

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/12/2025
NAME OF PROVIDER OR SUPPLIER  Windsor Vallejo Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 Tuolumne Street Vallejo, CA 94589	

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 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>39489</p> <p>Based on observation, interview and record review, the facility failed to follow the physician's order for a dressing change around an Intravenous Central Line (IVCL, flexible tube inserted into a vein to the heart and used to administer medications or nutrition) every 7 days for one of four sampled residents, Resident 1.</p> <p>This deficient practice may potentially cause a life-threatening infection to Resident 1.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record, indicated, Resident 1 was admitted in the facility on 1/24/25 with diagnoses that included Necrotizing Fasciitis (flesh eating bacteria), severe sepsis with septic shock (life-threatening condition when an infection spreads throughout the body and causes a dangerously low blood pressure) and gangrene (a serious condition where tissue dies due to a lack of blood supply).</p> <p>A review of Resident 1's Brief Interview for Mental Status, (BIMS, tool used to identify cognitive conditions) Section C, showed a score of 14, which indicated he was cognitively intact.</p> <p>During a concurrent observation and interview in Resident 1's room on 2/12/25 at 1:55 p.m., with Licensed Nurse 2 (LN 2), Resident 1's IVCL dressing on his right upper arm was dated 1/24/25. LN 2 confirmed the dressing of Resident 1's IVCL was not changed since 1/24/25, and stated per facility's policy and procedure, the dressing should have been changed every 7 days to prevent the occurrence of an infection at the site. LN 2 further stated, she did not check the dressing to determine if it needed to be changed before initiating the antibiotic infusion to Resident 1.</p> <p>During an interview on 2/12/25 at 2 p.m., with Resident 1, Resident 1 stated, the dressing to his right upper arm was done in the hospital and was never change since he was admitted here in the facility.</p> <p>During an interview on 2/12/25 at 3:30 p.m., with the Director of Nursing (DON), the DON stated, she expected the Registered Nurses (RN) to change the dressing every 7 days per policy and physician's order.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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NAME OF PROVIDER OR SUPPLIER  Windsor Vallejo Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2200 Tuolumne Street Vallejo, CA 94589	

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/13/25 at 1:52 p.m., with LN 3, LN 3 stated, she infused Resident 1's antibiotic thru his IVCL and did not check the date written on the dressing before she infused the antibiotics. LN 3 further stated, per policy and physician's order, they are supposed to change the dressing every 7 days to prevent possible infection.</p> <p>During an interview on 2/13/25 at 2:10 p.m., with LN 4, LN 4 stated, she infused Resident 1's antibiotic thru his IVCL and did not change the dressing as indicted in their policy. LN 4 further stated, she should have followed the physician's order to change the dressing every 7 days to prevent occurrence of infection.</p> <p>During a review of the Resident 1's Order Summary Report, [physician orders] indicated, . IV Central Lines active orders #1 Dressing change Q [every] 7 days &amp; PRN [as needed] . order date 01/24/2025 .</p> <p>During a review of Resident 1's MEDICATION ADMINISTRATION RECORD, dated 1/1/25 to 1/31/25, Resident 1's antibiotic was started on 1/25/25 and given intravenously (IV, given directly into a person's vein).</p> <p>During a review of Resident 1's MEDICATION ADMINISTRATION RECORD, dated 2/1/25 to 2/28/25, Resident 1 continued to receive his antibiotic as ordered by the physician.</p> <p>During a review of Resident 1's Progress Notes, dated 1/24/25, indicated, .Resident is on IV ATB [antibiotic, name of drug] every 8 hours. IV midline on right upper arm, single lumen .</p> <p>A review of the facility's policy and procedure titled, Physician Orders, effective date 3/22/22, indicated, . VIII. the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. Medication/treatment orders will be transcribed onto the appropriate resident administration record ., IX. Supplies/medications required to carry out the physician order will be ordered .</p> <p>A review of the facility's policy and procedure titled, PICC DRESSING CHANGE [Peripherally Inserted Central Catheter], dated June 2018, indicated . I. To Be Performed By: RN ' s and IV [intravenous] Certified LVN's according to state law and facility policy . B. Dressing changes sing transparent dressings are performed: . At least weekly .</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39489</p> <p>Based on observation, interview and record review, the facility failed to properly discard a used syringe for one of four sampled Residents (Resident 1), when the used syringe was observed on Resident 1's bedside table.</p> <p>This failure had the potential for Resident 1 and facility staff to accidentally poke themselves and cause injury.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record, indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis that included Necrotizing Fasciitis (flesh eating bacteria), severe Sepsis with septic Shock (life-threatening condition when an infection spreads throughout the body and causes a dangerously low blood pressure) and gangrene (a serious condition where tissue dies due to a lack of blood supply).</p> <p>A review of Resident 1's Brief Interview for Mental Status, (BIMS, tool used to identify cognitive conditions) Section C, indicated Resident 1 was cognitively intact.</p> <p>During a concurrent observation and interview at resident 1's room, with Licensed Nurse 1 (LN 1), on 2/12/25 at 1:15p.m., a used syringe was left unattended on Resident 1's bedside table. LN 1 acknowledged she gave Resident 1 his injection and left the syringe on his bedside table. LN 1 confirmed she should have discarded the syringe after use in the sharps container (container used to safely dispose of needles).</p> <p>During an interview on 2/12/25 at 3:30 p.m., with the Director of Nursing (DON), the DON stated, her expectations from the nurses was to discard used syringes in the sharps containers.</p> <p>A review of the facility's policy and procedure, titled Subcutaneous Injections, revised March 2011, indicated, . The following equipment and supplies will be necessary when performing this procedure . 6. Sharps container; and . 15. Discard uncapped needle and syringe into designated sharps container .</p>		