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	07/29/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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 0558 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 ensure staff answered call lights (device used by residents to signal his or her need for assistance from staff) in a timely manner for three of 4 sampled residents (Resident 3, Resident 4, and Resident 1).These failures had the potential to result in resident's care needs not being met and placed residents' safety at risk. Findings: 1a. A review of the admission Record indicated Resident 3 was admitted last week of July 2025 with diagnoses including acute respiratory failure with hypoxia (lungs unable to get enough oxygen into the blood) and protein calorie malnutrition (the body does not get enough protein and energy to function properly).A review of Resident 3's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 7/30/25 indicated Resident 3 was cognitively intact.A review of Resident 3's physician order dated 7/26/25 indicated Resident 3 had the capacity to make healthcare decisions.In a concurrent observation and interview on 7/29/25 at 12:29 p.m., Resident 3 was lying in bed with the head of the bed elevated and had ongoing oxygen via nasal cannula (a small plastic tube, which fits into the person's nostrils providing supplemental oxygen). Resident 3 stated she needed oxygen all the time. Resident 3 further stated she cannot walk, she had incontinent briefs and when she pressed the call light, she had to wait a long time to be changed. Resident 3 was asked to elaborate the specific time when she had to wait for assistance, resident stated whenever I go [opened bowels or urinated]. 1b. A review of the admission Record indicated Resident 4 was admitted [DATE] with diagnoses including encephalopathy (a condition where the brain is not working properly due to some damage or disease), and cerebrovascular disease (conditions that affect blood flow to the brain).A review of Resident 4's MDS dated [DATE] indicated Resident 4 was cognitively intact, dependent on staff for toileting, personal hygiene, dressing, and bed mobility.A review of Resident 4's physician order dated 7/3/25 indicated Resident 4 had the capacity to make healthcare decisions.In a concurrent observation and interview on 7/29/25 at 12:43 p.m. , Resident 4 was awake and lying in bed. Resident 4 stated sometimes it took 30 minutes for her call light to be answered. Resident 4 further stated it depends on how busy they are out there.1c. A review of the admission Record indicated Resident 1 was admitted [DATE] with diagnoses including fracture of upper of right humerus (upper arm bone), dislocation of right shoulder joint (the head of the upper arm bone comes out of the shoulder socket), and fall.A review of Resident 1's MDS dated [DATE] indicated Resident 1 was cognitively intact, dependent on staff for bed mobility, and required substantial/maximal assistance [staff does more than half of the effort] for toileting, upper and lower body dressing, and personal hygiene.In an interview on 7/29/25 at 2:12 p.m., Resident 1 stated at around 11:30 p.m. last night, she held and pressed the call light for assistance. Resident 1 further stated the staff ignored her call light, and somebody finally came at 11:45 p.m.In an observation conducted on 7/29/25 at 1:47 p.m., there were multiple call lights unanswered in Hall 6.An interview was conducted on 7/29/25 at 3:27 p.m. with the Director of Staff Development (DSD). The DSD stated her expectation was for call light to be answered in a timely manner. The DSD further stated anyone can answer the call light, she told staff do not pass the light, ask resident what they need. The DSD added that timely manner meant that call light should be answered within 2 to 3 minutes.In an interview on 7/29/25 at 3:53 p.m., the Assistant Director of Nursing (ADON) stated 30 minutes was too long for residents to wait for the call light to be answered. The best practice was for staff to ask residents what they needed when they see the call light was on.A review of the facility's policy and procedure revised 10/24/2024 and titled Answering the Call Light indicated, The purpose of this procedure is to ensure timely responses to the resident's requests and needs.If the resident needs assistance, indicate the approximate time it will take for you to respond.If the resident's request requires another staff member, notify the individual.If you are uncertain as to whether or not a request can be fulfilled, or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance.

