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	10/07/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 47197 Based on interview and record review, the facility failed to protect one out of four sampled residents' (Resident 4) right to be free from physical abuse by a resident (Resident 1) when Resident 1 yanked, tugged, and shook Resident 4's hair backwards. These failures resulted in Resident 4 getting hurt, being scared, and experienced emotional distress, and had the potential for Resident 4 and all residents in the facility to experience physical and/or psychosocial harm. Findings: A review of Resident 1's clinical record indicated Resident 1 was originally admitted July of 2016 and had diagnoses that included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 1's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 7/23/24, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 12 out of 15 which indicated Resident 1 had a moderately impaired cognition. A review of Resident 4's clinical record indicated Resident 2 was admitted November of 2022 and had diagnoses that included cerebral infarction (damage to a part in the brain due to a disrupted blood flow), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), and muscle weakness. A review of Resident 4's MDS Cognitive Patterns, dated 8/26/24, indicated Resident 4 had a BIMS score of 13 out of 15 which indicated Resident 4 had intact cognition. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 4's progress notes, dated 9/28/24, indicated, at 1043 [10:43 a.m.] this resident [Resident 4] was involved in a seen resident-to-resident altercation. This resident [Resident 4] was passing another female resident [Resident 1] in a wheelchair in her wheelchair I [Licensed Nurse (LN) 3] was sitting at nurses station charting i [LN 3] then heard yelling from residents and heard another resident [Resident 1] shout for [name of Resident 4] to get out of her space then as i [LN 3] looked up i seen her [Resident 1] grab [name of Resident 4] back of her hair and shake and pull hair. a housekeeper [Housekeeping Staff (HKS)] was a few feet from them [Resident 1 and Resident 4] and yelled for her [Resident 1] to stop i was able to get [name of Resident 4] way [sic] and made sureother [sic] resident [Resident 1] went back to her room . A review of HKS' written statement, dated 9/28/24, indicated, [Resident 1] went and grabbed [Resident 4] poneytail [sic] and was yanking and shaking here [sic] hend [sic] by it hard also cussing her [Resident 4] out I [HKS] told her [Resident 1] to stop. During an interview on 10/7/24 at 1:20 p.m. with Resident 4, Resident 4 stated, .She [Resident 1] just flipped out and pulled my hair .I don't know why . Resident 4 stated she felt scared at that time of incident. During an interview on 10/7/24 at 1:42 p.m. with LN 2, LN 2 stated, .She [Resident 4] was scared before, like in the first few days after that [incident] . LN 2 also stated, .She [Resident 1] can tend to be violent when she's [Resident 1] upset .She [Resident 1] can be physical or verbal [physically or verbally violent] if she gets upset . LN 2 further stated there should have been more supervision for Resident 1 because of Resident 1's behavior. Staff could not just leave Resident 1 with other residents since altercations could happen. During an interview on 10/7/24 at 1:55 p.m. with Certified Nurse Assistant (CNA) 2, CNA 2 stated, She [Resident 1] can become violent and be abusive .I saw her throwing stuff around in her [Resident 1] room . She [Resident 1] can be verbal [verbally violent] when she's angry . A review of Resident 1's care plan, revised 10/28/23, indicated, [name of resident 1] demonstrate verbally abusive behaviors towards others r/t [related to] Poor impulse control .Unpredictable behavior - physically aggressive during care at times During an interview on 10/7/24 at 4:08 p.m. with the Director of Nursing (DON), the DON stated, All residents have the right to not get abused by other residents or anyone. A review of the facility's policy and procedure (P&P) titled, Abuse Prohibition Policy and Procedure, dated 2/23/21, indicated, Health Care Centers prohibit abuse .for all residents .The Center will implement an abuse prohibition program through the following: .Prevention of occurrences .5. Actions to prevent abuse .will include: .5.2 Identifying, correcting, and intervening in situations in which abuse, neglect, and/or misappropriation of patient property is more likely to occur .6.2.1 The Center will provide adequate supervision when the risk of resident-to-resident altercation is suspected.