STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056324	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Hampton Care Center	442 Hampton Street Stockton, CA 95204

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50716 Based on interview and record review, the facility failed to provide adequate supervision to prevent an avoidable accident for one of three sampled residents (Resident 3) when, Resident 3 exhibited exit seeking behaviors (type of wandering where residents actively try to leave a designated area, often with the intention of going to a familiar place), Resident 3 was not re-evaluated for risk of elopement (when a resident leaves the premises or a safe area without the facility's knowledge and supervision), and interventions to prevent Resident 3's exit seeking behaviors were not created. This failure resulted in Resident 3 falling from a wheelchair on 3/28/25 while exiting the front door and striking her head on the concrete causing a one-and-a-half-inch open wound that required 6 stitches (used to close a wound by sewing the edges of the cut together to help with wound healing), an abrasion (an injury caused by the skin rubbing off) to Resident 3's right elbow and right knee. Findings: A review of Resident 3's ADMISSION RECORD indicated, Resident 3 was admitted to the facility in early 2020 with a diagnosis that included, Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions). During an interview on 4/8/25 at 4:42 PM, in the [NAME] Station Hallway, Licensed Nurse (LN) 1 confirmed she was working PM shift (evening shift from 3 PM - 11:30 PM) on 3/28/25 when Resident 3 eloped and was injured. LN 1 stated Resident 3 was awake and in a wheelchair following LN 3 around the [NAME] Station. LN 1 explained later in the shift, LN 3 came up to her and asked if she had seen Resident 3. LN 1 further explained she went looking for Resident 3 toward the front lobby because Resident 3 has a history of .always trying to leave . LN 1 stated she found an empty wheelchair inside the lobby near the front door. LN 1 further stated she checked the name on the wheelchair, and it belonged to Resident 3. LN 1 stated she opened the front door and then found Resident 3 outside on the ground. LN 1 explained she observed Resident 3 partially sitting up, holding a napkin to her head, and had blood running down her face. LN 1 stated she quickly assessed Resident 3 and went to get staff to assist Resident 3. LN 1 further stated Resident 3 had known behaviors of stating she wanted to leave the facility in the past and was making statements earlier in the evening on 3/28/25. LN 1 stated on the evening of 3/28/25 prior to Resident 3 falling, Resident 3 was very adamant and stated several times she wanted to go home. (continued on next page)

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 4/9/25 at 3:29 PM, LN 3 stated on 3/28/25, during the PM shift, Resident 3 was in a wheelchair and followed LN 3 from room to room in the [NAME] Hallway while medications were being passed to other residents. LN 3 explained just before 9 PM she had to go into a room where she had to put on full personal protective equipment (PPE -clothing and equipment that is worn or used to provide protection against germs) and give a medication through a gastrostomy tube (GT -a surgically placed tube that provides direct access to the stomach for food or medications) which takes more time to prepare and give. LN 3 further explained she came out of the room, documented the medication in the electronic health record (a collection of resident health information stored in a digital format), and then moved to the next room. LN 3 stated she then realized Resident 3 was no longer following her. LN 3 further stated she checked the nurse's station, the resident's room, bathroom, and other resident's rooms while LN 1 went toward the sound of an alarm at the front door. LN 3 stated LN 1 came back and said she found Resident 3 outside the front door and needed assistance getting her back in the wheelchair. LN 3 stated she checked Resident 3 for injuries, called the MD (medical doctor) and received an order to send Resident 3 to the hospital for evaluation and treatment. LN 3 confirmed Resident 3 did not have on a monitoring bracelet (a device used to alert staff of a resident leaving the premises) on the date of the fall (3/28/25). LN 3 explained Resident 3 had a previous incident of being agitated and verbalized she wanted to leave in the recent past. LN 3 stated last week the resident had wandered (move in a leisurely, casual, or aimless way) into another resident's room towards East