

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 12/20/2024
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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49933</p> <p>Based on observation, interview, and record review, the facility failed to promote dignity and respect for three out of 26 sampled residents (Resident 1, Resident 14 and Resident 33) when:</p> <ol style="list-style-type: none"> 1. Certified Nursing Assistant 9 (CNA 9) remained standing while assisting Resident 1 and Resident 33 with lunch; and, 2. Resident 14 was served her lunch tray late while other residents in the table were already eating. <p>These failures had the potential to impact the three residents' self-esteem and self-worth.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Resident 1 was admitted in late 1989 and readmitted in late 2024 with diagnoses which included hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following cerebral infarction (stroke) affecting the right-dominant side, and dysphagia (difficulty swallowing). <p>During a review of Resident 1's care plan (CP), dated 12/7/24, the CP indicated, EATING: At times the resident can need assistance at an intensity level of limited (guiding and maneuvering of extremities) .</p> <p>Resident 33 was admitted in early 2021 with diagnoses which included dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 33's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/8/24, the MDS indicated Resident 33 had severe memory impairment and needed supervision or assistance with eating.</p> <p>During an observation on 12/17/24 at 12:14 p.m. in the dining room, Resident 1 was sitting in a wheelchair and her lunch placed on the table. CNA 9 stood over Resident 1 while feeding her lunch with a spoon. At 12:16 p.m., CNA 9 stopped feeding Resident 1 when she nodded 'no,' then CNA 9 moved on to feed Resident 33. Resident 33 was sitting in her wheelchair and CNA 9 stood over Resident 33 while feeding her lunch with a spoon.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/17/24 at 12:33 p.m. with CNA 9, CNA 9 confirmed that he stood over Resident 1 and Resident 33 while assisting them with their meals.</p> <p>During an interview on 12/17/24 at 1:45 p.m. with Resident 1, Resident 1 stated, It doesn't make me feel good that someone is standing over me. I am a person too .</p> <p>During an interview on 12/19/24 at 12:45 p.m. with the Director of Staff Development (DSD), the DSD indicated staff standing over residents while assisting residents increased the risk of aspiration (food, liquid entering the lungs) and choking. The DSD further acknowledged that the CNA standing over the resident did not promote the residents' dignity.</p> <p>2. Resident 14 was admitted early 2024 with diagnoses of diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 14's MDS, dated [DATE], the MDS indicated she had moderate cognitive impairment.</p> <p>During a concurrent observation and interview on 12/17/24 at 12 p.m., in the dining room, four residents seated at one table, and two of the four residents were already eating with 50% consumed. Resident 14 was sitting in wheelchair and waited for food to be served. Resident 14 indicated she frequently had to wait because meals were not served at the same time in her table. Resident 14 stated it bothered and frustrated her to have to wait and watch while the others ate.</p> <p>During a concurrent observation and interview on 12/17/24 at 12:05 p.m., Resident 14 received lunch tray and CNA 9 confirmed that lunch was not served at the same time to the table.</p> <p>During an interview on 12/19/24 at 12:50 p.m. with the DSD, the DSD stated that serving lunch trays at different times may cause food temperatures to not be palatable. The DSD further stated that it could negatively affect the residents and make them feel left out.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Quality of Life-Dignity,, the P&P 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, feeling of self worth and self esteem .Residents are treated with dignity and respect at all times .staff are expected to promote dignity and assist residents.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>49950</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident needs were accommodated for one of 26 sampled residents (Resident 89) when Resident 89 did not have their call light within reach.</p> <p>This failure had the potential to result in Resident 89 further falls with injury.</p> <p>Findings:</p> <p>Resident 89 was admitted to the facility in January 2023 with multiple diagnoses which included dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 89's care plan (CP), initiated 5/8/24, the CP indicated Resident 89 was a fall risk. The care plan indicated interventions to prevent falls that included, .place call light within reach .</p> <p>During a review of Resident 89's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/21/24, the MDS indicated Resident 89 needed assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 89's Interdisciplinary Care Conference (IDT), dated 11/16/24, the IDT indicated Resident 89 fell , injured her head, and was sent to the hospital.</p> <p>During a concurrent observation and interview on 12/18/24 at 9:19 a.m. with Certified Nursing Assistant 12 (CNA 12), Resident 89 was lying in bed. Resident 89's call light was not visible or accessible to Resident 89. CNA 12 confirmed Resident 89's call light was not within reach and located the call light under Resident 89's bed. CNA 12 acknowledged the call light should be within the resident's reach.</p> <p>During an interview on 12/19/24 at 1:44 p.m. with Director of Nursing (DON), DON stated the expectation was for call lights to be within the residents' reach. The DON further stated there was a risk for falls and the resident needs were not being met if call lights were not within reach.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, revised 10/24/24, the P&P indicated, .ensure that the call light is accessible to the resident .</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>41838</p> <p>Based on observation, interview, and record review the facility compromised resident personal privacy and confidentiality when the shred box containing meal tickets was overfilled, exposing resident information.</p> <p>This had the potential of exposing resident information to non-staff individuals.</p> <p>Findings:</p> <p>During surveyor initial set-up on 12/17/24 at 7:49 a.m., the survey team was briefly set up in the large dining room off the kitchen. A shred box was located next to the main door with meal tickets coming through the box opening. The survey team was able to read resident information from meal tickets at the box's opening.</p> <p>During the initial kitchen tour on 12/17/24 at 8:03 a.m., the Dietary Manager (DM) was escorted to the shred box. She concurred that the shred box was full to the brim. The DM tried without success to push the meal tickets back inside of box. The DM believed the meal tickets were picked up every two weeks.</p> <p>During a review of meal tickets for lunch for Wednesday, 12/18/24 at 2:16 p.m., the meal tickets included the following information:</p> <p>Resident name, room location, the area that the meal was eaten, therapeutic diet order (which may correlate to diagnosis), fluid texture (which may correlate to diagnosis), resident likes/dislikes, resident food allergies, and special instructions.</p> <p>During an interview on 12/19/24 at 8:30 a.m. Certified Nursing Assistant 6 (CNA 6), while discussing the process for meals brought in from outside sources, she stated that family can eat with the residents in the dining room.</p> <p>During a return visit to the dining room on 12/19/24 at 9:43 a.m., the shred box was again overfilled with meal tickets. During a subsequent observation and interview on 12/19/24 at 9:55 a.m. with the Administrator (ADM), the ADM concurred that the meal tickets were accessible to others, and stated, It shouldn't be that full.