State of California—Health and Human Services Agency
California Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Health Officer

EDMUND G. BROWN JR.
Governor

July 8, 2016

CERTIFIED MAIL
70150640000351362485

Mr. Shlomo Rechnitz
River Valley Healthcare & Wellness Centre, LP
5900 Wilshire Blvd., Suite 1600
Los Angeles, CA 90036

Dear Mr. Rechnitz,

RE: NOTICE OF DENIAL OF APPLICATION

On February 20, 2015, you applied for a license from the California Department of Public Health (CDPH), to operate the River Valley Healthcare & Wellness Centre, LP located at 2490 Court Street, Redding, CA 96001.

After careful review and consideration of your application and all of the supporting information, CDPH denies your application for a license to operate the above-reference facility.

This denial action is pursuant to Health & Safety Code, Section 1265, subdivision (f).

In determining an applicant's ability to comply with Chapter 2 (commencing with Section 1250) of the Health and Safety Code and the rules and regulations promulgated under that chapter, CDPH reviews the compliance history of facilities owned, managed, or operated, either directly or indirectly, by the applicant for the past three years. The enclosure provides a list of the facilities CDPH included in its compliance review for this application.

CDPH's review revealed 265 federal regulatory violations at a deficiency scope and severity level of F or higher in facilities the applicant owned, managed, or operated, directly or indirectly, at any time from June 22, 2013 through June 22, 2016. The table below shows the number of deficiencies by deficiency level.

Three-Year Federal Regulatory Violation History

Deficiency Level	Scope & Severity Level Description	Number of Deficiencies
F	No actual harm with potential for more than minimal harm that is not immediate jeopardy but is widespread	172
G	Actual harm that is not immediate jeopardy and is isolated	45
H	Scope is pattern present, severity level of actual harm that is not immediate jeopardy.	9
J	Immediate jeopardy to resident health or safety and is isolated	11
K	Immediate jeopardy to resident health or safety and is a pattern	16
L	Immediate jeopardy to resident health and safety and is widespread	12

Below are details by facility, including the federal regulatory violation designation, of the "J", "K" and "L" level deficiencies (those that presented immediate jeopardy) included in the above chart.

Alta Vista Healthcare and Wellness Centre
On September 15, 2015, during a complaint investigation survey at the Alta Vista Healthcare Centre, located at 9020 Garfield Avenue, Riverside, CA 92123, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level J – F223 – Free from Abuse / Involuntary Seclusion**
  The facility failed to provide for five residents an environment free from verbal abuse, harassment, and intimidation by Resident A.

  This failure resulted in emotional distress and fear for four residents, placing them in jeopardy of severe, negative psychosocial response from ongoing persistent expressions of anger and harassment from Resident A.

Clairemont Healthcare & Wellness Centre, LLC
On September 8, 2014, during a recertification survey at the Clairemont Healthcare & Wellness Centre, LLC, located at 8060 Frost Street, San Diego, CA 92123, three (3) immediate jeopardies were identified and violations written at harm level:

- **Level K – F431 – Drug Records, Label / Store Drugs & Biologicals**
  The facility failed to ensure controlled substance (CS) medications were accurately accounted for as evidenced by:

  1. A review of controlled substance records for residents reflected 126 tablets of CS medications were not accurately accounted for five residents since August 1, 2014, as follows:
     a. 65 tablets of Percocet & Tylenol 325 mg, a Schedule II (high potential for abuse) narcotic for pain) for Resident 48 from 8/17/14 to 9/17/14 (a one-month period);
     b. 11 tablets of oxycodone 10 mg, a Schedule II narcotic for severe pain for Resident 63;

c. 24 tablets of Norco (hydrocodone 5 mg & acetaminophen 325 mg, a potent narcotic for moderate to severe pain) for Resident 38;
d. 18 tablets of Norco 5/325 mg for Resident 80; and
e. 8 tablets of Norco 5/325 mg for Resident 39;

The CS were signed off the Controlled Drug Record (CDR) without subsequent documentation on the medication administration record (MAR) and/or pain assessment flow sheet (PAF) as given in accordance with facility procedures. It was undeterminable what happened to these medications. Also, for two residents with identified CS drug unaccountability, the facility could not provide controlled drug records prior to 8/17/14 for Resident 48, and records prior to 8/19/14 for Resident 80.

The frequent and repeated failures to document CS medication administration on the MAR and/or on the PAF, and failure to account for all CS medications had the potential to result in CS medication overdose (such as when the medication is given too soon before due time) for a universe of 32 residents who were receiving CS medications, and the misuse/diversion of controlled substances in the facility. Overdosing of CS narcotic medication could lead to adverse effects such as respiratory depression (a condition of having a breathing rate that becomes too low to ventilate the lung), extreme sedation, muscle weakness, slow heart rhythms, low blood pressure, loss of consciousness, and death.

2. The facility could not provide controlled drug disposition records to account for all discontinued/discharged controlled drugs from 5/5/14 to 8/11/14.

- **Level L – F441 – Infection Control, Prevent Spread, Linens**

The facility failed to ensure an Infection Control Program was in place. As a result, staff were not following infection control practices, which placed all residents at risk for acquiring the transmission of disease and infection.

- **Level L – F520 – QAA Committee – Members / Meet Quarterly**

The facility failed to provide evidence of a viable, ongoing, and comprehensive Quality Assurance Program which evaluated the facility's ability to provide continuous assessment of issues related to quality of care, quality of life and facility practices.