station and was asking another residents family member to give her a ride home. LN 3 stated she did not complete an elopement risk assessment but documented the behaviors. During an interview on 4/8/25 at 5:35 PM, Certified Nursing Assistant (CNA) 3 confirmed she was working PM shift on 3/28/25 and assisted in helping Resident 3 back into the wheelchair. CNA 3 further stated she heard the front door alarm sounding for about 5-8 minutes before she was asked to help Resident 3 back into the wheelchair after the fall. CNA 3 explained Resident 3 did not have a monitoring bracelet on at the time of the fall. CNA 2 further explained the front door was armed to alert staff when someone came or left the front door after the front desk staff left for the evening. During a concurrent interview and record review on 4/8/25 at 4:52 PM, Resident 3's Elopement Evaluation, dated 7/12/24 and 3/29/25, were reviewed with LN 2. LN 2 stated Resident 3 was assessed for elopement risk on 3/29/25, one day after the fall with injuries. LN 2 further stated Resident 3 was not considered an elopement risk prior to 3/28/25 because she did not meet criteria when assessed for an elopement risk on 7/12/24. LN 2 explained the elopement risk criteria included: Elopement attempts, verbalizing wanting to leave, and exit seeking behaviors. LN 2 further explained when a resident was on elopement risk monitoring, they add additional interventions like the use of a monitoring bracelet, redirecting the resident from known elopement behaviors, and ensuring the residents are more closely watched. During an interview on 4/8/25 at 5:53 PM, the Assistant Director of Nursing (ADON-Interim Director of Nursing) stated her expectation when a new behavior occurs in cognitively impaired (problems with a person's ability to think, learn, remember, use judgement, and make decisions) resident was the staff were required to complete a Change of Condition (COC) form and then they collaborate with their Interdisciplinary Team (IDT - a team of healthcare professionals) to come up with a goal to help the resident. The ADON explained an elopement risk assessment should be completed on admission and when the resident displayed any behaviors that would trigger an assessment. The ADON stated a resident who verbalized they wanted to leave or had exit seeking behaviors would trigger an elopement risk assessment to be done and the resident should be placed on additional monitoring for elopement, including a monitoring bracelet placement. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 4/8/25 at 6:15 PM, the ADON reviewed the facility policy titled, Elopements, revised 2/25, and Resident 3's progress notes (a written record of events related to resident care), dated 3/20/25, 3/23/35, and 3/25/25. The ADON stated, per the facility's elopement policy, an elopement risk assessment should be completed on admission, yearly, and when a resident exhibits elopement behaviors of wandering, repetitively verbalizing a desire to go home or leave, and wanders the facility. The ADON reviewed Resident 3's Progress Notes and confirmed Resident 3 had documented exit seeking behaviors on 3/20/25, 3/23/25 and 3/25/25 when Resident 3 went outside stating she wanted to go home and refused to come back inside the facility. The ADON confirmed these three documented events all occurred prior to Resident 3's fall on 3/282/5. The ADON confirmed Resident 3's elopement risk assessment and care plan (a detailed individualized resident document outlining the specific needs, goals and interventions to meet the goals) for elopement risk was not completed until after the elopement and fall. The ADON further stated a monitoring bracelet was placed on Resident 3 however, it was not documented as placed and monitored until 3/31/25, three days after Resident 3 eloped and was injured. The ADON explained the fall possibly could have been prevented if additional interventions had been in place including: a monitoring bracelet, every 15-minute visual checks (resident safety visual checks to verify resident location) when Resident 3 was in the wheelchair, and an update to the resident's care plan with additional interventions related to an elopement risk. The ADON reviewed Resident 3's, Interdisciplinary Care Conference (a meeting where a team made up of different healthcare disciplines meet to discuss resident care and create a plan for interventions) dated 3/31/25, and stated the root cause of the elopement and fall for Resident 3 was due to cognitive impairment and inadequate supervision. A review of Resident 3's clinical record titled, SBAR [Situation Background Assessment Recommendation; a communication tool used to structure conversations] Communication Form dated 3/20/2025, indicated, . [Resident 3] INCREASED CONFUSION .REPEATEDLY SAYING SHE WANTS TO GO HOME . REQUESTING FOR A RIDE, HEADING TO EXITS .THEN BECAME AGGRESSIVE .Primary Care Clinician notified .3/20/2025 Time: 11:00 PM . A review of Resident 3's clinical record titled, Progress Notes *NEW*, dated 3/23/25 at 3:49 PM, indicated, . [Resident 3] got in her wheelchair and stated she was going home .