

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055962	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER Windsor Monterey Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 Skyline Drive Monterey, CA 93940	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35386</p> <p>Based on interview and record review, the facility failed to ensure one allegation of abuse was reported to the California Department of Public Health (CDPH) within 24 hours for one sampled resident (Resident 1) when Resident 1 filed a grievance of an allegation of abuse on 1/27/24 but the facility did not report to CDPH until 2/2/24. This failure resulted in the delay of the abuse allegation investigation and had the potential to result in further abuse.</p> <p>Review of Resident 1's Face Sheet (document that contains a summary of personal and demographic information), indicated Resident 1 was admitted to the facility on [DATE] with a primary diagnosis of fracture (break in bone) of neck, unspecified, subsequent encounter. Face Sheet further indicated Resident 1 was self-responsible.</p> <p>Review of Resident 1's Discharge Summary from an acute care hospital, dated 1/26/24, indicated Resident 1 suffered a head on collision in a motor vehicle accident (MVA), she had chronic pain and required high doses of opiates (a substance used to treat pain).</p> <p>Review of Resident 1's Minimum Data Set (MDS, as assessment tool), dated 12/6/23, indicated Resident 1 had no cognitive impairment.</p> <p>Review of a Resident Grievance/Complaint Investigation Report, dated 1/27/24, indicated . at approximately 2:00 a.m. Resident 1 notified a certified nursing assistant (CNA) of feeling unwell .CNA checked vital signs and reported to nurse .per patient nurse entered room shouting, what do you want me to do! . while speaking to patient nurse had her hand on patient's left leg. Nurse repeatedly shouted what do you want me to do?! . patient responded, I don't know.Nurse responded, there's nothing we can do, we do not have your meds yet! . per patient nurse walked away and touched her leg rough. Resident</p> <p>Grievance/Complaint Investigation Report further indicated Resident 1 asked CNA to accompany nurse into patient's room for the rest of the shift which CNA was unable to do. Resident Grievance/Complaint Investigation Report indicated response to grievance was nurse will require witness to be present during any interactions with patient.</p> <p>Review of State of California (SOC 341, Report of Suspected Dependent Adult/Elder Abuse), dated 2/2/24, indicated reported to CDPH on 2/2/24.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 055962	If continuation sheet Page 1 of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055962	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER Windsor Monterey Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 Skyline Drive Monterey, CA 93940	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the alleged perpetrator Registered Nurse (RN) employee file indicated the RN received a written warning for yelling and smacking left leg of resident. Employee file also indicated the RN was suspended on 2/2 and returned to work on 2/7.</p> <p>During a concurrent telephone interview and record review, on 5/29/24 at 10:51 a.m., with the Assistant Director of Nurses (ADON), the Resident Grievance/Complaint Investigation Report, dated 1/27/24 was reviewed. ADON acknowledged Resident 1's grievance was an allegation of abuse and ADON stated she does not know why it took so long to report. ADON acknowledged it should have been reported within 24 hours.</p> <p>Review of the facility's revised August 2022 policy Abuse Prohibition & Prevention indicated, the facility will report allegations of abuse .no later than 24 hours .to state survey agency, law enforcement, ombudsman and adult protective services (APS).</p>