STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055308	A. BUILDING _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR ELK GROVE CARE AND REHABILITATION CENTER	9461 BATEY AVENUE ELK GROVE, CA 95624

(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 facility reported incident #CA00832792. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 32096 The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility.	F 000	DISCLAIMER CLAUSE PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the resident call system was functioning for one of three sampled residents (Resident 2) when the light above the resident's door to her room was not functioning. This failure resulted in the facility staff not being aware of the resident's needs. Findings:	F 919	**F919 – Resident Call System** **CFR(s): 483.90(g)(1)(2)** ***Correction for resident(s) affected:*** On 3/29/23, the Maintenance Supervisor and Assistant pulled the call light electrical box out of the wall for Resident 2 and identified that one of the electrical wires that powers the call light came loose from the wire nut that holds it in place (inside the electrical panel) inside the wall.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE RN - DON | (X6) DATE 4/28/23

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.

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F 919	Continued From page 1 Resident 2 was a long-term resident in the facility with diagnoses that included diabetes. In a concurrent observation and interview on 3/29/23 at 11:30 a.m., Resident 2 was observed to be yelling for help lying in her bed. Resident 2 complained no one answered her call light and she was thirsty. Resident 2 voiced she wanted water, but no one brought water for her; therefore, she had been yelling, yet no one still answered her. There were two white small disposable plastic cups and a pinkish water jug on her bedside table. Each plastic cup contained a couple of melting ice cubes with no water and the water jug next to the cups was empty. Resident 2 pushed the call light again and continued the interview; however, no one answered the light until the interview was over. Resident 2 started yelling again for help. Upon checking the resident's call light system, it was noted that the light above the resident's door to her room in the hallway which visually signaled staff, was not on. There were no audible signals observed contacting staff, either. Review of Resident 2's clinical record, dated 1/26/22, a care plan for potential fluid deficit indicated the care plan goal was for the resident to be free of symptoms of dehydration with interventions to, "Monitor... signs and symptoms of dehydration:..fever, thirst..." Review of Resident 2's care plan, initiated 1/7/21, for communication indicated the resident had a communication problem related to language barrier for English not being her primary language. The care plan included an intervention for staff to "anticipate and meet needs" of the	F 919	How to identify residents with potential to be affected by similar practice: The Maintenance Director conducted a test of the nurse call system which was completed on 3/30/23. All resident room call lights passed inspection; therefore, no other residents were identified with the potential to be affected by similar practice. ***Measures taken and put in place to maintain systematic changes:*** By 4/28/23, the DSD/DON/Designee will in-service staff to 1) the facility Policy titled "Call Light Answering" including event of call light malfunction, promptly notify maintenance and obtain alternate call bell device (i.e. hand-bell). Place in easy reach and explain use to resident. ***Monitoring to ensure solution is sustained:*** Monthly, the Maintenance Supervisor or Assistant will conduct a test of the nurse call system, which checks all devices transmitting to and receiving input from the nurse call system. Findings will be repaired as necessary Quality Assurance Performance Improvement (QAPI) committee until substantial compliance is met and maintained or as determined by the QAPI committee. ***Person(s) responsible for correction:*** The Administrator is responsible for this correction, alleging compliance on 04/28/2023.	

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F 919	Continued From page 2 resident. In an interview on 3/29/23 at 11:50 p.m., Licensed Nurse (LN) 1 verified the light above the resident's room was not working and acknowledged the light was the means of resident directly contacting staff. In an interview on 3/29/23 at 12:05 p.m., the Director of Nursing (DON) verified Resident 2's water jug was empty and acknowledged the resident's call light should always work for the resident to have the ability to communicate with staff. In an interview on 3/29/23 at 12:23 p.m., in the presence of the DON, the Maintenance Assistant explained Resident 2's call light did not work because one of the wires was not connected resulting in no light above the door or at the nursing station. In an interview on 3/29/23 at 12: 40 p.m., the Maintenance Supervisor provided the facility's call light system check log which indicated Resident 2's call system was last checked on 2/10/23. Review of the facility Policy, titled "Call Light, Answering " , revised date of 4/1/19, indicated, "It is the policy of Windsor Healthcare that each resident call light will be answered in a reasonable and timely manner to meet the needs of the residents ...In the event of call light malfunction, notify maintenance and obtain alternate call bell device ... "	F 919		