospital. We have many foggy early mornings in June which have already begun. Then we have in the same day a heat wave of 85 degrees. That dramatic change in temperature as any physician can explain to you is detrimental to their health. And as I understand it, there is a stipulation with this healthcare agency that clearly states the room temperatures must be between 71-81 degrees -when on numerous mornings this week her room temperature was 65. Other family members have also documented the low temperature in the early morning hours.

4) **STAFF NOT TRAINED**

I understand that on Sunday evening May 25th the newly trained nurse on duty did not have the key to open the refrigerator to access insulin and had to obtain bolt cutters from a visiting family member to cut open the lock to access medicine. Why? A clear violation of their training agreement with you. I've informed Susan, the administrator of this on May 27th via email.

What is happening at this facility? Are they in the midst of a sell out? Are they bankrupt? Can they afford Staffing?

It's also curious to note: I have never seen an itemized billing and only recently requested it of this facility. I'm curious if SUNBRIDGE bills both my mother's Medicare and Medi-Cal accounts, as she's had numerous medicare eligible treatments / benefit days, yet SUNBRIDGE assures me she's still considered Medi-Cal eligible and we must pay her co-share payment, which I've complied with. I therefore requested Medi-Cal this week to send me copies of all SUNBRIDGE's billings to them so that I can confirm the charges. Medicare has always sent me the bills of who charges them which have been fine so far. It's odd to me I'd have to ask Medi-Cal to do so at a cost of $25 for three years billings, being that I'm interested in ultimately Saving Medi-Cal money. I'll keep you abreast of that outcome.

Sincerely,

Deborah S. Calvert
Daughter of Evelyn M. Calvert, Resident in Room 4-B