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BEFORE THE STATE OF CALIFORNIA
DEPARTMENT OF HEALTHCARE SERVICES
OFFICE OF ADMINISTRATIVE HEARINGS AND APPEALS

In Matter of the Accusation Against: WISH-I-AH SKILLED NURSING & WELLNESS CENTRE, LLC, dba WISH-I-AH HEALTHCARE & WELLNESSCENTER License Number: 040000167 Facility ID Number: 040000074 Respondent	CDPH Case No. 14-AL-LNC- 10826 **ACCUSATION**

I.

JEAN IACINO, Complainant herein (Complainant), files this Accusation in her official capacity as the duly appointed Interim Deputy Director, Center for Health Care Quality, Licensing and Certification, Department of Public Health, State of California.

II

JURISDICTION

THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (Department) is the agency of the State of California responsible for licensing of Skilled Nursing Facilities pursuant to California Health and Safety Code section 1250 et seq. and California Code of Regulations, Title 22, section 720001 et seq.

WISH-I-AH SKILLED NURSING & WELLNESS CENTRE, LLC, (Respondent), is licensed by the Department to operate and maintain WISH-I-AH HEALTHCARE & WELLNESS CENTER (Facility), a skilled nursing facility located at 35680 North Wish-I-Ah Road, Auberry, CA 93602 under License No. 040000167.

Pursuant to said license, Respondent is required to comply with Health and Safety Code section 1250, et seq., and California Code of Regulations, Title 22, section 720001, et seq.

Respondent's license to operate and maintain said facility is current and will expire on June 10, 2015. Respondent's license is attached as "Exhibit A" hereto.

Wherever it is alleged in this Accusation that Respondent violated one or more statutes or regulations, the allegation shall be deemed in each case to mean that Respondent, through its employees or agents, violated the statute or regulation, and that Respondent aided, abetted, or permitted the violation.

III
LEGAL AUTHORITY FOR SUSPENSION AND REVOCATION OF SKILLED NURSING FACILITY LICENSE

Health and Safety Code section 1294 provides that the Department may revoke a license to operate a skilled nursing facility for violation by the licensee of any of the provisions of chapter 2, division 2, of the Health and Safety Code, or of the rules and regulation promulgated there under; or for conduct inimical to the public health, morals, welfare, or safety of the people of the State of California in the maintenance and operation of a skilled nursing facility.

Health and Safety Code Section1296 provides that the Director may temporarily suspend any license or special permit prior to any hearing, when in his or her opinion the action is necessary to protect the public welfare. This temporary suspension shall remain in effect until the hearing is completed and the Director has made a final determination on the merits.

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IV

BACKGROUND

During an inspection conducted by the Department, numerous deficiencies were noted in the Respondent's Facility that are detailed in State Form 2567. (A true and correct copy of the State Form 2567 is attached hereto as Exhibit B.)

On or about October 30, 2014, the Office of Statewide Health Planning and Development – Facilities Development Division, conducted an inspection of Respondent's Facility and detailed its findings in the "Construction Advisory Report – Field Visit Report." (A true and correct copy is attached hereto as Exhibit C.)

Based upon the findings in both of the above-referenced reports, the Director has made a determination that, in order to protect the welfare of the facility's residents, Respondent's license to operate the skilled nursing facility should be temporarily suspended effective November 10, 2014.

Good cause exists for the revocation of Respondent's license, pursuant to Health and Safety Code section 1294, in that Respondents have violated, and permitted the violation of State regulations governing the operation of the facility, and has engaged in conduct inimical to the public health, welfare, and safety of the people of the State of California. Wherever it is alleged in this Accusation that Respondents violated one or more statutes or regulations, the allegation shall be deemed in each case to mean that Respondents, through its employees or agents, violated the statute or regulation, and that Respondent aided, abetted, or permitted the violation.

V.

RESPONDENT STAFF FAILED TO PROVIDE COMPETENT WOUND CARE TO PATIENT CAUSING BLACK SPONGE FROM THE WOUND DRESSING TO GROW INTO THE PATIENT'S SKIN

On 10/1/14, the Department determined that Respondent's staff provided wound care to Resident 1 using a V.A.C. (Vacuum Assisted Closure) system without staff training or competence in the procedure to perform wound vacuum

dressing changes. As such, the facility did not perform the wound care as directed by the manufacturer instructions or with the frequency ordered by the physician. Because of the lack of training and competence, Resident 1 was admitted to an Acute Care Hospital with a diagnosis of sepsis. Resident 1 also had a black sponge from the wound vacuum dressing growing into the skin. Resident 1 expired within a week of admission.