As a result, the facility was unable to identify system issues, develop and implement plans to address areas of concern and opportunities for improvement in a timely manner.

On October 7, 2014, during a recertification survey at the Clairemont Healthcare & Wellness Centre, LLC, located at 8060 Frost Street, San Diego, CA 92123, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level L – F224 – Prohibit Mistreatment/Neglect/Misappropriation**
The facility failed to ensure Resident A, who was unable to care for self, unable to walk, unable to provide food for herself, unable to toilet self, and unable to obtain necessary medications for her illnesses, was safely discharged to an appropriate care setting. In addition, the facility failed to provide goods and services to ensure a safe and appropriate discharge.

As a result, Resident A was physically unable to care for self, was discharged to her trailer without a physician being notified, was discharged with a urinary catheter in place, and without means to care for herself. Resident A did not have a phone to call for help in case of an emergency, was unable to get out of bed on her own, unable to walk, unable to use the toilet, was a diabetic without medications or means to test her blood sugars, was a diabetic that had not eaten since lunch time, had no food in her trailer, and had no medications for her pain, and other critical medications that were required. Resident A laid in her bed at her home for hours before the police arrived. Resident A was found dirty and without necessary care/equipment to sustain life. More concerning is that any of the 93 residents in the facility could have been discharged before the facility ensured goods and services were arranged for a safe and appropriate discharge.

Gridley Healthcare & Wellness Centre, LLC
On March 25, 2014, during a recertification survey at the Gridley Healthcare & Wellness Centre, LLC, located at 246 Spruce Street, Gridley, CA 95948, two (2) immediate jeopardies were identified and violations written at harm level:

- **Level J – F309 – Provide Care / Services For Highest Well-Being**
The facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being of residents by failing to:

    1. Provide prompt emergency care when a Licensed Nurse (LN) failed to adequately assess, monitor and intervene for one Resident. The LN failed to notify resident's physician of their ongoing complaint of chest pain for more than eight hours. This had the potential to worsen an existing heart condition and cause a heart attack and/or death, and resulted in an extended hospitalization.
    2. Adequately orient new nurses as well as ensure nurse competency to investigate and address the situation, and develop and implement a plan of action to prevent similar occurrences.
    3. Complete nursing assessments before and after dialysis treatments for two residents. This had the potential for serious complications to go unnoticed and untreated.

- **Level J – F327 – Sufficient Fluids to Maintain Hydrations**
The facility failed to provide sufficient fluids to maintain proper hydration and prevent dehydration for one resident. This resulted in severe dehydration and caused and/or contributed to the death of the resident.

  The facility did not respond and intervene to resident's change of condition over four days, including adequate oversight of resident fluid intake and notification of the physician, investigating and addressing the situation, and developing and implementing a plan of action to prevent similar occurrences.

On September 2, 2014, during a complaint investigation survey at the Gridley Healthcare & Wellness Centre, LLC, located at 246 Spruce Street, Gridley, CA 95948 by federal suveryors from the Centers for Medicare and Medicaid Services (CMS) two (2) immediate jeopardies were identified and violations written at harm level:

- **Level K – F224 – Prohibit Mistreatment / Neglect / Misappropriation**
The facility failed to protect residents from neglect. The facility failed to provide the necessary (staff supervision) services to protect residents from physical altercations, verbal altercations, fear and intimidation by confused, and wandering residents. The failure to assure that residents received the necessary services to prevent physical, verbal, and mental abuse affected three residents.

- **Level K – F323 – Free of Accident Hazards / Supervision / Devices**
The facility failed to ensure that each resident receives adequate supervision and assistance to prevent accidents. This failure affected residents who were wanderers, elopers, smokers, with recurrent falls, and with suicidal ideation.

As a result of the findings of this survey, the Centers for Medicare and Medicaid Services (CMS) placed Gridley Healthcare & Wellness Centre, LLC on a termination track for the Medicare program, issued civil monetary penalties and denied payment for new admissions. The facility was terminated from the Medicare program on October 2, 2014. CMS also imposed a 2-year bar on re-enrollment in the Medicare and Medicaid Programs.

<u>Lakewood Healthcare Center</u>
On May 30, 2014, during a complaint investigation survey at the Lakewood Healthcare Center, located at 12023 Lakewood Blvd., Downey, CA 90242 (2) immediate jeopardies were identified and violations written at harm level:

- **Level K – F323 – Free Of Accidents Hazards / Supervision / Devices**
The facility failed to provide a safe and secure environment and supervision for a resident who was assessed at high risk for elopement, who also had short and long-term memory problems and was experiencing auditory hallucinations telling him/her to kill him/herself, with no established measures to prevent the resident from eloping.

  Resident eloped from the facility by using the linen barrels and trash can as a

stepping stool to climb over the fence. Resident came back and was sent out to the acute care hospital for evaluation. Resident was not re-admitted back to the facility. This failure placed resident and 67 other residents, who were also assessed at risk for elopement, at risk for harm and injuries.

The facility was also identified with a systems failure by not implementing corrective actions after the facility identified Resident 1 being at risk for elopement and having other residents elope from the same facility. According to the facility's discharge lists, in 2013, there were 3 residents who eloped. In 2014, there were 2 residents who eloped from the same facility.

