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	08/01/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43943 Based on observation, interview, and record review, the facility failed to ensure 2 of 37 sampled residents (Resident 71 and Resident 100) were treated with dignity when, 1. Dentures were not provided in a timely manner for Resident 71, and; 2. Certified Nursing Assistant (CNA) 4 stood over Resident 100 while assisting him with his meal. These failures resulted in Resident 71 having feelings of sadness, and not wanting to smile due to not having dentures and Resident 100 not receiving his meal with dignity. Findings: 1. A review of Resident 71's clinical record titled, ADMISSION RECORD (a document that contains the resident's demographic information), indicated Resident 71's diagnoses included mild protein - calorie malnutrition and major depressive disorder. During a concurrent observation and interview on 7/29/24, at 2:10 p.m., with Resident 71, Resident 71 was noted to not have teeth. Resident 71 stated she had dentures, and they broke three times. Resident 71 stated someone assessed her dental status approximately 6 months ago and discussed getting dentures, but she had not received an update. Resident 71 stated it had been hard to express herself because she did not want to laugh and show her missing teeth. Resident 71 stated she had wanted dentures, and she was sad that she had not received them. A review of Resident 71's clinical record titled, Progress Notes, dated 9/6/23, at 12:26 p.m., by the Social Services Department, indicated, SS [Social Service] was informed by resident to make a referral for dentures . A review of Resident 71's clinical record titled, Oral Health Care, dated 9/22/23, by the Dentist (DMD), indicated Resident 71 did not have teeth and a Treatment Assessment Referral (TAR - approval from the insurance company to proceed with the recommended treatment plan) was written for full upper and lower dentures. A review of Resident 71's clinical record titled, Oral Health, dated 5/22/24, by DMD, indicated Resident 71 had an approved TAR for full upper and lower dentures. (continued on next page)

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
	055735	A. Building B. Wing	08/01/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/30/24, at 4:45 p.m., with Social Services Director (SSD) 1, SSD 1 stated she was unsure if Resident 71 came to the facility with dentures because it was not listed on the inventory list. SSD 1 stated Resident 71 had the referral for dentures approximately ten months ago and acknowledged ten months was too long to wait for dentures. SSD 1 stated not having teeth or dentures was a dignity issue because Resident 71 did not want to smile. During an interview on 7/31/24, at 12:09 PM, with SSD 2, SSD 2 stated when it was noted Resident 71 wanted dentures, she should have been fitted for dentures as soon as possible. SSD 2 stated when Resident 71's TAR was approved, dentures should have been ordered. During an interview on 7/31/24, at 12:35 p.m., with the Licensed Nurse (LN) 5, LN 5 stated she had noticed that Resident 71 had not liked to smile and acknowledged not having teeth negatively affected Resident 71's dignity. LN 5 stated Resident 71 has had to wait too long for dentures. During an interview on 7/31/24, at 12:44 p.m. with SSD 2, SSD 2 acknowledged Resident 71 requested dentures in September 2023. SSD 2 stated Resident 71 was not treated with dignity when she was not provided dentures in a timely manner. SSD 2 stated she should have followed up on the TAR. During a concurrent interview and record review on 7/31/24, at 12:51 p.m., with the Director of Nursing (DON) and Administrator (ADM), the facility's policy and procedure (P&P) titled, Quality of Life - Dignity, dated 2/2020, indicated, . Residents are treated with dignity and respect at all times . The DON and ADM stated there was a dignity concern for Resident 71 when it came to the delay in the fitting and purchasing of dentures. The DON and ADM stated the P&P was not followed. 49823 2. Resident 100 was admitted to the facility in early 2024 with diagnoses including quadriplegia (the loss of the ability to use ones arms and legs), and fracture of the sixth cervical vertebra (a broken bone in the neck). During an observation in room [ROOM NUMBER] A on 7/31/24 at 7:37 a.m., Certified Nursing Assistant (CNA) 4 assisted Resident 100 with breakfast. CNA 4 was observed to be standing over Resident 100 assisting him with his meal while Resident 100 was in bed. During an interview on 7/31/24 at 9:35 a.m. with CNA 4, CNA 4 was asked how he fed Resident 100. CNA 4 stated that he elevated Resident 100's head of bed and stood next to his bed and fed him. During an interview on 7/31/24 at 9:36 a.m. with LN 3, LN 3 was asked if staff stood or sat while they assisted residents with meals. LN 3 stated that staff sat in chairs. LN 3 stated that if CNAs stood while they assisted residents with meals, it gave the impression the CNA was rushed. During an interview on 7/31/24 at 10:34 a.m. with the DON, the DON stated that the expectation was the resident and the staff assisting the resident were at eye level. The DON stated staff sat at the bedside to assist residents with meals. When asked what the risk was if staff stood while they assisted residents with meals, the DON stated the risks were choking, aspiration (food in the windpipe which can cause choking), discomfort for the resident, and a loss of dignity. (continued on next page)

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	08/01/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of a facility policy and procedure (P&P), revised December 2021, titled, Resident Rights, the P&P indicated, .Employees shall treat all residents with kindness, respect, and dignity .

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	08/01/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 43943 Based on observation, interview, and record review, the facility failed to ensure four of 37 sampled residents had accommodations in place to have their needs met when: 1. Resident 11's call light was not within reach, and 2. Resident 37's side rails were not in the correct position for self-adjustment in bed, and 3. Resident 62's call light was not within reach, and 4. Resident 16's call light was not within reach. These failures could have resulted in injury, loss of physical function, and residents' needs not being met. Findings: 1. A review of Resident 11's clinical record titled, ADMISSION RECORD, (a document that contained the resident's demographic information), indicated Resident 11's diagnoses included respiratory failure (difficulty breathing on your own), heart failure, and muscle weakness. During a concurrent observation and interview on 7/29/24, at 10:08 a.m., with Resident 11, Resident 11 was in her bed with the call light above her head on the right side of the pillow. Resident 11 attempted to reach her call light and her arm was unable to reach above her head. Resident 11 stated she wished the staff would have placed the call light where she could reach it because she did not have full range of motion in her right arm. A review of Resident 11's clinical record titled Section GG - Functional Abilities and Goals (a portion of a comprehensive assessment that indicated Resident 11's functioning of everyday activities), dated, 5/8/24, indicated Resident 11 required moderate to maximum assistance with Activities of Daily Living (ADL - dressing, toileting, eating, standing, walking, and transferring). During a concurrent observation and interview on 7/29/24, at 10:12 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 verified Resident 11 was unable to reach her call light. CNA 1 stated Resident 11 was unable to contact staff in the event of a medical emergency, pain management needs, or any other concerns without her call light. CNA 1 stated the call light should have been within reach of Resident 11. During a follow up interview on 7/29/24, at 10:14 a.m., with Resident 11, Resident 11 stated it made her feel helpless when she could not reach the call light when she needed help to use the bathroom. During an interview on 7/29/24, at 10:15 a.m., with Licensed Nurse (LN) 1, LN 1 verified Resident 11 was unable to reach her call light with it above her head. LN 1 stated Resident 11 was at risk for her needs not being met because Resident 11 was dependent on staff to help her perform her ADLs. (continued on next page)

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	08/01/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 11's clinical record titled, Care Plan (a document that identified goals, problems and interventions), dated 3/5/22, indicated, . Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance . Encourage the resident to use bell to call for assistance . During an interview on 7/31/24, at 9:44 a.m., with the Director of Nursing (DON), the DON stated she expected that all residents had their call lights within reach while in the bed. The DON stated Resident 11's inability to reach the call light was a safety concern because Resident 11 could not reach staff when help was needed. 2. A review of Resident 37's clinical record titled, ADMISSION RECORD indicated Resident 37's diagnoses included muscle weakness, reduced ability to move, abnormalities with walking, and a history of a stroke (lack of oxygen to the brain that resulted in brain damage and a loss of physical function). A review of Resident 37's clinical record titled, Orders, dated 5/30/24, indicated Resident 37's bed was supposed to have both 1/4 (one fourth) upper bed ride rails (bars attached to the upper side of the bed that allows the resident to grab on to for repositioning while in bed) in an accessible position to aid with turning and repositioning while in bed. During an observation on 7/29/24, at 2:35 p.m., Resident 37's 1/4 side rails were incorrectly positioned (per physician's order) in the back position (above the head of the bed and not within reach). During a concurrent observation and interview on 7/29/24, at 2:42 p.m., with the Director of Nursing (DON), the DON confirmed Resident 37's side rails were incorrectly positioned and were not in an accessible position for Resident 37. The DON confirmed the 1/4 upper side rails were supposed to be accessible to enable Resident 37 to assist with repositioning himself in bed to build strength in his arms. During an interview on 7/30/24, at 1:44 p.m., with CNA 6, CNA 6 stated the purpose of the 1/4 side rails was for Resident 37 to be able to grab the bar and adjust himself in bed. During an interview on 7/31/24, at 1:56 p.m., with LN 5, LN 5 stated Resident 37 needed the 1/4 upper side rails in position in order to grab onto during repositioning to maintain his level of functioning and not to regress in his function. During an interview on 7/31/24, at 2:04 p.m., with Restorative Nursing Assistant (RNA) 1, RNA 1 stated the 1/4 upper side rails were important for Resident 37 to have access to because it allowed him to participate in his own care by helping the nursing staff with dressing and turning. RNA 1 stated the nursing staff was supposed to follow the physician's order and have the upper 1/4 side rails within reach. A review of Resident 37's clinical record titled, Braden Scale for Pressure Sore Risk Original (an assessment tool used to determine a resident' risk for developing skin sores), dated 7/9/24, at 7:55 a.m., indicated Resident 37 was at high risk for developing pressure sores partly related to mobility limitations. (continued on next page)

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	08/01/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident' 37's clinical record titled, Section GG (a portion of an assessment that identified functional abilities and goals), dated 7/9/24, indicated Resident 37 needed assistance when turning to the left and right. A review of Resident 37's clinical record titled, Care Plan, dated 7/17/24, indicated, . provide the positioning bar/rail(s) enabler to bed: Upper bilateral quarter - 1/4 Rail. Positioning. Rail(s) is needed or desired for increased mobility and transfers to promote resident independence . During a concurrent interview and record review on 7/31/24, at 2:09 p.m., with the Administrator (ADM), the facility's document titled, Side Rails, dated 12/28/23, was reviewed. The Policy and Procedure (P&P) indicated, . Purpose - to ensure the safe use of side rails as an assistive device, to aid mobility, or to treat medical symptoms . The ADM stated Resident 37 did not have access to his 1/4 upper side rails which limited his ability to assist with repositioning himself. The ADM stated without the use of the 1/4 upper side rails, there were concerns that Resident 37 could have lost the ability he currently had to participate in his care. The ADM stated Resident 37 could have had a loss of dignity without having the ability to participate in his day-to-day care. The ADM stated the facility did not follow the P&P. 47046 3. A review of Resident 62's Admission Record, indicated Resident 62 was admitted to the facility in mid-2024 with diagnoses which included, metabolic encephalopathy (a problem in the brain caused by a chemical imbalance due to an illness or organs that are not working as well as they should) and dementia (loss of memory). A review of Resident 62's Minimum Data Set (MDS, an assessment and care screening tool) dated 5/11/24, indicated Resident 62 had the ability to understand and be understood by others with an intact memory and a Brief Interview for Mental Status (BIMS) score of 14 (The BIMS assessment uses a points system that ranges from 0 to 15 points. 13 to 15 points suggests that memory is intact). During an observation on 7/29/24 at 9:39 a.m., in Resident 62's room, Resident 62 was observed lying in bed with no call light visible. During a concurrent observation and interview, on 7/29/24 at 9:46 a.m., with the Treatment Nurse (TN) in Resident 62's room, the TN confirmed the call light was on the floor and out of Resident 62's reach. The TN stated call lights were to always be within reach of the resident. The TN also stated Resident 62 would not have been able to call for assistance when needed without the call light. The TN further stated Resident 62 was at risk for falls without the call light being within reach to ask for assistance. During an interview on 7/31/24, at 3:12 p.m., with the DON, the DON stated residents should have access to their call light. The DON also stated when the call light was not within reach of the resident, facility staff would not be able to meet the resident's needs. The DON further stated when the call light was not within reach, facility staff may not be able to prevent falls. 50598 (continued on next page)