There was also no documented evidence that Resident 1's wound had been assessed timely and/or continually reassessed with appropriate interventions, and no evidence of a care plan which addressed the wound care to be delivered.

Pursuant to Title 22 CCR § 72311:

(a) Nursing service shall include, but not be limited to, the following:

(1) Planning of patient care, which shall include at least the following:

(A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission.

(B) Development of an individual, written patient care plan which indicates the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited.

VI
RESPONDENT'S FAILURE TO ESTABLISH AND MAINTAIN AN EFFECTIVE INFECTION CONTROL PROGRAM HAS CAUSED OR IS LIKELY TO CAUSE HARM TO THE PATIENTS AND STAFF IN RESIDENT FACILITY

Specifically, Respondent's failure to establish and maintain an effective infection control program was evidenced by the following:

1) A foodborne illness outbreak that caused 16 of 80 residents (Residents 2, 3, 4, 5, 6, 7, 8, 9, 10, 11,12, 13, 14, 15, 16, and 17) in the facility to develop signs and symptoms of gastroenteritis. In addition, Resident 1's positive blood culture for Salmonella was confirmed prior to Resident 1's death. Resident 1 contracted sepsis secondary to

Salmonella infection. Multiple violations identified by the Local Department of Public Health dated 10/1/14):

i. Failure to Prevent Contamination by Hands.

ii. Failure to provide hot water for the kitchen sink at 120 degrees Fahrenheit.

iii. Failure to prevent Employees who work in the kitchen to use the restroom located close to the entry of the building. This restroom has only cold water at 77 degrees. However, employees are required to wash their hands after the restroom in warm water at 100 degrees F (Fahrenheit).

iv. Failure to provide sanitizing solution to sanitize large utensils in the utensils sink at all times.

2) Allowing Facility staff to return to work after illness while still infectious. Dietary Aide 1 became ill with nausea and diarrhea on 9/19/14, which he believed was the result of consuming undercooked chicken at his home residence. His job duties include making each person's plate in the dining room, putting the silverware on the tray, preparing the evening snack, etc. Following his return to work, a Review of the facility document titled, "Infection Control Surveillance" indicated Resident 8 became symptomatic with gastrointestinal (nausea, vomiting, and/or diarrhea) symptoms on 9/23/14, and was placed on contact precautions (procedures that reduce the risk of spread of infection through direct or indirect contact). Resident 9 became symptomatic on 9/23/14, and was placed on precautions. Resident 6 became symptomatic on 9/23/14, and placed on precautions. Resident 10 became symptomatic on 9/23/14 with symptoms, and place on precautions. Resident 11 became symptomatic on 9/23/14, and placed on precautions. All resident infections were coded as Healthcare-Associated Illness (HAI), (acquired while in the facility).

3) Facility bathrooms were not maintained in a safe, functional, and sanitary manner. On 10/20/14 at 3:33 p.m., during an observation of Room 2 resident

bathroom, standing water was found pooling behind the base of the toilet. Fecal matter was in the bowl and around the seat. Respondent staff entered the bathroom, and stated, "We are going to do something [about the toilet]." The toilet was flushed and immediately filled with brown water containing fecal material. Water rose to edge of the toilet bowl.

On 10/20/14 at 3:35 p.m., Resident 18 told Department that "It's like that all the time, they need to fix it." She then turned to another resident in the room, and asked, "Isn't it?" The other resident stated, "All the time." Resident 18 stated the day prior she slipped in the standing water around her bed and fell.

5) Facility ice machine was not cleaned and sanitized according to manufacturer's recommendations.

On 10/8/14 at 3:35 p.m., during an interview with Respondent Maintenance staff (MS), the MS, regarding his procedure for cleaning the ice machine, stated, "I follow the manufacturer's recommendations." On inquiry regarding how the machine was sanitized, he stated, "I fill a big bucket with the sanitizer from the kitchen sink and I soak the parts for about half an hour." He further stated he rinsed them and replaced them. He stated he cleaned the ice bin using kitchen sanitizer, wiped down the ice bin, and then wiped it with water soaked clean towels [rinsed].

On 10/9/14 at 11:30 a.m., during an interview with Respondent administrator regarding the MS interview, she produced a partially filled bottle of ice machine sanitizing solution. She stated the MS used the manufacturer's sanitizer for the ice machines, and stated, "He said that because that's what the Registered Dietician told him to say, but that's not what he does..."

6) Facility staff did not maintain contact isolation precautions when caring for a symptomatic resident.

On 10/12/14 Department observed Respondent maintenance worker (MW) in a patient's room who was not using appropriate personal protective equipment even though a sign on patient's door stated that contact precautions were to be

used. The Director of Nursing (DON) instructed certified nurse assistant (CNA) 3 to assist MW with double bagging the maintenance worker's duffle bag. CNA 3 stated he had received training that morning on contact precautions from the DON. On inquiry to CNA 3 regarding the location of his gloves used during the red bagging of the duffle bag, he stated, "They are right here...I should throw the gloves out," and pulled the gloves from the right pocket of his uniform smock. On inquiry regarding why they were not discarded, he stated, "I was going to throw them away when I went back into the room." He stated he had not washed his hands.

7) Facility linen was not available for residents.

8) Facility failed to maintain its sewage treatment system. Facility staff removed and disposed of raw sewage without appropriate personal protective equipment (PPE) and without a designated washing facility.

On 10/18/14 at 2:05 p.m., Department observed that the sewage drains from all three of facility's buildings emptied downhill into a sewage area. There the sewage went through a process of mixing with very hot water to dissolve solid feces, then moved to a concrete structure with rocks where it was filtered, then dumped into a liquid sewage area. A large green pond was observed behind the concrete structure with rocks. He further added no chemicals were added to the process, but if the feces did not dissolve, the maintenance staff picked up the feces and put it into trash bags and dumped it in the trash.

On inquiry regarding protective gear worn by maintenance staff, he stated, "I just use gloves, I get some from the boxes they use to take care of the residents...I wash my hands in the downstairs bathroom...the one we just replaced [the same bathroom used by dietary staff]."

9) Respondent Facility bathroom in dangerous condition

On 10/29/14 at 3 p.m., Department observed, in the Bo-Hin-To Building, that a bathroom had a cracked piece of floor tile in the midst of eight floor tiles approximately 6 inches wide each were cracked. The tiles were uneven. When MS 5

stepped on the broken tile with his shoe, the tile fell through to the next floor level. The tile caught on a piece of wood under the floor tile which appeared to be coming apart and in pieces. These tiles were next to the shower and close to the wall. The remaining tile was "spongy" when stepped lightly on. MS 5 stated it would not be safe to allow residents to use the shower.

Department also observed, in the second resident shower/bathroom of the Bo-Hin-To building called, "The women's restroom," an area of five tiles approximately each 6 inches wide around the floor of the perimeter of the shower stall was soft and squishy when stepped on by the surveyor's shoe. This bathroom contained toilets and a shower for resident use.

Department also observed that in the Canyon View Building in room 27, when the toilet was flushed, the water would not drain.

VII

RESPONDENT HAS DEMONSTRATED A PATTERN OF CONDUCT INIMICAL TO THE HEALTH, MORALS, WELFARE, AND SAFETY OF ITS PATIENTS

THE PROVIDER IS HEREBY NOTIFIED that the Director has made a determination, in accordance with Health and Safety Code section 1296 to temporarily and immediately suspend Respondent's license to operate the skilled nursing facility. This temporary suspension shall remain in effect until the conclusion of the administrative proceedings herein. However, if the director fails to make a final determination on the merits within 60 (sixty) days after the hearing has been completed, the temporary suspension shall be deemed vacated.

EFFECTIVE IMMEDIATELY, your license to operate the skilled nursing facility is temporarily suspended; and; you must immediately cease operation

RESPONDENT IS HEREBY ADDITIONALLY NOTIFIED that, after hearing or conclusion of these proceedings, the Complainant also seeks that: Respondent's license to operate Wish-I-Ah be revoked.

WHEREFORE, Complainant seeks to have the Respondent's license be temporarily

suspended.

DATED: November 3, 2014

JEAN IACINO
Interim Deputy Director
Center for Health Care Quality
Licensing and Certification
California Department of Public Health