- **Level K – F520 – QAA Committee-Members / Meets Quarterly / Plan**

The Quality Assessment and Assurance (QAA) committee failed to monitor the effects of implemented changes and make needed revisions to the action plans in order to correct the residents' potential risks for elopement.

Las Flores Convalescent Hospital

On June 26, 2014, during a recertification survey at the Las Flores Convalescent Hospital, located at 14165 Purche Avenue, Gardena, CA 90249, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level K – F323 – Free of Accidents Hazards / Supervision / Devices**

The facility failed to implement preventive or corrective measures to ensure residents with escalating behavior problems were supervised; were not placed in situations where law enforcement and/or staff intervention was required to prevent serious injury, and all residents in the facility were protected from being placed at risk for injury from a resident with behavioral needs the facility was not able to meet. This deficient practice resulted in:

1. All residents in the facility that walked or used wheelchairs in the hallways of the facility being placed at risk for injury from being hit by a motorized wheelchair used by a problematic resident.
2. Resident 12 leaving the facility unsupervised in a motorized wheelchair, without a valid physician's order. The resident's assessment had indicated he was incapable of safely operating the wheelchair.
3. Law enforcement intervening to prevent Resident 12 from pulling Resident 2, a visually impaired resident through the streets on his motorized wheelchair while Resident 2 was held onto in a manual wheelchair.
4. Resident 12 turning off the alarm that would notify staff whenever Resident 16, a resident with a history of multiple falls, was standing up unassisted.

Oxnard Manor Healthcare Center

On May 19, 2015, during a recertification survey at the Oxnard Manor Healthcare Center, located at 1400 W. Gonzales Road, Oxnard, CA 93036, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level J – F281 – Service Provided Meet Professional Standards**
The facility failed to ensure services provided to three residents met professional standards of quality. The facility failed to ensure residents on insulin (a medication for diabetes) received the correct dose, as ordered by the physician.

These failures placed three residents at risk for serious harm, including change in mental status, coma, and death.

Pacific Rehabilitation & Wellness Center, LP
On December 19, 2013, during a complaint investigation survey at the Pacific Rehabilitation & Wellness Center, LP, located at 2211 Harrison Avenue Eureka, CA 95501, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level L – F323 – Free of Accidents Hazards / Supervision / Devices**
The facility failed to provide a safe environment by placing all 57 residents at risk when seven (7) portable space heaters were used in resident care areas accessible to both, ambulatory and wheelchair bound residents. This practice had the potential to cause harm by fire.

Presidio Health Care Center
On March 18, 2014, during a Federal Monitoring survey at the Presidio Health Care Center, located at 8625 Lamar Street, Spring Valley, CA 91977, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level K – F329 – Drug Regimen Is Free From Unnecessary Drugs**
The facility failed to monitor for dangerous adverse effects of psychotropic medications for six (6) residents who were prescribed psychotropic medications. This failure placed these residents at risk of staff not recognizing serious, potentially life threatening adverse effects of psychotropic medication.

On most of the physician's orders, medication administration records (MAR), consents, and care plans for residents who had psychotropic medications prescribed listed the exact same side effects for staff to monitor which was, "Dry mouth, dizziness and drowsiness". However, the physician's orders did not include warnings of potentially dangerous, or life threatening side effects or the FDA issued boxed warnings for the use of Seroquel.

On June 26, 2014, during a compliant investigation survey at the Presidio Health Care Center, located at 8625 Lamar Street, Spring Valley, CA 91977, two (2) immediate jeopardies were identified and violations written at harm level:

- **Level L – F363 – Menus Meet Resident Needs / Prep in Advance / Followed**
The facility failed to maintain sufficient food supplies to ensure the planned menus would be followed as developed by the Registered Dietitian to meet the nutritional needs of 46 residents.

In addition, the facility failed to maintain the facility's planned par level of disaster food supplies to meet the nutritional needs of the residents and staff in the event of a disaster or emergency resulting in the loss of gas or electricity.

The lack of sufficient food supplies posed an immediate threat to the health and safety of the facility residents. There was no guarantee that the facility staff would have the means to meet the residents' nutritional needs in day–to-day meal planning. The lack of sufficient emergency food supplies could also result in not meeting the nutritional needs of the residents during a disaster. The facility failed to have a system in place to ensure adequate food supplies and to implement the facility's planned menus in order to meet the nutritional needs of the residents. The lack of guidance and monitoring of the facility staff to direct, prepare recipes and the quantities of food to serve to the residents impeded the staff's ability to ensure that the planned amount of calories, proteins, vitamins and minerals were provided to the residents on a daily basis for approximately 10 days. The lack of planning and food supplies had the potential to impact the nutritional status of the residents. In addition, there was inadequate guidance of dietary staff to ensure that therapeutic diets as ordered were provided in terms of modified textures. Dietary staff were not provided sufficient guidance and were not following recipes and planned menus.

- **Level L – F490 – Effective Administration / Resident Well-Being**

The facility failed to ensure that the administrator managed the facility in a manner that enhanced and supported the physical, mental and psychological well-being of the residents as evidenced by a failure to maintain sufficient food supplies at the facility to implement planned menus for daily operations, and failed to maintain sufficient disaster food supplies on hand. Thus, the facility was incapable of implementing the facility's disaster menu in the event of loss of gas or electricity. The facility further failed to ensure that there was a qualified full-time dietary services supervisor (DSS) or full-time Registered Dietician when a DSS was not employed full-time for the adequate oversight of the food-service operation. As a result, residents were placed at immediate risk for the potential of not having their nutritional needs met on a day to day basis or in the event of a disaster.

