STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055954	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Gardens Conv Center of San Diego	220 East 24th Street National City, CA 91950

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 40610 Based on observation and interview, the facility failed to ensure a clean, safe and comfortable homelike environment when insects were observed in a resident ' s room and the screen of the sliding door was in disrepair. These failures had the potential to negatively impact the residents' health and well-being. Findings: On 4/22/25, the Department received a complaint related to physical environment. On 4/29/25 at 9:56 A.M., an unannounced on-site visit was conducted. On 4/29/25 at 5:17 P.M., a joint observation of Resident 5 and Resident 6 ' s room, an interview of Resident 5 and Resident 6, and an interview were conducted with the Maintenance Supervisor (MS). Resident 5 stated she had placed an insect trap because she was afraid the insects would come to them. Resident 5 stated the screen door was slightly open and did not know if it was broken. Resident 5 stated she did not go to the patio. The MS checked the insect trap and noted big black insect. The MS stated the sliding door was opened. The MS stated, Sometimes the resident opens the sliding door. On 5/13/25 at 3:13 P.M., a concurrent review of Resident 1 ' s clinical record and an interview was conducted with the Director of Nursing (DON), the Administrator (ADM) and the Medical Records Director (MRD). The ADM stated, I expect the sliding door to be closed especially the summertime. If it is closed, to ensure there is no insect coming in. It is not acceptable and will have the maintenance guy to make rounds to make sure all the doors have sliding door to ensure the insects don ' t come in. A review of the facility ' s policy titled, Homelike Environment, revised 2/2021, indicated, Residents are provided with a safe, clean, comfortable and homelike environment .

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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview and record review, the facility failed to identify in a timely manner the development of pressure injuries (skin damaged by lack of movement for staying in a position for too long) for one of three sampled residents reviewed for pressure injuries/ wounds. In addition, the facility did not consistently provide treatments for Resident 1 ' s existing surgical wounds in his right foot. As a result, Resident 1 developed a new pressure wound on his coccyx (tailbone). In addition, Resident 1 ' s surgical wounds in his right foot did not heal properly, developed an infection and eventually Resident 1 underwent an amputation (surgical removal of a limb) of his right leg. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses which included orthopedic aftercare following surgical amputation, diabetes (high blood sugar) and generalized muscle weakness, per the facility ' s Admission Record. A review of Resident 1 ' s minimum data set (MDS, a federally mandated resident assessment tool), dated 2/25/25, indicated Resident 1 had a brief interview for mental status (BIMS, ability to recall) score of 14/15, which suggested Resident 1 ' s cognition was intact. Resident 1 ' s functional abilities of the MDS dated [DATE], indicated Resident 1 required supervision or touching assistance from a staff member when turning and repositioning in bed. Resident 1 ' s skin condition on 2/25/25 indicated he had no pressure wound in the coccyx. A review of Resident 1 ' s Braden scale for predicting pressure sore form dated 1/16/25, indicated Resident 1 was at moderate risk for developing pressure sore related to very limited mobility which meant Resident 1 was unable to turn himself independently. A review of Resident 1 ' s skin assessment on 1/16/25, and 2/21/25, indicated Resident 1 did not have pressure wound in the coccyx. A review of the Interdisciplinary team (IDT, a group of professional and direct care staff that have primary responsibility for the development of a plan for the care and treatment of a patient) dated 4/11/25 indicated that Resident 1 had an open wound in the buttocks measuring 3.5 centimeters long and 3.0 centimeters wide with uneven borders. The IDT note indicated Resident 1 ' s wound was stage 2 (the skin breaks open, wears away, or forms an ulcer, which is usually tender and painful). On 4/29/25 at 12:15 P.M., an observation and an interview were conducted of Resident 1 in his room. Resident 1 sat in a wheelchair right above the knee amputation with dressing on it. Resident 1 stated he could speak a little English. Resident 1 stated he developed an open wound in his tailbone which he did not have upon admission. Resident 1 stated, Sometimes it hurts. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/25 at 3:02 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated Resident 1 needed help repositioning in bed and had not refused to be repositioned. CNA 1 stated Resident 1 did not have open wounds in his tailbone on his first admission. On 4/29/25 at 3:09 P.M., an interview was conducted with CNA 2. CNA 2 stated Resident 1 was frequently assigned to CNA 2. CNA 2 stated Resident 1 could not reposition himself in bed. CNA 2 stated Resident 1 needed some push from the staff to fully reposition himself in bed. CNA 2 stated Resident had not have refused to be repositioned. CNA 2 stated Resident 1 did not have wound in his tailbone before. On 4/29/25 at 4:38 P.M., an interview was conducted with CNA 3. CNA 3 stated Resident 1 did not refuse to be repositioned in bed. CNA 3 stated Resident 1 had no wounds in his coccyx before. CNA 3 stated she saw redness on Resident 1 ' s coccyx and reported it to the Licensed Nurse (LN). CNA 3 stated she did not remember whom she reported the change in Resident 1 ' s skin condition. CNA 3 stated, He looks better now compared to when prior to sending him to the hospital. On 4/29/25 at 11:18 A.M., an interview was conducted with LN 1. LN 1 stated he regularly provided care to Resident 1 and was familiar with Resident 1. LN 1 stated, Most of the time, we don ' t have a treatment nurse. LN 1 stated the medication (med) nurses were responsible for a lot of assigned tasks aside from providing treatments for the residents ' wounds. LN 1 stated, It was a challenge, we are overwhelmed. LN 1 stated Resident 1 developed pressure wound in his coccyx, and no one knew until it was already opened. LN 1 stated the presence of Resident 1 ' s pressure wound was not identified and reported until 4/11/25. LN 1 stated he did not know the stage of Resident 1 ' s coccyx wound. LN 1 stated the med nurses were not certified to do treatments and so were not allowed to stage Resident 1 ' s wounds. On 4/29/25 at 10:50 A.M., an interview was conducted with the Nurse Practitioner (NP). The NP stated Resident 1 initially came to the facility for treatment of his surgical wounds after an amputation of Resident 1 ' s right big toe. The NP stated Resident 1 ' s surgical wound in his right big toe wound had not healed and had right below the knee amputation (BKA) in February 2025. The NP stated Resident 1 ' s right BKA stump (a small part of something that remains when the rest of it has been removed or broken off) did not heal and so Resident 1 later had right above the knee amputation (AKA) in April 2025. The NP stated she was not following Resident 1 ' s coccyx wound. The NP stated the med nurse/ treatment nurse followed up Resident 1 ' s coccyx wound. The NP stated Resident 1 ' s coccyx wound developed while Resident 1 was in the facility. On 4/29/25 at 1:50 P.M., an interview was conducted with LN 2. LN 2 stated the med nurse did the treatment on the residents ' wounds since the facility had no treatment nurse. LN 2 stated the med nurses had no formal training on wound management. LN 2 stated I was informed to do the treatment, we are expected to do the treatment, I will do the treatment. LN 2 further stated, For today, I rarely have the opportunity, it is difficult to tackle. We do meds, admission, discharge, carry out the NP or the physician ' s orders. LN 2 stated, It is very unlikely that the resident will get 100% of treatment. LN 2 stated wound management of the residents ' wounds would be the med nurse ' s responsibility when the facility did not have a wound nurse. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/25 at 2:22 P.M., a review of Resident 1 ' s clinical record and an interview was conducted with LN 3. LN 3 stated the med nurses had no formal training for wound management. LN 3 stated there was no treatment nurse in the facility. LN 3 stated before Resident 1 left the facility to the acute hospital on 4/16/25, the med nurses were treating Resident 1 ' s right BKA stump. LN 3 stated Resident 1 ' s clinical record did not indicate Resident 1 had a coccyx wound and there was no indication the coccyx wound was treated. LN 3 stated she did not remember treating Resident 1 ' s coccyx wound in the past. LN 3 stated Resident 1 ' s change in condition