STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055402	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor El Camino Care Center	2540 Carmichael Way Carmichael, CA 95608

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 32096 Based on interview and documentation review, the facility failed to provide food at an appetizing temperature when three residents (Resident 3, Resident 4, and Resident 5) complained that hot foods were consistently served cold, staff were aware of the complaints, and residents brought up the food temperature issue during the resident council meeting and yet unresolved for a census of 165. This failure resulted in the residents' preference consistently not being honored, therefore, Resident 5 feeling disrespected and Resident 3 and Resident 4 settling for having hot food cold. Findings: In a telephone interview on 5/8/24 at 4:01 p.m., Resident 1's family member voiced that the facility served the hot food cold for the resident. In an interview on 5/9/24 at 11:18 a.m., Resident 3 was in the wheelchair in the hallway and complained, Food comes cold. Resident 3 stated, I am kind of settling for having cold food. But I like to have hot food hot, like eggs in the morning. In an interview on 5/9/24 at 11:24 a.m., Resident 4 was in her wheelchair in her room. The resident stated, Food is always cold and when she asked to re-heat the food, staff said there was no microwave. The resident stated, I guess the only one [microwave] is at the staffing lounge. Resident 4 complained all the food came cold always and stated, They need new carts [meal delivery carts]. In an interview on 5/9/24 at 11:49 a.m., Resident 5 was in her room and complained that foods came cold stating, almost all meals, egg fry coming cold, pancakes, oatmeal, dinner tray, sometimes it's a little warm but mostly cold, pasta, steamed vegetables are cold, mashed potatoes coming cold. It's not fair. The resident stated residents in the facility complained each other about meals were cold but the foods still served cold. Resident 5 stated breakfast pancakes came with butter, but the butter did not melt because the pancakes were cold. The resident muttered she did not understand why they even send the butter when the pancakes served cold. Resident 5 reported if the meal came cold once, I would ask to reheat but when they come cold all the time, I just eat. The resident sated I want hot food hot. I want my pancakes hot. The resident stated she felt disrespected when she ate a hot meal cold. In an interview on 5/9/24 at 11:58 a.m., Certified Nurse Assistant (CNA 1) at the nursing station, stated she was aware of residents complained about hot foods being served cold. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a concurrent interview and review of the resident council minutes on 5/9/24 at 12:24 p.m., the Activity Director (AD) verified residents brought the food temperature issues in a meeting on 4/16/24. The AD stated residents complained food temperature that breakfast being served cold and stated it had been an issue for a while. The AD stated, [It] Doesn't surprise me because the carts [meal delivery carts] are old. Review of the facility's 2018 policy and procedure, Meal Service stipulated, Meals , and served at the appropriate temperatures .Resident preferences for meal times & food temperatures shall be honored. In an interview on 5/9/24 at 12:40 p.m., the Director of Nursing (DON) in the front hall, stated she was aware of residents had food temperature issues before. The DON stated, Hot food should be served hot. They [residents] look forward to the food .hot enough for them to enjoy, indicating the hot foods to be served in an appetizing temperature for residents to enjoy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 32096 Based on observation, interview and documentation review, the facility failed to provide a functioning call light system for two of three sampled residents (Resident 1 and Resident 2) when neither the light above their room nor the call light panel at the nursing station were working when the residents put the call lights on. This failure compromised the major communication link for staff to meet the needs of the residents and placed the residents at risk for safety. Findings: Resident 1 was a long-term resident in the facility with diagnoses that included right side weakness and the need for assistance with personal care. In a concurrent observation and interview on 5/9/24 at 10:40 a.m., with Licensed Nurse (LN 1), Resident 1's call light was tested and noted the light above the resident's room in the hallway did not turn on. Resident 2, Resident 1's roommate, pushed her call button on and no light lit up, either. LN 1 stated when the resident put a call light on, it also beeped at the nursing station with flashing lights. The call light monitoring panel at the nursing station was checked and there was no beeping sound or flashing lights when the residents' call buttons were put on. There were no audible or visual signals to notify staff when the residents pushed the call lights on. LN 1 verified the malfunctioning call lights for Resident 1 and Resident 2 and acknowledged the residents were not provided with alternate means of communication other than the call buttons. In an interview on 5/11/24 at 11:12 a.m., the Maintenance Assistant (MA) verified the call light system was not working for Resident 1 and Resident 2 and stated the facility had a lot of old wiring. The MA stated the call light was a lifeline for the residents and it should have worked at all times. Review of the facility's September 2022 policy and procedure, Call System, Resident, stipulated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station .The call system remains functional at all times. If audible .the volume is maintained at an audible level that can be easily heard. If visual .the lights remain functional. In an interview on 5/9/24 at 12:40 p.m., the Director of Nursing stated residents communicated with staff via call lights and it should work at all times.