

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055402	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2025
NAME OF PROVIDER OR SUPPLIER Windsor El Camino Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>48860</p> <p>Based on observation, interview, and record review the facility failed to ensure professional standard of care was provided for one of three sampled residents (Resident 3), when the physician's order for fluid restriction (a diet which limits the amount of daily fluid consumption) was not followed.</p> <p>This failure placed Resident 3 at risk for dehhdration or fluid overload.</p> <p>Findings:</p> <p>Resident 3 was admitted to the facility in late-2024 with diagnoses which included heart failure and end-stage kidney disease.</p> <p>During a concurrent observation and interview on 4/15/25 at 12:34 p.m., in Resident 3's room with Certified Nurse Assistant (CNA) 3, CNA 3 confirmed there was a pitcher filled with water and ice, a fruit juice in tetra pack, water bottle, and prune juice in a sealed cup were located on Resident 3's bedside and over-bed table, all within the residents reach. CNA 3 was unable determine the amount of fluid found in Resident 3's room and stated it was already there when CNA 3 started his shift. CNA 3 also added there was no fluid restriction warning in Resident 3's room. CNA 3 stated, I was not aware and I didn't get any report when I got here. When asked who provides the report with residents on fluid restriction, CNA 3 responded, The nurse should give me report . When CNA 3 was asked the importance of monitoring Resident 3's fluid intake CNA 3 stated, The patient should not have this because she is on fluid restrictions. It will be hard to determine how much fluid she had in a day.</p> <p>During a concurrent observation and interview on 4/15/25 at 12:40 p.m., in Resident 3's room with Licensed Nurse (LN) 1, LN 1 confirmed there was a pitcher filled with water and ice, a fruit juice in tetra pack, water bottle, and prune juice in a sealed cup were located on Resident 3's bedside and over-bed table, all within the residents reach. LN 1 stated, Those should not be there because the patient might drink it. LN 1 was unable to determine if it was documented in the I&O (intake and output of fluid) monitoring. LN 1 also confirmed that there was no fluid restriction information in Resident 3's room. She added, Nurses should give CNA's report on any patient that has monitoring, so they know who to look out for such as residents on fluid restrictions.</p> <p>(continued on next page)</p>		

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a interview on 4/15/25 at 2:27 p.m., with the Director of Nursing (DON), the DON stated that the facility only start residents on I&O monitoring when there was a doctors order and added, We do not have anybody on I&O monitoring now. The DON further stated that the dietary staff was also involve and added, They should send certain amount of fluids during meals. The DON also stated the dietician was always aware of residents on fluid restrictions and stated, So she can follow up and assess residents and make dietary staff aware. The DON confirmed there were no residents currently on fluid restrictions and stated, We have to have an order to do that, if there's an order for fluid restrictions then the expectation is, it must be done. The DON stated that Nurses and CNA's were in charge of monitoring fluid intakes. When asked how the nurses and CNA's monitor residents fluid intake, the DON stated, CNA's should give the amount to nurses. The DON stated that every fluid that the resident consumed should be documented and that residents should not have water pitchers, water bottles, and fruit juices. The DON further added, We do not put water pitchers in the patients room when they are on fluid restrictions.</p> <p>During a review of Resident 3's Order Summary Report, the report indicated, FLUID RESTRICTION: 1000CC (A measure of volume in the metric system) PER 24 HOUR DIETARY: 600CC B[Breakfast]= 240cc L[Lunch]= 240cc Dinner =120cc NURSING: 400CC 7-3 PM=200CC 3-11PM=100CC 11-7AM=100CC every shift with start date of 12/4/24.</p> <p>During a review of Resident 3's Care Plan Report, the report indicated, [Resident 3's name] is at risk for dehydration as evidence by insufficient intake DX [Diagnoses] of DM [Diabetes Mellitus], CVA. [Cerebrovascular Accident, Stroke]> FLUID RESTRICTION: 1000CC PER 24 HOUR . Monitor I&O per protocol and report as indicated. Date Initiated: 11/21/24.</p> <p>During a records review of the facilities Policy and Procedure (P&P), the P&P indicated, 1. Verify that there is a physician's order for this procedure . General Guidelines .2. Be accurate when recording fluid intake 3. Record fluid intake on the intake side of intake and output record .7. When a resident has been placed on restricted fluids, remove the water pitcher and cup from the room. 8. Be sure an intake and output record is maintained in the resident room . Equipment and Supplies 1. Intake and output record.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48860</p> <p>Based on observation, interview and record review, the facility failed to ensure the infection prevention and control program guidelines and practices were maintained for a census of 163, when uncovered disposable razors on top of an overfilled sharps container (used to safely dispose of hypodermic needles and other sharp medical instruments,) inside the residents shower room in nursing station seven was not properly disposed and replaced timely by staff.</p> <p>This failure had the potential to result in transmission, spread of infection, and caused harm for the residents.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 2/15/25 at 11:21 a.m., with License Nurse 1 (LN1), inside the resident's shower room in one of the nursing station, LN 1 confirmed the sharps container was full and multiple uncovered disposable razors were on top it. LN 1 verified the door of the resident's shower room was left open. LN 1 stated, The door should not be left open because the residents can access the sharps and other things inside. LN 1 also stated, Whoever has to touch that has a risk of cutting through a glove. LN 1 stated that it was a safety concern that affects both staff and residents.</p> <p>During a concurrent observation and interview on 2/15/25 at 11:35 a.m., with Certified Nursing Assistant (CNA 1), inside the resident's shower room in nursing station seven, CNA1 stated the door needs to be always closed because of contamination and resident's privacy. CNA1 stated, We have dirty linens inside and used resident clothing's when they shower. CNA1 stated the sharps container should be clean and replaced by nurses. CNA1 indicated that used razors were contaminated and resident that had suicidal thoughts could access and use the blades to hurt themselves. CNA1 confirmed the residents' shower room was left open and the sharps container was full with used and uncapped razors on top.</p> <p>During an interview on 4/15/25 at 12:50 a.m., with the Infection Prevention (IP, a healthcare worker with specialty training and oversight in preventing infections among residents and staff), stated IP collected all the used sharps container from the utility room after the nurses collect them from the unit. The IP stated, Once its full, they put them in there [utility room]. The IP confirmed the sharps container should have been replaced and that staff should not place used uncovered razors on top. She stated, It needs to be thrown away because somebody can get poked and it's a risk for infection. She further stated the shower room door should be closed to prevent residents from entering and accessing the sharps container.</p> <p>During an interview on 4/15/25 at 2:27 p.m., with the Director of Nursing (DON), The DON stated the nurses and CNA's were in charge of making sure the sharps container was disposed properly and replaced. Thep DON stated that he expected the nurses and CNA's to change and replace the sharps container with a new one once its full. The DON further stated improperly discarded and used razors can be a safety risk for both the residents and staff.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's undated Policy and Procedure (P&P) titled, Sharps Disposal, indicated, This facility shall discard contaminated sharps into designated containers . 3 . c. Designated individuals will be responsible for sealing and replacing containers when they are 75% to 80% full to protect employees from punctures and/or needlesticks when attempting to push sharps into the container . 4 . 3 . a. Seal and replace containers when they are 75% to 80% full .</p>		