

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 08/22/2024
NAME OF PROVIDER OR SUPPLIER Windsor Care Center of Sacramento		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>48445</p> <p>Based on observation, interview, and record review, the facility failed to protect two of five sampled residents (Resident 2 and Resident 3) from abuse when Resident 1 punched Resident 2 on the face and bit Resident 3 on the right hand.</p> <p>These failures resulted in Resident 2 sustaining a scratch on the left lower lip and Resident 3 sustaining a skin tear on the right hand.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s admission record, the record indicated Resident 1 was admitted in March 2024 with diagnoses that included dementia (group of symptoms affecting memory, thinking and social abilities) and depression. Resident 1 ' s Minimum Data Set (MDS, an assessment tool) indicated Resident 1 had severe cognitive impairment.</p> <p>During a review of Resident 1 ' s care plan, initiated on 3/29/24, the plan indicated, Resident/patient exhibits, or has the potential to exhibit physical behaviors related to: Cognitive Loss/Dementia. History of behaviors . and has the potential to strike out at others.</p> <p>During a review of Resident 2 ' s admission record indicated Resident 2 was admitted in March 2024 with diagnoses that included dementia, Alzheimer ' s Disease (a brain disorder that slowly destroys memory and thinking skills) and depression. Resident 2 ' s MDS indicated Resident 2 had severe cognitive impairment.</p> <p>During a review of Resident 2 ' s care plan, initiated on 3/27/24, the care plan indicated, Resident/patient exhibits, or has potential to exhibit personal behaviors related to: Cognitive Loss/Dementia.</p> <p>During a review of Resident 3 ' s admission record indicated Resident 3 was admitted in August 2023 with diagnoses that included dementia and alcohol dependence. Resident 3 ' s MDS indicated Resident 3 had severe cognitive impairment.</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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s SBAR Communication Form, dated 8/15/24, the form indicated, Resident had a physical altercation with multiple residents. It was reported that [Resident 1] approaches [Resident 2] and punch him on the face that results to scratch on the left lower lip and after separating both residents. [Resident 1] then approached [Resident 3] who was assisting a peer .to activity and then bite [Resident 3] on the right hand that results to skin tear .</p> <p>During a review of Resident 2 ' s Change in Condition (CIC) Notes, dated 8/15/24, the CIC notes indicated, [Resident 1] approaches [Resident 2] and punch him on the face results to a scratch to lower lip and was separated by staff. Upon assessment resident noted with scratches to lower lip with no blood noted.</p> <p>During a review of Resident 3 ' s CIC Notes, dated 8/15/24, the notes indicated, It was reported that [Resident 1], as peers were walking along the hallway, bite [Resident 3] this happened after separating the same resident (aggressor) from a different peer altercation. Staff separated both resident and took [Resident 1] to his room. Upon assessment skin tear was noted on the right hand (back) .</p> <p>During a concurrent observation and interview on 8/22/24 at 10:01 a.m. at Resident 2 ' s room, Resident 2 was observed alert and calm, lying on bed, and confused but verbally responsive to questions. No scratches were noted on lower lip. Resident 2 was not able to remember any recent incidents with other residents and stated, No one punched me.</p> <p>During an interview on 8/22/24 at 10:27 a.m. with Licensed Nurse 1 (LN 1), LN 1 stated, I was there. I saw what happened. [Resident 1] was going to punch [Resident 3] and [Resident 3] raised his hand. [Resident 1] grabbed his hand, he kind of scratched him. We were running to separate them. The scratch was on the back of the right hand .There was also another resident. [Resident 2] was along the hallway, [Resident 1] saw him, and he punched his mouth. It wasn ' t a serious punch. [Resident 2] got away from him, it is not injury, but he touched him. His knuckles were able to touch [Resident 2] ' s mouth.</p> <p>During an interview on 8/22/24 at 10:50 a.m. with LN 2, LN 2 stated, I was at the nurses ' station. [Residents] were coming from activity, [Resident 3] was pushing [another resident ' s wheelchair], [Resident 2] was walking in the hallway, and [Resident 1] was there. There was a commotion. [Resident 1] strike out at [Resident 2] first. [Resident 3] said he got bitten .[Resident 1] was redirected to him [sic] room and came back to the hallway like nothing happened. It happened so fast.</p> <p>During a concurrent observation and interview on 8/22/24 at 11:30 a.m. with Resident 3 in his room, Resident 3 was observed standing by the bed, alert and calm, holding a remote control and watching tv. Wound observed on the back of right hand, approximately 2x1 centimeters (cm, a unit of measure), clean, no discharge was observed. When asked regarding the incident, Resident 3 stated, I had a guy, he bit me, a Mexican guy, his name was [Resident 1 ' s name]. My girlfriend was in a wheelchair, and he was going after her, the staff put him on the ground, everybody was close and gathered together. He was going after her I stood in front, I don ' t know what he was thinking. He got [Resident 2], he got a little thing on his nose, he was behind me. I think he was trying to go to my girlfriend. He ' s been in trouble before. Resident 3 showed wound at the back of right hand and stated, It was bigger than this, it is improving.