STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055735	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Elmhaven Care Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50598 Based on interview and record review, the facility failed to ensure care provided to one of three sampled residents (Resident 1) met professional standards when, Resident 1's medication ordered upon discharge from the hospital, insulin lispro (fast acting insulin to control the levels of sugar in the blood), was not continued at the skilled nursing facility upon admission. This failure had the potential for Resident 1 to have complications related to high blood sugar (normal fasting blood sugar range is 70 to 100). Findings: A review of Resident 1's admission documents indicated, Resident 1 was admitted to the facility with a diagnosis of dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a concurrent interview and record on 2/6/25 at 9:04 AM, Resident 1's untitled discharge documents from the hospital, dated 1/29/25, and Resident 1's clinical record was reviewed with Licensed Nurse (LN) 1. LN 1 confirmed Resident 1's discharge paperwork from the hospital indicated the following, .Take these medications .CONTINUE [insulin lispro] Mix 50/50 .CONTINUE [insulin lispro] Mix 75/20 .30 unit(s) 3 times a day .NEW [insulin lispro] Mix 75/25 .40 unit(s) .2 times a day .C/w [consistent with] home dose insulin . LN 1 confirmed Resident 1's Medication Administration Record (MAR), dated 1/2025, did not include orders for Resident 1's insulin lispro 50/50 and insulin lispro 75/25. LN 1 reviewed multiple areas in Resident 1's clinical record to assess if the orders were misplaced in which LN 1 had no success. LN 1 stated she was unable to find any documentation to support administration of Resident 1's insulin. LN 1 stated the insulin medication for Resident 1 should have been ordered and on the MAR. During a concurrent interview and record review with LN 1 on 2/6/25 at 9:34 AM, LN 1 stated the admitting nurse should have checked all the orders with the MD and made sure all the orders were inputted into the computer. LN 1 stated it was important for residents to receive their ordered medication and missing the insulin order placed Resident 1 at risk for a stroke (damage to the brain from interruption of its blood supply, a medical emergency), elevated blood sugar, and they could lose consciousness. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the Director of Nursing (DON) on 2/6/25, at 10:10 AM, the DON reviewed Resident 1's clinical record and confirmed that the facility did not transcribe the orders from the discharging hospital correctly and left out the insulin lispro mix 50/50 and insulin lispro mix 75/25 orders. The DON stated the practice did not meet her expectations and was not the facility's practice. The DON stated she expected all orders that were to be continued from the hospital to have been carried over and continued at the facility. During an interview with Resident 1's Medical Doctor (MD) on 1/6/25, at 12:54 PM, the MD stated she did not authorize Resident 1's insulin lispro 50/50 and insulin lispro 75/25 insulin to be discontinued. The MD stated Resident 1 was supposed to continue the ordered insulin when discharged from the hospital to the skilled nursing facility. A review of facility policy and procedure titled, Physicians Orders, dated 3/22/22, indicated, .This will ensure all physicians orders are complete and accurate .The Medical Records Department will verify that all physicians' orders are complete, accurate, and clarified as necessary .