<u>Point Loma Convalescent Hospital</u>
On November 12, 2013, during a recertification survey at the Point Loma Convalescent Hospital, located at 3202 Duke Street, San Diego, CA 92110, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level J – F323 – Free of Accidents Hazards / Supervision / Devices**

The facility failed to identify and manage potential smoking hazards for 4 residents. As a result:

1. Resident 61 was documented as a known smoker; however, was not assessed for safe smoking.
2. Resident 5 was identified as an unsafe smoker (requires supervision while smoking), per the Safe Smoking Assessment but was allowed to smoke

independently. As an unsafe smoker, Resident 5 kept personal smoking materials at the bedside, which included cigarettes and lighters.

3. Resident 23 was identified as an unsafe smoker, per the Safe Smoking Assessment but was allowed to smoke independently. Resident 23 was not identified on the facility's smoking list.
4. Resident 34 was initially identified as a safe smoker by the activity director. Upon re-assessment by a licensed nurse, Resident 34 was identified as an unsafe smoker who required supervision and a smoking apron. Resident 34 reported on several occasions that cigarettes and lighters were stolen off the bed.

The fire extinguisher was out of reach of the wheelchair bound residents. The facility did not provide a safe access to staff in case of an emergency situation while on the smoking patio. The facility process in place was to have the activity director, as a member of the interdisciplinary team, conduct the smoking assessment on all smokers. This assessment failed to take into consideration any resident's medical and medication history or health/or behavioral issues that would impact a resident's ability to smoke safely. The facility's systems failure presented a risk that residents who smoke could catch their clothes on fire when lighting cigarettes. Residents who smoke also could cause a fire inside the facility since they were allowed to keep their personal smoking materials in their rooms. These residents who smoke also could have been severely injured since there was no staff supervision and residents were allowed to smoke independently.

San Pablo Healthcare Center

On September 29, 2014, during a recertification survey at the San Pablo Healthcare Center, located at 13328 San Pablo Avenue, CA 94806, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level L – F441 – Infection Control, Prevent Spread, Linens**

The facility failed to establish and maintain an Infection Control Program that helped to prevent the transmission of disease and infection when one (Resident 4) of 21 sampled residents had a transmittable disease and proper infection control practices were not followed throughout the facility.

On April 27, 2015, during a complaint investigation survey at the San Pablo Healthcare Center, located at 13328 San Pablo Avenue, San Pablo, CA 94806, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level J – F365 – Food in Form to Meet Individual Needs**

The facility failed to ensure that food served to a resident was appropriate to meet his/her individual needs. Resident was served whole grapes for lunch when a mechanical soft diet was ordered. This deficient practice had the potential to result in choking and could lead to death.

This failure had the potential to cause all residents to be unnecessarily exposed to unsafe, unsanitary, harmful transmittable disease processes.

San Rafael Healthcare & Wellness Centre, LP
On November 3, 2015, during a recertification survey at the San Rafael Healthcare & Wellness Centre, LP, located at 1601 5th Avenue, San Rafael, CA 94901, one (1) immediate jeopardy (IJ) was identified and violations written at harm level:

- **Level K – F441 – Infection Control, Prevent Spread, Linens**

The facility failed to ensure infection control procedures were followed when:

1. Staff didn't clean glucometers between five residents. This resulted in the potential for transfer of blood borne organisms and infection between residents through cross contamination.
2. Housekeeping staff were not aware of the contact cleaning time for a disinfectant cleaner used to clean resident's room. This could result in the spread of infection to another resident.
3. Staff were not washing their hands after the removal of gloves which could lead to cross contamination and illness among facility residents.
4. Sterile urine culture cups were not stored out of the way of possible water droplet or spray contact.
5. Family member obtained water from a container on the medication cart after assisting a resident to eat and without washing their hands, which could lead to cross contamination of bacteria between residents.

South Pasadena Convalescent Hospital
On May 12, 2014, during a recertification survey at the South Pasadena Convalescent Hospital, located at 904 Mission Street, South Pasadena, CA 91030, two (2) immediate jeopardies were identified and violations written at harm level:

- **Level K – F323 – Free of Accidents Hazards / Supervision / Devices**

The facility failed to ensure the attending physician conducted an assessment for 7 residents with mental illness and "out on pass" medical orders as indicated in their policy and procedure prior to allowing a resident to leave out on pass unaccompanied by an adult.

This deficient practice consequently resulted in the actual harm and subsequent death of Resident 70, due to third degree burns and the potential for serious harm that is an immediate jeopardy to the health and safety of the remaining residents with mental illness diagnoses and "out on pass" medical orders.

Additionally, the facility failed to ensure Resident 57, who had a contracture to the left hand and used an electric flat iron was closely monitored to ensure safety. This deficient practice had the potential to result in possible injuries such as burns.

- **Level L – F309 – Provide Care / Services for Highest Well-Being**
The facility failed to ensure cardiopulmonary resuscitation (CPR) was performed correctly by a certified nursing assistant and licensed vocational nurse.

The nursing staff failed to use the proper technique for providing chest compressions to Resident 12 by not delivering chest compressions to the center of the resident's chest. This resulted in the resident not receiving an effective resuscitation effort. The LVN failed to provide the correct amount of chest compressions as indicated by the CPR Guidelines (American Heart Association) for Resident 12 during a Code Blue emergency response.

