

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 10/22/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>47046</p> <p>Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of needs for 1 of 9 sampled residents (Resident 1) when Resident 1's call light (a device used to call for assistance) was not within reach.</p> <p>This failure had the potential to result in Resident 1 being unable to ask for needed assistance and placed Resident 1's safety at risk.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility with multiple diagnoses which included Encephalopathy (a disease in which the functioning of the brain is affected) and Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body).</p> <p>During an observation on 10/18/24, at 11:22 a.m., in Resident 1's room, Resident 1 was observed laying in his bed with no call light visible. Resident 1 was screaming for help.</p> <p>During a concurrent observation and interview on 10/18/24, at 11:30 a.m., with Licensed Nurse (LN) 1 in Resident 1's room, LN 1 confirmed Resident 1's call light was on the floor and out of reach. LN 1 stated when Resident 1's call light was not within reach, Resident 1 would not be able to call for assistance. LN 1 also stated Resident 1 could fall while trying to reach out to staff.</p> <p>During an observation on 10/22/24, at 11:30 a.m., in Resident 1's room, Resident 1 was observed laying in his bed and screaming for help. Resident 1's call light was hanging on the tube feeding pump pole and was not within reach.</p> <p>During a concurrent observation and interview on 10/22/24, at 11:37 a.m., with LN 2 in Resident 1's room, LN 2 confirmed Resident 1's call light was hanging on a pole and was out of reach. LN 2 stated when Resident 1's call light was not within reach, Resident 1 would not be able to call for assistance and facility staff would not be able to meet Resident 1's needs. LN 2 also stated Resident 1 could fall.</p> <p>During an interview on 10/18/24 at 4:20 p.m. with the Assistant Administrator (AADM), the AADM stated, residents should have access to their call light. The AADM also stated if the call light was not within reach of Resident 1, he would not be able to call for help.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's Care plan initiated on 5/8/24, indicated, . [Resident 1] had an unwitnessed fall . Interventions .Remind resident to use call light for assistance .</p> <p>A review of the facility's policy and procedure (P&P) titled, Answering the Call Light, undated, indicated, .The purpose .is to ensure timely responses to the resident's requests and needs .Ensure that the call light is accessible to the resident when in bed .</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47046</p> <p>Based on observation, interview, and record review, the facility failed to provide one of nine sampled residents (Resident 1) with twice weekly scheduled bathing.</p> <p>This failure had the potential to negatively impact Resident 1's personal hygiene and psychosocial well-being as well as promote infection.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated, Resident 1 was admitted to the facility with multiple diagnoses which included Encephalopathy (a disease in which the functioning of the brain is affected) and Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body).</p> <p>A review of Resident 1's Minimum Data Set (MDS, an assessment and care screening tool) the functional status section of MDS dated [DATE], indicated Resident 1 was dependent on facility staff for his personal hygiene and showers/bathing.</p> <p>During a concurrent observation and interview on 10/18/24 at 11:22 a.m. with Resident 1, Resident 1 was observed lying in bed on his back. Resident 1 stated, he had not been getting his scheduled showers. Resident 1 stated he had been itching all over his body and he had rashes on his body.</p> <p>During an interview on 10/18/24, at 11:22 a.m., Resident 1 stated, his scheduled shower days were Tuesday and Friday in the evening. Resident 1 stated, he was supposed to get a shower Tuesday (10/15/24) but was not provided one. Resident 1 also stated, staff did not inform him that he would not receive a shower. Resident 1 explained that he had not gotten a shower twice a week for more than two months. Resident 1 stated, over a four-week period, he did not receive a shower, but he received bed baths approximately three times out of eight scheduled shower days. Resident 1 stated, when a shower was not provided, he started to feel uncomfortable. Resident 1 also stated he had been sweating and had rashes on his body.