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	07/24/2025

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 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. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a safe and protective environment for one of three sampled residents (Resident 1), when Resident 1 was hit on the side of his face by Resident 3. During a record review of Resident 1's Face Sheet (FS), the FS indicated Resident 1 was admitted to the facility in early 2025 with diagnoses which included cerebral infarction (condition where a part of the brain is damaged or dies due to a lack of blood supply), hemiplegia (a condition characterized by weakness or paralysis affecting one side of the body), and aphasia (language disorder that affects a person's ability to communicate or speak). During a review of Resident 1's Minimum Data Set (MDS - federally mandated resident assessment tool), dated 7/5/25, the MDS indicated Resident 1 had a moderate cognitive impairment and had difficulty speaking but used a phone for communication. During a record review of Resident 3's FS, the FS indicated Resident 3 was admitted to the facility in early 2021 with diagnoses which included schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), dementia (term describing a decline in mental ability severe enough to interfere with daily life), psychotic disturbance (collection of symptoms that affect the mind, where there has been some loss of contact with reality). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had severe cognitive impairment. During an interview on 7/24/25 at 1:30 p.m. with the Social Services Director (SSD), the SSD indicated Resident 1 and Resident 3 were involved in a resident-to-resident altercation on 7/21/25 at approximately 8:30 p.m. when Resident 1 was in his wheelchair near the medication cart while Licensed Nurse 5 (LN 5) was passing medications inside one of the resident rooms. The SSD indicated Resident 3 attempted to get at the pitcher of juice that was on top of the medication cart. When Resident 3 attempted to grab the pitcher of juice, Resident 1 tried to prevent Resident 3 from grabbing the pitcher of juice on top of the medication cart. There was yelling between the two residents and LN 5 went out of the room and found Resident 3 hit Resident 1 with his fist hitting him at the left side of his head. During an interview on 7/24/25 at 1:32 p.m. with the SSD, the SSD indicated Resident 3 was ambulatory and had been known to walk from one nursing station to the next and went in and out of other resident's room searching for food and grabbing the pitcher of juice on the medication cart. The SSD stated Resident 3 could be hostile at times when you redirect him. Because of the incident that occurred on 7/21/25, both Resident 1 and Resident 3 were sent to the acute hospital emergency room (ER) for evaluation. During a concurrent observation and interview on 7/24/25 at 1:40 p.m. with Resident 1, Resident 1 was found sitting in his wheel chair, appeared alert and oriented and responded when name was called out. Resident 1 had difficulty in speaking but was capable of answering yes or no by nodding or shaking his head to indicate yes or no. Resident 1 nodded yes when asked if he was hit on the left side of face and pointed towards the left side of his face near the eye socket. During an interview on 7/24/25 at 2 p.m. with LN 1, LN 1 stated that Resident 1 had a right sided weakness, alert and oriented and had difficulty speaking. LN 1 indicated she was aware Resident 1 was hit on the left side of his face by Resident 3. LN 1 described Resident 3 was ambulatory and confused and he had behaviors of wandering to other nursing units and going in and out of other residents rooms. LN 1 indicated Resident 3 would steal food and snacks and tried to get into the juice pitchers that were on top of the medication carts. Resident 3 could be redirected at times but other times he could get hostile and postures like he would hit you. During an interview on 7/24/24 at 2:45 p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 indicated Resident 1 was quiet in his wheelchair and was cooperative with care and Resident 3 was confused and difficult with care. CNA 1 stated, [Resident 3] goes to different nursing stations and goes to other residents rooms in search of food. He would help himself to the pitcher of juice on the medication cart. CNA 1 indicated she and the other CNAs would attempt to redirect him sometimes but other times Resident 3 would wave his arms around in a menacing manner like he would hit you. During an interview on 7/24/25 at 3 p.m. with Resident 2, Resident 2 stated he was familiar with Resident 3's behavior going in and out of other resident's rooms searching for food and he had observed Resident 3 attempt to get into the medication carts' pitcher of juice. Resident 2 indicated staff would try to redirect Resident 3 but Resident 3 became hostile and aggressive towards the staff.During a record review of Resident 3's Psychiatry Consultation report follow up, dated on 7/7/25, the report indicated: . PERCEPTUAL DISORDERS: No perceptual disorder noted .THOUGHT CONTENT: No mania (state of abnormally elevated or irritable mood, accompanied by increased energy and activity), no psychosis

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure physician's order was followed in accordance with the professional standards of practice for one of three sampled residents (Resident 3), when the physician was not notified of Resident 3's blood sugar level. This failure had the potential for Resident 3 to receive inaccurate and inadequate care.During a record review of Resident 3's Face Sheet (FS), the FS indicated Resident 3 was admitted to the facility in early 2021 with diagnoses which included diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), dementia (term describing a decline in mental ability severe enough to interfere with daily life), psychotic disturbance (collection of symptoms that affect the mind, where there has been some loss of contact with reality). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had severe cognitive impairment. During a review of Resident 3's Order Summary Report (OSR), the OSR indicated Resident 3 had multiple insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) orders to treat and control his blood sugars. The OSR, dated 2/17/25, indicated a physician order, .insulin Lispro [a fast-acting insulin analog used to manage blood sugar levels in individuals with diabetes] as per sliding scale (based on the blood sugar value the dosage of insulin to be given) a sliding scale value 401 plus give 5 units of insulin and call MD (physician), with meals and at HS (hour of sleep).During a review of Resident 3's Electronic Medication Administration Record (eMAR), dated 7/11/25, the eMAR indicated Resident 3's blood sugar was 411 and the nurse administered six (6) units of Lispro insulin. The nursing progress notes and eMAR had no indications the physician was notified of the blood sugar value of 411 as directed in the physician's orders.During a concurrent interview and record review of Resident 3's eMAR with Licensed Nurse 4 (LN 4), LN 4 confirmed the nurse failed to notify the MD at 5 p.m. of the blood sugar value of 411. LN 4 indicated the nurse did not follow the physician's order, and stated, The expectations were the licensed nurse taking care of the resident were to follow the physician's orders as written.A policy and procedure on following MD orders was requested from the Assistant Director of Nursing (ADON) but none was provided.During a review of the undated document titled, Nursing Practice Act Rules and Regulations, the document indicated, Article 2. Scope of Regulation 2725 (b). The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require substantial amount of specific knowledge of the following: (2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement treatment, disease prevention, or rehabilitative regiment . ordered by and within the scope of licensure of a physician . as defined by Section 1316.5 of the Health and Safety Code. (Nursing Practice Act Rules and Regulations Issued by Board of Registered Nursing 1997 State of California Department of Consumer Affairs. pp. 5).