In addition, staff failed to respond correctly, when asked what to do if they were to find an unresponsive resident. The nursing staff responded with the incorrect information for both the ratio of Chest Compressions to Ventilation in two person adult CPR and the proper hand position for delivering CPR chest compressions.

These deficient practices resulted in the resident not receiving an effective resuscitation effort in violation of the resident's desire to be fully resuscitated, as indicated in the resident's wishes for life sustaining treatment of Full Code status. These deficient practices have the potential to result in physical injury to residents caused by improper and incorrect chest compressions for residents who have requested full Code status.

As a result of the findings of this survey, the Centers for Medicare and Medicaid Services (CMS), placed South Pasadena Convalescent Hospital on a termination track for the Medicare program, issued civil monetary penalties and denied payment for new admissions. The facility was terminated from the Medicare program on January 1, 2015. CMS also imposed a 2-year bar on re-enrollment in the Medicare and Medicaid Programs.

Verdugo Valley Skilled Nursing & Wellness Centre
On May 27, 2015, during a compliant investigation survey at the Verdugo Valley Skilled Nursing & Wellness Centre, located at 2635 Honolulu Avenue, Montrose, CA 91020, two (2) immediate jeopardies were identified and violations written at harm level:

- **Level K – F281 – Services Provided Meet Professional Needs**
The facility failure to provide skilled and timely emergency response to Resident 1, who was in need of immediate emergent care during a Code Blue (all-staff alert to gather in a life-saving effort) situation and Resident 1 died. The facility also failed to ensure that the nursing staff responding to such situations were properly trained in providing emergency care and services, according to professional standards to respond to life threatening medical emergency situations in a timely and effective manner.

In addition, the facility failed to ensure emergency equipment, which included walkie-talkies, was available for use, and failed to maintain updated staff records with updated information including current Basic Life Support [BLS - a level of medical care which is used for victims of life threatening medical situations until they can be given full medical care at a hospital] certification status for the staff.

- **Level K – F517 – Written Plans to Meet Emergencies / Disasters**

The facility failed to implement their written plans and procedures to meet all potential emergencies, including but not limited to ensuring:

1. Communication devices (walkie-talkie which is a two-way radio) were charged and available for use during an emergency;
2. Emergency equipment and supplies were available at the crash cart (a wheeled cart with drawers which carries medicine and equipment for the use in emergency resuscitations); and
3. Staff were current on CPR and emergency response procedures.

This deficient practice caused a delay in providing the appropriate level of response to Resident 1 during a medical emergency.

<u>Vernon Healthcare Center</u>

On September 8, 2014, during a compliant investigation survey at the Vernon Healthcare Center, located at 1037 W. Vernon Avenue, Los Angeles, CA 90037, five (5) immediate jeopardies were identified and violations written at harm level:

- **Level J – F333 – Resident Free of Significant Med Errors**

The facility failed to ensure that residents were free of any significant medication errors. Residents 4 and 76, did not have medications administered to them in accordance with the facility's pharmacy policy and procedure for medication administration guidelines. This failure had the potential to cause resident discomfort by not treating the infection timely and negatively affect the resident's health and safety.

- **Level K – F224 – Prohibit Mistreatment/Neglect/Misappropriation**

The facility failed to assure that each resident was free from mistreatment and neglect. The facility failed to ensure residents received the care they needed to avoid harm; failed to ensure residents were provided supervision when they left the facility and to ensure actions were taken to monitor their safety when their whereabouts were unknown for days; failed to ensure residents received essential medications including, but not limited to, insulin, anti-seizure medication and pain medication as ordered; failed to ensure physician orders were implemented; and failed to ensure staff did not falsify the administration of medication and monitoring related to clinical conditions.

The failure to provide the services each resident needed affected 49 residents and presented a risk of death or serious harm.

- **Level K – F309 – Provide Care / Services for Highest Well-Being**

The facility failed to provide the necessary care and services to ensure each resident attained their highest practicable well-being; failed to ensure residents received the care they needed to avoid harm; failed to ensure facility staff followed physician orders; failed to ensure residents received essential medications; failed to ensure staff did not falsify the administration of insulin and monitoring; failed to ensure pain management was provided when needed; failed to ensure residents were not subjected to pain and suffering and failed to ensure monitoring for clinical condition was completed.

The failure to provide the necessary care and services to meet each resident's individual needs affected 19 residents.

- **Level L – F225 – Investigate / Report Allegations / Individuals**

The facility failed to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, were reported immediately to the administrator of the facility and to the State Survey Agency (SSA). Allegations of abuse and injuries of unknown origin were not immediately reported and investigated. The facility failed to complete thorough investigations. Results of all investigations were not reported to required officials, including the SSA, within five working days of the incident. The failure to thoroughly investigate and/or report allegations of abuse as required included 17 residents.

In addition, the facility failed to ensure it did not employ staff who had a finding of abuse or neglect entered against them into the State Nurse Aide registry prior to employment.

- **Level L – F226 – Develop / Implement Abuse / Neglect / Etc Policies**

The facility failed to develop and implement policies and procedures to protect residents from abuse and neglect. The facility failed to assure policies included specific information necessary to assure compliance with regulatory requirements in the areas of reporting and screening. In addition, the facility failed to implement abuse policies relevant to the seven required components (screening, training, prevention, identification, investigation, protection, and reporting).

