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	08/07/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to implement the proper transmission-based precautions (TBP-additional infection control measures used in healthcare settings to prevent the spread of infectious diseases that are transmitted through specific routes) when there was no correct signage posted on the door for one of three sampled residents (Resident 3) who was observed to be positive for Covid-19 (a respiratory illness caused by the SARS-CoV-2 virus). This failure had the potential to increased risk of infection transmission for a facility census of 167 residents.Findings:Resident 3 was re-admitted to the facility in August 2017 with multiple medical diagnoses which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), Type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and pulmonary embolism (a blood clot that blocks and stops blood flow to an artery in the lung). Resident 3 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 12 out of 15 which indicated Resident 3 was moderately impaired.Resident 4 was admitted to the facility in June 2023 with multiple medical diagnoses which included cardiac arrest (a medical emergency that occurs when the heart suddenly stops beating effectively, preventing blood from circulating to the body) and anoxic brain damage (occurs when the brain is deprived of oxygen, leading to cell damage or death). Resident 4 had a BIMS score of 6 out of 15 which indicated Resident 4 was severely impaired.Resident 5 was re-admitted to the facility in April 2024 with multiple medical diagnoses which included chronic respiratory failure with hypoxia (a long-term condition where the lungs cannot adequately oxygenate the blood, leading to low oxygen levels in the body), asthma, and cerebral infarction (a condition where brain tissue dies due to a lack of blood supply). Resident 5 had a BIMS score of 9 out of 15 which indicated Resident 5 was moderately impaired. During an interview on 8/7/25 at 9:24 a.m. with Licensed Nurse (LN) 1, LN 1 stated Resident 3 tested positive for COVID-19 on 7/30/25. Resident 3 was being monitored for ten days, along with her roommates (Resident 4 and Resident 5), who all shared a room in the facility.During a review of Resident 3's physician orders (PO), dated 7/30/25, the PO indicated, Monitor s/s (signs and symptoms) related to COVID positive test .for 10 (ten) days .end date 8/10/25.During a review of Resident 3's care plan (CP), dated 7/31/25, the CP indicated, Resident .risk for .complication of covid 19 illness due to positive covid results. No TBP care plan was implemented.During a review of Resident 4's PO, dated 7/31/25, the PO indicated, Monitor s/s for covid exposure .for 10 (ten) days .end date 8/10/25.During a review of Resident 5's PO, dated 7/31/25, the PO indicated, Monitoring for covid s/s d/t (due to) exposure .for 10 (ten) days .end date 8/10/25.During an observation on 8/7/25 at 9:49 a.m. outside the open doorway of Resident 3's room, there was no droplet precautions (a TBP measure designed to prevent the spread of diseases that are transmitted through respiratory droplets) signage found on the doorway indicating the need to wear a mask. Coughing was heard coming from the room. During a concurrent observation and interview on 8/7/25 at 10:09 a.m. outside the open doorway of Resident 3's room with Phlebotomist (PHL) 1, PHL 1 stated he was about to enter Resident 3's room without wearing an N95 (a disposable face mask that covers the user's nose and mouth which offers protection from small solid or liquid droplets found in the air). PHL 1 stated he was in the facility to draw blood from Resident 3 for a physician ordered laboratory test. When PHL 1 was asked what signage he would expect to see posted on the door for a resident with COVID-19, PHL 1 stated, Droplet. PHL 1 verified there was no signage indicating HCP should wear a mask when entering the room. When PHL 1 was asked what type of mask he would wear for a resident with COVID-19, PHL 1 stated, An N95. When PHL 1 was asked if Resident 3 had COVID-19, PHL 1 stated, I don't know if she has Covid (COVID-19), but I try to read the sign on the door first. During a concurrent observation and interview on 8/7/25 at 10:16 a.m. outside the open doorway of Resident 3's room with Certified Nursing Assistant (CNA) 1, CNA 1 verified there was no signage indicating HCP should wear a mask before entering the room. CNA 1 further stated it was unsafe for staff, family members, or other residents that a sign wasn't posted and it could lead to an outbreak.During a subsequent observation and interview on 8/7/25 at 10:49 a.m. outside the open doorway of Resident 3's room with LN 1, LN 1 verified there was no signage indicating HCP should wear a mask before entering the room. LN 1 stated anyone who doesn't know the resident wouldn't know to wear an N95. LN 1 further stated the infection could spread to other residents and staff potentially leading to an outbreak. During an observation and interview on 8/7/25 at 11:00 a.m. outside the open doorway of Resident 3's room with Infection Preventionist (IP), the IP verified

