

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/02/2025
NAME OF PROVIDER OR SUPPLIER WINDSOR EL CAMINO CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2540 CARMICHAEL WAY CARMICHAEL, CA 95608		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of two (2) complaints #CA00953216 and #CA00953269. The inspection was limited to the specific complaint and facility reported incidents investigated and does not represent the findings of a full inspection of the facility.	F 000	POC Received: 5/7/25 POC Approved: 5/7/25 BIC: 4/14/25 Per Hannah Quinn		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide intravenous (IV, the administration of substances directly into a vein) care in accordance with professional standards of quality for two of six sampled resident's (Resident 2 and Resident 3) when Resident 2 and Resident 3 did not have physician orders for IV flushes (used to clear out IV lines after medication is used and to prevent blockages in the line). This failure had the potential for the residents to not receive the full dose of medication ordered, to receive the incorrect type or amount of IV flush and increased the risk for a blockage in the IV line. Findings:	F 658			

LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.