

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2025
NAME OF PROVIDER OR SUPPLIER Windsor Hampton Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>47369</p> <p>Based on observation, interview, and record review the facility failed to maintain the dignity and privacy of one unsampled resident (Resident 1) when staff transported Resident 1 from his bedroom to the shower room with his penis and scrotum exposed.</p> <p>This failure violated Resident 1's right to privacy and dignity, with the potential to negatively affect Resident 1's psychosocial wellbeing.</p> <p>Findings:</p> <p>During a review of Resident 1's ADMISSION RECORD, indicated he was admitted to the facility in late 2024 with diagnoses that included unsteadiness on feet.</p> <p>During a concurrent observation and interview on the west wing hallway on 4/23/25, at 4:01 PM, Certified Nurse Assistant (CNA) 4 was observed transporting Resident 1, in a shower chair with a toilet seat opening, across the hallway from his room to the shower room. Resident 1 was unclothed with a blanket in his lap covering the front of his legs, the sides were uncovered. Resident 1's penis and scrotum were observed from the side of the shower chair, hanging below the shower seat opening. The Infection Preventionist (IP) confirmed Resident 1 was not covered in a manner that promoted dignity and privacy.</p> <p>During an interview on 4/23/25, at 4:05 PM, the Director of Staff Development (DSD), DSD stated staff were educated on the importance of maintaining residents' privacy and dignity. The DSD further stated Resident 1 should have been covered and not exposed to others. The DSD stated Resident 1's privacy was not maintained when his genitals were exposed to others in the hallway.</p> <p>During an interview on 4/23/25, at 4:18 PM, CNA 4 confirmed she had received training about covering residents and the importance of maintaining their dignity. CNA 4 further stated she had not realized Resident 1 was exposed when she transported him through hallway.</p> <p>A review of a facility policy titled, Dignity, revised 2/2021, indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Residents are treated with dignity and respect at all times .Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care .</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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