STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Care Center of Sacramento	501 Jessie Avenue Sacramento, CA 95838

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39489 Based on observation, interview and record review, the facility failed to follow their Policy and Procedure, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, and report an alleged abuse for one of four sampled residents (Resident 2) when Resident 3 physically harmed Resident 2. This deficient practice placed Resident 2 and other residents in the facility for potential injury from Resident 3. Findings: 1. During a review of Resident 3's Admission Record, indicated, Resident 3 was admitted in the facility on 12/22/23, with diagnoses that included major depressive disorder, unspecified dementia, and with other behavioral disturbances (a pattern of disruptive behaviors). During a review of Resident 3's Brief Interview for Mental Status (BIMS, tool used to identify cognitive conditions) Section C, Cognitive Patterns showed a score of 3 which suggested severe cognitive impairment. During a review of Resident 3's SBAR, Communication Form [SBAR, Situation, Background, Assessment and Recommendation, a communication tool between the staff], dated 7/6/24, indicated, . Peer to peer altercation as an aggressor, resident seen by the CNA 1 [Certified Nursing Assistant] physically twisting another resident's [Resident 2] arm and hitting . During a review of Resident 3's Progress Notes, dated 7/6/24 at 11:19 a.m., indicated, . On 7/5/24 Peer to peer altercation as aggressor, resident seen by the CNA 1 physically twisting another resident's arm [Resident 2] and hitting ., During a review of Resident 3's Care Plan, dated 7/6/24, indicated, On 7/5/24 Resident was involved with peer-to-peer altercation as the suspected aggressor ., During a review of Resident 3's Follow-up Documentation, dated 7/8/24 at 1:47 p.m., indicated, ., Peer-to-peer altercation as a abuser ., (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/24 at 9 a.m., with the Director of Nursing (DON), The DON confirmed Resident 3 and Resident 2 were roommates and CNA 1 witnessed Resident 3 grab Resident 2's arm on 7/5/24. The DON further confirmed the alleged abuse were not reported the day it happened to the nurse on duty, DON, ADON (Assistant Director of Nursing), or to the Abuse coordinator. The DON stated, I expect them to report the alleged abuse right away to the nurse in charge, me, or ADON, separate the residents right away for safety reasons, change their rooms right away and perform a head-to-toe assessment for both residents. The DON added, The staff should have done all that when an alleged abuse like this happens. The DON further added, Resident 2 is bedbound and was transferred to another room. During a concurrent observation and interview with Resident 3, in her room on 7/10/24 at 12 p.m., Resident 3 was laying down on her bed. When asked, Resident 3 stated her name correctly but did not remember the alleged abuse with Resident 2. 2. During a review of Resident 2's Admission Record, the Admission Record indicated, Resident 2 was admitted in the facility on 4/19/22, with diagnoses that included unspecified dementia, major depression, and palliative care (specialized medical care on providing relief from pain and other symptoms of a serious illness). During a review of Resident 2's BIMS, Cognitive Skills for Daily Decision Making, showed Severely Impaired. During a review of Resident 2's SBAR, dated 7/6/24, indicated, ., Peer to peer altercation ., CNA 1 saw [Resident 3] twisting and hitting Resident 2 ., During a review of Resident 2's Progress Notes, dated 7/6/24 at 11:50 a.m., indicated, On 7/5/24 Resident had peer to peer altercation as Victim, resident seen by CNA 1 when resident [Resident 3] is twisting her arms and hitting ., During a review of Resident 2's Progress Notes, dated 7/6/24 at 12 p.m., indicated, . AT AROUND 11:00AM Resident RP [Responsible Party, name of family member] visited today 7/6/24, reported to this writer CNA [1] informed to her that yesterday 7/5/24 am Resident 3, twisted Resident 2's [name of residents] hand and hit ., Resident 2 [name] moved to [another room] ., During a review of Resident 2's Care Plan, date initiated 7/6/24, indicated, Resident with potential/risk to exhibit Psycho-Social distress related to alleged resident to resident altercation ., During an interview with Resident 2's Responsible Party (RP) on 7/10/24 at 10:40 a.m., RP stated she visited her mom on 7/6/24 at around 10 a.m. in the same room where the alleged abuse happened on 7/5/24. The RP stated, CNA 1 was in her mom's room and mentioned she witnessed Resident 3 twisted her mom's wrist. The RP confirmed her mom was bedbound related to contracted lower legs, unable to defend herself, and cannot communicate if she's in pain or not. After she learned about the alleged abuse, she went to the Nurses Station and told the staff about it. The RP further stated, I was so furious when I found out about the incident and told them that I don't want that lady near my mom. She demanded that the other resident or her mom should go to another room, and the staff should have separated them right after the incident to keep her mom safe. The RP verbalized, It's terrifying to think that she shared the same room with that resident after the incident. She confirmed her mom was moved to another room on 7/6/24, and stated, No, I was not told of the incident, nobody called me, they should have informed me if something happens to my mom. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with Resident 2, in her room on 7/10/24 at 11:30 a.m., Resident 2 was laying down on her bed, asleep with family member at bedside. Resident 2 did not respond to questions. During an interview on 7/10/24 at 2:15 p.m., with the DON, the DON confirmed, CNA 1 worked on 7/5/24, and when Resident 2's RP came to visit on 7/6/24, CNA 1 told her about the alleged abuse she witnessed on 7/5/24. The RP then informed the staff about the alleged abuse, and the staff immediately transferred Resident 2 to another room. During an interview on 7/10/24 at 2:35 p.m., with CNA 1, CNA 1 confirmed she worked on 7/5/24, when she witnessed Resident 3 in her wheelchair, holding, and twisting Resident 2's wrist and then heard Resident 3 smack Resident 2. CNA 1 stated, she called for help and CNA 2 came to the resident ' s room and helped CNA 1. When asked, CNA 1 acknowledged she did not report the alleged abuse because she informed CNA 2 of what had happened and hoped that she would report the alleged abuse to the nurse. CNA 1 left the room while CNA 2 stayed because Resident 3 and Resident 2 are not assigned to her. CNA 1 acknowledged on 7/6/24, she informed the RP about the alleged abuse she witnessed on 7/5/24. CNA 1 further acknowledged, she should have reported it to the nurse the day it happened to keep both residents safe. During an interview on 7/10/24 at 2:40 p.m., with CNA 2, CNA 2 confirmed she worked on 7/5/24. CNA 2 stated, she was at the nurses' station when she heard CNA 1 call for a nurse, her scream attracted me and caught my attention. CNA 2 got up and went to Resident 3 and Resident 2's room and saw CNA 1 standing by the door and told her about the alleged abuse she witnessed between the two residents. CNA 2 acknowledged she did not report the incident to the nurse because she did not witness the alleged abuse and assumed Licensed Nurse 1 (LN 1) heard CNA 1 because she was loud when she called for help. CNA 2 further acknowledged it is important to report the alleged abuse to the nurse the day it happened to avoid injuries and keep the residents' safe, It is my duty to report it as a CNA. During an interview on 7/10/24 at 2:50 p.m., with LN 1, LN 1 confirmed he worked on 7/5/24 the day the alleged abuse happened, Resident 3 and Resident 2 were assigned to him, and he did not find out about the alleged abuse until the following day, (7/6/24). LN 1 further confirmed Resident 3 twisted the arm of Resident 2 and CNA 1 informed the RP about the altercation on 7/6/24. The RP came to the nurses' station and told us what happened, and as soon as she informed us, we assessed both residents and changed the room of Resident 2. LN 1 acknowledged and stated, Resident 2 was still sharing a room with Resident 3 until the next day, which is not good because Resident 3 could do that again, twisting Resident 2's arm, it's not safe for both. LN 1 stated, he did not hear CNA 1 call for help, and CNA 2 did not tell him either. LN 1 further stated, We need to separate the residents' after the alleged abuse for their safety, and then assess for any injuries. During an interview on 7/10/24 at 3:25 p.m., with the DON, the DON confirmed, CNA 1 was oriented as part of new hire orientation about the importance of reporting abuse, and all staff are mandated to report abuse. The DON stated, My expectation from the staff is to report abuse as soon as possible to the nurse, myself, ADON or coordinator for abuse. Late reporting and staying in the same room may have caused injuries to the residents' and the aggressor may have attacked the victim one more time. The DON further stated, it's not safe for both residents to be in the same room after the altercation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised date September 2022, indicated, . 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law ., 3. immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; ., must be reported immediately to the administrator and to other officials according to state law ., 3. immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; .,