

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Windsor Elmhaven Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6940 Pacific Avenue Stockton, CA 95207	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>47046</p> <p>Based on interview and record review, the facility failed to ensure that 1 of 37 sampled residents (Resident 30) was free from verbal abuse by facility staff when Certified Nursing Assistant (CNA) 7 called Resident 30 derogatory names.</p> <p>This failure caused an unsafe environment for Resident 30 in the facility, made her feel uncomfortable, and resulted in psychosocial distress.</p> <p>Findings:</p> <p>Review of a facility reported incident received on 7/18/24, indicated, .RESIDENTS . [Resident 30] .Alleged Perpetrator . [CNA 7] . Date of Alleged Event: 07/13/2024 . Resident reported to social services that CNA was harassing her verbally .</p> <p>A review of Resident 30's Admission Record indicated Resident 30 was admitted in early 2024 and had diagnoses that included diabetes mellitus (inadequate control of blood sugar levels in the body), anxiety, and depression.</p> <p>A review of Resident 30's Minimum Data Set (MDS, an assessment and care screening tool) dated 7/2/24, indicated Resident 30 had the ability to understand and be understood by others with an intact memory and a Brief Interview for Mental Status (BIMS) score of 15 (The BIMS assessment uses a points system that ranges from 0 to 15 points. 13 to 15 points suggests that memory is intact).</p> <p>During an interview on 7/29/24, at 3:24 p.m., with Resident 30, Resident 30 stated on 7/11/24 her blood sugar was low, and she was very hungry. Resident 30 explained her assigned nurse was going to bring a sandwich for her but after waiting for a long time, Resident 30 called the front desk for help. Staff at the front desk paged overhead for someone to assist Resident 30. Resident 30 further explained CNA 7 came up to her bed and was upset because CNA 7 was on break and had to bring a sandwich for her. Resident 30 stated CNA 7 threw the sandwich on her table.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 7/31/24 at 4:27 p.m. with Resident 30, Resident 30 stated on 7/13/24, CNA 8 was pushing her in her wheelchair to the activity room and CNA 7 was in the hallway outside the activity room. Resident 30 stated CNA 7 called her a [derogatory name]. Resident 30 explained later in the day on 7/13/24, CNA 7 was in her shared bathroom (the bathroom shared with the room next door) with the bathroom doors open and was talking to the residents in the other room and said, those two [derogatory term] are liars. Resident 30 stated CNA 7 made the comment towards her and her roommate and she was very upset about the comment made by CNA 7. Resident 30 was observed to be crying during the interview. Resident 30 stated she did not feel safe in the facility.</p> <p>During an interview on 8/1/24 at 2:12 p.m. with Resident 77 (Resident 30's roommate), Resident 77 confirmed CNA 7 said those two [derogatory term] are liars on 7/13/24. Resident 77 stated CNA 7 made the comment toward her and her roommate, Resident 30. Resident 77 also stated she was upset and sad but she did not report the incident to management at that time. Resident 77 further stated she told the Social Services Director (SSD) about the incident later when the SSD came to interview her on, or around, 7/17/24.</p> <p>During an interview on 7/31/24 at 8:59 a.m., CNA 8 confirmed CNA 7 called Resident 30 a [derogatory term]. CNA 8 stated when CNA 7 made the comment she was pushing Resident 30's wheelchair to the activity room and confirmed CNA 7 was in the hallway outside the activity room.</p> <p>During an interview with the Administrator (ADM) on 7/31/24, at 7:57 a.m., the ADM stated the Director of Nursing (DON) called her on Saturday and told her about the comment CNA 7 made towards Resident 30 and was confirmed by CNA 8.</p> <p>A review of Resident 30's Activities note dated 7/17/24, indicated, .Staff to resident verbal abuse allegation. Day one: A.D. [Activity Director] spoke with [Resident 30] regarding staff to resident verbal abuse allegation. [Resident 30] was very upset and expressed feeling harassed and unsafe. A.D. informed [Resident 30] that the employee was not in the building and reassured her that she is safe in the facility .Activities to continue to visit [Resident 30] to make sure she feels safe and supported emotionally .</p> <p>A review of Resident 30's Social Services note dated 7/17/24, indicated, .Psychosocial well-being f/u [follow up] day #1: SS (Social Services) met with pt [Patient- Resident 30] to f/u on alleged verbal abuse incident . Patient mentioned that she does not feel safe when that certain staff member [CNA 7] is around .</p> <p>A review of Resident 30's care plan initiated on 7/17/24, indicated, .Resident [Resident 30] with potential/risk to exhibit Psycho-social distress related to abuse allegation. Resident reported alleged verbal harassment from staff member that occurred on 7/13/24 .</p> <p>During an interview on 8/1/24 at 1:19 p.m. with the DON, the DON stated facility staff should treat all residents with respect and dignity. The DON also stated all residents should be free from verbal and physical abuse. The DON further stated all the residents should feel safe in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure titled Abuse Prohibition Policy and Procedure dated 2/23/21, indicated, .Healthcare Centers prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents .Verbal Abuse is any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to patients or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability .The Center Executive Director, or designee, is responsible for operationalizing policies and procedures that prohibit abuse .</p> <p>During a review of the facility's policy and procedure titled, Resident Rights revised December 2021, indicated, .Employees shall treat all residents with kindness, respect and dignity .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .be free from abuse .</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>47046</p> <p>Based on interview and record review, the facility failed to implement its abuse policy for one resident (Resident 30) who alleged verbal abuse by a staff member, in a sample of 37, when the facility did not initiate a timely investigation of the alleged verbal abuse incident which occurred on 7/13/24, and did not send the results of the investigation to the Department within five working days of the incident.</p> <p>This failure placed Resident 30 and other residents in the facility at risk for unidentified abuse and hindered protection from potential ongoing abuse.</p> <p>Findings:</p> <p>Review of a facility reported incident received on 7/18/24, indicated, .RESIDENTS . [Resident 30] .Alleged Perpetrator . [Certified Nursing Assistant-CNA 7] . Date of Alleged Event: 07/13/2024 .Resident reported to social services that CNA was harassing her verbally .</p> <p>The Department had not received an investigative summary from the facility by the time an on-site visit was made on 7/29/24, 16 days after the alleged incident on 7/13/24.</p> <p>A review of Resident 30's Admission Record indicated Resident 30 was admitted in early 2024, with diagnoses including depression and anxiety.</p> <p>A review of Resident 30's Minimum Data Set (MDS, an assessment and care screening tool) dated 7/2/24, indicated Resident 30 had the ability to understand and be understood by others with an intact memory and a Brief Interview for Mental Status (BIMS) score of 15 (The BIMS assessment uses a points system that ranges from 0 to 15 points. 13 to 15 points suggests that cognition is intact).</p> <p>During an interview on 8/1/24 at 3:03 p.m. with the Administrator (ADM), the ADM could not locate the 5-day follow-up investigation into the alleged abuse incident. The ADM confirmed the facility had not reported the results of its investigation into the allegation of Resident 30's abuse within 5 working days to the Department.</p> <p>A review of the facility's policy and procedure titled Abuse Prohibition Policy and Procedure dated 2/23/21, indicated, .The Center Executive Director, or designee, is responsible for operationalizing policies and procedures that prohibit abuse . initiate an investigation within 2 hours of an allegation of abuse .the investigation will be thoroughly documented .Report findings of all completed investigation within five (5) working days to the Licensing District Office [the Department].</p>		