</p> <p>During a review of facility provided policy and procedure (P&P) titled, Confidentiality of Information and Personal Privacy, revised 10/17, the P&P indicated, The facility will protect and safeguard resident confidentiality and personal privacy. Bullet 2 further indicated that the facility will strive to protect the resident's privacy regarding his or her: a. accommodations; b. medical treatment .d. personal care .</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>47197</p> <p>Based on interview and record review, the facility failed to have an accurate Minimum Data Set (MDS-a federally mandated assessment) assessment for one of 26 sampled residents (Resident 49), when Resident 49's comprehensive MDS behavioral assessment was inaccurate.</p> <p>This failure placed the facility to not have an accurate health status data of Resident 49, and had the potential for Resident 49 to not achieve his highest practicable well-being.</p> <p>Findings:</p> <p>Resident 49 was admitted in January of 2024 and had diagnoses that included dementia (a progressive state of decline in mental abilities) and major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</p> <p>During a review of Resident 49's MDS Cognitive Patterns and Behavior, dated 10/22/24, the MDS indicated, Resident 49 had a severely impaired cognition (mental process of acquiring knowledge and understanding), and did not exhibit any physical or verbal behavioral symptoms directed toward others or other behavioral symptoms not directed toward others.</p> <p>During a review of Resident 49's Medication Administration Record (MAR, a legal document used to record medications given and resident's behavior being monitored), for the month of October 2024, the MAR indicated, Resident 49 exhibited .yelling out after needs met . 17 times from 10/14/24 to 10/22/24.</p> <p>During an interview on 12/18/24 at 9:05 a.m. with Certified Nurse Assistant 2 (CNA 2), CNA 2 stated, [Resident 49] can be very loud .and combative and it's hard to give her [Resident 49] care she needs .She refuses things .She'll yell or kick .</p> <p>During a concurrent interview and record review on 12/19/24 at 1:27 p.m. with the MDS Assistant (MDSA), the MDSA confirmed the clinical records of Resident 49 on comprehensive MDS behavioral assessment inaccurately reflected Resident 49's behavioral symptoms. The MDSA stated she would expect that MDS assessment would accurately reflect the condition of the residents.</p> <p>During a concurrent interview and record review on 12/19/24 at 3:13 p.m. with the Social Services Director (SSD), Resident 49's clinical records were reviewed. The SSD agreed that Resident 49's yelling behavior should have been reflected in Resident 49's MDS behavior assessment.</p> <p>During an interview on 12/19/24 at 3:21 p.m. with the Director of Nursing (DON), the DON stated that she would expect that MDS assessments are accurate for appropriate patient care.</p> <p>During a review of the facility's policies and procedures (P&P) titled, Resident Assessments, revised 10/2023, the P&P indicated, 12. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observation/interviews.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43238</p> <p>Based on observation, interview, and record review, the facility failed to ensure two out of 26 sampled residents (Resident 72 and Resident 59) was assisted with their activities of daily living (ADLs- normal daily functions required to meet basic needs) when:</p> <ol style="list-style-type: none"> 1. Resident 72 had blackish substance underneath the fingernails; and, 2. Resident 59 was not provided with oral care as indicated. <p>These failures had the potential for Resident 72 and Resident 59 to acquire an infection and not achieve their highest practicable well-being.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Resident 72 was admitted January of 2023 and had diagnoses that included dementia (a progressive state of decline in mental abilities), and major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). <p>During a review of Resident 72's Minimum Data Set (MDS - a federally mandated assessment) Cognitive Patterns and Functional Abilities and Goals, dated 9/15/24, the MDS indicated, Resident 72 had a severely impaired cognition (mental process of acquiring knowledge and understanding), and required partial/moderate assistance with oral hygiene, toileting hygiene, shower/bathing, and lower body dressing, and supervision or touching assistance with eating, upper body dressing and personal hygiene.</p> <p>During a concurrent observation and interview on 12/17/24 at 9:21 a.m. with Resident 72, in Resident 72's room, Resident 72 had blackish substance underneath her fingernails. Resident 72 was not able to recall when was the last time she had shower and stated she wanted her fingernails to be cleaned.</p> <p>During another concurrent observation and interview on 12/18/24 at 9:46 a.m. with Resident 72, in Resident 72's room, Resident 72 still had blackish substance underneath her fingernails. Resident 72 stated she wanted her fingernails to be cleaned.</p> <p>During an observation on 12/18/24 at 12:15 p.m. of Resident 72, at the courtyard dining area, Resident 72 was observed eating her lunch meal by her own and still had blackish substance underneath her fingernails.</p> <p>During a concurrent observation and interview on 12/18/24 at 12:19 p.m. with Certified Nurse Assistant 3 (CNA 3), at the courtyard dining area, CNA 3 confirmed that Resident 72 had blackish substance underneath her fingernails and was eating by her own. CNA 3 stated she would expect that Resident 72's fingernails should be clean because the blackish substances underneath her fingernails could get into her food. CNA 3 further stated staff were supposed to check resident's nails every time, especially during shower days.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 12/19/24 at 9:03 a.m. with Licensed Nurse 1 (LN 1), LN 1 confirmed the clinical records of Resident 72 had no documented refusals of personal hygiene assistance and nail care.</p> <p>During an interview on 12/19/24 at 1:18 p.m. with the Infection Preventionist (IP), the IP stated residents with blackish substance underneath their fingernails were susceptible for infection.</p> <p>During an interview on 12/19/24 at 3:21 p.m. with the Director of Nursing (DON), the DON stated that residents' nail care should be done daily or as needed. The DON further stated that having blackish substance underneath the fingernails could cause hygiene or infection control problems, and dignity issues.</p> <p>During a review of Resident 72's care plan (CP), revised 1/20/23, the CP indicated, The resident [Resident 72] has an ADL Self Care Performance Deficit r/t [related to] Dementia. During a review of Resident 72's CP intervention, revised 12/7/23, the CP intervention indicated, PERSONAL HYGIENE .The resident [Resident 72] requires one staff participation with personal hygiene .</p> <p>2. Resident 59 was last admitted in the middle of 2024 with diagnosis which included dementia and malnutrition (reduced sufficient nutrients in the body).</p> <p>During a review of Resident 59's care plan (CP), dated 8/11/24, the CP indicated Resident 59 was at risk for oral health or dental care problems, the goal was to maintain intact oral mucous membranes, and the interventions were to provide oral hygiene/mouth care twice per day and as needed.</p> <p>During a review of Resident 59's clinical record titled, Documentation Survey Report, for November and December 2024, the record indicated nine missed opportunities in November 2024 (Nov. 1, 2, 4, 5, 12, 16, 19, 27, and 30) and six missed opportunities in December 2024 (Dec. 2, 7, 11, 16, 18, and 19) to provide oral hygiene twice per day.</p> <p>During a review of Resident 59's MDS, dated [DATE], the MDS indicated Resident 59 required 100% assistance from staff for oral hygiene.</p> <p>During an observation on 12/18/24 at 8:47 a.m., Resident 59 was in bed asleep with mouth opened and noted white matter caked on upper and lower teeth.</p> <p>During an observation on 12/19/24 at 8:31 a.m., Resident 59 was in bed awake and noted still with white matter caked on upper and lower teeth.