On September 18, 2014, during a compliant investigation survey at the Vernon Healthcare Center, located at 1037 W. Vernon Avenue, Los Angeles, CA 90037, one (1) immediate jeopardies was identified and violations written at harm level:

- **Level K – F323 – Free of Accidents Hazards / Supervision / Devices**

The facility failed to implement the one-to-one supervision according to the plan of care that was developed to manage the wandering behavior for Resident 1.

Resident 1, who had dementia, was able to wander into the rooms of female residents, at various times between 4/25/14 and 9/20/14, and was able to enter the room of a male resident with dementia, Resident 3, and hit him on the left eye area of his face two weeks prior to 9/20/14 (exact date undetermined). The facility did not conduct a comprehensive assessment on Resident 1 to identify his wandering behavior since his admission to the facility.

The facility placed Resident 1 on 1:1 supervision on 9/12/14 to prevent him from hurting other residents and wandering into other residents' rooms. However, on 9/18/14, Resident 1 was able to enter the room of Resident 5 and 6 by himself. On 9/20/14, Resident 1 was able to enter inside the room of Resident 4 by himself. These female residents, Resident 4, 5, and 6, felt threatened that Resident 1 might hit them. Resident 4 was scared that Resident 1 might do something inappropriate to her.

This failure resulted in psychological harm to the female residents who felt threatened by Resident 1's behavior and had the potential to result in physical harm to Resident 1 himself and to other residents.

Windsor Chico Creek Care and Rehabilitation Center[1]

On March 24, 2015, during a complaint investigation survey at the Windsor Chico Creek Care and Rehabilitation Center, located at 587 Rio Lindo Avenue, Chico, CA 95926, two (2) immediate jeopardies were identified and violations written at harm level:

- **Level J - F223 – Abuse / Involuntary Seclusion**

  The facility failed to protect four (4) Residents from abuse when Resident 2 made verbal insults towards Resident 1, punched Resident 1 in the face, and squeezed Resident 1's hand resulting in redness, bruising, and psychological trauma. The facility continued to allow Resident 2 to move through the hallway unsupervised, which resulted in another interaction where Resident 2 made verbal insults and threatened physical harm to Resident 1.

  The facility then failed to ensure documentation of and follow-up treatment and services for the incident. Resident 2 made verbal insults and threats of physical harm to Resident 8. Resident 9 was fearful and did not feel safe due to Resident 2's violent talk. Resident 2 was verbally abusive to Resident 7 who was fearful and did not feel safe when around Resident 2.

- **Level J - F225 – Investigation / Report**

  The facility failed to prevent, address, and report willful acts of verbal abuse by Resident 2 towards four residents and potentially any resident in close proximity of Resident 2.

[1] Effective August 1, 2014, Anaheim Point Healthcare & Wellness Centre, LP entered into a Management and Operations Transfer Agreement with the current licensee, Windsor Anaheim Healthcare, LTD.

The facility was aware of Resident 2's verbally abusive behaviors towards other residents and allowed Resident 2 to move throughout the facility unsupervised, placing residents at risk for continued abuse and for the abuse to go unrecognized, unaddressed, and unreported.

Windsor Healthcare Center of Oakland[2]

On April 16, 2015, during a recertification survey at the Windsor Healthcare Center of Oakland, located at 2919 Fruitvale Avenue, Oakland, CA 94602, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level J – F333 – Medications**

The facility failed to ensure residents were free of significant medication errors.

Resident 12 did not receive five doses of Triumeq necessary to slow down the replication of HIV which and can lead to Acquired Immune Deficiency Syndrome (AIDS) as ordered.

Resident 7 did not receive 4 doses of IV (intravenous) and 2 doses IM (intermuscular) Rocephin, once a day, prescribed for osteomyelitis, which could result in increasing the risk of further infection that is resistant to antibiotics. During an extended survey on 5/21/15, Resident 7's 9 am dose of IV Rocephin was administered at 11:23 a.m., more than two hours after it was due.

Resident 21 received two doses of Tylenol instead of aspirin which thins the blood and prevents clots which can lead to a stroke.

The IJ could not be lifted by the end of the standard survey, which was then extended due to substandard care. During the extended survey on 5/20/15 and 5/21/15, the IJ could not be lifted because of the continued significant medication errors. The IJ was abated on 6/08/15.

On May 4, 2015, during a complaint investigation survey, at the Windsor Healthcare Center of Oakland, located at 2919 Fruitvale Avenue, Oakland, CA 94602, two (2) immediate jeopardies were identified and violations written at harm level:

- **Level K – F224 – Prohibit Mistreatment / Neglect / Misappropriating**

The facility failed to provide services for untreated and unassessed skin ulcers, and untreated pain for six residents resulting in the neglect of residents' skin ulcers placing them at risk for infection and neglect of not receiving pain medications timely.

Resident 1 had physician's orders for daily treatment of an extensive diabetic ulcer

[2] Effective August 1, 2014, Brookdale Healthcare & Wellness Centre, LP entered into a Management and Operations Transfer Agreement with the current licensee, Windsor Oakridge Healthcare, L.P.

of the right heel and pressure ulcers on the buttocks and was not given the treatments as ordered for nine (9) days, resulting in Resident 1 being at risk for further damage to skin, bones, the possibility of losing one leg and at risk for infection due to the lack of nursing care as prescribed by the physician.