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	08/01/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. A review of Resident 16's clinical record titled ADMISSION RECORD, indicated Resident 16's admitting diagnoses included, dementia, respiratory failure, heart failure, chronic pain syndrome (pain that lasts over six months), and cerebral infarction (decreased or no blood flow to the brain). During an observation on 7/29/24 at 3:12 PM, Resident 16 was observed yelling Help, Help, Help from her bed in her room. During a concurrent observation and interview on 7/29/24 at 3:14 PM with LN 7, LN 7 confirmed Resident 16's call light was tied to the back of her siderail near the headboard and out of Resident 16's reach. LN 7 released the siderail and tilted the bed frame at the head of the bed to allow Resident 16 full access to the call light. LN 7 stated Resident 16 not having access to her call light placed Resident 16 at risk for falls, and access to immediate care if needed such as difficulty breathing. LN 7 stated that call lights should always be in reach of the resident. During a concurrent interview and record review on 8/1/24 at 11:49 AM with the DON, the DON stated the facility's expectation was for residents to always have their call light in reach. The DON stated the risk of not having their call light in reach included a risk for falling out of bed, not receiving emergency support when needed, and not getting their needs met when there's a need to notify staff. Review of the facilities policy and procedure titled, Answering the Call Light, revised 9/22, indicated, .The purpose of the procedure is to ensure timely response to the resident requests and needs .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 .

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	08/01/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47046 Based on observation, interview, and record review, the facility failed to provide a homelike environment for 1 of 37 sampled residents (Resident 43), when the facility did not ensure Resident 43's personal belongings were stored per the resident's preference. This failure placed Resident 43 at an increased risk for falls/accidents and potentially psychosocial distress. Findings: A review of Resident 43's Admission Record indicated, Resident 43 was admitted in 2020, with diagnoses including Multiple Sclerosis (a disorder marked by weakness, numbness, a loss of muscle coordination, and problems with vision, speech, and bladder control) and repeated falls. A review of Resident 43's Minimum Data Set (MDS, an assessment and care screening tool) dated 6/2/24, indicated Resident 43 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: 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). The functional status section of Resident 43's MDS also indicated Resident 43 required the use of a wheelchair for mobility. During a concurrent observation and interview on 7/29/24 at 10:28 a.m. with Resident 43 in her room, the following items were observed lying on the floor: Resident 43's clothes, four boxes of snacks, a box of water bottles, a box of soft drinks, an opened bag of incontinent pads, two empty cardboard boxes, and other miscellaneous personal items. Resident 43 stated she asked the Activity Director to help her put her belongings into the dresser drawer and closet. Resident 43 stated facility staff informed her they were too busy to assist with her request. During a concurrent observation and interview on 7/29/24, at 10:30 a.m., with Certified Nursing Assistant (CNA) 5 in Resident 43's room, CNA 5 confirmed Resident 43's room was overly cluttered. CNA 5 stated the room being cluttered put Resident 43 at an increased risk for falls. During an interview on 8/1/24 at 9:27 a.m., with the Activity Director (AD), the AD confirmed she was aware Resident 43's room needed to be organized. The AD stated it was a team effort to arrange residents' rooms. The AD further stated, the risk of a cluttered room could be pests, infection control issues, and a fire and safety hazard. During an interview on 8/1/24 at 2 p.m., with the Director of Nursing (DON), the DON stated it was her expectation that residents' rooms should be clutter free to prevent it from being a safety hazard. The DON also stated residents' rooms should provide a home-like environment. (continued on next page)

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	08/01/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy and procedure titled, Homelike Environment, undated, indicated, .Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings .The facility staff and management maximizes, to the extent possible .clean, sanitary and orderly environment .

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	08/01/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 47046 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. This failure caused an unsafe environment for Resident 30 in the facility, made her feel uncomfortable, and resulted in psychosocial distress. Findings: 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 . 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. 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). 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. 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. (continued on next page)

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	08/01/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. 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 . 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 . 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 . 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. 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 . 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 .

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	08/01/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 47046 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 occured on 7/13/24, and did not send the results of the investigation to the Department within five working days of the incident. This failure placed Resident 30 and other residents in the facility at risk for unidentified abuse and hindered protection from potential ongoing abuse. Findings: 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 . 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. A review of Resident 30's Admission Record indicated Resident 30 was admitted in early 2024, with diagnoses including depression and anxiety. 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). 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. 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].

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	08/01/2024

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 50598 Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR- to ensure that individuals with mental illness receive specialized services) Level II (2) was completed for 1 of 37 sampled residents (Resident 89). This failure had the potential for Resident 89 to not receive adequate services to prevent mental health decline. Findings: A review of Resident 89's ADMISSION RECORD indicated Resident 89 was admitted in early 2024 with diagnoses including schizoaffective bipolar disorder (a mood disorder that affects your thoughts, mood, and behavior including hearing and seeing things that are not there), and schizophrenia (a serious mental health condition that affects the way people think and behave). A review of Resident 89's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 2/1/24 indicated, Result of level I screening .Positive . Hx [history] Schizophrenia . The individual has been prescribed psychotropic medication [A psychotropic describes any drug that affects behavior, mood, thoughts, or perception] for mental illness . A review of Resident 89's clinical record revealed a letter from a state agency regarding the PASRR Evaluation II dated 6/19/24 which read, UNABLE TO COMPLETE LEVEL II EVALUATION FOR SERIOUS MENTAL ILLNESS (SMI) . Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening. During concurrent interview and record review of Resident 89's clinical record on 8/1/24 at 12:41 p.m., with the Director of Nursing (DON) and the Social Services Director (SSD) the SSD confirmed the document from the state agency indicated the facility was unable to be contacted for initiation of a PASRR Evaluation II. The SSD stated that she was unaware of how this occurred and stated, it's possible we just missed it. The SSD stated the delay in Resident 89's PASRR Evaluation II placed Resident 89 at risk for not receiving the services needed to meet her mental health needs while in the facility. The DON stated her expectations were for Resident 89 to be adequately evaluated and receive the services needed to best support Resident 89. A review of the facility policy, PASRR Completion Policy .Policy Statement .The center will make sure that all admissions have the appropriate Patient Assessment and Resident Review (PASRR) completed . PRACTICE GUIDELINES: Center Administrator will designate either the Admissions Director or Social Worker to make sure that the PASRR and/or Level of Care (LOC) is done on all potential residents . Administrator will also designate a backup in case the designated person is not available .

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	08/01/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50598 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a document describing agreed goals of care, and outlining planned medical, nursing and health activities for a resident) for 1 of 37 sampled residents (Resident 95) when Resident 95's mobility care plan interventions did not include items to assist Resident 95 to reach the care plan goal of using bedrails for mobility, and there were no bedrails present on Resident 95's bed. This failure placed Resident 95 at risk for loss of independence, falls and injury. Findings: A review of Resident 95's ADMISSION RECORD indicated Resident 95 was admitted to the facility in early 2024 with diagnoses of Acquired Absence of Right Leg Below Knee (surgical removal of right leg below the knee), abnormalities of gait and mobility (unstable when standing), and muscle weakness. During a concurrent observation and interview on 7/29/24, at 11:28 a.m., Resident 95 was observed sitting in her wheelchair next to her bed. Resident 95 mentioned she has requested to staff to have bed rails placed on her bed multiple times since April of this year to help her move around and get out of bed. Resident 95 stated that she expressed her fear of falling and difficulty getting out of her bed with staff. Resident 95 stated she recently had her leg below her knee removed. Review of Resident 95's care plan initiated on 1/4/24 indicated, Focus .Resident/patient requires assistance/is dependent for mobility related to: ACQUIRED ABSENCE OF RIGHT LEG BELOW KNEE .Goal .Resident will utilize 1/4 x [times] 2 bed rail (s); with assistance for turning and repositioning while in bed; transferring to/from bed . In the section titled Interventions, only one intervention was listed which indicated, . Head of bed elevated as a mobility enabler . Resident 95's care plan was last revised on 1/17/24. During a concurrent observation, interview, record review on 7/31/24 at 10:44 a.m., with the Treatment Nurse (TN) and Resident 95, the TN confirmed Resident 95 did not have bed rails on her bed. The TN explained that the bed rails were used to maintain or enhance Resident 95's mobility such as to help the resident sit up on the side of the bed, transfer to the wheelchair, and get back to bed. During the interview with the TN, Resident 95 addressed the TN and stated that she had asked all staff members for bed rails and was told No. Resident 95 stated that she needed them and should have had them on her bed. The TN reviewed Resident 95's mobility care plan, dated 1/4/24, and confirmed that the facility was not in compliance with the care plan. The TN also stated the care plan was not customized to Resident 95's needs and medical diagnoses. (continued on next page)

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	08/01/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/1/24 at 12:12 a.m., with the DON, the DON reviewed Resident 95's mobility care, dated 1/4/24. The DON stated the care plan was not up to facility standards and did not meet her expectations. The DON explained that the care plan was missing important information in the interventions. The DON stated that more interventions needed to be added. The DON confirmed that the facility was not in compliance with this care plan due to Resident 95's bed not having side rails. The DON confirmed that noncompliance with the care plan placed the resident at risk for injury and harm. Review of a facility policy titled CARE PLAN COMPREHENSIVE, dated 8/25/21, indicated, PURPOSE .An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident. The following section titled POLICY indicated, The facilities Interdisciplinary Team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframe's to meet a residents medical, physical and mental and psychosocial needs that are identified in the comprehensive assessment . PROCEDURE .Each resident's comprehensive care plan is designed to: Build the residents individualized needs, strengths, preferences. Build on the resident's individualized needs, strengths, preferences, Reflect the resident's expressed wishes regarding care and treatment goals . Identify the professional services that are responsible for each element of care .Enhance the optimal functioning of the resident by focusing on a rehabilitative program .