</p> <p>During an interview on 10/22/24, at 4:48 p.m., Certified Nursing Assistant (CNA) 5 stated, Resident 1 had not refused personal care. CNA 5 checked the shower sheet schedule and confirmed Resident 1's shower was scheduled for Tuesday and Friday evenings. CNA 5 stated, she used the printed shower schedule sheet located at the nurses' station to confirm who was scheduled for a shower on which day. CNA 5 explained staff always documented on scheduled shower days that the resident either received a shower, bed bath, or refused.</p> <p>During an interview on 10/23/24, at 1:43 p.m., CNA 7 stated, Resident 1 had not refused personal care. CNA 7 stated, she did not provide a shower to Resident 1 because she needed three to four CNAs to take Resident 1 to the shower room. CNA 7 also stated she did not offer Resident 1 a shower. CNA 7 explained staff always document on shower sheets, either a shower or bath occurred or was refused. CNA 7 further explained not applicable was documented when a resident was unavailable, either not in their room or at an appointment.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/23/24, at 3:10 p.m., CNA 8 stated Resident 1 did not refuse personal care and he liked to take a shower. When asked if Resident 1 preferred a shower or bed bath, CNA 8 stated, Resident 1 preferred a shower. CNA 8 stated staff always document on scheduled shower days, either a shower or bath occurred or was refused. CNA 8 also stated she gave Resident 1 a bed bath on 10/1/24 but documented shower by mistake.</p> <p>Review of Resident 1's [Resident 1] Task: Bathing, from 9/23/24 to 10/23/24, indicated, Resident 1 received a bed bath/sponge bath on 9/24/24 (Tuesday), 10/4/24 (Friday), 10/7/24 (Monday), 10/9/24 (Tuesday), and 10/18/24 (Friday). Not applicable was documented on 9/27/24 (shower day), 10/11/24 (shower day), 10/15/24 (shower day), and 10/23/24 (not a scheduled shower day). No other documentation occurred for the month of October 2024.</p> <p>During an interview on 10/24/24, at 3:10 p.m., CNA 8 explained, not applicable was documented when it was not a resident's scheduled shower day.</p> <p>During a concurrent interview and record review on 10/18/24, at 3:02 p.m. with the Medical Record Director (MRD), Resident 1's shower sheets (completed by the certified nurse assistants) for the months of September and October were reviewed with the MRD. The MRD provided three shower sheets for the month of September (9/6/24, 9/7/24 and 9/24/24) and four shower sheets for the month of October (10/1/24, 10/4/24, 10/7/24 and 10/15/24). The MRD confirmed there were no other shower sheets available.</p> <p>During an interview on 10/18/24 at 4:20 p.m. with the Assistant Administrator (AADM), the AADM stated residents should receive showers or bed baths at least two times a week, preferably a shower or at least a bed bath if the resident refused a shower.</p> <p>A review of Resident 1's ADL care plan, dated 1/31/24, indicated, Resident [Resident 1] is dependent for ADL [Activities of Daily Living] care in bathing, grooming, personal hygiene .Requires assistance with . bathing/shower .</p> <p>A review of a facility policy titled Bath, Shower/ Tub, revised February 2018, indicated, .The purposes for this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin .</p> <p>A review of the facility policy titled Activities of Daily Living (ADLs), Supporting revised March 2018, indicated, .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain .grooming and personal and oral hygiene .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .including appropriate support and assistance with .Hygiene (bathing, dressing, grooming, and oral care) .</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>47046</p> <p>Based on observation, interview, and record review, the facility failed to provide services that meet professional standards of quality for one of nine sampled residents (Resident 1) when Certified Nursing Assistant (CNA) 3 applied a discontinued, prescription (ordered by a physician) cream on Resident 1.</p> <p>These failures decreased the potential to provide safe, effective care and services to Resident 1.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated, Resident 1 was admitted to the facility with multiple diagnoses which included Encephalopathy (a disease in which the functioning of the brain is affected) and Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body).</p> <p>1. During a concurrent observation and interview on 10/18/24 at 11:30 a.m. with CNA 3, CNA 3 was observed holding a medication cup with white cream in it. CNA 3 stated the cream was given to him by Licensed Nurse (LN) 1 and he was instructed to apply the cream on Resident 1's back, arms, and legs.</p> <p>During an interview on 10/18/24 at 11:39 a.m., CNA 3 confirmed he put the cream on Resident 1's shoulders, upper back, arms, and legs.