

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>055735</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>03/13/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>WINDSOR ELMHAVEN CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>6940 PACIFIC AVENUE STOCKTON, CA 95207</b>	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0684  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<p><b>Provide appropriate treatment and care according to orders, resident's preferences and goals.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) received treatment and care as ordered by the physician when: 1. A physician's orders [REDACTED]. Physical therapy (PT) for Resident 1 was not carried out until 42 days after the original physician's orders [REDACTED]. Findings: 1. According to the admission record, Resident 1 was admitted to the facility with hypertension (high blood pressure). The quarterly minimum data set (MDS, an assessment tool) dated 1/5/18, indicated a brief interview for mental status (BIMS) of 15, which indicated Resident 1 was cognitively intact. In a review of Resident 1's clinical record, the physician's orders [REDACTED]. During further review of Resident 1's clinical record, there was no documented evidence Resident 1 was seen by a rheumatologist. In an interview with the director of nursing (DON) on 3/10/20, at 1:09 p.m., she stated if the physician ordered a rheumatology consult, the licensed nurses should have made a rheumatology consult appointment for Resident 1. In an interview with the medical record director (MRD) on 3/10/20, at 1:15 p.m., she said she reached out to the local general acute care hospitals and was told Resident 1 was not seen in any of the local hospitals for a rheumatology consult in 2017 or in 2018. The MRD added, she reviewed Resident 1's clinical record and was unable to find evidence a rheumatology consult appointment was made. 2. In an interview with Resident 1 on 3/28/18, at 4:27 p.m., she stated her orthopedic physician prescribed PT for her, but she has not had PT yet. In a review of Resident 1's clinical record, the physician's progress notes from the orthopedic (branch of medicine dealing with the correction of deformities of bones or muscles) clinic dated 2/27/18, indicated, I have recommended PT for her (Resident 1). She will begin at her facility and if discharged we will order outpatient. Resident 1's licensed nurse progress note dated 2/27/18, at 3:26 p.m., indicated, resident came back from ortho (orthopedic) follow up, called ortho clinic to clarify the (name of physician) notes, unable to read, spoke with (name of clinic staff), says ortho clinic will fax to facility the notes. Resident 1's licensed nurse progress note dated 4/10/18, at 2:30 p.m., indicated, called ortho spoke with (name of clinic staff), to fax over the notes from MD (medical doctor) since 2/27/18, will fax the progress notes from (name of physician). Resident 1's licensed nurse progress note dated 4/11/18, at 12:52 p.m., indicated, spoke with resident regarding therapy order. The progress note dated 4/12/18, at 2:41 p.m., indicated, Patient was evaluated by PT on 4/11/18. In an interview with the DON on 3/10/20, at 1:09 p.m., she stated as soon as a resident comes back from an appointment, a licensed nurse should review all paperwork and communicate with PT if PT was ordered by the physician. The DON added, licensed nurses should carry out a physician's orders [REDACTED]. In a phone interview with the MRD on 3/17/20, at 12:24 p.m., she said she reviewed the clinical record for Resident 1 and was unable to find evidence Resident 1 received PT from 2/27/18 through 4/10/18. The MRD added, she found a PT progress note for PT evaluation dated 4/11/18, but no physical therapy treatment before that.</p>		
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.