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	08/20/2024

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43247 Based on observation, interview, and record review, the facility failed to provide necessary means of communication for one of four sampled residents (Resident 1), when staff did not use translation services including phone translation services and Resident 1 was not provided with a communication board (an alternative communication device with symbols and pictures to help people with limited English communicate). This failure had the risk potential for Resident 1's care needs to be unmet leading to inadequate care. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility in September 2023 for multiple diagnoses including hemiplegia (paralysis of one side of the body) of right side, diabetes (too much sugar in the blood), and dysphagia (difficulty swallowing). A review of Resident 1's Minimum Data Set (MDS- an assessment tool), Cognitive Patterns, dated 7/10/24, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 9 out of 15 which indicated Resident 1 was moderately cognitively impaired. A review of Resident 1's Order Summary Report indicated order dated 1/8/24, .Patient has capacity to make decisions . A review of Resident 1's Progress Note, dated 6/15/24, indicated .Can make needs known mostly in Spanish and atended [sic] in timely manner. Alert and verbally responsive and can make needs known most of the time and attended in a timely manner . A review of Resident 1's Progress Note, dated 8/20/24, indicated .A Communication Board in Spanish with pictures in it was provided for the resident and staff to use to aid with communication. The Language Line option for staff to call was also provided on the cover of the Communication Folder .The resident was spoken to regarding the provision of the Communication Folder that is currently situated by the wall on top of her bed and verbalized understanding as she can understand basic English especially when you speak slowly and allow time for her to process what is being conveyed to her . (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Care Plan, revised 4/11/24, indicated .Focus [Name of resident] has a communication problem r/t [related to] Language barrier Spanish speaking-minimal English .Interventions . Provide translator as necessary to communicate with the resident. Translator is Language line solutions [phone line for translation services] ., Family or Spanish speaking staff .Use alternative communication tools as needed, such as communication book/board, writing pad, gestures, signs, and pictures . During a telephone interview on 8/20/24 at 9:05 a.m. with Resident 1's Family Member (FM), the FM stated Resident 1's main language was Spanish but speaks broken English and tries to communicate with the nurses. The FM stated the staff doesn't listen and doesn't understand Resident 1. During a joint interview on 8/20/24 at 12:37 p.m. with the Senior Administrator (SADM), the [NAME] President of Operations (VPO), and the Regional Nurse Consultant (RNC), the SADM stated that staff speak multiple languages or staff can use the Language Line to speak with Non-English or limited English speaking residents. During an interview on 8/20/24 at 1:07 p.m. with Resident 1, Resident 1 stated Spanish was her main language. Resident stated she mostly understood staff when they talked to her. During an interview on 8/20/24 at 1:25 p.m. with Licensed Nurse (LN) 1, LN 1 stated Resident 1 mostly speaks Spanish and broken English or uses gestures to indicate needs. LN 1 stated if Resident 1 was in pain she will point to where it hurts. LN 1 stated if she needed translation will get a Certified Nursing Assistant (CNA) who speaks Spanish. When asked if CNA was not available, she stated she will find someone else who speaks Spanish. When further asked what she would do if no staff were available to translate, LN 1 stated that had not happened but can usually understand what Resident 1 wants. LN 1 stated she had not used the Language Line and was not sure how to use it. During an interview on 8/20/24 at 1:27 p.m. with MDS Coordinator (MDSC) and Resident 1 in Resident 1's room, the MDSC confirmed Resident 1 does not have a communication board in her room. The MDSC stated that staff should be using the Language Line, but may not be aware to use the Language Line. During an interview on 8/20/24 at 1:45 p.m. with CNA 1, CNA 1 stated she communciated with Resident 1 using another CNA who speaks Spanish. CNA 1 stated if that CNA was not available, will find another CNA who speaks Spanish. CNA 1 stated she does not use the Language Line to communicate with Resident 1. CNA 1 stated she has the number, but not sure how it works. During an interview on 8/20/24 at 2:58 p.m. with the RNC, the RNC acknowledged that Resident 1 did not have a communication board in her room. Reviewed with the RNC that staff indicated were not aware how to use the Language Line. The RNC stated that his expectation was that staff should be able to use the Language Line. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedure (P&P) titled Translation and /or Interpretation of Facility Services, revised 11/20, indicated .The facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility .Competent oral translation of vital information that is not available in written translation, and non- vital informationshall be provided in a timely manner and at no cost to the resident through the following means .A staff member who is trained and competernt in the skill of interpreting .A staff interpreter who is trained and competent in the skill of interpreting .Contracted interpreter service .Telephone interpretation service . Interpreters and translators must be appropriately trained in medical terminology, confidentiality of protected health information, and ethical issues that may arise in communicating health-related information .It is underrstood that providing meanigful access to services provided by this facility requires also that the LEP resident's needs and questions are accurately communicated to the staff. Oral interpretation services therefore shoud include interprtation from the LEP resident's primary language back to English .It is understood that in order to provide meaningful access to services provided by this facility, translation and /or interpretation services must be provided in a way that is culturally relevant and appropriate to the LEP individual . A review of the facility P&P titled Quality of Life-Dignity, revised 2/20, indicated .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem .The facility culture is one that supports and encourages humanization and individuation of residents .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 43247 Based on observation, interview, and record review, the facility failed to provide a comfortable and sanitary environment for one of four sampled residents (Resident 1), when Resident 1's privacy curtain had a brown crusted stain on it and the top drawer of the bedside dresser had insect fragments, stains, and solid particle matter on the bottom of the drawer. This failure resulted in an unsanitary and uncomfortable environment for Resident 1 with the risk potential for infection or harm. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility in September 2023 for multiple diagnoses including hemiplegia (paralysis of one side of the body) of right side, diabetes (too much sugar in the blood), and dysphagia (difficulty swallowing). A review of Resident 1's Minimum Data Set (MDS- an assessment tool), Cognitive Patterns, dated 7/10/24, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 9 out of 15 which indicated Resident 1 was moderately cognitively impaired. A review of Resident 1's Progress Note, dated 5/13/24, indicated .Residents daughter and grandaughter [sic] came to visit today .Family cleaned out her nightstand and noticed there were bugs in the drawer, maintenance notified . During a telephone interview on 8/20/24 at 9:05 a.m. with Resident 1's Family Member (FM), Resident 1's FM stated, about two weeks ago, the top drawer of the dresser next to Resident 1's bed, had bugs and mold in it. Resident 1 does not have anything in the top drawer, but has things in the bottom drawer. Resident 1's FM also stated, Curtain has poop splattered on it. Resident 1's FM stated she is concerned for Resident 1's safety. During an observation on 8/20/24 at 1:02 p.m. of Resident 1's privacy curtain, brown crusted stain on curtain was observed and the top drawer of bedside dresser was locked. During a concurrent observation and interview on 8/20/24 at 1:07 p.m. with the Accounts Manager (AM) and Resident 1 in Resident 1's room, the AM stated he was in the room reviewing for quality improvement. The AM confirmed a brown crusted stain on Resident 1's privacy curtain. The AM stated it may be food. Resident 1 stated it may be blood. During a follow-up interview on 8/20/24 at 1:10 p.m. with Resident 1, the resident stated she does not use the top bedside dresser drawer as it was locked and she was not able to open it. During an interview on 8/20/24 at 1:51 p.m. with the Maintenance Director (MD), the MD confirmed Resident 1's top drawer of bedside dresser was locked and did not have the key. He removed the lock and stated he would replace it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with Licensed Nurse (LN) 1, LN 1 confirmed unidentified particles, what appear to be insect fragments, and stains in Resident 1's top drawer of bedside dresser. LN 1 stated, It's nasty. LN 1 acknowledged that Resident 1 was unable to use that drawer. LN 1 confirmed brown crusted stain on privacy curtain. During an interview on 8/20/24 at 2:10 p.m. with the Housekeeper (HK), the HK stated deep cleaning of every room is done once a month. The HK stated the curtains are cleaned and the inside of the drawers cleaned if empty. During an interview on 8/20/24 at 2:58 p.m. with the Regional Nurse Consultant (RNC), the RNC acknowledged the uncleanliness of Resident 1's top drawer in bedside dresser and brown crusted stain on privacy curtain. The RNC stated the dresser needed to be removed and the curtains changed. A review of the facility's Policy and Procedure (P&P) titled Homelike Evvironment, revised 2/21, indicated . Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible .The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary, and orderly environment . A review of the facility's P&P titled Housekeeping Procedures, revised 9/5/17, indicated .Daily Patient Room Cleaning .Every room to be cleaned is that resident's home .The goal of cleaning is Infection Control .Spot clean. With a cloth & disinfectant spot clean all vertical services . Complete Room Cleaning .Nursing Assistants should strip beds & empty closets & drawers . Cleaning Cubicle Curtains .Examine curtains .If curtain is stained, remove immediately .Have spare curtains on hand to immediately replace dirty or torn curtains . A review of the facility's P&P titled Quality of Life-Dignity, revised 2/20, indicated .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem .Residents private space and property are respected at all times