</p> <p>During an interview on 10/18/24 at 11:53 a.m. with LN 1, LN 1 confirmed she gave the cream to CNA 3 to apply to Resident 1. When asked which cream she gave to CNA 3, LN 1 took the cream out of the treatment cart and stated the cream was Clotrimazole and Betamethasone (a medication applied to the skin that works by killing fungus and reducing redness, swelling, itching).</p> <p>A review of Resident 1's Treatment Administration Record (TAR) for 9/2024 and 10/2024, indicated there was no order for Clotrimazole and Betamethasone cream.</p> <p>A review of Resident 1's Order Summary Report indicated the Clotrimazole and Betamethasone cream was ordered on 6/21/24 and was to be applied twice a day for 30 days with a discontinued date of 7/22/24.</p> <p>During a concurrent interview and record review on 10/18/24, at 12:14 p.m., with the Treatment Nurse (TN), Resident 1's physician orders were reviewed. The TN confirmed there was no active order for Clotrimazole and Betamethasone cream. The TN stated the nurse should not have used the discontinued cream for Resident 1. The TN explained the licensed nurses were responsible for applying prescription ointment on residents, not CNAs.</p> <p>During an interview on 10/18/24 at 4:20 p.m. with the Assistant Administrator (AADM), the AADM stated nurses should look at the orders before administering a medication. The AADM explained the discontinued medications should have been taken out of the treatment cart. The AADM stated all medications including topicals (medications applied on the surface of the body) should be administered by licensed personnel to prevent potential harm to residents.</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a Facility document titled, Certified Nursing Assistant Job description for Long-Term Care Facilities, did not indicate that applying prescription cream on residents was in a CNAs' job description.</p> <p>During a review of facility's policy titled, Administering Medications, revised April 2019, indicated, . Medications are administered in a safe and timely manner, and as prescribed .Only persons licensed or permitted by this state to .administer .medication .Medications are administered in accordance with prescriber orders .the individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication .Topical medications .are recorded on the resident's treatment record (TAR) .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47046</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe infection prevention and control practices were implemented for one of 9 sampled residents (Resident 7) when three bedpans (a container used to collect urine or feces, and it is shaped to fit under a person lying or sitting in bed) in Resident 7's shared bathroom, were soiled and unlabeled with a resident name and were left on the floor in a plastic storage basket.</p> <p>These deficient practices could contribute to the spread of infection.</p> <p>Findings:</p> <p>1. During an observation on 10/17/24 at 2:47 p.m., in Resident 7's shared bathroom (shared with Resident 3), two grey colored and one pink used and soiled bedpans with no resident name were observed in a black storage basket on the floor.</p> <p>During a concurrent observation and interview on 10/17/24 at 10:30 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 confirmed the bedpans in Resident 7's shared bathroom were used, soiled, and did not have a name or other resident identifier placed on the bedpans. CNA 1 stated all soiled bedpans should have been cleaned after use and should have a resident identifier placed on the bedpans. CNA 1 stated staff were responsible to clean all bedpans. CNA 1 also stated that the risk of leaving soiled bedpans without a name in a shared bathroom was the spread of infection. CNA 1 further stated the bedpans could have been used for a resident that they did not initially belong to.</p> <p>During an interview on 10/18/24 at 3:14 p.m., with Resident 7, Resident 7 stated that she bought those three bedpans because the facility only had small bedpans. Resident 7 also stated CNAs placed the bedpans in the bathroom after she used them.</p> <p>During an interview on 10/18/24 at 4:20 p.m., with the Assistant Administrator (AADM), the AADM stated his expectation was that the bedpans should have been cleaned once used and labeled with a resident's name or room number. AADM also stated staff were responsible for cleaning used and soiled bedpans. The AADM stated this practice could be a source of infection.</p> <p>During an interview on 10/22/24 at 12:45 p.m. with the Infection Preventionist (IP), the IP stated the bedpans should be cleaned after use and should be labeled with a room number to prevent the spread of infection.</p> <p>A review of the facility's policy and procedure (P&P) titled, Bedpan/Urinal, Offering/Removing, revised February 2018, indicated, .Clean the bedpan or urinal. Wipe dry with a clean paper towel .Do not leave it in the bathroom or on the floor .</p>		