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to provide a call light within reach for two of five sampled residents (Resident 1 and Resident 2). This failure had the potential to result in unmet care needs and compromise the residents safety.Findings:Resident 1 was admitted to the facility in June 2025 with multiple medical diagnoses including multiple sclerosis (MS-a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), muscle weakness, and need for assistance with personal care. Resident 1 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 9 out of 15 which indicated Resident 1 was moderately impaired.Resident 2 was admitted to the facility in May 2022 with multiple medical diagnoses including cerebral infarction (a condition where brain tissue dies due to a lack of blood supply) affecting the left side, muscle weakness, and dysphagia (difficulty or inability to swallow). Resident 2 had a BIMS score of 6 out of 15 which indicated Resident 2 was severely impaired. During a concurrent observation and interview on 8/7/25 at 11:47 a.m. with Resident 1 in Resident 1's room, Resident 1's call light was out of reach of Resident 1. When Resident 1 was asked where her call light was, Resident 1 stated, I don't even see the button right now. There's a pillow. Resident 1 was observed moving her arms with profound jerky movements while she attempted to move the pillow and access her call light. After a few minutes of trying, Resident 1 stated she was unable to reach the call light. During a concurrent observation and interview on 8/7/25 at 12:03 p.m. with Resident 1 and Certified Nursing Assistant (CNA) 2 in Resident 1's room, CNA 2 confirmed Resident 1's call light was out of reach. CNA 2 stated Resident 1's call light should be within reach so that she could call for help anytime. When Resident 1 was asked if she would like to have her call light where she could reach it, Resident 1 stated, Yes, that would be nice.During a concurrent observation and interview on 8/7/25 at 12:13 p.m. with Licensed Nurse (LN) 2, LN 2 confirmed Resident 1's call light was out of reach. LN 2 stated the call light should be within reach.During a concurrent observation and interview on 8/7/25 at 1:26 p.m. with Resident 2 in Resident 2's room, Resident 2's call light was in a drawer out of reach. When Resident 2 was asked to push the call light button to request staff, Resident 2 stated, I don't know where it is. I don't have it. During a concurrent observation and interview on 8/7/25 at 1:38 p.m. with LN 1 and CNA 3 in Resident 2's room, both LN 1 and CNA 3 stated Resident 2's call light was out of reach in the drawer of his bedside table. Both LN 1 and CNA 3 stated the call light should be within reach of the resident to obtain help when needed. During an interview on 8/7/25 at 3:24 p.m. with Administrator (Admin), the Admin stated it was the expectation to always have call lights within reach while residents are in bed, unless staff were assisting the resident. The Admin further stated without a call light within reach, non-verbal residents would not be able to call out for help or alert staff. The Admin then stated verbal residents would have to shout out for staff assistance, which would be undignified. During a review of Resident 1's care plan (CP), dated 6/26/25, the CP indicated, [Resident 1] is at risk for falls/self-injury r/t (related to) impaired balance/gait, limited mobility, generalize weakness .Place call light within reach while in bed & place all necessary personal items .within reach.During a review of Resident 2's CP, dated 6/13/22, the CP indicated, [Resident 2] is high risk for falls/self injury r/t deconditioning, gait/balance problems, weakness .had a HX (history) of fall .Be sure the resident's call light is within reach. During a review of the facility's policy and procedure titled, Answering the Call Light, dated 10/24/24, indicated, Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.