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	08/01/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47046 Based on observation, interview, and record review, the facility failed to ensure activities of daily living (ADL) were provided to maintain good hygiene for one of thirty-seven sampled residents (Resident 40) when Resident 40's fingernails were long with sharp edges and contained a black substance under the fingernails. This failure resulted in Resident 40's nails not being well groomed, and the potential for injury due to sharp edges, and infection due to harboring microorganisms (bacteria, virus, or fungus). Findings: A review of Resident 40's Admission Record indicated Resident 40 was admitted in 2021 and had diagnoses that included hemi-plegia (inability to move one side of the body). A review of Resident 40's Minimum Data Set (MDS, an assessment and care screening tool) dated 6/19/24, indicated Resident 40 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). A review of Resident 40's MDS Functional Status, dated 6/19/24, indicated Resident 40 needed maximum assistance for personal hygiene. During a concurrent observation and interview on 7/29/24, at 3:14 p.m., with Resident 40 in the activity room, Resident 40 sat in his wheelchair playing bingo. Resident 40 was observed to have long fingernails with sharp edges and a blackish substance underneath the fingernails of the right hand. Resident 40 stated he wanted to have his fingernails trimmed and the underneath of his fingernails cleaned. Resident 40 stated he was waiting for staff to cut and trim his nails. During an observation on 7/31/24 at 1:02 p.m., in Resident 40's room, Resident 40 was sitting at the edge of his bed. Resident 40 was observed to now have a blackish substance underneath the fingernails of both hands. During a concurrent observation and interview on 7/31/24, at 1:08 p.m., with the Director of Staff Development (DSD), the DSD confirmed Resident 40 had long fingernails with sharp edges on the right hand, and a blackish substance underneath the fingernails of both hands. The DSD stated Resident 40's long and dirty fingernails were not acceptable and should be trimmed. The DSD also stated during their shower, residents' fingernails and toenails should be checked and trimmed if needed. During an interview on 7/31/24 at 3:16 p.m., with the Director of Nursing (DON), the DON stated residents' fingernails, toenails, and any skin abnormalities should be checked during their shower. The DON also stated the risk to Resident 40 if his nails were not clean and trimmed would be infection. A Review of Resident 40's Care Plan indicated, [Name of Resident 40] has an ADL Self Care Performance Deficit . Resident [Resident 40] requires total assistance with personal hygiene care . (continued on next page)

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	08/01/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Review of Resident 40's shower sheet (a communication form filled out by facility staff after a resident receives a shower that lists any issues found during bathing), dated 7/29/24, indicated Resident 40 needed his fingernails and toenails cut. Both a Certified Nursing Assistant and a Licensed Nurse signed the sheet on 7/29/24. During a review of the facility's policy and procedure 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 .hygiene .

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	08/01/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43943 Based on observation, interview, and record review, the facility failed to ensure a living environment free from the potential of accidents and hazards for 2 of 37 sampled residents (Resident 95 and Resident 96), when: 1. Resident 96's room was full of clutter; and 2. Resident 95 was not provided a bed rail to assist with transfers and enhance mobility. These failures placed Resident 95 and Resident 96 at an increased risk for falls and possible injury. Findings: 1. During a review of Resident 96's clinical record titled, ADMISSION RECORD (a document that contained the resident's demographic information), indicated Resident 96's diagnoses included a history of a stroke (blood supply to part of the brain is blocked and the brain becomes damaged, resulting in a disability) and weakness on the left side of the body. During an observation on 7/29/24, at 10:01 a.m., Resident 96's room had eight large cardboard boxes, five large grey storage bins, one large black trash bag, seven grocery bags, and clothes and trash on top of the boxes lying on the floor. The items blocked the bathroom and spilled over into the roommate's area of the room. During an interview on 7/30/24, at 1:43 p.m., with Certified Nursing Assistant (CNA) 9, CNA 9 stated Resident 96 had refused to sort through her belongings in her room. CNA 9 stated all the items on the floor belonged to Resident 96 and not her roommate. CNA 9 stated she did not know the content of the boxes, bins, or trash bags. CNA 9 stated if Resident 96 had a medical emergency, it would be difficult to provide care to her in the cluttered room. During an interview on 7/30/24, at 1:49 p.m., with Resident 96, Resident 96 told the [STATE AGENCY] to get out of her room because Resident 96 did not want to talk. During an interview on 7/30/24, at 2:00 p.m., with Licensed Nurse (LN) 5, LN 5 stated Resident 96 did not allow staff to move her items to clean the room. LN 5 stated Resident 96 had a lot of food in her room and will not throw the food away. LN 5 stated if Resident 96 had a medical emergency, it would be difficult to provide care due to the amount of clutter in the room. During an interview on 7/30/24, at 3:08 p.m., with the Infection Preventionist (IP), the IP stated Resident 96 had difficulty accessing the bathroom due to the clutter in the room. The IP stated Resident 96's belongings spilled over into her roommate's space. (continued on next page)

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	08/01/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/31/24, at 9:27 a.m., with the Director of Nursing (DON), the DON acknowelged Resident 96 had a lot of clutter in her room. The DON acknowelged the clutter posed a risk for falls. A review of Resident 96's clinical record titled, Care Plan, dated, 7/29/24, indicated Resident 96's behavior included hoarding (collection of an excessive number of items and storing them in a chaotic manner) her belongings and putting them on the floor. A review of Resident 96's clinical record titled, Care Plan, dated 3/14/24, indicated, Resident is at risk for falls . maintain a clutter-free environment in the resident's room . During a concurrent interview and record review on 7/31/24, at 9:53 a.m., with the Administrator, (ADM), the facility's Policy and Procedures (P&P) titled, Assessing Falls and Their Causes, dated 3/2028 and Homelike Environment, dated 2/22 were reviewed. Assessing Falls and Their Causes indicated, . Identifying Fall Risk . environmental risk factors . objects in the way . Homelike Environment indicated, .The facility staff and management maximizes . clean, sanitary and orderly environment . The ADM stated Resident 96 had hoarding behavior and her room, was a mess. The ADM acknowelged Resident 96's room posed a risk for falls due to the clutter. The ADM stated the P&Ps were not followed. 50598 2. A review of Resident 95's ADMISSION RECORD indicated Resident 95 was admitted to the facility in early 2024 with diagnoses which included Right Leg Below Knee Amputation (surgical removal of right leg below the knee), Abnormalities of Gait (unstable when walking), and muscle weakness. During a concurrent interview and observation on 7/29/24, at 11:28 a.m., Resident 95 was sitting in her wheelchair next to her bed. Resident 95 stated she requested to have side rails on her bed multiple time over the past few months and was denied. Resident 95 stated she recently had her leg removed below the knee and still had the sensation her leg was there. Resident 95 stated she almost fell out of bed when she forgot and tried to get up. Resident 95 stated she had a hard time getting in and out of bed without something to hold on to. She used her walker at her bedside to grab, but the brakes were broken so it would slide away. During a review of Resident 95's medical record, her care plan initiated on 1/4/24, indicated, Focus . Resident/patient requires assistance/is dependent for mobility related to: AQUIRED ABSENCE OF RIGHT LEG BELOW KNEE .Goal .Resident will utilize 1/4 x2 bed rail (s) [a quarter bed rail is approximately 1/4 the length of the bed. x2 refers to two rails] for turning and repositioning while in bed; transferring to/from bed . Interventions . Head of bed elevated as a mobility enabler . The care plan was last revised on 1/17/24. During a concurrent observation, interview and record review on 7/31/24, at 10:44 a.m., with Resident 95 and the Treatment Nurse (TN), the TN stated Resident 95 did not have siderails. The TN explained side rails were used for mobility and to help a resident sit up on the side of the bed. Resident 95 stated she had asked all staff members for siderails and was told no. Resident 95 stated she needed them and should have them on her bed. The TN reviewed Resident 95's care plan and confirmed the facility was not in compliance with the care plan. (continued on next page)

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	08/01/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/1/24, at 12:12 p.m., with the Director of Nursing (DON), the DON reviewed the Resident 95's care plan, AQUIRED ABSENCE OF RIGHT LEG. The DON stated the care plan was missing important information in the interventions, including educating Resident 95 on the proper use of side rails and having therapy assess Resident 95. The DON confirmed Resident 95 should have been provided with the siderails and this placed Resident 95 at risk for injury. Review of the facility's General Policy Guidelines Titled, CARE PLAN COMPREHENSIVE, dated 8/25/21, indicated, .The facility's Interdisciplinary Team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a residents medical, physical and mental and psychosocial needs that are identified in the comprehensive assessment . PROCDURE .Each resident's comprehensive care plan is designed to .Build on the resident's individualized needs, strengths, preferences .

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	08/01/2024

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 41838 Based on observation, interview, and record review, the facility failed to maintain acceptable parameters of nutritional status when care planned interventions and food preferences were not provided for one of four sampled residents (Resident 37) who had a history of unplanned weight loss. This failure had the potential for Resident 37 to have further weight loss, skin breakdown, and malnutrition. Findings: A review of Resident 37's admission record indicated the resident was admitted to the facility in early 2024, with diagnosis of, but not limited to, mild protein-calorie malnutrition, dysphagia (difficulty swallowing) following cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). During a review of Resident 37's clinical record, Weights and Vitals Summary report dated 7/31/24, the Weights and Vitals Summary report indicated Resident 37 lost 18.2 pounds (10.9% of his body weight) between the dates of 1/4/24 and 7/31/24 which was a severe weight loss. The Weights and Vitals Summary report indicated as follows: 7/31/24 - 148.4 Lbs (pounds) 7/1/24 - 150.0 Lbs 6/1/24 - 153.2 Lbs 5/1/24 - 153.6 Lbs 4/7/24 - 152.8 Lbs 4/1/24 - 154.4 Lbs 3/1/24 - 162.0 Lbs 2/1/24 - 163.4 Lbs 2/1/24 - 163.4 Lbs 1/21/24 - 164.2 Lbs 1/14/24 - 166.6 Lbs 1/7/24 - 167.0 Lbs (continued on next page)

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	08/01/2024

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/4/24 - 166.6 Lbs During a review of Resident 37's Interdisciplinary Team (IDT) Weight report, dated 4/1/24, the IDT (Interdisciplinary Team) Weight report indicated Resident 37 had, Difficult(y) seeing. Needs some help. Members of the IDT team included the Registered Dietitian (RD) and the Social Services Director (SSD). During a review of Resident 37's Progress Note, dated 7/1/24, the Progress Note indicated, Resident is noted with 10.2% weight loss in 180 days. During a review of Resident 37's clinical record, Dietary/Nutritional Progress Note, dated 7/5/24, the Dietary /Nutritional Progress Note indicated Resident 37's food preferences were updated and he would like to receive a banana or alternative fruit at breakfast and dinner. Also, Resident 37 would be receiving a peanut butter and jelly sandwich once daily. During an observation on 7/30/24 at 1:43 p.m. with Resident 37, Resident 37 was in his room eating lunch. Resident 37 was observed feeding himself his dessert (apple crisp) which had approximately 50% left. Food crumbs were noted on his gown and he stated he was unable to see into his dessert bowl that was placed on the overbed table. Upon tilting the bowl to better align with his sight line, Resident 37 was able to use his spoon to eat the dessert without difficulty. During a breakfast observation and interview on 7/31/24 at 8:49 a.m. with Resident 37, Resident 37 stated he had a hard time seeing, which made it hard for him to feed himself. Resident 37 stated he needed a pair of reading glasses to help him see his meals. Resident 37 further stated he would like a snack of a peanut butter and jelly sandwich in between breakfast and lunch mealtimes. During an interview on 7/31/24 at 9:35 a.m. with the SSD, the SSD stated that she was not aware of the need for glasses for Resident 37. During an interview on 7/31/24 at 9:58 a.m. with the Dietary Service Assistant (DSA), the DSA stated Resident 37 could not have a peanut butter and jelly sandwich because of his easy to chew diet. Review of IDDSI.org, the easy to chew diet is defined as, Normal, everyday foods of soft/tender texture . Included in the examples was soft bread, which was, .suitable for individuals who may have some difficulty with chewing hard/firm textures but do not have .problems with swallowing. During an interview on 7/31/24 at 11:45 a.m. with the RD, the RD stated the DSA may have been confused about the diet order restrictions. The RD also stated there should not be restrictions for a peanut butter and jelly sandwich for Resident 37. The RD further stated the facility should be able to meet Resident 37's food preferences and assist with his vision needs.

