STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555717	A. Building B. Wing	07/23/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49814 Based on interviews, and record review, the facility failed to protect one of three sampled residents' (Resident 1) right to be free from physical abuse when Resident 2 kicked Resident 1 on the right side of his torso. This failure had the potential to result in serious physical injury to the Resident 1. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses of encephalopathy (brain disease that alters brain function or structure) and alcohol dependance with withdrawal delirium (confused thinking and reduced awareness of surroundings). During a review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 7/16/24, the MDS indicated Resident 1 had a Brief Interview for Mental Status (BIMS) score of 3 indicating he had severe cognitive impairment. A Behavior Note for Resident 1, dated 7/15/24, indicated, Patient is very intrusive .he goes to other peoples' rooms .he is up multiple times in the night and is hard to redirect. Resident 2 was admitted to the facility on [DATE] with a diagnosis of dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had a BIMS score of 5 indicating he had significant cognitive impairment. A General Note for Resident 2, dated 7/17/24, indicated, According to CNA [Certified Nursing Assistant] staff at about 0225 they heard yelling in room [ROOM NUMBER]. There, [Resident 2] was kicking [Resident 1] on the right side several times and the CNAs yelled stop to [Resident 2], and he walked away. During an interview on 7/23/24 at 11:24 a.m. with Resident 2, Resident 2 indicated that Resident 1 had tried to enter his room through the shared restroom and get into his belongings, which agitated Resident 2. Resident 2 admitted to pushing against Resident 1 using the restroom door and that Resident 1 had fallen while doing so. Resident 2 stated, I laid my hands on him .it was in self-defense. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/23/24 at 11:52 a.m. with CNA 1, CNA 1 indicated she was in the hallway when she heard screaming on 7/17/24 around 2:00 a.m. CNA 1 stated, I opened the door and found [Resident 1] on the floor in the doorway of the shared restroom and [Resident 2] was kicking [Resident 1] on the right side of his torso. CNA 1 indicated that before the incident took place, Resident 1 was known to wander the facility and exhibit intrusive behaviors, such as going through the belongings of other residents and trying to lay down in other residents' beds. During an interview on 7/23/24 at 1:07 p.m. with CNA 3, CNA 3 stated, [Resident 1] tried to enter [Resident 2's] room through the restroom. [Resident 2] was redirected to his room, but [Resident 1] returned. That's when I heard yelling and found [Resident 1] on the floor of [Resident 2's] room, with [Resident 2] kicking him 3-4 times on the right side. We intervened, redirected Resident 2, and reported the incident. CNA 3 indicated that it was known by facility staff that Resident 2 has a history of becoming angry when someone enters his room. During a review of the facility's policy and procedure (P&P) titled, Abuse Prohibition & Prevention Policy and Procedure, dated 8/22, the P&P indicated, Each resident has the right to be free from abuse .by anyone, including but not limited to, facility staff, other residents Ongoing resident assessments and care planning for appropriate interventions will be performed to monitor resident needs and address behaviors that may lead to conflict .