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	02/20/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49933 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) were cared for in a manner which promoted their dignity when CNA 1 spoke to Resident 1 with a rude and upset tone while helping during toileting. These failures had the potential to negatively impact residents' psychosocial well-being. Findings: Resident 1 was admitted to the facility February 2025 with multiple diagnoses which included chronic kidney disease, muscle weakness, and need for assistance with personal care. Resident 1's Minimum Data Sheet (MDS - a federally mandated resident assessment tool), dated 2/8/25, indicated Resident 1 had no memory impairment. The MDS further indicated that Resident 1 needed substantial/maximal assist (helper does more than half the effort) for toileting. During a review of Resident 1 ' s progress notes, dated 2/17/25, indicated .resident was wet and needed to be changed. So, resident turned on her call light for assistance. CNA (Certified Nursing Assistant) responded but got upset at the resident why she was on the light . During an interview on 2/20/25, at 1:45 p.m., Resident 1 stated she had waited up to half an hour to have her call light answered. Resident 1 stated she had an accident and needed assistance to go to the bathroom to get all her wet clothes off. Resident 1 stated she was already embarrassed due to the toileting accident and CNA further caused her to feel horrible. Resident 1 stated she had to continually apologize to CNA so that the CNA can calm down. Resident 1 and roommate was informed by CNA 1 that she was the only CNA on the floor. Resident 1 stated that CNA continued to assist her with frustration and threw a new disposable brief and landed on her chest. During a telephone interview on 2/20/25 at 2:15 p.m. with Resident 2, Resident 2 stated she was in the room when she witnessed CNA 1 had a rude and upset tone to Resident 1 while assisting her in the bathroom. Resident 2 confirmed that she was in the room and witnessed CNA 1 throwing a new disposable brief and gown at Resident 1. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 2/20/25 at 4:05 p.m., with the Director of Nursing (DON), the DON stated it was his expectation that all staff treat all residents with dignity and respect. DON acknowledged CNA should have treated Resident 1 with respect and maintain dignity. During an interview on 2/20/25 at 4:30 p.m. with Administrator (ADM), the ADM stated that the CNA ' s behavior was a concern. ADM acknowledged that Resident 1 was not treated with dignity and respect. During a review of the facility's policy and procedure (P&P) titled, Resident Rights revised December 2021, indicated, Employees shall treat all residents with kindness, respect, and dignity . These rights include the resident ' s right to .a dignified existence. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) were cared for in a manner which promoted their dignity when CNA 1 spoke to Resident 1 with a rude and upset tone while helping during toileting. These failures had the potential to negatively impact residents' psychosocial well-being. Findings: Resident 1 was admitted to the facility February 2025 with multiple diagnoses which included chronic kidney disease, muscle weakness, and need for assistance with personal care. Resident 1's Minimum Data Sheet (MDS - a federally mandated resident assessment tool), dated 2/8/25, indicated Resident 1 had no memory impairment. The MDS further indicated that Resident 1 needed substantial/maximal assist (helper does more than half the effort) for toileting. During a review of Resident 1's progress notes, dated 2/17/25, indicated .resident was wet and needed to be changed. So, resident turned on her call light for assistance. CNA (Certified Nursing Assistant) responded but got upset at the resident why she was on the light . During an interview on 2/20/25, at 1:45 p.m., Resident 1 stated she had waited up to half an hour to have her call light answered. Resident 1 stated she had an accident and needed assistance to go to the bathroom to get all her wet clothes off. Resident 1 stated she was already embarrassed due to the toileting accident and CNA further caused her to feel horrible. Resident 1 stated she had to continually apologize to CNA so that the CNA can calm down. Resident 1 and roommate was informed by CNA 1 that she was the only CNA on the floor. Resident 1 stated that CNA continued to assist her with frustration and threw a new disposable brief and landed on her chest. During a telephone interview on 2/20/25 at 2:15 p.m. with Resident 2, Resident 2 stated she was in the room when she witnessed CNA 1 had a rude and upset tone to Resident 1 while assisting her in the bathroom. Resident 2 confirmed that she was in the room and witnessed CNA 1 throwing a new disposable brief and gown at Resident 1. During an interview, on 2/20/25 at 4:05 p.m., with the Director of Nursing (DON), the DON stated it was his expectation that all staff treat all residents with dignity and respect. DON acknowledged CNA should have treated Resident 1 with respect and maintain dignity. (continued on next page)

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