Resident 3 was placed on Hospice care and did not receive medications and pressure ulcer care as ordered. Resident 3 went without Morphine Sulfate for 19 hours when it was to be given every four hours, and the open pressure ulcers went untreated. The nurses did not follow doctor's orders for Hospice care resulting in Resident 3 suffering from pain and agitation due to not receiving Hospice medication, and not receiving pressure ulcer treatment.

Resident 13 was paralyzed and had extensive pressure ulcers to the buttocks and upper thighs. Resident 13 was exhibiting symptoms of illness and Resident 13's family insisted that Resident 13 be sent to the hospital. Resident 13 was sent to the ER where the doctor documented they found the resident covered in feces from the mid-back to the upper thighs, and was subsequently place in the intensive care unit for sepsis.

Resident 14 was admitted to the facility with orders for a medication to treat the pain which was not provided by the facility resulting in Resident 14 stating that Resident 14 felt like Resident 14 was going to die if Resident 14 did not get the medication. Resident 14 called 911 to take him/herself to the hospital in order to obtain the medication.

During the extended survey on 5/20/15 and 5/21/15, two additional residents were found to have ulcerated skin that was not assessed or treated.

Resident 29 had an open pressure ulcer on the right elbow which was identified by the Occupational Therapist (OT) and reported to the Director of Staff Development (DSD). The DSD did not notify the physician, obtain treatment orders or treat the resident's open area which put them at risk for further breakdown and/or infection.

Resident 30 had a pin (metal rod) in the left lower leg that had an open area around the pin site and was on antibiotic medication to treat a bone infection at the site. There was a doctor's order for pin care which was not clarified as to what pin care was needed. The wound around the pin had some depth, was crater shaped, was moist with yellow tissue, and loosely covered with a gauze wrap.

The IJ could not be lifted by the end of the standard survey, which was then extended due to substandard care. During the exit conference on 5/26/15, the IJ could not be lifted because of the continued neglect in not caring for Resident 29's newly acquired pressure ulcer and not following up on physician's orders for Resident 30 pin care resulting in a new open wound at the pin site. The IJ was abated on 6/8/15.

- **Level L – F441 – Infection Control, Prevent Spread, Linens**

The facility failed to establish and maintain an Infection Control Program to provide a safe and sanitary environment and to help prevent the development and transmission of disease and infection affecting Resident 9 who had an intestinal infection due to Clostridium difficile (C.Diff) with active diarrhea.

Resident 9 was identified during the survey as having an active C.Diff. infection beginning on 4/8/15. The facility did not have surveillance records for infections in March or May, 2015, and Resident 9 was the only identified infection in April 2015.

The facility also failed to prevent the spread of infection by not implementing their policies and procedures for handling the soiled linen, housekeeping and meal delivery for a Resident with active C.Diff.

The facility licensed nurses failed to follow policies and procedures for dressing changes when the DSD and LVN did not wear gloves while setting up the treatment supplies for two Residents.

The facility's staff lack of awareness of infected individuals, and lack of an infection control program with an appointed coordinator to monitor, control and prevent the spread of infection was a threat to the health of the individuals living and working in the facility.

The Director of Nursing nor any other nursing staff had any knowledge of the numbers of infected residents in the facility at the time of the survey. One resident was identified as having C.Diff. and had been moved to a single room from a three bed room two weeks ago. The facility records however, reflect the resident had C.Diff. since February 2015. The Certified Nursing Assistants, Laundry worker, Housekeeping, and Dietary departments were not notified and the contaminated linens were sent with the regular laundry, the meal trays sent to that resident was commingled with the other dirty trays after eating, and the housekeeper was not clear on the housekeeping procedures to prevent the spread of infection from the resident's room to the rest of the facility.

Wish-I-Ah Healthcare & Wellness Centre

On October 10, 2014, during a complaint investigation survey at the Wish-I-Ah Healthcare & Wellness Centre, located at 35680 Wish-I-Ah Road, Auberry, CA 93602, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level L – F441 – Infection Control, Prevent Spread, Linens**

The facility failed to establish and maintain an effective Infection Control Program to prevent resident infection when the facility failed to identify a foodborne outbreak when 11 residents in the facility were identified with signs and symptoms of gastroenteritis. Resident 1's positive blood culture for Salmonella was confirmed prior to Resident 1's death. These failures were identified as follows:

1. Kitchen sanitation procedures were not maintained to minimize resident exposure to foodborne illness.
2. Facility staff returning to work after illness while still infectious.
3. Facility bathrooms were not maintained in a safe, functional, and sanitary manner.
4. Facility ice machine was not cleaned and sanitized according to manufacturer's recommendations.
5. Facility staff did not maintain contact isolation precautions when caring for a symptomatic resident.
6. Facility linen was not available for residents.
7. Resident contracted sepsis secondary to Salmonella infection. Resident was sent to the acute care hospital where she expired 7 days after admission.
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.

These failures exposed residents and staff to infectious disease which resulted in resident illness and harm to two known residents with laboratory confirmed Salmonella infection, and exposure of all residents and staff to gastrointestinal illness.

