

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 05/27/2025
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47369</p> <p>Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) was free from physical abuse when Resident 2 was alleged to have hit Resident 1 on the chin and stomach on 3/16/25 and was witnessed hitting Resident 1 on the face on 4/1/25.</p> <p>This failure caused Resident 1 to suffer emotional distress and had the potential to negatively affect her physical and psychosocial wellbeing.</p> <p>Findings:</p> <p>A review of Resident 1 ' s ADMISSION RECORD, indicated, she was admitted to the facility with diagnoses that included dementia (condition characterized by memory disorders, personality changes, and impaired reasoning).</p> <p>A review of Resident 1 ' s Brief Interview for Mental Status [BIMS], (a tool used to screen for cognitive impairment that uses a points system with ranges from 0 to 15 points: 0 to 7 points suggests severe cognitive impairment, 8 to 12 points suggests moderate cognitive impairment, 13 to 15 points suggests that cognition is intact) dated 2/21/25, indicated a score of 1.</p> <p>A review of Resident 1 ' s care plan revised 10/18/21, indicated, The resident has a psychosocial well-being problem r/t [related to] Family discord. Pt has been in abusive relationship for over [AGE] years with spouse .</p> <p>A review of Resident 1 ' s progress notes dated 3/17/25, at 2:38 AM, indicated, Change in Condition Progress Note At approximately 2300 [11 PM on 3/16/25] CNA came to writer and reported that resident in [Resident 3 bed number] reported that he heard his roommate, [Resident 2], have a physical altercation with resident [Resident 1]. [Resident 3] reported that he heard [Resident 1] tell [Resident 2] to stop hitting her. [Resident 3] also reported thathe [sic] heard his roommate [Resident 2] push [Resident 1] around. CNA immediately took [Resident 1] out of [Resident 3's] room. When writer asked [Resident 1] what happened and resident said that [Resident 2] hit her on the chin and stomach.</p> <p>A review of Resident 1 ' s progress notes dated 3/18/25, at 11:11 AM, indicated, Interdisciplinary Care Conference IDT [interdisciplinary team; group of healthcare professionals who assess and coordinate care] team met with resident to discuss the incident of alleged physical altercation staff will monitor both residents to prevent further escalation between both of them.</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>A review of Resident 1 ' s care plan, initiated 3/17/25, indicated, Focus Resident is the victim of a resident to resident alleged physical altercation. The areas titled, Goal and Intervention/Tasks were blank.</p> <p>A review of Resident 1 ' s progress notes dated 4/1/25, at 11:30 PM, indicated, Change in Condition Progress Note At approximately 2010 [8:10PM] station 2 nurse informed writer that resident was on station 1 and 2 ' s phone talking to the police because resident in [Resident 2 bed number] hit her on the right side of her face and head resident was noted on the phone crying while talking to the police holding the right side of her face. Writer asked resident what happened, and resident stated, [Resident 2] hit me on my face. Resident was visibly distressed. Resident in [Resident 4 bed number] was sitting next to resident and state [sic], Yes, I saw him hit her.</p> <p>During an interview on 5/27/25, at 12:38 PM, Licensed Nurse (LN) 2 stated she was at the nurse ' s station on 4/1/25, when Resident 1 and Resident 4 passed her on their way to the lobby. LN 2 further stated Resident 2 came to the nurse ' s station looking for Resident 1. LN 2 stated resident 2 went to the lobby and a few minutes later Resident 1 and Resident 4 hurriedly returned to the nurse ' s station. LN 2 further stated Resident 1 had a large red mark on her face and reported that Resident 2 had hit her. LN 2 stated Resident 1 called the police.</p> <p>During a concurrent interview and record review on 5/27/25, at 2:05 PM, the Social Services Assistant (SSA) stated she was unaware of Resident 1 ' s history of domestic abuse until after the first altercation occurred on 3/16/25. The SSA stated she was unaware of Client 1 ' s active care plan revised 10/18/21, that indicated a history of an abusive spousal relationship. The SSA further stated Resident 1 was placed on one to one observation after the altercation on 4/1/25.</p> <p>During a concurrent interview and record review on 5/27/25, at 3:39 PM, the ADON confirmed Resident 2 ' s electronic health record did not contain documentation after 3/17/25 to indicate he was being monitored by nursing staff due to the alleged altercation. The ADON stated the documentation was important to show that Resident 2 was monitored to prevent another altercation from happening.</p> <p>During a concurrent interview and record review on 5/27/25, at 4:13 PM , the Director of Nurses (DON) stated IDT meetings were held as soon as possible after an incident occurred to determine the residents needs and update the plan of care. The DON confirmed Resident 1 ' s care plan, dated 3/17/25, did not include interventions of monitoring, as indicated in the IDT note, to prevent further altercations.</p> <p>A review of a facility policy titled, Abuse Prevention Program, revised 2016, indicated, Our residents have the right to be free from abuse, neglect, misappropriation of property and exploitation. As part of the resident abuse prevention, the administration will. Protect our residents from abuse by anyone including other residents family members.</p> <p>(continued on next page)</p>		

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