

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 05/14/2025
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 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>49823</p> <p>Based on observation, interview, and record review, the facility failed to follow its infection control policy and procedures when there was no sign for Enhanced Barrier Precautions (EBP - infection control intervention to reduce transmission of resistant microorganisms through gown and glove use during high-contact resident care activities) nor a cart with the required personal protective equipment (PPE - gowns, gloves, eye protection, facemasks or respirators used to prevent the spread of germs) outside of Resident 2's room.</p> <p>This failure could have resulted in the spread of a multidrug resistant organism (MDROs, germs that are more difficult to kill with antibiotics) and the need for additional medical interventions (medications and/or treatments) for a census of 115 residents.</p> <p>Findings:</p> <p>A review of Resident 2's ADMISSION RECORD, indicated Resident 2 was admitted to the facility in 2023 with diagnoses which included chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing related problems, shortness of breath and cough), and heart failure (a chronic condition in which the heart does not pump blood as well as it should, causing fluid to back up into the lungs).</p> <p>A review of Resident 2's Acute Care Discharge Summary, dated 4/12/25, indicated, .the patient was admitted .the patient also had .an abnormal UA (urinalysis, a test of urine to check for illness) .she was placed on ertapenem (medication prescribed to treat infection [illness caused by germs]) .after several days the culture (test to check for germs in a urine sample) resulted with CRE (Carbapenem-resistant Enterobacteriaceae, a germ that is difficult to kill with medications prescribed to treat infection) .likely colonization (presence of germs in or on the resident without signs or symptoms of illness but with the ability to spread germs to other people and their environment) .</p> <p>A review of Resident 2's Physician Order Summary, dated 5/7/25, indicated, .Enhanced Barrier Precautions For: CRE .</p> <p>A review of Resident 2's Care Plan Report, dated 5/7/25, indicated, .Focus: Resident is colonized with .CRE and has bowel incontinence, increasing the risk of transmission .Goal: Prevent transmission of CRE to other residents and staff .Interventions .Implement Enhanced Barrier Precautions .</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 2's Progress Notes, dated 5/7/25, at 10:29 a.m., indicated, .Resident is colonized with . CRE, without active infection, wounds, invasive devices (tubes or catheters), or incontinence .Resident is managed with Enhanced Barrier Precautions .</p> <p>During an observation outside of Resident 2's room on 5/14/25, at 10:30 a.m., Resident 2 was noted in her room with a visitor at her bedside. A Maintenance worker was observed changing the battery in the wall clock in Resident 2's room. There was no sign outside Resident 2's door that indicated EBP. There was no cart with PPE outside or near Resident 2's room door.</p> <p>During an interview on 5/14/25, at 12:09 p.m., with the Infection Preventionist (IP), the IP stated Resident 2 was on EBP for CRE. The IP stated that both Resident 2 and Resident 2's roommate required total care for toileting and did not use the shared bathroom. The IP confirmed that there was not a sign on the wall near the door of Resident 2's room that indicated EBP. The IP further confirmed that there was no cart with PPE outside or near Resident 2's room. The IP stated that the risk of not having an EBP isolation sign and a cart with PPE equipment outside or near Resident 2's room was that the staff would not know the proper PPE to wear when providing direct care to the resident and could spread infection.</p> <p>During a review of a facility policy and procedure (P&P) titled, Enhanced Standard/Barrier Precautions, revised 2/21/25, the P&P indicated, .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organism .2. Initiation of Enhanced Barrier Precautions .b. The residents that will benefit with [sp] EBP are the following: ii. Infection or colonization with a MDRO .3. Implementation of Enhanced Barrier Precautions: a. Make personal protective equipment available near or outside of the resident's room .6. Examples of MDROs .Carbapenem-resistant Enterobacteriaceae .</p> <p>Review of an online document published by the Centers for Disease Control and Prevention (CDC) titled, Carbapenem-resistant Enterobacteriales CRE An Urgent Public Health Threat, at https://www.cdc.gov/cre/hcp/infection-control/index.html indicated, .CRE infections don't respond to common antibiotics . Patients colonized with CRE can be a source of spread to other patients .How your facility can prevent the spread of CRE .perform hand hygiene (hand washing with soap and water and/or alcohol-based hand sanitizer) .Enhanced Barrier Precautions .PPE .Follow your facility's cleaning and disinfection protocols .</p>		