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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 observation, interview, and record review, the facility failed to ensure services provided meet professional standards of quality for one of 4 sampled residents (Resident 1) when:1. Resident 1's order for the immobilizer sling (a device used to restrict arm and shoulder movement to aid in the healing process after an injury) was not followed; and2. Resident 1's order for supplemental oxygen was not followed and updated according to residents' needs. These failures increased the risk for Resident 1 to experience increased pain, worsening of injury and be given supplemental oxygen that was not needed. Findings:A review of the admission Record indicated Resident 1 was admitted [DATE] with diagnoses including fracture of upper of right humerus (upper arm bone), dislocation of right shoulder joint (the head of the upper arm bone comes out of the shoulder socket), and fall.A review of the Nurses Progress Note dated 7/16/25 indicated, New admit.alert and oriented x3-4.initially admitted to the hospital for a fall. Hospital findings fx [fracture, broken bone] to right humerus (non-operative; med mgmt [medication management]. She has an immobilizer to right humerus and right hand.responses are appropriate. has weakness to all extremities. A review of Resident 1's physician orders dated 7/17/25 indicated:-an order for NWB [non weight bearing] RUE [right upper extremity], Immobilizer sling on shoulder check.every shift; and,-an order for Oxygen at 2L/min [liters per minute, unit of measurement] Via NC [nasal cannula- a small plastic tube, which fits into the person's nostrils providing supplemental oxygen] continuously every shift. A review of Resident 1's Medication Administration Record (MAR) for July indicated licensed nurses were signing both the orders for the NWB RUE, immobilizer sling and the continuous oxygen since 7/17/25 through 7/29/25.A concurrent observation and interview was conducted on 7/29/25 starting at 11:49 a.m. inside Resident 1's room. Resident 1 was lying in bed with her head elevated with a pillow. Resident 1's right upper arm had a band attached to a chest band. Resident 1 had no sling, and her wrist was off the wrist band. Resident 1 stated she did not feel good, and she was in pain. Resident 1 stated she had a fall at home and broke her shoulder, she went to the hospital and there was no surgery done. Resident pointed to the immobilizer and said, was not doing anything for her. There was an oxygen concentrator in the room near the resident's bed, and it was not in use. In a concurrent interview and record review on 7/29/25 at 1:54 p.m. with Licensed Nurse (LN), the LN stated Resident 1 used to receive oxygen. The LN further stated Resident 1 did not use oxygen this morning. The LN reviewed Resident 1's electronic MAR and she confirmed she signed the oxygen order. The LN stated the oxygen order should have been changed. A concurrent observation and interview was conducted on 7/29/25 at 1:56 p.m. inside Resident 1's room with the LN. The LN confirmed Resident 1 had no sling, the wrist was out of the immobilizer, and resident was not on oxygen. Resident 1 stated she only used oxygen 2 or 3 times. The LN stated Resident 1 was admitted with the immobilizer and she asked the physical therapist if Resident 1 can have a sling and she was told Resident 1 would be evaluated first. In an interview on 7/29/25 at 3:08 p.m. , the Physical Therapist (PT) stated she checked on Resident 1 and she confirmed Resident 1 had the immobilizer, she had no sling, and resident's wrist was out of the loop.In an interview on 7/29/25 at 3:53 p.m. , the Assistant Director of Nursing (ADON) stated her expectation was for physician's order to be carried out. The ADON further stated if the order was signed, it should be done. A review of the facility's policy and procedure effective 3/22/2022 and titled, Physician Orders indicated, .Supplies/medications required to carry out the physician order will be ordered.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a call light was within reach for one of 4 sampled residents (Resident 2).This failure had the potential to not meet the needs and placed Resident 2 at risk for safety.Findings: A review of the admission Record indicated Resident 2 was admitted [DATE] with diagnoses including multiple sclerosis (the coating that protects the nerves is damaged which disrupts the communication between the brain and the rest of the body leading to wide range of symptoms) and abnormalities with gait and mobility.A review of Resident 2's Minimum Data Set (MDS- federally mandated resident assessment tool) dated 6/27/25 indicated Resident 2 had moderate cognitive impairment and she was dependent on staff for self-care and bed mobility.A review of Resident 2's care plan initiated 6/26/25 indicated, [Resident 2] is at risk for falls/self-injury r/t [related to] Impaired balance/gait, limited mobility, generalize weakness. The interventions indicated, .Place call light within reach while in bed.A concurrent observation and interview was conducted on 7/29/25 at 12:11 p.m. inside Resident 2's room. Resident 2 was lying in bed. Resident 2's call light was observed hanging from the side of her bed and the call light was not within reach.A concurrent observation and interview was conducted on 7/29/25 at 12:25 p.m., inside Resident 2's room with Certified Nursing Assistant 2 (CNA 2). The CNA 2 confirmed Resident 2's call light was hanging on the side of her bed. In an interview on 7/29/25 at 2:39 p.m., the state surveyor showed the Licensed Nurse (LN) a picture of Resident 2's call light taken at 12:16 p.m. The LN stated, it was not acceptable, the call light should be within reach. The LN further stated Resident 2 had episodes of confusion and she was still able to use her call light.A review of the facility's policy and procedure revised 10/24/2024 and titled, Answering the Call Light indicated, .Ensure that the call light is accessible to the resident when in bed.