

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  03/05/2025
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>46242</p> <p>Based on observation, interview, and record review, the facility failed to safely administer medications in accordance with acceptable professional standards of quality for one of five sampled residents (Resident 1), when Resident 1 was found in his room with unattended medications at his bedside table.</p> <p>This failure decreased the facility's potential to prevent medication errors.</p> <p>Findings:</p> <p>A review of Resident 1's admission record, dated 3/5/25, indicated Resident 1 was admitted to the facility in the fall of 2024.</p> <p>A review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/25/25, indicated Resident 1 was cognitively intact and had no memory issues.</p> <p>A review of Resident 1's care plan, dated 3/5/25, indicated no care plans related to self-administration of medications.</p> <p>A review of Resident 1's Order Summary Report (OSR, a summary of all physician and care-related orders), dated 3/5/25, indicated no orders for self-administration of oral medications.</p> <p>During a concurrent observation and interview on 3/5/25 at 10:11 a.m. with Resident 1 in his room, no staff were observed supervising Resident 1, and two medication cups were on top of his bedside table. One cup contained two similar-looking small white pills, and another cup contained eight different-looking pills. Resident 1 stated nurses were overworked and were dropping his medications for weeks without observing him taking them. Resident 1 also stated one or two of the medications in the cups were controlled substances and his roommate had dementia (a progressive state of decline in mental abilities) and was occasionally touching his bedside table.</p> <p>During an interview on 3/5/25 at 10:32 a.m. with Licensed Nurse 1 (LN 1), LN 1 confirmed she provided Resident 1's medications earlier and stated she was supposed to watch Resident 1 take them. LN 1 also stated Resident 1 did not have any order for self-administration of medications.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/5/25 at 4:46 p.m. with the Director of Nursing (DON), DON confirmed Resident 1 was not assessed for self-administration of medications and LN 1 was supposed to observe Resident 1 taking his medications before leaving the room. DON further stated leaving the medications unsupervised in the room was unacceptable.</p> <p>A review of the facility's policy and procedure titled, Administering Medications, revised in April 2019, indicated, . Medications are administered in accordance with prescriber orders, including any required time frame . The individual administering the medication initials the resident's MAR [Medication Administration Record] on the appropriate line after giving each medication and before administering the next ones . Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46242</p> <p>Based on observation, interview, and record review, the facility failed to implement infection control practices for a census of 150 residents, when Licensed Nurse 1 (LN 1) did not conduct hand hygiene after leaving Resident 1's room.</p> <p>This failure decreased the facility's potential to prevent the spread of infections among residents.</p> <p>Findings:</p> <p>A review of Resident 1's admission record, dated 3/5/25, indicated Resident 1 was admitted to the facility in the fall of 2024.</p> <p>During an observation on 3/5/25 at 10:11 a.m. two medication cups were placed unattended on top of Resident 1's bedside table.</p> <p>During a concurrent observation and interview on 3/5/25 at 10:32 a.m. with Licensed Nurse 1 (LN 1), LN 1 was observed bringing eight medication bubble packs to Resident 1's room then placing them on top of Resident 1's bed. LN 1 compared the bubble packs' medications to the contents of medication cups on the bedside table; then left Resident 1's room without conducting hand hygiene and returned the medication bubble packs back into the medications cart. LN 1 confirmed she did not conduct hand hygiene upon exiting Resident 1's room and stated returning contaminated medication bubble packs back into the clean medications cart increased the risk for spread of infection.</p> <p>During an interview on 3/5/25 at 4:46 p.m. with the Director of Nursing (DON), DON agreed that staff have to conduct hand hygiene upon exiting residents' rooms and stated bringing medication packs that touched surfaces inside Resident 1's room back to the medications cart presented a risk of cross-contamination.</p> <p>A review of the facility's Policy and Procedure (P&amp;P) titled, Administering Medications, revised in April 2019, indicated, Staff follows established facility infection control procedures . handwashing, antiseptic technique, gloves, isolation precautions . for the administration of medications, as applicable.</p> <p>A review of the facility's P&amp;P titled, Handwashing/Hand Hygiene, dated 9/18/23, indicated, All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . Use an alcohol-based hand rub . Before and after contact with the resident . After contact with blood, body fluids, visibly contaminated surface or after contact with objects in the resident room .</p>