[Resident 3]went to the front .staff continued to redirect .[Resident 3] to stay inside the facility. After multiple attempts, [Resident] agreed to wait inside in the lobby . A review of Resident 3's clinical record titled, Progress Notes *NEW*, dated 3/25/25 at 3:39 PM, indicated, . [Resident 3] was noted to be agitated .repeatedly stating she wanted to go home, requesting a ride .MD [medical doctor] was notified, and orders were received .for agitation .Behavior monitoring initiated . A review of Resident 3's clinical record titled, View Progress Note, dated 3/25/25 at 4:22 PM, indicated, . [Resident 3] brought in by staff to use the restroom. [Resident 3] still demanding to go home, went back outside the facility. Staff present with [Resident 3] in front of the facility . A review of Resident 3's clinical record titled, Progress Notes *NEW*, dated 3/28/25 at 10:54 AM, indicated, . [Resident 3] requested to talk to family member .stating she wants to go home . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 3's clinical record titled, View Progress Note, dated 3/28/28 at 10:42 PM, indicated, . Found [Resident 3] laying in partial supine/sitting position by the front door .checked for injuries .MD [medical doctor] notified with order to send [Resident 3] out to [Hospital name] ED [emergency department]. Noted and carried out . A review of Resident 3's clinical record titled, Progress Notes *NEW*, dated 3/39/25 at 2:41 AM, indicated, . Back to the facility .from [hospital name] .head injury, fall .1 1/2 inch laceration to right side of forehead with 6 stitches .slight swelling and bruising and bleeding, abrasion to right elbow, abrasion to right knee . A review of Resident 3's clinical record titled, Care Plan Report, revised 9/20/23, indicated, .The resident is at high risk for falls r/t [related to] Confusion .Alzheimer's Dementia .unsafe independent activities .Resident attempted to get OOB [out of bed], Resident was agitated, anxious and was exit seeking and attempted to ambulate [walk] by herself . A review of Resident 3's clinical record titled, Care Plan Report, revised 3/13/24, indicated, .[Resident 3] is at risk for falls: cognitive loss [a decline in thinking, learning, and remembering abilities], lack of safety awareness [a deficiency in recognizing, understanding, and reacting to potential hazards and risks in various situation], Impaired mobility [limitation in a person's ability to move independently] .Interventions .Assess for changes in medical status .mental status and report MD as indicated .Assist resident getting in and out of bed with assistance .Assist resident with ambulation providing assistance using a front wheel walker . A review of Resident 3's clinical record titled, Care Plan Report, initiated on 3/4/25, indicated, .[Resident 3] has an ADL [Activities of Daily Living - tasks you do on a regular basis to take care of your body and overall well-being] Self Care Performance Deficit r/t Alzheimer's, impaired balance .Goal .[Resident 3] will remain free of complications related to .fall related injury . A review of Resident 3's clinical record titled, Care Plan Report, initiated 3/29/25, indicated, .Elopement risk R/T [related to] Dementia and verbalization of wanting to go home. 3/28/25 WENT TO THE FRONT UNATTENDED. WILL HAVE NO FURTHER EPISODES OF LEAVING THE FACILITY. MONITOR WHEREABOUTS WHEN UP ON HER WHEELCHAIR .[brand name of monitoring bracelet] device #8732 to Right side of wheelchair. Date initiated 4/11/25 . A review of the facility policy and procedure titled, Elopements, revised 2/21/25, indicated, .residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care .1. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risk, implementing interventions to reduce hazards and risks .Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering. a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and annually .further evaluate the unique factors contributing to risk in order to develop a person-centered care plan .effectiveness of interventions will be evaluated, and changes will be made as needed .