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 43247 Based on observation, interview, and record review, the facility failed to revise the Care Plan for one of four sampled residents (Resident 1), when Resident 1's Care Plan did not accurately reflect the feeding assistance provided. This failure had the potential for Resident 1 to receive incorrect feeding assistance not in accordance with her wishes. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility in September 2023 for multiple diagnoses including hemiplegia (paralysis of one side of the body) of right side, diabetes (too much sugar in the blood), and dysphagia (difficulty swallowing). A review of Resident 1's Minimum Data Set (MDS- an assessment tool), Cognitive Patterns, dated 7/10/24, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 9 out of 15 which indicated Resident 1 was moderately cognitively impaired. A review of Resident 1's MDS, Functional Abilities and Goals, dated 7/10/24, indicated Resident 1 was independent with eating. A review of Resident 1's Order Summary Report indicated order dated 1/8/24, .Patient has capacity to make decisions . A review of Resident 1's Progress Note, dated 6/14/24, indicated .Noted with very slow eating of meals. Diet and diet texture tolerated well. No s/s [signs/symptoms] of aspiration. OFFERED assistance but vehemently refuse and stated I can eat by myself . A review of Resident 1's Nutritional Assessment, dated 8/13/24, indicated .DIET HABITS: Independent to supervisory assistance . A review of Resident 1's Care Plan for feeding, created on 6/7/24, indicated Focus Resident is independent for feeding .Interventions Resident declines assistance from staff when attempting to assist with meal time. Staff encourage Resident to participate in task to promote and maintain independence. Staff to continue to offer assistance and mealtime [sic] .Provide patient with total assist for feeding . During a concurrent observation and interview on 8/20/24 at 1:27 p.m. with Resident 1, Resident 1 stated she was able to feed herself. Observed Resident 1 use fork in her left hand to eat fruit. During an interview on 8/20/24 at 1:45 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 is able to feed herself with her left hand. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/20/24 at 4:22 p.m. with the Regional Nurse Consultant (RNC), reviewed Resident 1's Care Plan for feeding. and the interventions. The RNC acknowledged the discrepancy in the interventions. The RNC stated he was not aware what assistance Resident 1 needed for feeding. During an interview on 8/20/24 at 4:32 p.m. with Occupational Therapist (OT), the OT stated Resident 1 is able to feed herself. The OT stated Resident 1 refuses assistance and wants to do it herself. Resident 1 is able to use regular utensils, does not need special utensils. Reviewed Resident 1's Care Plan for feeding and the interventions with the OT. The OT stated the Care Plan Interventions are misleading and should be revised. The OT stated nursing updates the Care Plans. During a subsequent interview on 8/20/24 at 4:48 p.m. with the RNC, the RNC acknowledged that Resident 1's Care Plan for feeding did not reflect Resident 1's current feeding assistance status. A review of the facility's Policy and Procedure (P&P) titled Care Planning - Interdisciplinary Team, effective 8/25/21, indicated .Our facility's Interdisciplinary Team is reposnsible for the development of an individual comprehensive care plan for each resident .The care plan is based on the resident's comprehensive assessment and is developed by an Interdisiplinary Team which includes but is not necessarily limited to the following personnel .A registered nurse with responsibility for the resident .Specialized Rehabilitative Service Therapists .the participationof the resident and the resident's representative(s) .Nursing Assistants with responsibility for the resident .others, as appropriate or necessary to meet the needs of the resident or as requested by the resident .The resident, the resident's family and/or the resident's representative are encouraged to participate in the development of and revisions to the resident's care plan . A review of the facility's P&P titled Resident Food Preferences, revised 7/17, indicated .Nursing staff will document the resident's food and eating preferences in the care plan . A review of the facility's P&P titled Quality of Life- Dignity, revised 2/20, indicated .The facility culture is one that supports and encourages humanization and individuation of the residents, and honors resident choices, preferences .