</p> <p>During a concurrent observation and interview on 12/19/24 at 11:45 a.m., in Resident 59's room with CNA 7, CNA 7 confirmed the white matter caked on Resident 59's teeth. CNA 7 stated that he thought wiping the mouth of Resident 59 counted as oral care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 12/19/24 at 2:06 p.m., the DON confirmed that care plan for Resident 59 was current and should be followed as written. The DON indicated that the expectation was for CNAs to provide oral hygiene daily at a minimum, but for Resident 59 the expectation would be to follow the care plan as written. The DON confirmed the clinical record for Resident 59 indicated that oral hygiene documentation provided during the months of November and December (to date) of 2024 had missing entries for both months, with multiple entries of 97 meaning not applicable. The DON confirmed this was not in accordance with the care plan.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, revised 3/2018, the P&P indicated, .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (.grooming .).</p> <p>47197</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>49950</p> <p>Based on observation, interview, and record review, the facility failed to ensure two of 26 sampled residents (Resident 35 and Resident 30) were offered activities that meet their interests and preferences when;</p> <p>1) Resident 35 did not receive activities that met her preferences and was only offered activities once a week; and</p> <p>2) The facility did not provide Resident 30 any activity that meets his psychosocial needs from 11/12/24 to 12/16/24;</p> <p>These failures had the potential for Resident 30 and Resident 35 to not achieve their highest mental, emotional, spiritual, and psychosocial well-being.</p> <p>Findings:</p> <p>1. Resident 89 was admitted to the facility in January 2023 with multiple diagnoses which included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).</p> <p>During an observation on 12/17/24 at 9:15 a.m., 10:35 a.m., and 3:50 p.m., Resident 35 remained in her room without activities.</p> <p>During an observation on 12/18/24 at 9:12 a.m., 2:25 p.m., and 4:00 p.m., Resident 35 remained in her room without activities.</p> <p>During a review of Resident 35's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 2/2/23, the MDS indicated it was important for Resident 35 to participate in activities including books, animals, music, news, and doing things with groups of people.</p> <p>During a review of Resident 35's care plan (CP), initiated 2/2/23, the CP indicated, .observe at least one recreational group activities of choice each week .the resident will be invited by staff to participate in horticultural, music, entertainment, sensory activities of choice .provide a program of activities that is of interest and empowers the resident .</p> <p>During a review of Resident 35's Recreation Participation Record, dated December 2024, the record indicated Resident 35 was not provided group activities on 12/1/24 through 12/18/24. Resident 35 received a one-to-one activity on 12/5/24 and 12/12/24. There were no notes indicating Resident 35 refused group activities or was offered activities two to three times per week.</p> <p>During an interview on 12/19/24 at 9:17 a.m. with the Activities Director (AD), the AD stated Resident 35 had activity interests that included music and animals. The AD acknowledged that activities once a week was not sufficient and could affect resident's physical, psychosocial and mental well-being.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/19/24 at 1:44 p.m. with the Director of Nursing (DON), the DON stated activities once a week would not meet the psychosocial needs of a resident and could affect physical, psychosocial and mental well-being.</p> <p>During a review of the facility's policy and procedure (P&P) titled, ACTIVITY ONE-TO-ONE PROGRAMMING/INDIVIDUAL INTERVENTIONS POLICY, revised August 2011, the P&P indicated, .as a general guideline, one-to-ones are provided two-three times a week for those residents unable to attend groups and one time per week for those who refuse or choose not to attend groups (resident who refuse programs must be alert, oriented, and competent) .The Activity Director and staff will provide one-to-one programs to the residents whose condition dictates individual intervention and programs that are designed to meet individual needs and interests of the resident.</p> <p>47197</p> <p>2. Resident 30 was readmitted in July of 2023 and had diagnoses that included dementia a progressive state of decline in mental abilities) and brain cancer.</p> <p>During a review of Resident 30's care plan (CP), initiated 1/7/19, the CP indicated, Resident [Resident 30] occasionally attends group activities .Majority of the time likes to observe in live entertainment, special events and socials that includes food and walk throughout facility halls . The care plan interventions indicated, Encourage [Resident 30] to attend activities of interest such as; music (live entertainment), arts & crafts, movies (comedies, animated or action films.)</p> <p>During a review of Resident 30's Activity Participation Review, dated 11/29/23, the clinical record indicated, Resident [Resident 30] enjoys watching television in his room. Resident attends activities occasionally. Resident enjoys walking around the facility interacting with staff and peers using gestures and facial expressions .C. Activity Plans/Review .Activities staff to encourage resident to participate in group activities 2x [two times] weekly. Group resident in smaller groups with peers whom [sic] shares same interests, background.</p> <p>During a review of Resident 30's CP intervention, revised 12/7/23, the CP intervention indicated, Introduce the resident [Resident 30] to residents with similar background, interest and encourage/facilitate interactions holding small groups discussions.</p> <p>During a review of Resident 30's MDS Cognitive Patterns and Functional Abilities and Goals, dated 10/27/24, the MDS indicated, Resident 30 was rarely or never understood, and had short-term and long-term memory problem, and required substantial/maximal assistance with oral hygiene, lower body dressing, and personal hygiene, and was dependent with toileting hygiene, shower/bathing, and putting on/taking off footwear, and required supervision or touching assistance with sit to lying, sit to stand, chair and toilet transfers, and walking 10-50 feet (unit of measurement).</p> <p>During an observation on 12/17/24 at 8:26 a.m., in Resident 30's room, Resident 30 was lying on his bed, eyes were closed, and breathing was unlabored (something natural, flowing, or relaxed, and doesn't require effort). Resident 30 did not respond to greetings.</p> <p>During an observation on 12/18/24 at 10:14 a.m., in Resident 30's room, Resident 30 was again lying on his bed, eyes closed, and breathing was unlabored. Resident 30 again did not respond to greetings.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 12/19/24 at 9:26 a.m., in Resident 30's room, Resident 30 was again lying on his bed, eyes closed, and breathing was unlabored. Resident 30 again did not respond to greetings.</p> <p>During an interview on 12/19/24 at 9:57 a.m. with the AD, the AD stated she would expect that Resident 30 will be provided with activities that met his psychosocial needs three times in a week.</p> <p>During a concurrent interview and record review on 12/19/24 at 10:40 a.m. with the AD, Resident 30's activity records were reviewed. The AD confirmed that Resident 30 was not provided any activity that met his psychosocial needs for 35 days from 11/12/24 to 12/16/24, and indicated it was not acceptable because Resident 30's physical, mental, and psychosocial health could be affected.</p> <p>During an interview on 12/19/24 at 3:21 p.m. with the DON, the DON stated she expected that residents were provided with an ongoing activity program that met their psychosocial needs 2-3 times weekly.</p> <p>During a review of the facility's P&P titled, Activities and Social Services, undated, the P&P indicated, the facility will provide activities, social events, and schedules that are compatible with the resident's interests, physical and mental assessment, and overall plan of care.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>49933</p> <p>Based on observation, interview and record review, the facility failed to ensure physician's orders were followed in accordance with professional standards of care for one of 26 sampled residents (Resident 91), when:</p> <ol style="list-style-type: none"> Resident 91 did not receive spironolactone (medication used for high blood pressure) for four days (four scheduled doses) due to the medication not being re-ordered timely (Within 3-5 days of medications running out), and the licensed nurse (LN) did not notify the physician for Resident 91's missed medications; and Resident 91 did not receive a full dose of antidepressant medication (medication used for depression) for four days due to the medication not being re-ordered timely, and the physician was not notified for the missed medications. <p>These failures had the potential for not meeting the resident's treatment needs or worsening of her medical conditions.</p> <p>Findings:</p> <p>Resident 91 was admitted to the facility in late 2024 with diagnosis of hypertension (HTN-high blood pressure) and depression.</p> <p>During a review of Resident 91's physician order (PO), dated 12/19/24, the PO indicated, Spironolactone . tablet .25 MG (milligrams) .Give 1 tablet by mouth one time a day related to .HYPERTENSION .</p> <p>During a review of Resident 91's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 12/7/24, 12/8/24, 12/9/24 and 12/10/24, the MAR indicated spironolactone was not administered.</p> <p>During a review of Resident 91's MAR for December 2024, the MAR indicated Resident 91 had blood pressure readings of 169/69 on 12/7/24, 156/69 on 12/8/24, 155/70 on 12/9/24 and 176/64 on 12/10/24.</p> <p>During a review of Resident 91's Progress Notes (PN), dated 12/7/24 to 12/10/24, the PN indicated, awaiting pharmacy. There was no documented evidence that the physician was notified of missed doses.</p> <p>During a concurrent interview and record review on 12/19/24 at 2:18 p.m. with LN 4, LN 4 confirmed that she worked on 12/9/24 and spironolactone was not administered because the medication was not available.</p> <p>2. During a review of Resident 91's PO, dated 12/19/24, the PO indicated, Venlafaxine .Oral Capsule .37.5 MG .Give 1 capsule by mouth two times a day .GIVE WITH 75 MG TOTAL DOSE INTAKE 112.5 MG .</p> <p>During a review of Resident 91's MAR, dated 12/8/24, 12/9/24, 12/10/24, 12/11/24, the MAR indicated venlafaxine 37.5 mg was not administered as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 91's PN, dated 12/8/24 to 12/11/24, the PN indicated, awaiting pharmacy. No documented evidence that the physician was notified of missed doses.</p> <p>During a concurrent interview and record review on 12/19/24 at 9:58 a.m. with LN 5, LN 5 confirmed that he worked 12/10/24 and 12/11/24 and venlafaxine 37.5 mg was not administered to Resident 91 because the medication was not available. LN 5 confirmed that he did not administer the correct total dose of 112.5 mg of venlafaxine.</p> <p>During an interview on 12/19/24 at 10:43 a.m. with the MD, the MD confirmed that the nursing staff did not contact him of missed doses of spironolactone and venlafaxine. The MD further acknowledged that missing blood pressure medications could lead to uncontrolled blood pressure. The MD acknowledged that Resident 91 had high blood pressures readings during missed doses, and he was not contacted for new orders or changes to medication regimen.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Preparation and General Guidelines, dated October 2017, the P&P indicated Medications are administered as prescribed in accordance with good nursing principles.</p> <p>During a review of the facility's P&P titled, Physician Orders, dated 3/22/2022, the P&P indicated, Supplies/medications required to carry out the physician order will be ordered.</p> <p>The facility's P&P on missed medications was requested but not provided.</p> <p>During a review of the undated document titled, Nursing Practice Act Rules and Regulations, the document indicated, Article 2. Scope of Regulation 2725 (b). The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require substantial amount of specific knowledge of the following: (2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement treatment, disease prevention, or rehabilitative regimen .ordered by and within the scope of licensure of a physician .as defined by Section 1316.5 of the Health and Safety Code. (Nursing Practice Act Rules and Regulations Issued by Board of Registered Nursing 1997 State of California Department of Consumer Affairs. pp. 5).</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>47197</p> <p>Based on interview and record review, the facility failed to ensure one out of 26 sampled residents (Resident 102) received trauma-informed care (a framework of care for helping people who have experienced trauma) in accordance with professional standards of practice and accounting for residents' experiences when Resident 102's trauma trigger(s) was not identified and her Post-traumatic stress disorder (PTSD-a mental health condition that can develop after a person experiences or witnesses a traumatic event) diagnosis was not care planned.</p> <p>This failure placed Resident 102 at risk for re-traumatization (re-experience/relives a traumatic event or experiences causing similar stress reactions to a new event), and to not achieve her highest physical, mental, and psychosocial well-being.</p> <p>Findings:</p> <p>Resident 102 was admitted in October of 2024 and had diagnoses that included dementia a progressive state of decline in mental abilities), major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and PTSD.</p> <p>During a review of Resident 102's Minimum Data Set (MDS- a federally mandated assessment tool) Cognitive Patterns, dated 10/9/24, the MDS indicated, Resident 102 had a severely impaired cognition (mental process of acquiring knowledge and understanding).</p> <p>During a concurrent interview and record review on 12/19/24 at 9:03 a.m. with Licensed Nurse (LN) 1, LN 1 confirmed that the clinical records of Resident 102's indicated the trauma trigger(s) was not identified, and her PTSD diagnosis was not care planned. LN 1 stated she was assigned to Resident 102 for the shift but was not aware about her trauma trigger(s). LN 1 further stated she would expect that Resident 102's diagnosis of PTSD to be care planned so staff would know how to care for the resident.</p> <p>During an interview on 12/19/24 at 9:18 a.m. with Certified Nurse Assistant 4 (CNA 4) , CNA 4 stated she was assigned to Resident 102 for the shift and she was aware about Resident 102's behavior of striking out when getting activities of daily living (ADLs - normal daily functions required to meet basic needs) care. CNA 4 stated she was not sure if Resident 102 has PTSD diagnosis, and she had no idea what were Resident 102's trauma trigger(s).</p> <p>During an interview on 12/19/24 at 3:21 p.m. with the Director of Nursing (DON), the DON stated that identification of the trauma trigger(s) was important for residents with PTSD to prevent the resident from having an episode (of re-traumatization) and exacerbation (of stress reactions to trauma). The DON further stated that Resident 102's PTSD diagnosis and trauma triggers should be care planned so Resident 102 will receive proper and appropriate care treatment.</p> <p>(continued on next page)</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Trauma Informed Care, dated 8/20/23, the P&P indicated, 6. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan .7. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma .</p> <p>During a review of the facility's P&P titled, CARE PLAN COMPREHENSIVE, dated 8/25/21, the P&P indicated, 2. The comprehensive care plan includes the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .6. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS).</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>47197</p> <p>Based on interview and record review, the facility failed to have sufficient nurse staffing for a census of 111 residents, when the facility's Actual Direct Care Service Hours Per Patient Day (DHPPD- use to measure the total number of hours dedicated to direct care provided by caregivers, like nurses and certified nurse assistants to each patient in a facility over a 24-hour period) were below the required minimum standard of 3.5 DHPPD and 2.4 hours per patient day for certified nurse assistants (CNA DHPPD) from 11/1/24 to 11/7/24.</p> <p>This failures resulted to 10 recorded resident falls from 11/1/24 to 11/7/24 and had the potential for facility residents to not receive needed health treatment and personal care, and to not achieve their highest physical, mental, and psychosocial well-being.</p> <p>Findings:</p> <p>During a review of the facility's DHPPD documents, for the month of November 2024, the documents indicated the facility had actual DHPPD and actual CNA DHPPD as follows:</p> <p>11/1/24: resident census- 125, Actual DHPPD- 2.66, Actual CNA DHPPD- 1.75.</p> <p>11/2/24: resident census- 125, Actual DHPPD- 2.68, Actual CNA DHPPD- 1.76.</p> <p>11/3/24: resident census- 123, Actual DHPPD- 2.64, Actual CNA DHPPD- 1.73.</p> <p>11/4/24: resident census- 122, Actual DHPPD- 2.98, Actual CNA DHPPD- 1.84.</p> <p>11/5/24: resident census- 121, Actual DHPPD- 2.79, Actual CNA DHPPD- 1.75.</p> <p>11/6/24: resident census- 124, Actual DHPPD- 2.78, Actual CNA DHPPD- 1.69.</p> <p>11/7/24: resident census- 123, Actual DHPPD- 2.88, Actual CNA DHPPD- 1.93.</p> <p>During a review of the facility's MONTHLY FALLS TRACKING FORM, for the month of November 2024, the documents indicated the facility had recorded a total of 10 resident falls from 11/1/24 to 11/7/24 as follows:</p> <p>11/1/24: one newly admitted resident fell from a chair during the morning shift.</p> <p>11/2/24: one resident with no known history of falls fell from a chair, and one resident fell while walking in the room during the afternoon shift.</p> <p>11/3/24: one resident fell from a chair during the afternoon shift.</p> <p>11/4/24: one resident fell while transferring during the afternoon shift.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>11/5/24: one resident with no known history of falls fell from a chair in the room during the morning shift, and one resident fell from a chair in the room during the afternoon shift.</p> <p>11/6/24: one resident with no known history of falls fell from bed during the evening shift, and one resident fell from bed which resulted to head injury and was sent to the emergency room for treatment during the evening shift.</p> <p>11/7/24: one resident fell from bed during the evening shift.</p> <p>During an interview on 12/17/24 at 3:23 p.m. with the Staffing Coordinator (SC), the SC indicated the facility did not have a staffing waiver (exemption from staffing regulations).</p> <p>During an interview on 12/18/24 at 9:05 a.m. with the Certified Nurse Assistant (CNA 2), CNA 2 stated that sometimes, there would only be a few of CNAs in the afternoon shift. CNA 2 further stated that resident care would be hard because there were a lot of things for the CNAs to do like, fall precautions, assisting with showers, helping residents with dinner, and other CNA duties.</p> <p>During a concurrent interview and record review on 12/19/24 at 1:37 p.m. with the SC, the facility's DHPPD documents and MONTHLY FALLS TRACKING FORM for the month of November 2024 were reviewed. The SC verified and confirmed that the facility's Actual DHPPD and Actual CNA DHPPD from 11/1/24 to 11/7/24 were below the required minimum standard. The SC stated the minimum actual DHPPD should be 3.5 overall and a minimum of 2.4 for the CNAs. The SC stated, I know that we did lose quite a few CNAs before that .and .we had a lot of call out [when staff contact the employer to let them know they are unable to work] . and we fell through on the staff coverage .</p> <p>During an interview on 12/19/24 at 3:21 p.m. with the Director of Nursing (DON), the DON stated she was aware about a day of low DHPPD but was not aware that it was for seven days. The DON further stated that patient care would be affected for low staffing.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, revised 8/2022, the P&P indicated, 6. Staffing numbers .of direct care staff are determined by the needs of the residents .7. Factors considered in determining appropriate staffing ratios and skills include an evaluation of the diseases, conditions, physical or cognitive limitations of the residents and the facility assessment. 8. Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staffing.</p> <p>During a review of a document titled, California Code, Health and Safety Code, section 1276.65, dated 1/1/23, the document indicated, (B) Effective July 1, 2018, skilled nursing facilities .shall have a minimum number of direct care services hours of 3.5 per patient day .(C) Skilled nursing facilities shall have a minimum of 2.4 hours per patient day for certified nurse assistants in order to meet the requirements in subparagraph (B).</p> <p>(https://codes.findlaw.com/ca/health-and-safety-code/hsc-sect-1276-65/)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>49933</p> <p>Based on observation, interview and record review, the facility failed to provide pharmaceutical services to meet the needs of one of 26 sampled residents (Resident 91), when:</p> <ol style="list-style-type: none"> 1. Resident 91 did not receive spironolactone (medication used for high blood pressure) for four days (four scheduled doses) due to the medication not being re-ordered timely (Within 3-5 days of medications running out); and, 2. Resident 91 did not receive the full dose of the antidepressant medication (medication used for depression) for four days due to medication not being ordered timely. <p>These failures had the potential for not meeting the resident's therapeutic needs or worsening of her medical conditions.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Resident 91 was admitted to the facility in late 2024 with diagnosis of hypertension (HTN-high blood pressure) and depression. <p>During a review of Resident 91's physician order (PO), dated 12/19/24, the PO indicated, Spironolactone . tablet .25 MG (milligrams) .Give 1 tablet by mouth one time a day related to .HYPERTENSION .</p> <p>During a review of Resident 91's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 12/7/24, 12/8/24, 12/9/24 and 12/10/24, the MAR indicated spironolactone was not administered.</p> <p>During a review of Resident 91's MAR for December 2024, the MAR indicated Resident 91 had blood pressure readings of 169/69 on 12/7/24, 156/69 on 12/8/24, 155/70 on 12/9/24 and 176/64 on 12/10/24.</p> <p>During a review of Resident 91's Progress Notes (PN), dated 12/7/24 to 12/10/24, the PN indicated, awaiting pharmacy.</p> <p>During a concurrent interview and record review on 12/19/24 at 2:18 p.m. with LN 4, LN 4 confirmed that she worked on 12/9/24 and spironolactone was not administered because the medication was not available.</p> <ol style="list-style-type: none"> 2. During a review of Resident 91's PO, dated 12/19/24, the PO indicated, Venlafaxine .Oral Capsule .37.5 MG .Give 1 capsule by mouth two times a day .GIVE WITH 75 MG TOTAL DOSE INTAKE 112.5 MG . <p>During a review of Resident 91's MAR, dated 12/8/24, 12/9/24, 12/10/24, 12/11/24, the MAR indicated venlafaxine 37.5 mg was not administered as ordered.</p> <p>During a review of Resident 91's PN, dated 12/8/24 to 12/11/24, the PN indicated, awaiting pharmacy.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 12/19/24 at 9:58 a.m. with LN 5, LN 5 confirmed that he worked 12/10/24 and 12/11/24 and venlafaxine 37.5 mg was not administered to Resident 91 because the medication was not available. LN 5 confirmed that he did not administer the correct total dose of 112.5 mg of venlafaxine.</p> <p>During an interview on 12/19/24 at 10:43 a.m. with the MD, the MD confirmed that the nursing staff did not contact him of missed doses of spironolactone and venlafaxine. The MD further acknowledged that missing blood pressure medications could lead to uncontrolled blood pressure. The MD acknowledged that Resident 91 had high blood pressures readings during missed doses, and he was not contacted for new orders or changes to the medication regimen.</p> <p>During an interview on 12/19/24 at 1 p.m. with the Pharmacy Consultant (PC), the PC indicated that medications were refilled and delivered to the facility when the pharmacy was notified after the missed doses of medications.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Preparation and General Guidelines, dated October 2017, the P&P indicated Medications are administered as prescribed in accordance with good nursing principles.</p> <p>During a review of the facility's P&P titled, Physician Orders, dated 3/22/2022, the P&P indicated, Supplies/medications required to carry out the physician order will be ordered.</p> <p>The facility's P&P on missed medications was requested but not provided.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>48874</p> <p>Based on observation, interview and record review, the facility failed to ensure one of 26 sampled residents (Resident 6) was free of unnecessary medications, when Resident 6 was prescribed a psychotropic (any drug that affects behavior, mood, thoughts, or perception) medication without adequate indication or a target behavior.</p> <p>This failure resulted in the use of unnecessary psychotropic medication that could potentially cause adverse reactions and consequences.</p> <p>Findings:</p> <p>Residents 6 was admitted in the middle of 2024 with diagnoses which included vascular dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 6's Psychiatrist Consult Note dated 9/26/24, the note indicated, Bedside staff report that [Resident 6] is very calm with no behavioral issues, easy to manage. Talks a lot but doesn't make any sense.</p> <p>During a review of Resident 6's care plan (CP) initiated 9/27/24, the CP indicated there were no behavioral interventions attempted or included for Resident 6's of aggressive behavior of yelling out for needs.</p> <p>During a review of Resident 6's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/30/24, the MDS indicated Resident 6 had no potential indicators for psychosis (loss of contact with reality).</p> <p>During a review of Resident 6's physician's order dated 10/7/24, the physician's order indicated, Risperidone (an antipsychotic), oral tablet 1 mg (milligram, a unit of measurement), Give 0.5 mg tablet by mouth three times a day for aggressive behavior manifested by yelling out for needs. Administer 0.5 mg related to vascular dementia,</p> <p>During a concurrent interview and record review with Licensed Nurse 3 (LN 3) on 12/19/24 at 12:53 p.m., LN 3 confirmed that risperidone 0.5 milligrams was being given for behaviors related to vascular dementia only and Resident 6 had no psychotic disorders.</p> <p>During an interview on 12/19/24 at 1:46 p.m. with the Consultant Pharmacist (CP), the CP confirmed that risperidone may not be an appropriate indication for Resident 6, and stated, Yelling out for one's needs is not a psychotic behavior.</p> <p>During a review of Lexicomp (a nationally recognized drug information resource), the resource indicated, ALERT: US Boxed Warning .Risperidone is not approved for the treatment of patients with dementia-related psychosis.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the manufacturer's full prescribing information for risperidone, the document indicated, INDICATIONS AND USAGE .1.1 Schizophrenia .1.2 Bipolar Mania .1.3 Irritability Associated with Autistic Disorder .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Antipsychotic/Psychotropic Medication, undated, the P&P indicated, Diagnosis alone do not warrant the use of antipsychotic/psychotropic medication. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are met: the behavioral symptoms present a danger to the resident or others; AND: 1) The symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia, or grandiosity); or 2) Behavioral interventions have been attempted and included in the plan of care except in an emergency.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49950</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were stored and labeled correctly for a census of 111, when:</p> <ol style="list-style-type: none"> 1. One opened vial and three bottles of perishable medications were not labeled with an open or use by date in the medication room; and, 2. One bottle of glucose strips, one inhaler and one insulin pen were not labeled with an open or use by date in the medication cart. <p>These failures had the potential for residents to receive expired medications with reduced potency.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an inspection of the medication room on 12/17/2024 at 8:30 a.m. with Licensed Nurse 2 (LN 2), LN 2 verified there were three bottles of latanoprost (a medication to treat glaucoma - chronic eye disease that can lead to vision loss) eye drops and one vial of tuberculin (a protein mixture to diagnosis tuberculosis - an infectious disease caused by bacteria that affects the lungs) that were not labeled with an open date or use by date. LN 2 stated not having open date and use by date on multi dose vials and eye drops could result in residents receiving expired medications. <p>During a review for manufacturer's labeling information for latanoprost, the information indicated, .once the bottle has been opened .Latanoprost must be used within 6 weeks .</p> <p>During a review of manufacturer's labeling information for tuberculin, the information indicated, .a vial .which has been entered and in use for 30 days should be discarded .</p> <ol style="list-style-type: none"> 2. During an inspection of medication cart three on 12/17/2024 at 11:49 a.m. with LN 3, LN 3 verified that one opened bottle of Assure glucose testing trips was not labeled with an open or use by date, one Spiriva Respimat (a medication to treat asthma and chronic obstructive pulmonary disease) inhaler was not labeled with a use by date, one bottle of and one Humulin 70/30 (a medication used to treat high blood sugar) KwikPen was not labeled with a use by date. LN 3 acknowledged the medications should have been labeled with an open or use by date. LN 3 stated residents are at risk for receiving expired medications if they were not labeled with open or use by dates. <p>During a review of the manufacturer's labeling information for Assure glucose testing strips, the information indicated, .test strips are good up to three months after opening .</p> <p>During a review of manufacturer's labeling information for Spiriva Respimat inhaler, the information indicated, .discard .inhaler 3 months after inserting the .cartridge .even if it contains some unused medication .</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of manufacturer's labeling information for Humulin 70/30 KwikPen, the information indicated, .throw away the HUMULIN 70/30 Pen you are using after 10 days, even if it still has insulin in it .</p> <p>During an interview on 12/19/24 at 1:44 p.m. with the Director of Nursing (DON), the DON stated the expectation was for medications to be labeled with an open or use by date. The DON further stated there was a risk for residents receiving expired medications if medications were not labeled as indicated.</p> <p>During a review the facility's policy and procedure (P&P) titled, MEDICATION STORAGE IN THE FACILITY, dated April 2008, the P&P indicated, .Medications and biologicals are stored .following manufacturer's recommendations .</p> <p>During a review of the facility's P&P titled, Medication Labeling and Storage, revised February 2023, the P&P indicated, .labeling of medication and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices .the medication label includes .expiration date, when applicable .</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50517</p> <p>Based on observation, interview, and record review, the facility failed to store supplies in accordance with professional standards for food service safety for the 110 residents eating facility prepared meals, when:</p> <ol style="list-style-type: none"> 1. Three large steam table pans were found stored wet; and 2. A bag of frozen spinach was not closed, exposing the spinach to the environment. <p>These failures had the potential to result in food-borne illnesses.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During initial kitchen tour on 12/17/2024 at 8:03 a.m., three large steam table pans were observed on the bottom shelf of the cook's station in storage. When removed, three of the large steam table pans were found with water droplets on inner and outer surfaces of the pans. <p>During a subsequent interview with the Dietary Manager (DM) on 12/17/2024 at 8:03 a.m., the DM concurred that the pans were wet. The DM stated that the condition of the wet pans could lead to contamination.</p> <p>During a review of the 2022 US Food and Drug Administration (FDA) Food Code section 4-901.11, the food code indicated, Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow.</p> <ol style="list-style-type: none"> 2. During an observation on 12/17/2024 at 8:03 a.m. within the initial kitchen tour with the DM; a bag of frozen spinach was not closed, exposing the spinach to the environment. <p>During a subsequent interview with the DM on 12/17/2024 at 8:03 a.m., the DM concurred and stated, It [the bag of frozen spinach] should be tightly closed due to contamination.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, undated, the P&P indicated, All foods stored in the refrigerator or freezer are covered, labeled, and dated .Wrappers of frozen foods must stay intact until thawing.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49950</p> <p>Based on observation, interview and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 111 residents, when:</p> <ol style="list-style-type: none"> 1. A shared blood pressure cuff equipment was not cleaned and sanitized in between resident use; 2. Staff did not wear required personal protective equipment (PPE) while providing care for Resident 96, who was on Enhanced Barrier Precautions (EBP); 3. Certified Nursing Assistant 9 (CNA 9) did not perform hand hygiene when feeding multiple residents during lunch; and 4. Two facility staff and a hospice staff did not wear PPE when provided care to Resident 79 and Resident 117 who were both on EBP. <p>These failures resulted in increased risk for cross-contamination (transfer of bacteria from one person, object, or place to another) and may cause transmission of infection to a vulnerable population.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on 12/17/24 at 7:37 a.m. with Licensed Nurse 3 (LN 3), LN 3 was checked Resident 14's blood pressure with a blood pressure cuff that was shared between residents. LN 3 placed the blood pressure cuff on Resident 14's wrist and checked the resident's blood pressure. LN 3 exited the room with the blood pressure cuff and placed it on top of the medication cart. LN 3 proceeded to use the same blood pressure cuff on Resident 113 and Resident 112. LN 3 did not sanitize the blood pressure cuff in between use with Resident 113 and Resident 112. LN 3 acknowledged she did not sanitize the blood pressure cuff in between residents and stated that the blood pressure cuff should have been sanitized. LN 3 further stated there was a risk for infection when blood pressure cuffs were not sanitized in between resident use. <p>During an interview on 12/19/24 at 1:44 p.m. with Director of Nursing (DON), DON stated that blood pressure cuffs should be sanitized in between residents. The DON further stated there was a risk of spreading infection when medical equipment was not sanitized after use.</p> <p>During a review of the facility's policy and procedure (P&P), titled Cleaning and Disinfection of Resident-Care Items and Equipment, revised September 2022, the P&P indicated, .resident care equipment is decontaminated and/or sterilized between residents .</p> <ol style="list-style-type: none"> 2. Resident 96 was admitted to the facility October 2023 with multiple diagnoses which included encephalopathy (a group of conditions that cause brain dysfunction) and dysphagia (difficulty swallowing). <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 96's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/30/24, the MDS indicated Resident 96 was totally dependent with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and had a feeding tube.</p> <p>During a concurrent observation and interview on 12/17/24 at 12:26 p.m., Resident 96 was transferred from her wheelchair to her bed by Certified Nursing Assistant 10 (CNA 10) and CNA 11. CNA 10 and CNA 11 did not wear PPEs during the transfer. CNA 10 stated she was not sure if PPE was needed during the transfers for residents who were on EBP. CNA 10 confirmed there were signs on the Resident 96's door indicating Resident 96 was on EBP. CNA 10 acknowledged the EBP sign on the door and indicated gloves and gown should be worn for mobility assistance.</p> <p>During an interview with DON on 12/19/24 at 1:44 p.m., DON stated the expectation was to follow EBP guidelines including the use of gown and gloves during transfers. DON further stated there was a risk of spreading infection if EBP were not followed.</p> <p>49933</p> <p>3. During an observation on 12/17/24 at 12:14 p.m. in the dining room, CNA 9 stood over Resident 1 while feeding her lunch with a spoon. At 12:16 p.m., CNA 9 stopped feeding Resident 1 then moved on to feed Resident 33. CNA 9 stood over Resident 33 while feeding her lunch with a spoon. At 12:19 p.m., CNA 9 finished feeding Resident 33, then put one empty lunch tray back into the lunch cart. CNA 9 then came back to the table and fed Resident 1. At 12:33 p.m., CNA 9 finished feeding Resident 1 then put away more empty lunch trays. CNA 9 did not perform proper hand hygiene between residents and between the tasks observed.</p> <p>During an interview on 12/17/24 at 12:35 p.m. with CNA 9, CNA 9 confirmed that he did not perform hand hygiene before and after putting the meal trays to the cart and in between the residents when assisting them with their lunch.</p> <p>During an interview on 12/19/24 at 12:45 p.m. with the Director of Staff Development (DSD), the DSD stated staff should use hand sanitizer or hand sanitizer wipes for hand hygiene before and after meal tray as well as assisting between each resident.</p> <p>During an interview on 12/19/24 at 1:15 p.m. with the Infection Preventionist (IP), the IP stated hand hygiene should be performed due to the risk of spreading infection.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Hand washing/Hand Hygiene, revised 9/18/23, the P&P indicated, Use an alcohol-based hand rub containing at least 62% alcohol .Before and after contact with the resident .or after contact with objects .</p> <p>47197</p> <p>4a. Resident 79 was admitted in February of 2024 and had diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions causing memory loss and confusion), and dementia (a progressive state of decline in mental abilities).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 79's MDS Cognitive Patterns, dated 11/7/24, the MDS indicated, Resident 79 had severely impaired cognition (mental process of acquiring knowledge and understanding).</p> <p>During a concurrent observation and interview on 12/17/24 at 9:19 a.m., with Licensed Nurse 1 (LN 1), in front of Resident 79's room, LN 1 confirmed that Resident 79's room door had a signage which indicated, STOP .Enhanced Barrier Precautions .Everyone must: Clean hands on room entry and when exiting . PROVIDERS AND STAFF MUST ALSO: .Wear gloves and a gown for the for the [sic] high-contact resident care activities below .2 .Toileting & changing incontinence briefs .4 .Wound care . LN 1 stated Resident 79 was on EBP because of her wound on her bottom.</p> <p>During an observation on 12/17/24 at 10 a.m., of CNA 5 in Resident 79's room, CNA 5 changed Resident 79's briefs wearing gloves but not wearing a gown.</p> <p>During an observation on 12/17/24 at 10:04 a.m., of Hospice Licensed Nurse 2 (HLN 2), in Resident 79's room, HLN 2 provided wound care and changed the wound dressing of Resident 79's bottom wearing gloves but not wearing a gown.