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	08/01/2024

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47046 Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for one of two sampled residents (Resident 375) with a peripherally inserted central catheter (PICC, a type of long catheter that is inserted through a peripheral vein, often in the arm, passed through to larger veins near the heart and used to give fluids, nutrition, drugs, or other treatments), when Resident 375's PICC line dressing was not changed for 12 days. This failure increased the risk of Resident 375 developing infection (the invasion and growth of germs in the body) and/or sepsis (a serious condition that happens when the body's immune system has an extreme response to an infection). Findings: A review of Resident 375's Admission Record indicated Resident 375 was admitted in 2024 with diagnoses including infection and inflammatory reaction (when tissues are injured by bacteria, injury, or any other cause). During a concurrent observation and interview on 7/29/24, at 9:18 a.m., Resident 375 stated she was receiving antibiotics through a PICC line. Resident 375 showed the Department her PICC line located on her right upper arm. The PICC line insertion site was noted to be covered with a clear dressing which was loosened. During a concurrent observation and interview on 7/29/24, at 9:22 a.m., with the Assistant Director of Nursing (ADON), the ADON indicated the date written on Resident 375's PICC line dressing was 7/16/24, which indicated when the dressing was last changed. The ADON stated Resident 375's PICC line dressing was to be changed every week. The ADON confirmed Resident 375's PICC line dressing was not changed for more than a week. A review of Resident 375's Order Summary Report indicated, . RIGHT UPPER ARM PICC Line: Dressing change Q7 [every 7] days & PRN [as needed]. Remove old dressing using sterile technique . During a review of Resident 375's clinical record, Progress Notes dated 7/17/24, the note indicated Resident 375 was readmitted on [DATE] and had a PICC line to her right forearm. A review of Resident 375's clinical record, Progress Notes dated 7/29/24, indicated, .The Change in condition/s reported .Noted right upper arm PICC line dressing last changed was on 7/16, over a week . Primary Care Provider responded with the following feedback .Change right upper arm PICC line site dressing today and change as scheduled . During an interview on 8/1/24, at 1:26 p.m., with the Director of Nursing (DON), the DON stated Resident 375's PICC line dressing was to be changed once a week and as needed. The DON also stated there was a risk of infection if the PICC line dressing was not changed at least weekly. (continued on next page)

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	08/01/2024

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Central Venous Catheter Care Dressing Changes, revised April 2016, indicated, .The purpose .is to prevent catheter-related infections that are associated with contaminated, loosened, soiled . Change transparent . dressings at least every 5-7 days and PRN . Review of an undated online document from the Agency of Healthcare Research and Quality (AHRQ) titled, INSTRUCTIONS Selected Best Practices and Suggestions for Improvement, in the section titled, Recommended Practice: Daily Monitoring and Assessment, indicated, .For nontunneled catheters [for short term use, a PICC line is a nontunneled catheter], change the transparent dressing and perform site care . every 5 to 7 days or more frequently if the dressing is soiled, loose, or damp . (https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/qitoolkit/d4a-crbsi-bestpractices.pdf)

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	08/01/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 43943 Based on observation, interview, and record review, the facility failed to ensure respiratory care practices were consistent with professional standards of practices for five residents using oxygen in a sample of 37 when, 1. Resident 47's oxygen tubing was not changed and dated per facility standards of practice; 2. Resident 53's doorframe did not contain signage that indicated oxygen was in use; and, 3. Resident 84 and Resident 106's oxygen concentrator [a machine which converts room air to oxygen] filters contained a large amount of dust and debris; and Resident 64's oxygen concentrator had no filter, and the air intake contained a large amount of dust and debris. These failures put vulnerable residents ar risk for infection, and placed Resident 53 at risk for injury related to use of a flammable gas. Findings: 1. During a review of Resident 47's clinical record titled, ADMISSION RECORD (a document that contains the resident's demographic information), indicated Resident 47's diagnoses included sepsis (overwhelming infection), respiratory failure, history of Methicillin Resistant Staphylococcus Aureus (MRSA - infection that is resistant to many antibiotics), and dependence on a ventilator (machine that breathes for the resident). During an observation on 7/29/24, at 11:02 a.m., Resident 47's oxygen tubing was dated with a piece of tape that indicated the tubing had last been changed on 7/8/24. During a concurrent observation and interview on 7/29/24, at 11:13 a.m., with Licensed Nurse (LN) 6, LN 6 verified Resident 47's oxygen tubing was last changed on 7/8/24. LN 6 stated the oxygen tubing should have been changed weekly. LN 6 stated the delay in changing the oxygen tubing placed Resident 47 at risk for infection. During a concurrent observation and interview on 7/29/24, at 11:26 a.m., with the Director of the Subacute Unit (DSU), the DSU verified Resident 47's oxygen tubing was labeled as changed on 7/8/24. DSU stated the tubing should have been changed once a week to ward off respiratory infection. A review of Resident 47's Care Plan (problems, goals, and interventions identified), dated 8/25/23, indicated Resident 47 was on oxygen therapy related to respiratory failure. A review of Resident 47's clinical record titled, Orders, dated 7/21/24, indicated Resident 47 was on a continuous ventilator. (continued on next page)

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	08/01/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/30/24, at 4:23 p.m., with the respiratory therapist (RT), the facility document titled, Physicians Respiratory Orders, not dated, was reviewed. The document indicated, . Oxygen via O2 [oxygen] Concentrator [machine that produces supplemental oxygen at a desired flow rate] . check, clean or replace O2 filters and change O2 tubing . (Dayshift Sunday) . The RT stated Resident 47's oxygen tubing should have been changed once a week. The RT stated the oxygen tubing was dirty and placed Resident 47 at risk for infection, especially because Resident 47 was on a ventilator. The RT stated there should have been a physician's order in the computer to change the oxygen tubing weekly. The RT verified the facility's standard of practice for changing the oxygen tubing was not followed. During a concurrent interview and record review on 7/31/24, at 9:36 a.m., with the Director of Nursing (DON) and the Administrator (ADM), the facility document titled, Physicians Respiratory Orders, not dated, was reviewed. The document indicated, . Oxygen via O2 [oxygen] Concentrator . check, clean or replace O2 filters and change O2 tubing . (Dayshift Sunday) . The DON and ADM verified Resident 47 was a at increased risk for infection due to being on a ventilator and the facility's standard of practice for changing the oxygen tubing was not followed. 49823 2. During a review of Resident 53's Order Summary Report, dated 5/17/24, the report indicated, .Oxygen .as needed for shortness of breath . During a concurrent observation and interview on 7/29/24, at 9:07 a.m., in Resident 53's room, Resident 53 stated he used oxygen when he felt dizzy. There was no oxygen in use safety sign on the door of Resident 53's room to alert oxygen was in use. During a concurrent observation and interview on 7/29/24, at 9:52 a.m., with the Assistant Director of Nursing (ADON) and the Director of Staff Development (DSD), the ADON and DSD stated if oxygen was in use, the room needed a sign on the door to indicate this. The ADON and the DSD confirmed there was no sign on the door indicating oxygen was in use in Resident 53's room. The ADON and the DSD stated people wouldn't know the resident was on oxygen. During an interview on 7/30/24, at 12:40 p.m., with the Director of Nursing (DON) at Station 1 Nurses' station, the DON stated she expected that the oxygen in use sign was on the resident's room doorframe. During a review of a facility policy and procedure (P&P) titled, Ensuring Oxygen Safety, undated, the P&P indicated, .Procedure Guidelines .Safety Guidelines .Oxygen in Use Signage: Place an 'oxygen in use' sign in the patient's room and on the door to inform personnel and visitors . 40583 3a. A review of Resident 84's Admission Record, indicated Resident 84 was admitted to the facility with diagnoses which included dependence on a ventilator (machine that helps you breath) and dependence on supplemental oxygen. During an observaton in Resident 84's room, on 7/29/24, at 10:28 AM, Resident 84's oxygen concentrator filter contained a large amount of dust and debris. (continued on next page)

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	08/01/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview with licensed nurse (LN) 7, on 7/29/24, at 10:38 AM, LN 7 stated she saw a lot of dust and debris on Resident 84's oxygen concentrator. LN 7 explained that the dust and debris could be introduced to the residents system and placed them at risk for pneumonia. During an interview with the Director of Nursing (DON), on 7/31/24, at 10:46 AM, the DON stated the oxygen concentrators should have oxygen filters that are clean. The DON stated Resident 84's oxygen concentrator filter had lint and a large amount of dust and debris. The DON explained it was an infection control issue and could lead to respiratory distress. 3b. A review of Resident 106's Admission Record, indicated Resident 106 was admitted to the facility with diagnoses which included dependence on a ventilator (machine that helps you breath) and a tracheostomy (an opening in the windpipe to help someone breathe). Resident 106's oxygen concentrator filter contained a moderate amount of dust and debris. During an interview with LN 7, on 7/29/24, at 10:40 AM, LN 7 confirmed there was a moderate amount of dust and debris on Resident 106's oxygen concentrator filter. During a concurrent observation and interview with the DON, on 7/31/24, at 10:46 AM, the DON observed Resident 106's concentrator filter and stated, . it looks like lint it. The O2 [oxygen] filter shouldnt look like that. It should be clean. 3c. A review of Resident 64's Admission Record, indicated Resident 64 was admitted to the facility with diagnoses which included acute respiratory failure (disease that affects breathing) and a tracheostomy. During an observation in Resident 64's room, on 7/29/24, at 11:32 AM, Resident 64's oxygen concentrator filter did not contain an oxygen filter, and there was a large amount of dust and debris in and around the air intake where the filter should have been. During a concurrent observation and interview with LN 7, on 7/29/24, at 11:43 AM, LN 7 stated there should be a filter on Resident 64's oxygen concentrator and there was not. LN 7 confirmed there was a large amount of dust and debris where the filter should have been. During an interview with the DON, on 7/31/24, at 10:46 AM, the DON stated there should have been a filter on Resident 64's oxygen concentrator. The DON explained without a filter Resident 64 was at risk for respiratory distress and other respiratory conditions related to particles Resident 64 could breathe in.