LN notes on 4/11/25 indicated Resident 1 had developed a wound in his coccyx. LN 3 stated Resident 1 ' s clinical record did not indicate Resident 1 ' s wound in his coccyx did not undergo the stages of wound. LN 3 stated Resident 1 ' s coccyx wound was identified when the wound was already opened. On 5/13/25 at 3:13 P.M., a concurrent review of Resident 1 ' s clinical record and an interview was conducted with the Director of Nursing (DON), the Administrator (ADM) and the Medical Records Director (MRD). Resident 1 ' s physician orders indicated the following treatment orders: On 1/17/25: - Right foot post amputation treatment one time a day for 21 days. - Right knee open wound treatment one time a day for 21 days. On 2/24/25: - Wound vacuum negative pressure (device that uses suction to help wounds heal faster) treatment to right knee every 72 hours. On 3/2/25: - Right BKA surgical site treatment one time a day. - right lateral knee skin tear treatment. On 3/21/25: - Right knee wound treatment one time a day. Resident 1 ' s treatment administration record (TAR) indicated the following dates were missing: - 1/22 & 1/23/25 for the right foot post amputation and right knee open wound treatments. - 3/11 for wound vacuum treatment to right knee. - 3/7, 3/13, 3/16, 3/19, 3/28 for right BKA surgical site treatment. - 3/7 for right lateral knee skin tear treatment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 3/28 for right knee wound treatment. The DON stated Resident 1 ' s wound in his coccyx was identified as located in Resident 1 ' s left buttock. The DON stated the wound was identified and reported on 4/11/25 when it was already stage 2. The DON stated the expectation was once the CNAs identified a skin change in the resident ' s skin that the CNAs needed to report the change to the LNs so the LN could have assessed the resident ' s skin timely to provide treatment and prevent development of pressure wounds. The DON stated the expectation for the LNs was to ensure treatments were provided to the resident ' s existing wounds to prevent infection and worsening of the condition of the wounds. A review of the facility ' s undated policy, titled Pressure Injury Risk Assessment, indicated, The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing pressure injuries (PIs) .1. The purpose of a pressure injury risk assessment is to identify all risk factors and then to determine which can be modified and which cannot, or which can be immediately addressed, and which will take time to modify .6. Once the assessment is conducted and risk factors are identified and characterized, a resident centered care plan can be created to address the modifiable risks for pressure injuries .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on interview and record review, the facility failed to ensure one of four residents (Resident 3) received food that accommodated her food preferences. This failure had the potential for Resident 3's wishes to be ignored. In addition, this failure had the potential to result in decreased food intake and weight loss. Findings: On 4/22/25, the Department received a complaint related to Dietary Services. On 4/29/25 at 9:56 A.M., an unannounced on-site visit was conducted. Resident 3 was admitted to the facility on [DATE], with diagnoses which included surgical after care after a surgery according to the facility ' s Admission Record. On 4/29/25 at 11:59 A.M., a joint review of Resident 3 ' s dietary record and an interview was conducted with the Certified Dietary Manager (CDM). The CDM stated she spoke to Resident 3 on 4/14/25 and found out Resident 3 preferred vegan diet and requested tofu. The CDM stated the facility did not have tofu. The CDM stated the kitchen provided Resident 3 with some green salad. The CDM stated she went to the grocery store to get some vegan food for Resident 3 but did not get tofu for Resident 3. The CDM stated Resident 3 did not get tofu for the rest of her stay at the facility. The CDM stated, I did not get the tofu. That is my fault, I should have gotten one for her because that is her preference. On 5/13/25 at 3:13 P.M., a concurrent review of Resident 1 ' s clinical record and an interview was conducted with the Director of Nursing (DON), the Administrator (ADM) and the Medical Records Director (MRD). The ADM stated, We have to meet the needs of the resident. We have to order tofu. A review of the facility ' s policy, titled Menus, revised 10/2017, indicated, Menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy .