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	04/02/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 46995 Based on observation, interview, and record review, the facility failed to provide intravenous (IV, the administration of substances directly into a vein) care in accordance with professional standards of quality for two of six sampled resident's (Resident 2 and Resident 3) when Resident 2 and Resident 3 did not have physician orders for IV flushes (used to clear out IV lines after medication is used and to prevent blockages in the line). This failure had the potential for the residents to not receive the full dose of medication ordered, to receive the incorrect type or amount of IV flush and increased the risk for a blockage in the IV line. Findings: Resident 2 was admitted to the facility early 2025 with diagnoses which included bone infection and infection in the hip joint. During an observation on 4/2/25 at 1:07 p.m. of Resident 2, Resident 2 had a Peripherally Inserted Central Cather (PICC, a thin flexible tube inserted into a vein in the upper arm that extends into a large vein near the heart) inserted into his left upper arm. During a review of Resident 2's Order Summary Report [OSR], Active Orders as of 4/2/25, the OSR indicated Resident 2 had three different antibiotics ordered to be administered intravenously. The OSR did not include any orders to flush his PICC line. Resident 3 was admitted to the facility early 2025 with diagnoses which included lower leg wound infection. During a review of Resident 3's OSR, order date 3/24/25, the OSR indicated Resident 3 had two different antibiotics ordered to be administered intravenously. The OSR did not include any orders to flush her PICC line. During a concurrent interview and record review on 4/2/25 at 3:28 p.m. with Licensed Nurse (LN 2), LN 2 stated all residents with PICC line should have physician orders for IV flushes. LN2 reviewed Resident 2 and Resident 3's orders and confirmed they did not include physician orders for IV flushes. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/2/25 at 3:47 p.m. of Resident 3, Resident 3 had a PICC inserted into her right upper arm. During a concurrent interview and record review on 4/2/25 at 4:01 p.m. with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), the ADON stated a physician order was needed for IV flushes. The DON reviewed Resident 2 and Resident 3's physician orders and confirmed there were no order for IV flushes. During a review of the facility's policy and procedure titled, Skilled Nursing Pharmacy: PICC FLUSHING, dated 6/18, the P&P indicated, A physician order is required to flush a catheter. The order must include 1. Flushing agent 2. Strength/concentration 3. Volume 4. Frequency .Flushing is performed using push/pause technique to ensure and maintain catheter patency and to prevent mixing of incompatible medications .

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46995 Based on observation, interview, and record review, the facility failed to provide safe, sanitary care for two of six sampled resident's (Resident 2 and Resident 3) intravenous (IV, the administration of substances directly into a vein) care when the Peripherally Inserted Central Cather (PICC, a thin flexible tube inserted into a vein in the upper arm that extends into a large vein near the heart) dressings were not changed, and IV tubing was not dated. These failures increased the risk of infection. Findings: Resident 2 was admitted to the facility early 2025 with diagnoses which included bone infection and infection in the hip joint. During a review of Resident 2's Order Summary Report [OSR], Active Orders as of 4/2/25, the OSR indicated Resident 2 had three different antibiotics ordered to be administered intravenously. During a review of Resident 2's Care Plan Report [CP], created 3/25/24, the CP indicated, .Change IV site per policy .Change dressing per policy . During an observation on 4/2/25 at 1:07 p.m. of Resident 2's left upper arm, Resident 2 had a clear plastic dressing which covered the PICC site dated 3/22. The IV tubing which ran from the IV pump attached to his arm was not dated or labeled with the time. During a concurrent observation and interview on 4/2/25 at 1:20 p.m. with Licensed Nurse (LN1) of Resident 2's PICC dressing and IV tubing, LN1 confirmed the IV tubing was not labeled and the date on the PICC dressing was 3/22. LN 1 stated, It needs to be changed .that has access to the bloodstream .need to change it to prevent any infection. LN 1 also stated, PICC dressings were supposed to be changed every three days, and IV tubing should be labeled with the date and time to make sure they are not being used for longer than they are supposed to. Resident 3 was admitted to the facility early 2025 with diagnoses which included lower leg wound infection. During a review of Resident 3's OSR, order date 3/24/25, the OSR indicated Resident 3 had two different antibiotics ordered to be administered intravenously. During an observation on 4/2/25 at 3:47 p.m. of Resident 3, Resident 3 had a PICC dressing to her right upper arm dated 3/23. The IV tubing which hung from the IV pump was not dated or labeled with the time. Review of the facility's P&P titled, Skilled Nursing Pharmacy: GENERAL POLICES FOR IV THERAPY, dated 6/18, the P&P indicated, .IV tubings (sic) will be labeled with the date, time and nurse hanging tubing . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Riview of the facility's P&P titled, Skilled Nursing Pharmacy: PICC DRESSING CHANGE, dated 6/18, the P&P indicated, .Dressing changes using transparent dressings are performed .At least weekly .change catheter securement device every 7 days . During an interview on 4/2/25 at 4:12 p.m. with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) the DON indicated PICC line dressings were changed weekly, and all IV tubing and bags should be labeled with nurse's initials, date, time, stating, It's important for infection control. Reiview of the facility's P&P titled, Skilled Nursing Pharmacy: Infection Control, dated 6/18, the P&P indicated, .Adhere to the specific IV therapy policy and procedure for site changes, tubing changes and dressing changes . During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control, dated 12/23, the P&P indicated, The facility adopted infection prevention and control policies and procedures are intended to help maintain a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections .all personnel are trained on infection prevention and control policies and procedures upon hire .