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	08/01/2024

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 40583 Based on interview and record review, the facility failed to ensure 1 of 37 sampled residents (Resident 178) was administered PRN (as needed) pain medication when Resident 178 requested the medication. This failure resulted in Resident 178's pain being unrelieved, negatively impacting Resident 178's health and well-being. Findings: A review of Resident 178's clinical document titled, Admission Record, indicated Resident 178 was admitted to the facility with diagnoses which included testicular and abdominal pain. During an interview with Resident 178 on 7/29/24, at 12:47 PM, Resident 178 stated he had asked for his pain medications around 10 AM. Resident 178 explained licensed nurse (LN) 4 stated he would get his pain medication for him and never did. Resident 178 stated his pain level was 7-8, on a pain scale of 10, with 10 being the highest level of pain. A review of Resident 178's clinical document titled, Order Summary Report, containing physician prescribed medications, indicated, Percocet [narcotic pain-relieving medication] Oral Tablet 10-325 MG [MG - Milligrams a unit of measure] .Give 1 tablet by mouth every 8 hours as needed for pain Mild 1-3, moderate 4-6, severe 7-10 . A review of Resident 178's clinical document titled, Medication Administration Record, dated 7/1/24 to 7/31/24, indicated Resident 178's last dose of the above ordered pain medication was given on 7/29/24, at 2:06 AM. During an interview with LN 4, on 7/29/24, at 12:55 PM, LN 4 verified Resident 178 had asked him for his pain medications. LN 4 stated Resident 178 did not have any pain medications in the cart, and he would need to call the pharmacy to get it out of the e-kit (emergency medication kit). LN 4 explained he had not called the pharmacy yet, approximately 3 hours after Resident 178 asked for his pain medication. LN 4 further explained he should have called the pharmacy right away in order to prevent Resident 178's pain from worsening. During an interview with the Director of Nurses (DON), on 8/1/24, at 10:10 AM, the DON explained her expectations were when Resident 178 stated he had pain, the LN should have assessed the resident for pain and reviewed the physician's orders to see what pain medications were available. The DON stated a resident should not wait three hours for the LN to assess and address their pain. (continued on next page)

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	08/01/2024

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Pain Management, effective date 8/25/21, indicated, Purpose: To maintain the highest possible level of comfort for Residents by providing a system to identify, assess, treat, and evaluate pain .Residents will be evaluated as part of the nursing assessment process for the presence of pain .Pain management that is consistent with professional standards of practice .Facility staff will report any observation or communication of pain to the nurse responsible for that Resident .Residents receiving interventions will be monitored for the effectiveness .in providing pain relief .

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	08/01/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50598 Based on observation, interview, and record review, the facility failed to provide medication to meet the needs of 2 of 37 sampled residents (Resident 50 and Resident 67), when: 1. Resident 50's medications were signed off as given prior to administering to Resident 50, and were administered late; and, 2. Resident 67's medication to keep blood pressure from being too low was not administered per physician orders. These failures had the potential to result in Resident 50 experiencing increased pain and a drop in her blood pressure, and Resident 67 not receiving the therapeutic effect of her medication with a potential for abnormal blood pressure Findings: A review of Resident 50's clinical record, MEDICATION ADMINISTRATION RECORD (MAR) with a date range 7/1/24 -7/31/24 indicated as follows: Midodrine HCL [a medication used to increase blood pressure] Give oral Tablet 10 MG [mg- a unit of measure] . 1 tablet by mouth three times a day for hypotension [low blood pressure] . The MAR indicated the Midodrine HCL was scheduled for 9 a.m., 1 p.m., and 5 p.m. Gabapentin [a medication used to treat nerve pain] Capsule 100 MG Give 2 capsule by mouth three times a day for peripheral neuropathy [nerve pain away from the center of your body] . The MAR indicated the gabapentin was scheduled for 9 a.m., 1 p.m., and 5 p.m. During a review of Resident 50's clinical record, the (MAR) indicated the ordered Gabapentin and Midodrine HCL which were ordered to be administered at 1 p.m., were signed as given at 2:33 p.m. During a concurrent observation and interview on 7/29/24 at 2:47 p.m. Resident 50 was yelling from her room Medicine, Medicine, I need my second medicine. Resident 50 stated she had not received her pills yet and her medication was late. Licensed Nurse (LN) 4 entered Resident 50's Room and asked what she wanted. Resident 50 stated she wanted her medication and her cream. During a concurrent observation and interview on 7/29/24 at 2:52 p.m. with LN 4, LN 4 was carrying a small clear cup with three medications in it. LN 4 stated he was administering Resident 50's two 100mg tablets of Gabapentin, and one tablet of Midodrine. During a concurrent interview and record review on 7/29/24 at 2:54 p.m., LN 4 confirmed he administered Resident 50's 1 p.m. medication at 2:52 p.m., and documented in Resident 50's MAR that the medications were given at 2:33 p.m. LN 4 stated the medication administration should be documented accurately. LN 4 stated the resident may refuse the medication and the documentation would indicate that the medications were already given. (continued on next page)

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	08/01/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/1/24 at 11:31a.m. with the Director of Nursing (DON), after reviewing Resident 50's MAR, the DON explained her expectations of the staff when administering medication. The DON stated signing medication prior to administration and late medication administration was not the facility's normal process with medication administration and did not meet the facility's expectations of the Licensed Nurses. The DON stated the medication should be administered either an hour before or an hour after the scheduled time. The DON stated she expected the licensed nurses to administer all medications as ordered and not sign medications off before given. Review of the facilities policy titled PREPARATION AND GENERAL GUIDELINES 11A2: MEDICATION ADMINISTRATION-GENERAL GUIDELINES dated 10/2017 indicated, Medications are administered as prescribed in accordance with good nursing principles and practice . Medications are administered in accordance with written orders of the attending physician .Medications are administered within 60 minutes of scheduled time (1hour before and 1 hour after) . Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility . The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass . 40583 2. A review of Resident 67's Admission Record, indicated Resident 67 was admitted to the facility with diagnoses which included respiratory failure with hypoxia (a condition where you don't have enough oxygen in the tissues in your body) and ventilator (machine that helps you breath) dependent. A review of Resident 67's Medication Administration Record (MAR), dated 5/1/24 to 5/31/24, indicated, Midodrine [medication for low blood pressure] HCl Oral Tablet 10 MG [MG milligrams a unit of measure] . Give 10 mg .three times a day .Hold if SBP [Systolic blood pressure is the first number. It measures the pressure your blood is pushing against your artery walls when the heart beats] is over 120 .Start Date 12/15/23 . The MAR indicated on the following days in May 2024, the medication was not administered and should have been: 5/7/24 at 1700 (5 PM) for a blood pressure (BP) of 118/69; 5/9/24 at 1700 for a BP of 117/70; 5/10/24 at 1700 for a BP of 117/68; 5/17/24 at 1700 for a BP of 117/68; 5/19/24 at 1700 for a BP of 116/64; 5/20/24 at 1700 for a BP of 112/62; 5/22/24 at 1700 for a BP of 113/70; and, 5/31/24 at 1700 for a BP of 112/68. (continued on next page)

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	08/01/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 67's Medication Administration Record (MAR), dated 6/1/24 to 6/30/24, indicated, Midodrine HCl Oral Tablet 10 MG .Give 10 mg .three times a day .Hold if SBP is over 120 .Start Date 12/15/23 . The MAR indicated on the following days in June 2024, the medication was not administered and should have been, and one time administered when it should not have been: Held on the following days: 6/13/24 at 1700 for a BP of 111/57; 6/18/24 at 1700 for a BP of 116/89; and, 6/25/24 at 1700 for a BP of 117/60. Administered on the following day: 6/7/24 at 0100 (1 AM) for a BP of 126/86. A review of Resident 67's Medication Administration Record (MAR), dated 7/1/24 to 7/31/24, indicated, Midodrine HCl Oral Tablet 10 MG .Give 10 mg .three times a day .Hold if SBP is over 120 .Start Date 12/15/23 . The MAR indicated on the following days in July 2024, the medication was administered when it should not have been: 7/7/24 at 0900 (9 AM) for a BP of 121/86; 7/7/24 at 1700 for a BP of 124/75; 7/9/24 at 1700 for a BP of 125/60; 7/10/24 at 0900 for a BP of 123/73; 7/13/24 at 0100 for a BP of 148/68; 7/18/24 at 0100 for a BP of 128/76; and, 7/18/24 at 1700 for a BP of 124/69. During an interview with the Assistant Director of Nursing (ADON), on 8/1/24, at 9:20 AM, the ADON stated Midodrine was administered to residents who have low blood pressure. The ADON explained it was to increase their blood pressure. The ADON further explained she would follow the parameters for administration. The ADON stated the resident could have a hypotensive (low blood pressure) crisis or a Hypertensive (high blood pressure) crisis if you administered or held the medication outside of the physician ordered parameters. (continued on next page)

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	08/01/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the Director of Nursing (DON), on 8/1/24, at 10:13 AM, the DON stated staff should check the BP before administering the Midodrine and follow the physician ordered parameters. The DON explained if the BP exceeded the parameters, she would expect staff to hold the medication. The DON further explained if staff administered the medication, it could cause an adverse event to the resident. The DON stated if the resident's BP was within parameters she would administer the midodrine. The DON further stated if staff held the midodrine there was a potential for the BP dropping and could cause adverse events to the resident. The DON confirmed the Midodrine was missed and/or administered to Resident 67 outside of physician ordered parameters for the months reviewed, May 2024, June 2024, and July 2024. A review of the facility policy titled, Medication Administration-General Guidelines, effective date 10/2017, indicated, Medications are administered as prescribed in accordance with good nursing principles and practices .Personnel authorized to administer medications do so only after they have familiarized themselves with the medication .Prior to administration, the medication and dosage schedule on the resident administration record (MAR) is compared with the medication label .Medications are administered in accordance with written orders of the attending physician .

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	08/01/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49823 Based on observation, interview, and record review, the facility failed to protect residents from significant medication errors when: 1. Resident 53 was given medication that was not ordered by the physician; and, 2. Resident 114's medications, including controlled substances, were left at Resident 114's bedside. These deficient practices had the potential for Resident 53 to suffer serious effects from a narcotic overdose, and had the potential for Resident 114 to miss or take her medications late, or for another resident to take them with the risk of serious effects. Findings: 1. Resident 53 was admitted to the facility in early 2024. Resident 53's admitting diagnoses included diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), malaise (a general feeling of discomfort, illness, or uneasiness whose exact cause is difficult to identify), and iron deficiency anemia (a condition where the body doesn't have enough healthy red blood cells due to low levels of iron in the body). During a review of Resident 53's clinical record, Progress Note, dated 5/19/24, the Progress Note indicated, . 5/19/24 8:07 [a.m] .Change in condition reported .Nursing observations .At approx. 0730 AM, a medication error incident .administration of Methadone HCl [an opioid medication used to help people reduce or quit their use of heroin or other opioid medications and can be used for the control of severe pain] oral 10 mg [unit of measure] medication. The error identified by Nurse during a routine check of Res [resident] MAR [Medication Administration Record]. Nurse immediately informed the MD [physician]. Resident stated, 'I feel drowsy and hungry.' Resident was under continuous monitoring for any adverse [harmful] effect due to medication error . A review of Resident 53's Progress Note, dated 5/19/24, indicated, .5/19/24 15:01 [3:01 p.m.] Naloxone [medication used to reverse effects of overdosage of an opioid medication] 0.4mg IM [intramuscular, administered as an injection into the muscle] injection given in the upper arm. Please continue to monitor of any adverse effect. Endorsed to oncoming nurse .5/19/24 15:16 [3:16 p.m.] Monitoring r/t [related to] medication error .Methadone 10mg @0730 . contacted MD/RP [Physician and Responsible Party]. MD ordered 72 hr [hour] monitoring .Pt [patient, resident] continues to be lethargic [drowsy, sluggish[and stable [not deteriorating in health]. Continue frequent visual checks/VS [vital signs] assessments . (continued on next page)