On October 14, 2014, during a complaint investigation survey at the Wish-I-Ah Healthcare & Wellness Centre, located at 35680 Wish-I-Ah Road, Auberry, CA 93602, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level J – F309 – Provide Care / Services For Highest Well-Being**

The facility failed to provide the necessary care and services to attain the highest practicable physical well-being for Resident 1 when:

1. Wound vacuum dressing changes were not done in accordance with manufacturer's guidelines and physician orders. Resident 1 had a piece of foam attached to the skin where the wound vacuum dressing was placed and developed an infection.
2. No process in place to ensure the licensed nurses had been instructed and/or were competent to perform the wound vacuum dressing care.
3. No comprehensive assessment of the right chest wound done in order to monitor progress in healing of the wound for 25 days after Resident 1 returned to the facility with the wound vacuum.
4. No Nursing Care Plan was developed to guide interventions in wound care or Vacuum Assisted Closure (VAC) care.
5. Physician orders had not been followed when Resident 1's ordered lab tests had not been drawn which led to the cancellation of a physician appointment.

These failures led to pieces of the sponge used in the wound vacuum dressing change adhering to Resident 1's skin and had a high potential for Resident 1 to

develop an infection. These failures had a high potential for infections and medical complications.

On October 30, 2014, during a complaint investigation survey at the Wish-I-Ah Healthcare & Wellness Centre, located at 35680 Wish-I-Ah Road, Auberry, CA 93602, one (1) immediate jeopardy was identified and violations written at harm level:

- **Level K – F465 – Safe / Functional / Sanitary / Comfortable Environment**
  The facility failed to maintain a functional, safe, and sanitary environment for all residents, staff and visitors when:

  1. Kitchen sanitation procedures were not maintained to minimize resident exposure to foodborne illness.
  2. Facility staff returning to work after illness while still infectious.
  3. Facility bathrooms were not maintained in a safe, functional, and sanitary manner.
  4. Facility ice machine was not cleaned and sanitized according to manufacturer's recommendations.
  5. Facility staff did not maintain contact isolation precautions when caring for a symptomatic resident.
  6. 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.
  7. Two of three Bathroom/Shower flooring had soft and spongy floor tiles near the shower and broken tiles and rotted subfloor beneath in the Bo-Hin-Tow building.
  8. Two resident bathrooms in the Administration building had soft squishy flooring around the toilet, and one room had water coming up around the toilet and onto the bathroom floor.
  9. There was no hot water in the Bo-Hin-Tow building and no water provided to residents for hand washing. Residents were given bed baths in tepid to cool water.

  These failures exposed residents and staff to infectious disease which resulted in resident illness and harm to two known residents with laboratory confirmed Salmonella infection, and exposure of all residents and staff to gastrointestinal illness.

As a result of the findings of this survey, on December 10, 2014, the Centers for Medicare and Medicaid Services (CMS) placed Wish-I-Ah Healthcare & Wellness Centre on a termination track for the Medicare program, issued civil monetary penalties, and denied payment for new admissions. Furthermore, CDPH issued a temporary suspension order on November 4, 2014, given the significant and on-going threats to the health and safety of the residents. The facility voluntarily closed on December 11, 2014.

In addition to the above federal regulatory violations, CDPH's review revealed the following citations for state licensing violations in facilities owned, managed, or operated, directly or indirectly, by the applicant for the past three years.

Three-Year State Licensing Citation History

Citation Level	Citation Level Description	Number of Citations
AA	A direct proximate cause of death of a patient of a long-term health care facility.	1
A	Imminent danger of death or serious harm to patients, or a substantial probability of death or serious physical harm to patients.	37
B	Has a direct or immediate relationship to patient health, safety, or security. Can include emotional and financial elements.	70

The enclosure displays the level AA and A state citations by facility.

Finally, CDPH's review revealed 13 administrative penalties for failure to comply with the legislatively mandated minimum staffing requirement of 3.2 Nursing Hours Per Patient Day (NHPPD) in facilities owned, managed, or operated, either directly or indirectly, by the applicant for the past three years.

The enclosure displays the NHPPD administrative penalties by facility.

CDPH has determined that you have not provided evidence satisfactory to be licensed as River Valley Healthcare & Wellness Centre, LP located at 2490 Court Street, Redding, CA 96001, as a change of ownership (CHOW) from the current licensee Windsor Redding Care Center, LLC, to comply with statutes and regulations related to the operation of a skilled nursing facility (SNF). Therefore, based on the non-compliance with the requirements to complete the application for licensure, your application is denied.

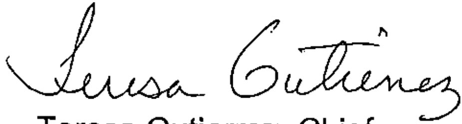
Pursuant to Health and Safety Code section 1269, you have 20 days from the mailing of this notice to request a hearing regarding this denial action. If you desire to have a hearing to contest this action, you should address your written petition to the Department of Public Health at the following address:

California Department of Public Health
Licensing and Certification Program
Centralized Applications Unit
1615 Capitol Avenue
P.O. Box 997377, MS 3207
Sacramento, CA 95899-7377

Upon receipt of such petition, the matter will be set for hearing in accordance with Section 131071 of the Health and Safety Code.

If you have any questions regarding this letter, contact me at (916) 552-8756.

Thank You,



Teresa Gutierrez, Chief
Center for Health Care Quality
Licensing & Certification Program
Centralized Applications Unit

Enclosure

cc: Windsor Redding Care Center, LLC
9200 Sunset Blvd., Suite 725
West Hollywood, CA 90069

Joanne Gilchrist, Health Program Manager II
California Department of Public Health
Center for Health Care Quality
Chico District Office
126 Mission Ranch Blvd.
Chico, CA 95926

bcc: Tze Ming U
Office of Legal Services
California Department of Public Health