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 8/22/24 at 11:48 a.m. in Resident 1 ' s room, Resident 1 was observed lying on his right side in bed, eyes closed and resting, fairly groomed. Attempted to communicate but did not respond to questions.</p> <p>During an interview on 8/22/24 at 12:10 p.m. with the Social Services Assistant Director (SSAD), the SSAD stated, They were in the hallway, went up with another resident [Resident 2], for no apparent reason he struck out on his face and had a skin tear in his lip. Staff redirected him and got him away. He approached another resident [Resident 3] and he bit his hand causing skin tear to his hand .They all have some cognitive impairment, [Resident 1] is confused with both languages. He didn ' t remember, he was smiling pleasant like nothing had happened.</p> <p>During an interview on 8/22/24 at 12:42 p.m. with the Director of Nursing (DON), the DON stated, [Resident 1] had some behaviors in the past. When he came back, he ' s been stable. He ' s had some incident with staff with the last admission .From my understanding, residents were going to activities, [Resident 1] struck out [Resident 2], he tried to go after another resident, [Resident 3] was pushing the wheelchair. [Staff] don ' t know if something escalated. [Resident 3] had recollection, but [Resident 2] didn ' t have recollection. [Resident 2] had a little bit of tiny scratch and went away the next day, [Resident 3] had a skin tear . The DON further stated, The expectation is to keep all resident safe from staff, residents and sometimes from themselves.</p> <p>During an interview on 8/22/24 at 1 p.m. with the Administrator (ADM), the ADM stated, We don ' t really know why [Resident 1] became aggressive, I don ' t know if somebody said something to him that made him aggressive. The ADM further stated, The expectation is to keep all residents safe from any safety concern or danger or abuse.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled Resident Rights, revised 12/2021, the P&P indicated, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident ' s right to: .c. be free from abuse, neglect, misappropriation of property, and exploitation .</p> <p>During a review of the facility ' s P&P titled Abuse Prohibition and Prevention Policy and Procedure and Reporting Reasonable Suspicion of a Crime Policy and Procedure, revised 8/2022, the P&P indicated, This facility prohibits and prevents abuse .Each resident has the right to be free from abuse .Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, .and any other individuals.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>48445</p> <p>Based on interview and record review, the facility failed to develop a person-centered care plan for one of five sampled residents (Resident 1) when there was no care plan developed for Resident 1 ' s use of Trazodone (medication used to treat depression).</p> <p>This failure had the potential to result in Resident 1 not maintaining the highest practicable well-being and preventing avoidable decline.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s admission record, the record indicated Resident 1 was admitted in March 2024 with diagnoses that included dementia (group of symptoms affecting memory, thinking and social abilities) and depression. Resident 1 ' s Minimum Data Set (MDS, an assessment tool) indicated Resident 1 had severe cognitive impairment.</p> <p>During a review of Resident 1 ' s Psychotropic Medication [drug that affects behavior, mood, thoughts, or perception] Administration Disclosure (Anti-Depressant), dated 7/31/24, the disclosure indicated, Physician order: Trazodone 50mg [milligrams, a unit of measurement] PO [by mouth] tablet QHS [hours of sleep].</p> <p>During a review of Resident 1 ' s Change in Condition (CIC) notes, dated 8/15/24, the CIC Notes indicated, Resident had a physical altercation with multiple residents. It was reported that resident approaches [Resident 2] and punch him on the face that results to scratch on the left lower lip and after separating both residents. He then approached [Resident 3] who was assisting a peer .to activity and then bite resident on the right hand that results to skin tear .Primary Care Provider responded with the following feedback: A. Recommendations: Order received from PA [Physician Assistant] to increase Trazodone 100 mg tablet PO one time a day .</p> <p>During a review of Resident 1 ' s physician order, dated 8/15/24, the order indicated, Trazodone .Oral Tablet 100MG .Give 100 mg by mouth one time a day for Sleeplessness related to MAJOR DEPRESSIVE DISORDER .</p> <p>During a concurrent interview and record review on 8/22/24 at 12:42 p.m. with the Director of Nursing (DON), the DON verified the Trazodone 50mg was started on 7/31/24 and was increased to 100mg on 8/15/24 following the physical altercation. The DON confirmed there was no care plan for Trazodone and stated, He should have a care plan for Trazodone .I don ' t see one. The DON further stated, Expectation is they should have a care plan for any psychotropic medication use.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled PSYCHOTROPIC MEDICATION MANAGEMENT, revised 10/24/17, the P&P indicated, 3. When psychoactive medications are prescribed for a specific condition or targeted behavior, the clinical record will be reflective of the diagnosis, reasons for use ., and have a care plan in place with medication use and non-drug interventions that had been attempted to alleviate the condition .</p>		