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	08/01/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 53's Progress Note, dated 5/19/24, indicated, .5/19/24 22:30 LATE ENTRY .Resident is on monitoring for medication error, five [5] tablets of Methadone 10 milligrams administered during AM [Day] shift. At approx.1613 [4:13 p.m.] writer went to assess resident's VS: BP [blood pressure] 104/56, P [pulse, heart rate] 77, RR [respiratory rate, number of breaths per minute] 12, O2 (oxygen) @ 96% via NC [nasal cannula a tube with prongs through which oxygen is delivered into the nose], afebrile [no elevated temperature]. Noted resident sleeping comfortable in bed without respiratory distress noted .At approx.1800 [6 p.m.], noted resident was lethargic/drowsy but easily aroused. 2 L's [amount of oxygen] . reassessed .VS: BP 95/68, P82, O2 at 94% via NC and noted RR was 7 breaths per minute. MD notified .Administered Naloxone HCl Nasal Liquid (nasal spray) 4 MG/0.1ML via nostril [one side of nose] and was effective . Resident VS: BP 132/68, P 80, RR 18, O2 @ 96% via nasal cannula .alert and oriented .consumed 75% of his dinner meal . During an interview on 7/30/24 at 12:45 p.m. with Resident 53 in room [ROOM NUMBER] B, Resident 53 was asked if he remembered the incident on 5/19/24 when the wrong medication was given to him. Resident 53 stated that he did not remember why the medication was given to him in error but stated that he remembered the nasal spray. Resident 53 stated that he was not told about the medication error. A review of Resident 53's Interdisciplinary Team (IDT) Progress Note, dated 5/22/24, indicated, .Met to discuss that he received methadone on 5/19/24 and needing Narcan [Naloxone] for respiration of 7 .He had his O2 tubing in his hand, reapplied nasal cannula, O2 sat was 93% .respiration even and unlabored, respiration rate 18 .regular heart rate at 70 BPM [beats per minute], BP 120/70 .Resident denies any pain or discomfort . During an interview on 7/30/24 at 1:10 p.m. with the DON in the DON's office, the DON was asked about the medication error for Resident 53 on 5/19/24. The DON stated she was not sure of the details of the medication error. A review of Resident 53's MAR, dated 5/19/24, indicated, .Naloxone HCl Injection Solution [Naloxone HCl] inject 0.4 ml intramuscularly one time only for symptoms of OD [overdose] .administered 5/19/24 at 1100 [11 a.m.] .Naloxone HCl Nasal Liquid 4mg/0.1ML 4mg in nostril one time only for opioid overdose for one day . administered 5/19/24 1820 [6:20 p.m.] .Oxygen at 3LM/min [3 liters per minute] via nasal cannula continuously for SOB [shortness of breath]/DOB [difficulty of breathing] . A review of Resident 53's Care Plan, dated 5/19/24, indicated, .Respiratory Distress r/t medication error . Goal .Resident will not have episode of respiratory distress .Notify MD if signs of respiratory distress observed .Oxygen as ordered .Naloxone HCl Nasal liquid 4mg/0.1ML one time only . During a review of a facility policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated October 2017, the P&P indicated, . Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label. If the label and the MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule . Residents are identified before medication is administered. Methods of identification include: a. Checking identification band b. Checking photograph attached to medical record c. If necessary, verifying resident identification with other facility personnel .12. Medications supplied for one resident are never administered to another resident . (continued on next page)

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	08/01/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an online document published by the National Library of Medicine, National Institutes of Health, titled, Methadone - StatPearls, last reviewed dated 1/11/24, indicated, . Management of overdose .In cases of Methadone overdose, patients should be closely monitored for oxygenation [the process of supplying oxygen to the body's cells] and ventilation [movement of air in and out of the lungs]. Naloxone should be administered if an overdose is suspected .in overdose situations, naloxone should be administered to prevent fatalities [death] . 40583 2. During a medication observation pass with licensed nurse (LN) 4, on 7/31/24, at 7:53 AM, LN 4 was observed preparing insulin (an injectable medication to manage blood sugar) for administration to Resident 114. While in Resident 114's room, LN 4 administered Resident 114's insulin and there was a medication cup, approximately 1/2 full with medications observed on Resident 114's bedside table. During an interview with LN 4, on 7/31/24, at 8 AM, LN 4 stated he gave Resident 114 the following oral medications: Adderall XR 30 mg (milligrams a unit of measure) for attention deficit disorder (a controlled substance) Alprazolam 0.5 mg for anxiety (a controlled substance) Ascorbic acid 500mg Vitamin C a dietary supplement Aspirin chewable 81 mg helps prevent heart attack or stroke Budesonide ER 9mg a steroid medication Vilazodone hcl 40 mg for depression Gabapentin 300 mg for nerve pain doxycycline 100 mg an antibiotic ferrous sulfate 325mg Iron a dietary supplement MVT multivitamin a dietary supplement morphine sulfate ER 15mg (a narcotic pain medication, a controlled substance) Protonix 40 mg used to treat heart burn NACL1gm (gram a unit of measures) an electrolyte replenisher During a follow-up interview with LN 4, on 7/31/24, at 8:01 AM, LN 4 stated he had not watched Resident 114 take her medications, he left them at the bedside and walked away because Resident 114 was still sleeping, and he did not want to wake her up. (continued on next page)

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	08/01/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview with the Infection Preventionist (IP), on 7/31/24, at 8:02 AM, the IP confirmed medications were left at the bedside for Resident 114. The IP confirmed there were 13 pills in the medication cup. The IP explained medications should not be left at the resident's bedside. The IP further explained there was a risk of someone else taking the medications, stating Resident 114's roommate was very alert. The IP stated if the roommate took the medications, she could be allergic to them, she could overdose, or the medications could cause an adverse reaction in Resident 114's roommate. During an interview with the Director of Nursing (DON), on 8/1/24, at 10:08 AM, the DON stated the LN's have to wait until the resident, takes the medication safely, to make sure the resident takes the medications. The DON explained other residents could potentially take the medication, stating there could have been an adverse effect to the resident and potentially cause harm to the other resident. A review of the facility policy titled, Medication Administration, effective date 10/2017, indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices .Personnel authorize to administer medications do so only after they have familiarized themselves with medications . Medications are administered at the time they are prepared .Medications are administered without unnecessary interruptions .The person who prepares the dose for administration is the person who administers the dose .The resident is always observed after administration to ensure that the dose was completely ingested .

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	08/01/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40583 Based on observation, interview, and record review, the facility failed to ensure a respiratory therapy treatment cart and a medication cart, in the facility's sub-acute area (offers more intensive care than what is provided in a skilled nursing facility) were locked and secured, for a census of 118, when: 1. A respiratory therapy treatment cart was left unlocked and unattended; and a medication cart was left unlocked and unattended in the sub-acute area of the facility. 2. The medication refrigerator for Station's 3/4 contained a basin with medications that were submerged or partially submerged in a clear liquid substance. These failures had the potential residents or unauthorized persons could access respiratory treatment supplies and medications they were not prescribed, with the potential for harmful effects; and had the potential for submerged medications to become contaminated and cause illness. Findings: 1. During an observation on 8/1/24, at 7:27 AM, in the sub-acute area of the facility, a respiratory therapy treatment cart, across the hall from the nursing station, was observed to be unattended and unlocked. During an interview with Respiratory Therapist (RT) 1, on 8/1/24, at 7:30 AM, RT 1 confirmed she had left her respiratory therapy treatment cart unlocked. RT 1 explained the cart contained resident medications, scissors, and dressing supplies. RT 1 further explained the medications and supplies should not be available to anyone walking by, including residents and staff. RT 1 stated anyone could steal the medications in the cart. During an observation on 8/1/24, at 7:27 AM, in the sub-acute area of the facility, a medication cart, across the hall from the nursing station and down about eight feet, was observed to be unattended and unlocked. During an interview with licensed nurse (LN) 8, on 8/1/24, at 7:31 AM, LN 8 confirmed the medication cart was unlocked. LN 8 stated the medication cart contained resident medications, including narcotic medications. LN 8 explained residents could get into the cart and take the medications. During an interview with the Director of Nurses (DON), on 8/1/24, at 9:53 AM, the DON explained her expectations were for the respiratory therapy treatment cart and the medication cart to be locked when left unattended. The DON further explained leaving the respiratory therapy treatment cart and the medication cart unlocked and unattended was a safety issue for the residents as the medications could be taken by residents and cause harm to residents. (continued on next page)

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	08/01/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Security of Medication Cart, revised April 2007, indicated, .The medication cart shall be secured during medication passes .The nurse must secure the medication cart during the medication pass to prevent unauthorized entry .Medication carts must be securely locked at all times when out of the nurses view . 2. During an observation, with the Infection Preventionist (IP), on 7/30/24, at 1:40 PM, in the Station 3/4 medication room, the medication refrigerator contained a basin with medications, including insulin (an injectable medication to control blood sugar), insulin pens, tuberculin solution (used to test for tuberculosis), and Ozempic (an injectable medication to control blood sugar and/or promote weight loss), which were submerged or partially submerged in a clear liquid substance. The insulin pens were in plastic bags, one bag containing an insulin pen, had a hole in it and the clear liquid substance was in contact with the insulin pen. The tuberculin solutions box was deteriorated on the bottom and the vial had been in contact with the clear liquid substance. The IP confirmed the finding. During an interview with the Director of Nurses (DON), on 7/30/24, at 1:45 PM, the DON confirmed there was a clear liquid substance covering the bottom of the basin and confirmed the medications and their packaging were in contact with the clear liquid substance. The DON explained this could be an infection control issue. During an interview with the IP on 7/30/24, at 1:55 PM, the IP stated she would be concerned about the clear liquid substance being unsafe. A review of the facility policy titled, Medication Storage In The Facility, effective April, 2008, indicated, Medications are stored safely, securely, and properly .Refrigerated medications are kept in closed and labeled containers, with internal and external medications separated and separate from fruit juices, applesauce, and other foods used in administering medications .Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal .Medication storage areas are kept clean .