</p> <p>During an interview on 12/17/24 at 10:15 a.m., with HLN 2 in Resident 79's room, HLN 2 confirmed that she only wore gloves when she provided the wound care and wound dressing change of Resident 79. HLN 2 stated she was not aware that Resident 79 was on EBP and that she was supposed to wear gown when doing Resident 79's wound care.</p> <p>During an interview on 12/17/24 at 10:17 a.m., with CNA 5 in Resident 79's room, CNA 5 confirmed that she only wore gloves when she changed Resident 79's briefs. CNA 5 stated she would see other staff not wearing gown when taking care of Resident 79 that's why she did not wear a gown too.</p> <p>During a review of a facility document on 12/17/24 at 11:57 a.m., provided by the Infection Preventionist (IP), titled, Enhanced Barrier Precautions, the document indicated Resident 79 was on EBP.</p> <p>During an interview on 12/19/24 at 1:18 p.m., with the IP, the IP stated staff should have worn both gloves and gown when changing incontinence briefs and doing wound care of Resident 79. The IP further stated that not wearing a gown when caring for a resident on EBP would expose the resident to pathogens (infectious agents) and possible infection.</p> <p>4b. Resident 117 was admitted in October of 2024 and had diagnoses that included hemiplegia (complete loss of the ability to move one side of the body) and hemiparesis (partial weakness of one side of the body), gastrostomy status (a surgical procedure that creates an opening in the abdomen and into the stomach), and need for assistance with personal care.</p> <p>During a review of Resident 117's MDS Cognitive Patterns, dated 10/9/24, the MDS indicated, Resident 117 was rarely or never understood, and had short-term and long-term memory problem.</p> <p>During an observation on 12/17/24 at 8:45 a.m., in front of Resident 117's room, Resident 117's room door had a signage which indicated, STOP .Enhanced Barrier Precautions .Everyone must: Clean hands on room entry and when exiting .PROVIDERS AND STAFF MUST ALSO: .Wear gloves and a gown for the for the [sic] high-contact resident care activities below .3. Caring for devices & giving medical treatments .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of a facility document on 12/17/24 at 11:57 a.m., provided by the Infection Preventionist (IP), titled, Enhanced Barrier Precautions, the document indicated Resident 117 was on EBP.</p> <p>During an observation on 12/17/24 at 12:29 p.m., with LN 1, in Resident 117's room, LN 1 was administered the prescribed feeding formula of Resident 117 via feeding tube (a medical device surgically inserted into the stomach used to provide nutrition) while wearing gloves but not wearing a gown.</p> <p>During an interview on 12/17/24 at 12:45 p.m., with LN 1, in Resident 117's room, LN 1 confirmed that she only wore gloves when she administered the prescribed feeding formula of Resident 117 via feeding tube. LN 1 stated she was not supposed to wear gown when administering Resident 117's prescribed feeding formula via feeding tube.</p> <p>During an interview on 12/19/24 at 1:18 p.m., with the IP, the IP stated staff should have worn both gloves and gown when administering the prescribed feeding formula of Resident 117 via feeding tube because the feeding tube was an indwelling device which goes inside the body. The IP further stated that wearing both gloves and gown when handling feeding tubes would keep the residents protected from infections.</p> <p>During an interview on 12/19/24 at 3:21 p.m. with the Director of Nursing (DON), the DON stated she expected that staff would follow the EBP for infection control.</p> <p>During a review of the facility's P&P titled, Enhanced Standard/Barrier Precautions, undated, the P&P indicated, It is the policy of this facility to implement enhanced standard/barrier precautions for the prevention of transmission of multidrug-resistant organisms [MDROs- bacteria that resist treatment with more than one antibiotic] .3. Implementation of Enhanced Barrier Precautions .c. Wear gown and gloves while performing the following task associated with the greatest risk for MDRO contamination .ii. Device care, for example . feeding tube .iii. Any care activity where close contact with the resident is expected to occur such as . changing incontinence briefs .wound care .</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>43238</p> <p>Based on observation, interview and record review, the facility failed to maintain a safe, sanitary and comfortable environment for 29 residents (Residents 53, 29, 54, 40, 83, 28, 22, 16, 71, 73, 59, 103, 20, 272, 47, 104, 98, 101, 95, 67, 56, 39, 27, 70, 273, 51, 24, 26, 92) for a census of 111 when their bathroom exhaust fans were not properly cleaned leading to dust buildup.</p> <p>This failure had the potential to pose a fire hazard and expose the residents to breathe in mold and bacteria from the dust buildup.</p> <p>Findings:</p> <p>During an observation on 12/17/24 at 9:50 a.m., the exhaust fan had a dust buildup in the shared bathroom of Residents 53,29,54,40,83,28.</p> <p>During an observation on 12/18/24 at 8:42 a.m., the exhaust fan had a dust buildup in the shared bathroom of Residents 22,16,71,73,59,103.</p> <p>During an observation on 12/19/24 at 8:30 a.m., the exhaust fans had dust buildup for all shared bathrooms for Residents 53,29,54,40,83,28,22,16,71,73,59,103,20,272,47,104,98,101,95,67,56,39,27,70,273,51,24,26, 92.</p> <p>During an interview on 12/19/24 at 8:37 a.m. with Certified Nurse Assistant 8 (CNA 8), CNA 8 verified the exhaust fan in the shared bathroom for Residents 22,16,71,73,59,103 and stated, This is not good. It's dirty. It can get the residents sick or maybe even catch fire .</p> <p>During an interview on 12/19/24 at 8:39 a.m. with the Infection Preventionist (IP), the IP confirmed the finding on the exhaust fan in the shared bathroom for Residents 53,29,54,40,83,28 and stated, I will get housekeeping staff to get this cleaned today.</p> <p>During an interview on 12/19/24 at 8:41 a.m. with the Housekeeping Staff (HS), the HS confirmed the finding on the exhaust fan in the shared bathroom for Residents 20,272,47,104,98,101 and stated, It is dirty. These are cleaned, but not every day. The HS indicated that she was unaware of any schedule to clean the exhaust fans.</p> <p>During an interview on 12/19/24 at 8:50 a.m. with the Housekeeping Manager (HM), the HM stated that every room was scheduled for a deep clean every month, and stated, The housekeepers should be spot checking on a daily basis during room cleaning. The HM confirmed that deep cleaning also includes cleaning exhaust fans in the bathroom. The HM stated, This particular housekeeper needs help in cleaning higher areas in the room and bathroom.</p> <p>(continued on next page)</p>		

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 12/20/2024
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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 12/20/24 at 9:15 a.m. with the HM, the HM reviewed the November and December 2024 Deep Clean Calendar and she indicated that if scheduled rooms shared a bathroom and were scheduled on consecutive days, the shared bathroom would then be deep cleaned twice. The HM confirmed that shared bathroom for Residents 53,29,54,40,83 and 28 were deep cleaned on 12/17/24 and 12/18/24 with bathroom deep cleaning on both days but the exhaust fan was not cleaned. The copy of the Deep Clean Check Off List (undated) was also reviewed. The HM indicated the list was for the HS to use while performing a deep clean, and stated, The list is handed to the HM upon completion. The HM confirmed that item number 23 on the Deep Clean Check Off List indicated, Clean and wipe down vents, and stated, That included the bathrooms as well any vents in the room. The educational in-service titled, 7-Step Daily Washroom Cleaning, was reviewed, and the HM indicated the in-service was provided to all housekeeping staff. The HM confirmed that there was no mention of daily cleaning of the bathroom exhaust fans.</p> <p>During a review of the document titled, Environmental Services Operations Manual, dated 9/5/17, the manual indicated, Vents .Timing and Method .vents in resident rooms should be cleaned daily as part of the 5 & 7 step cleaning method.</p>