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	08/01/2024

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 43943 Based on observation, interview, and record review, the facility failed to ensure 1 of 37 sampled residents (Resident 71) was provided dental services to meet her needs when Resident 71 was not fitted for dentures in a timely manner. This failure resulted in Resident 71 not having dentures, and had the potential to impact Resident 71's quality of life and self esteem. Findings: During a review of Resident 71's clinical record titled, ADMISSION RECORD (a document that contains the resident's demographic information), the record indicated Resident 71's diagnoses included mild protein - calorie malnutrition and major depressive disorder. During a concurrent observation and interview on 7/29/24, at 2:10 p.m., with Resident 71, Resident 71 was noted to not have any teeth. Resident 71 stated she had dentures, and they broke three times. Resident 71 stated someone assessed her dental status approximately 6 months ago and discussed getting dentures, but she had not received an update. Resident 71 stated she wanted dentures, and she was sad that she had not received them. A review of Resident 71's clinical record titled, Progress Notes, dated 9/6/23, at 12:26 p.m., by the Social Services Department, indicated, SS [Social Service] was informed by resident to make a referral for dentures . A review of Resident 71's clinical record titled, Oral Health Care, dated 9/22/23, by the Dentist (DMD), indicated Resident 71 did not have teeth and a Treatment Assessment Referral (TAR - approval from the insurance company to proceed with the recommended treatment plan) was written for full upper and lower dentures. A review of Resident 71's clinical record titled, Oral Health, dated 5/22/24, by the DMD, indicated Resident 71 had an approved TAR for full upper and lower dentures. During an interview on 7/30/24, at 4:45 p.m., with the Social Services Director (SSD) 1, SSD 1 stated she was unsure if Resident 71 came to the facility with dentures because the inventory list was blank. SSD 1 stated Resident 71 had waited too long for dentures. SSD 1 acknowledged she had not followed up on the TAR for dentures. During an interview on 7/31/24, at 12:09 PM, SSD 2 stated the social services department should have reassessed Resident 71's denture needs and made the needed appointments. SSD 2 stated when Resident 71's TAR was approved, dentures should have been ordered. During an interview on 7/31/24, at 12:35 p.m., with Licensed Nurse (LN) 5, LN 5 stated she noticed Resident 71 had not liked to smile and acknowledged not having teeth negatively affected Resident 71's mood. LN 5 stated Resident 71 had waited too long for dentures. (continued on next page)

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	08/01/2024

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/1/24, at 2:06 p.m., with the Director of Nursing (DON) and the Administrator (ADM), the Policy and Procedure (P&P) titled, Dental Services, dated 12/16, was reviewed. The P&P indicated, . Routine and 24-hour emergency dental services are provided to our residents through .a contract agreement with a licensed dentist that comes to the facility monthly . Social services representatives will assist residents with appointments . lost or damaged dentures will be replaced . The ADM stated the process of denture delivery was a dentist came for an initial visit, then a TAR was submitted to the insurance company. Once the TAR was approved, the dentist should have come back to fit Resident 71 for dentures. The ADM acknowledged it should not have taken this long for follow up on the dentures. The ADM stated the facility failed to follow up on the request for dentures. The ADM and the DON stated the P&P was not followed.

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	08/01/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50018 Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety when: 1. A dented can was found in canned foods storage, 2. Expired foods were not discarded and available to be served to residents, 3. Cereal in dry storage was not covered, 4. Food preparation and service items were found dirty, 5. Food items were mislabeled, 6. Rental coffee machine had not been recently serviced and filter was more than three years old, 7. Nursing staff did not protect resident food and beverage during meal service, 8. Adequate utensils were not available during meal service, 9. Custard did not undergo the cool down process, 10. Staff unable to state manual dish washing process, and, 11. Hot food was not kept out of the temperature danger zone when cooked food had to be rotated off and on burners during meal production. This had the potential of leading to food borne illnesses in the 94 residents eating facility prepared meals. Findings: 1. During an observation on [DATE] at 8:30 a.m. in the dry storage area of the kitchen, there was a dented can of red sweet bell peppers. During an interview on [DATE] at 11:55 a.m. with the Registered Dietician (RD), the RD stated that the risk of a dented can is that it can possibly lead to botulism (food poisoning caused by a bacteria growing on improperly sterilized canned meats and other preserved foods). The RD further stated that the food product will go bad in dented cans and should not be used. During a review of the facility's undated policy and procedure titled, Food Receiving and Storage, in the section, Dry Food Storage, indicated, . 3. Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use . (continued on next page)

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	08/01/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Food and Drug Administration 2022 Food Code indicated, .A primary line of defense in ensuring that food meets the requirements of S ,d+[DATE].11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting and processing, they do not fall victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. The Food and Drug Administration (FDA) considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted and pitted or dented cans may also present a serious potential hazard . 2. During an observation on [DATE] at 8:30 a.m. in the dry storage area of the kitchen, a bag of graham cracker crumbs was found expired. The graham cracker crumbs package had an open date of [DATE] and a use by date of [DATE]. During an observation on [DATE] at 9:08 a.m. in the walk-in refrigerator of the kitchen, three sandwich bags that contained cheese sandwiches had a prepared date of [DATE] and an expiration date of [DATE]. During an observation on [DATE] at 9:29 a.m. in the reach-in refrigerator of the kitchen, two expired broth concentrates were noted. A roasted garlic flavor base concentrate had an open date of [DATE] and a use by date of [DATE]. A turkey base concentrate had an open date of [DATE] and a use by date of [DATE]. During an observation on [DATE] at 9:37 a.m. in the reach-in freezer of the kitchen, frozen bread dinner rolls were noted with an open date of [DATE] and a use by date of [DATE]. During an observation on [DATE] at 9:32 a.m. in the walk-in refrigerator of the kitchen, three sandwich bags containing tuna sandwiches had a prepared date of [DATE] and an expiration date of [DATE]. During an interview on [DATE] at 9:35 a.m. with Dietary Aide (DA) 1, DA 1 stated that the tuna sandwiches were expired and that sandwiches should have a three day use by date, not four days that were written on the label. During an interview on [DATE] at 9:37 a.m. with the Certified Dietary Manager (CDM), the CDM stated that the new trainees kept making these mistakes. The CDM further confirmed the expiration of the tuna sandwiches and proceeded to toss them away in the garbage. During an interview on [DATE] at 11:55 a.m. with the RD, the RD stated that food-borne illnesses can occur with expired foods. The RD further stated she did not want that to happen. During an interview on [DATE] at 12:39 p.m. with the CDM, the CDM stated that the immune system of residents could be impaired (making them more susceptible to illness). She further stated the quality of canned or dried foods would diminish as they are expired. During a review of the facility's undated policy and procedure titled, Food Receiving and Storage, in the section, Dry Food Storage, indicated, . 3. Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use . (continued on next page)

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	08/01/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's undated policy and procedure titled, Food Receiving and Storage, in the section, Refrigerated/Frozen Storage, indicated, . 7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date 3. During an observation on [DATE] at 8:39 a.m. in the dry storage area of the kitchen, a bin containing raisin bran cereal was left uncovered when the lid was not placed securely. During an interview on [DATE] at 8:56 a.m. with the CDM, the CDM stated that critters could get into the bin if left uncovered. The CDM further stated that the cereal can get dry and stale. During a review of the facility's undated policy and procedure titled, Food Receiving and Storage, in the section, Dry Food Storage, indicated, . 3. Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use . 4. During an observation on [DATE] at 9:15 a.m. in the kitchen, a can opener was noted with metal wearing off the tip of the blade. Review of US FDA 2022 Food Code section ,d+[DATE].11 Good Repair and Proper Adjustment. indicated that (C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate FOOD when the container is opened. During an observation on [DATE] at 8:58 a.m. in the kitchen, a meat slicer was noted with food residue build-up on the side of the base. During an observation on [DATE] at 9:22 a.m. in the kitchen, the floor sink was noted to be dirty with dark grayish and rust stains as well as debris. The CDM confirmed that the floor sink was dirty. During an observation on [DATE] at 9:29 a.m. in the kitchen, three bowls were found to be dirty and three coated pans were found with over half of the surface showing metal with the coating flaking off. During an interview on [DATE] at 9:33 a.m. with the CDM, the CDM stated that those nonstick pans needed to be replaced. During an observation on [DATE] at 10:01 a.m., the grill was found to have black film around the grill top surface edges. The grease receptacle was full of food products and the cooking surface was covered in black grease. During an interview on [DATE] at 10:33 a.m. with the RD, the RD stated that the kitchen should be clean. The RD stated she expected the equipment to be free of debris. During an interview on [DATE] at 12:39 p.m. with the CDM, the CDM stated that when equipment is not cleaned, it can potentially cause a fire. The CDM also stated that if not cleaned, the kitchen could attract rodents and flies, especially since pests can come through the floor sink if left dirty. (continued on next page)

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	08/01/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure titled, Equipment dated ,d+[DATE], in the section, Procedures indicated, . 3. All food contact equipment will be cleaned and sanitized after every use . A review of the US FDA 2022 Food Code, section ,d+[DATE].11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, [DATE] version, indicated, .(C) Non-Food Contact Surfaces of Equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris . 5. During an observation on [DATE] at 8:59 a.m. in the dry storage area of the kitchen, a corn starch container had an open date of ,d+[DATE] and a use by date of ,d+[DATE]. There were no years listed. During an observation on [DATE] at 9:08 a.m. in the walk-in refrigerator of the kitchen, seven turkey and cheese sandwiches, nine ham and cheese sandwiches, and eight turkey sandwiches were left unlabeled without any prepared dates or use by dates listed on the packaging. During an observation on [DATE] at 9:20 a.m. in the walk-in refrigerator of the kitchen, a container of orange juice was labeled with an open date of [DATE] and a use by date of [DATE]. During an interview on [DATE] at 9:25 a.m. with DA 1, DA 1 stated that the orange juice has a shelf life of five days. DA 1 also stated that it contained the wrong use-by date of a three-day shelf life instead of a five-day shelf life. During an interview on [DATE] at 11:55 a.m. with the RD, the RD stated that foods should be labeled. The RD also stated that the kitchen staff would not know when food items go bad if it is not labeled correctly. The RD further stated that best practice would be to place a year on the labels. During an interview on [DATE] at 12:39 p.m. with the CDM, the CDM stated that mislabeling food items would be an issue since staff would not know how long items have been stored if there was no date or year listed. The CDM further stated that food items can get mixed up if they are not properly labeled and cause issues for residents with allergies. During a review of the facility's undated policy and procedure titled, Food Receiving and Storage, in the section, Refrigerated/Frozen Storage, indicated, . 1. All foods stored in the refrigerator or freezer are covered, labeled and dated . During a review of the facility's undated policy and procedure titled, Food Receiving and Storage, in the section, Dry Food Storage, indicated, . 4. Dry foods that are stored in bins and removed from original packaging, must be labeled and dated . A review of the US FDA Food Code 2022, section ,d+[DATE].17 (A)(B)(C)(D), indicated, Time/Temperature Control for Safety Food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed ., sold, or discarded . The day of preparation shall be counted as Day 1. 6. During an observation on [DATE] at 11:50 a.m. in the kitchen area, a water filter for the coffee machine was dated as of [DATE]. DA 2 was observed pouring water into a pitcher using the coffee machine. (continued on next page)

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	08/01/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 12:39 p.m. with the CDM, the CDM stated that an outside company serviced the machine and that they no longer had the contract. The CDM agreed that three years was a long time for a filter to not be changed. 7. During an observation on [DATE] at 12:19 p.m. in the main dining hall, Certified Nurse Assistant (CNA) 10 was noted handing two cups of ice and one cup of ice water to Resident 73. CNA 10 carried the cups with his bare hand covering the top (drinking surface) of the cups, and ice was overflowing from the top of the cups likely in contact with his bare hand. During an interview on [DATE] at 10:33 a.m. with the RD, the RD stated that staff should not carry food items or beverages with their bare hands over the top of the cups, as a transfer of bacteria from hands to the food items may occur. The RD further stated staff should use lids to protect the food and beverage items. During an interview on [DATE] at 12:39 p.m. with the CDM, the CDM stated there could be cross contamination issues if cups are carried with bare hands touching the food items. The CDM further stated it would not be visually appetizing for a resident to see that. During an interview on [DATE] at 9:33 a.m. with the Director of Staff Development (DSD), the DSD stated that is not okay for the staff to be carrying food items with their bare hands over the top of the food item. During a review of the facility's policy and procedure titled, Meal Distribution dated ,d+[DATE], in the section, Procedures indicated, . 3. All foods that are transported to dining areas that are not adjacent to the kitchen will be covered . During a review of the facility's policy and procedure titled, Food Preparation and Service dated ,d+[DATE], in the section, Food Distribution and Service indicated, . 7. Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks . 14. Staff does not handle ice with bare hands . 8. During an observation of the lunch meal plating on [DATE] at 1:13 p.m., the plating was held for approximately 10 minutes during the last cart. The CDM was noted at the dish machine looking for spoons to wash as staff had run out of spoons for the resident lunch meal. After several minutes of attempting to wash additional spoons, she returned and told staff to use plastic spoons on the remaining trays. During an interview at the Resident council meeting on [DATE] at 3:28 p.m., residents reported not getting proper utensils with the meals, often getting only two of the three items of silverware. A conversation ensued with residents discussing how they have had to use the handle of a fork or spoon to butter bread due to not having a knife available. During an interview on [DATE] at 12:39 p.m. with the CDM, the CDM stated that she had not been made aware of the lack of utensils. 9. During the initial kitchen tour on [DATE] at 8:18 a.m., three trays of custard cups (custard in muffin wells) were observed in the walk-in refrigerator. The CDM stated that they had been prepared the previous day for dessert that evening. (continued on next page)

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	08/01/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the cool-down log on [DATE] at 9:20 a.m. did not include the custard cups on the log. The CDM confirmed that they had not been added to the log. During an interview on [DATE] at 12:39 p.m., the CDM stated that most any food item can go bad and spoil which can lead to food borne illness, especially foods with a high protein content. Review of a facility provided Baked Custard Cup recipe (HPSI Menu Service ,d+[DATE] MGA, Inc.), indicated that the recipe for 50 servings included liquid eggs (1 quart plus ,d+[DATE] cup) and skim milk (1 gallon plus 1 quart). Review of facility provided policy titled Food Preparation and Service (Med-Pass, Inc., Revised 2022) in the section on Rapid Cooling indicated: 1. Potential hazardous foods are cooled rapidly. This is defined as cooling from 135 degrees F (Fahrenheit) to 70 degrees F within two hours and then to a temperature of 41 degrees F or below within the next 4 hours. Review of the US FDA 2022 Food Code indicated in section ,d+[DATE].14 on cooling that Safe cooling requires removing heat from food quickly enough to prevent microbial growth. Excessive time for cooling of time/temperature control for safety foods has been consistently identified as one of the leading contributing factors to foodborne illness.If the food is not cooled in accordance with this Code requirement, pathogens (disease producing organisms) may grow to sufficient numbers to cause foodborne illness. 10. During the initial kitchen tour on [DATE] at 9:38 a.m., Dietary Aide (DA) 2 was interviewed about the manual (3 compartment sink) dish washing process. The CDM appeared and prompted DA 2 on how to set up the 3 compartments. DA 2 was unable to give specifics of water temperature or sanitation time. During a return visit to the kitchen on [DATE] at 8:50 a.m., DA 3 was interviewed regarding the manual dishwashing process. DA 3 was unclear about how long to keep items in the sanitizer stating 10 seconds versus the 1 minute that was indicated on the directions above the sink. Review of the US FDA 2022 Food Code section ,d+[DATE].11 on Hot Water and Chemical sanitation indicated that After being cleaned, equipment food-contact surfaces and utensils shall be sanitized in: .(C) Chemical manual or mechanical operations, including the application of SANITIZING chemicals by immersion . Contact times shall be consistent with those on EPA [environmental protection agency] registered label use instructions . It further indicated that In order to effectively clean and sanitize food contact surfaces .the surface must be first cleaned properly to remove organic material. In most cases this requires use of detergents or other cleaners such as described in Section ,d+[DATE].14 of the Food Code. After the surface is clean to sight and touch, a sanitizing solution of adequate temperature with the correct chemical concentration should then be applied to the surface. The sanitizing solution must stay on the surface for a specific contact time as specified in this Code and in accordance with the manufacturer's EPA-registered label, as applicable. (continued on next page)

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	08/01/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11. During a kitchen observation on [DATE] at 8:50 a.m., [NAME] 1 started her lunch meal preparation by opening 4 bags of the California mix vegetables and emptied them into a steam table pan. [NAME] 1 put a medium steam table pan of water on to boil (which covered two of the six burners), after the water came to boil, she placed the pan of vegetables in the water bath to heat. During this kitchen observation on [DATE] at 9:13 a.m. [NAME] 1 poured 2 boxes of lasagna noodles into a medium steam table pan and covered with hot water. [NAME] 1 put the pan on the stove over two more of the six burners to bring to a boil. As [NAME] 1 continued with lunch preparation she made a cream sauce, country style gravy, and pureed bread on the remaining two stove burners (all items included milk and/or cheese). As items were heated, other items were removed from the heat and placed to the side of the stove with no temperature control occurring. Review of facility provided policy titled Food Preparation and Service (Med-Pass, Inc., Revised 2022) in the section on Food Preparation, Cooking and Holding Time/Temperatures indicated that: 1. 'Danger Zone' for food temperatures is above 41 degrees F (Fahrenheit, a unit of measurement) and below 135 degrees F. This temperature range promotes the rapid growth of pathogenic microorganisms (small living organisms) that can cause foodborne illness. 2. Potentially Hazardous Food (which requires time/temperature control for safety to limit the growth of pathogens] .includes egg, milk, yogurt, and cottage cheese. In the same policy under General Guidelines it further indicated the importance of Identification of potential hazards in the food preparation process and adhering to critical control points can reduce the risk of food contamination and thereby minimize the risk of foodborne illness. Review of the US FDA 2022 Food Code indicated that A full and adequate cook during the final cooking step is of critical importance to ensure destruction of any pathogens that may have survived and proliferated (to increase in numbers) during any initial heating and cooling stages of the non-continuous cooking process. Section ,d+[DATE].14 requires that an establishment using non-continuous cooking processes also establish procedures for identifying foods that have only been partially cooked and cooled. This is necessary to ensure these foods are not mistaken by food workers for foods that have been fully cooked . During an interview of the CDM on [DATE] at 11:12 a.m., the CDM stated that they previously had a steamer that was dedicated to heating vegetables and starches. It broke down a while ago, and a replacement was sent but it was not the correct model, so they have had to do without. The CDM further stated that it had been a challenge to cook vegetables to the correct texture without a steamer. During an interview on [DATE] at 2:31 p.m., Resident 71 complained that vegetables have been too hard for her to chew. She further stated that she had lacked teeth for many years and could eat most everything but has not been able to eat the vegetables here over 95% of the time. (continued on next page)

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	08/01/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 2:37 p.m., Resident 34 stated that she was unable to eat the vegetables here most days due to the texture.

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	08/01/2024

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 50018 Based on interview and record review, the facility failed to ensure implementation of their policy regarding personal food storage when there was not a microwave or refrigeration unit for the residents of the facility. This failure had the potential to limit resident rights and enjoyment of food brought by family and visitors as well as decrease the safety of food from both inside and outside the facility when proper storage and reheating was not available. Findings: During a review of the facility's policy and procedure titled, Personal Food Storage dated 4/17, in the section, Policy, indicated, . Food or beverage brought in from outside sources for storage in facility, refrigeration units, or personal refrigeration units will be monitored by the designated facility staff for food safety. During an interview on 7/29/24 at 2:55 p.m. with Licensed Nurse (LN) 4, LN 4 stated that refrigerators and resident microwaves have been gone for a while. During an interview on 7/29/24 at 2:58 p.m. with the Director of the Sub-Acute Unit (DSU), the DSU stated that there was not a microwave or refrigerator unit at the sub-acute station. During an interview on 7/29/24 at 3:01 p.m. with the Certified Dietary Manger (CDM), the CDM stated the facility did have two refrigeration units and two microwaves when she first started. The CDM also stated that one of the resident refrigerators stopped working and she believed the administration took out the other refrigerator at that time. The CDM further stated that the kitchen was given one of the microwaves and that she was unsure what happened to the other microwave. During an interview on 7/30/24 at 3:02 pm. with the Director of Maintenance (DOM), the DOM stated that the microwave and refrigerator were taken out by the previous administration due to safety concerns. The DOM further stated residents would go into the break room to use the microwave by themselves which they feared would lead to injury.

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	08/01/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47046 Based on observation, interview, and record review the facility failed to ensure safe infection prevention practices were used for a census of 118 when: 1. A bedpan (a container used to collect urine or feces, and it is shaped to fit under a person lying or sitting in bed) in Resident 43's shared bathroom was unlabeled with a resident name and was left on the floor, and 2. Resident 96's room contained clutter, unknown items, and trash. These failed practices could contribute to the spread of infection by cross-contamination in the facility. Findings: 1. During an observation on 7/29/24 at 10:28 a.m. in Resident 43's shared bathroom (shared with room [ROOM NUMBER]), a used bedpan with no resident name was observed on the floor. During a concurrent observation and interview on 7/29/24 at 10:30 a.m., with Certified Nursing Assistant (CNA) 5, CNA 5 confirmed the bedpan in Resident 43's shared bathroom was on the floor and did not have a name or other identifier placed on the bedpan. CNA 5 stated that the risk of leaving a used bedpan without a name in a shared bathroom on the floor was infection. CNA 5 stated the bedpan could have been used for a resident that it did not initially belong to. During an interview on 8/1/24 at 1:15 p.m. with the Director of Nursing (DON), the DON stated her expectation was that the bedpan should have been labeled with a resident's name and room number and should not have been placed on the floor. The DON stated this practice could spread infection among other residents in the facility. 43943 2. A review of Resident 96's clinical record titled, ADMISSION RECORD (a document that contained the resident's demographic information), indicated Resident 96's diagnosis included a history of a stroke (something blocks blood supply to part of the brain and the brain become damaged, resulting in a disability), and weakness on the left side of the body. During an observation on 7/29/24, at 10:01 a.m., Resident 96's room had eight large card board boxes, five large gray storage bins, one large black trash bag, seven grocery bags, and clothes and trash on top of the boxes lying on the floor. During an interview on 7/30/24, at 1:43 p.m., with CNA 9, CNA 9 stated she did not know the contents of the boxes, bins, or trash bags. During an interview on 7/30/24, at 1:49 p.m., with Resident 96, Resident 96 told the [Department] to get out of her room because Resident 96 did not want to talk. (continued on next page)

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	08/01/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/30/24, at 2:00 p.m., with Licensed Nurse (LN) 5, LN 5 stated Resident 96 did not allow staff to clean the room. LN 5 stated Resident 96's room has an odd smell in the air. LN 5 stated Resident 96 has a lot of food in her room and will not throw the food away. LN 5 stated Resident 96's room posed an infection control risk. A review of Resident 96's clinical record titled, Care Plan, dated, 7/29/24, indicated Resident 96's behavior included hoarding her belongings and putting them on the floor. During a review of the facility's documents titled, Homelike Environment, dated 2/22, indicated, . The facility staff and management maximizes . clean, sanitary and orderly environment . During a concurrent interview and record review on 7/31/24, at 9:53 a.m., with the Administrator, (ADM), the facility's Policy and Procedure (P&P) titled, Policies and Procedures - Infection Prevention and Control, dated 12/23, indicated, . The objectives of the infection prevention and control policies and procedures are to: a. monitor, prevent, detect, investigate, and control infections in the facility, b. maintaining a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the . public . The ADM stated Resident 96 had hoarding behaviors and had a lot of food and other items in boxes. The ADM stated the room was a mess and acknowledged the P&P was not followed.