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	07/02/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice when Licensed Nurses (LNs) failed to consistently follow physician's order related to eye drop therapy for one of one sampled resident (Resident 1) reviewed for ophthalmic (eye) medication. This failure had the potential to place Resident 1 at risk of vision loss and blindness. Findings: Resident 1 was readmitted to the facility on [DATE] with diagnoses which included glaucoma (damage to the optic nerve often related to high pressure in the eye that can cause vision loss and blindness), per the facility's admission Record. A review of Resident 1's clinical record was conducted. Resident 1's physician's order dated 6/7/25, indicated Resident 1 was to receive two eye drop medications. One of the physician's orders were as follows: - Latanoprost (ophthalmic solution) to be given on both eyes for glaucoma. A review of Resident 1's medication administration record (MAR) was conducted. Resident 1's MAR for June 2025 indicated, the License Nurses (LNs) missed to administer Resident 1's eye drop medication and documentation for 6/19 through 6/22/25 and 6/24/25. On 7/8/25 at 3:51 P.M., a joint review of Resident 1's clinical record and a telephone interview was conducted with the Director of Nursing and the Administrator (ADM). The DON stated she clarified with the LNs who were assigned to Resident 1 on 6/19/25 through 6/24/25. The DON stated the nurses notes also indicated Resident 1 did not receive his eye drop medication due to pending delivery of the medication from the pharmacy. The DON stated the expectation was for the LNs to notify the DON and or the ADM so the pharmacy could have expedited the delivery of the medication to meet the care of the resident. The DON stated the LNs should have followed the physician's order and provided care to Resident 1. A policy was requested related to following physician's orders. The facility provided a policy titled, Telephone Orders, revised 2/2014. The policy did not indicate following physician's orders.

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to provide a sufficient number of staff to answer call lights and deliver personal care in a timely manner for three of four sampled residents (1, 3 and 4), and six residents identified in the resident council meeting minutes. As a result, there was the potential for residents not to get their minimum daily care needs met. Findings: During a telephone interview with Resident 1's family member (FM) on 7/2/25 at 8:40 A.M., the FM stated Certified Nursing Assistants (CNAs) come after 30 minutes to an hour. The FM stated there were multiple occasions when she needed assistance to change Resident 1's incontinence brief, the staff informed FM the CNA assigned to Resident 1 was either on break or on one on one (1:1, sitters or constant observation) monitoring of another resident. FM 1 stated she ended up changing Resident 1's incontinence brief. During a concurrent observation and an interview of Resident 3 on 7/2/25 at 11:45 A.M., Resident 3 was observed alert and smiling, and asked another resident (Resident 4) to express his concerns. Resident 3 reported there were several instances where he had to wait 30 minutes to an hour for staff to change his incontinence brief. Resident 3 further stated, No good. During a concurrent observation and an interview of Resident 4 on 7/2/25 at 11:47 A.M., Resident 4 was alert, oriented and cooperative while sitting in her room in a wheelchair. Resident 3 approached Resident 4 to express his concerns and her concerns. Resident 4 reported after call light was pressed for assistance for brief change, lights, or to request something, she had to wait for 30 minutes to an hour for staff to respond on multiple occasions. Resident 4 further reported that when the resident asked the staff where the assigned CNA was, she was informed the assigned CNA was on 1:1 to another resident. Resident 4 stated That was good for that resident however who is going to take care for the rest of us? Resident 4 stated, Our issues is not well taken care of. The CNAs have a lot of issues, at the end of the day, we are suffering. They are already exhausted and upset, it affects us. Resident 4 stated the residents waited 30 minutes to an hour to get a brief change. Resident 4 stated, We will be soaking wet with poop and urine, we cannot do anything since we need assistance to be changed. Resident 4 stated there was already a discussion and nothing had happened. During a concurrent observation of Resident 1 and an interview of Resident 1's private caregiver (PC) on 7/2/25 at 12:22 P.M., Resident 1 was sitting in a wheelchair with his PC at the bedside. Resident 1's PC stated she assisted Resident 1 in his care needs. During an observation of Resident 1 in his room on 7/2/25 at 12:27 P.M., CNA 1 came to Resident 1's room and brought a lunch box to Resident 1. CNA 1 placed the lunch box in the bedside table and had the PC fed Resident 1. CNA 1 left Resident 1's room after handling the food utensils to the PC. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA 1 on 7/2/25 at 12:30 P.M., CNA 1 stated the CNAs do a rotation to do 1:1 to a resident. CNA 1 stated the 1:1 monitoring of one resident took some of the CNA's time. CNA 1 stated when the CNAs were scheduled to do 1:1 monitoring, one CNA will be responsible for taking care of his or her assigned residents and was responsible for taking care of the residents of the CNA who were on 1:1 rotation. CNA 1 stated there would be around 19-20 residents for a given period of time the CNA was away. CNA 1 stated the staff were aware of the residents' concerns and complaints related to call light response and timely brief change to the residents, But we can only do so much. During an interview with CNA 2 on 7/2/25 at 1:23 P.M., CNA 2 stated when they do 1:1 monitoring to a resident for 30 minutes to an hour, that time was taken away from their responsibilities with their other assigned residents. CNA 2 stated in order to finish things up, the CNAs would sometimes have to bring the resident on 1:1 monitoring while they change another resident. CNA 2 stated, What if the resident on 1:1 monitoring threw herself up and we are in the middle of changing another resident? It is not safe. CNA 2 stated the CNAs also have to provide showers to the residents. CNA 2 stated when the CNAs were done with the 1:1 rotation, their assigned residents were upset because they were soiled with their urine or feces. CNA 2 stated, We tried to finish but we cannot finish our job. During an interview with CNA 3 on 7/2/25 at 1:39 P.M., CNA 3 stated that the delayed staff response time to call lights was due to the shift being short-staffed and Licensed Nurses (LNs) did not help with the call lights. CNA 3 stated there was one time, she asked help from the LNs to mechanically lift a resident to a shower chair, CNA 3 stated the LNs answer was No. CNA 3 stated I have to give the resident a bed bath because no one help me to transfer her to shower chair. CNA 3 stated the CNAs were to provide showers to the residents since they had no shower person to do the task. CNA 3 stated there were times when CNAs were on 1:1 monitoring, the CNAs would have to take the resident with them while changing another resident's incontinence brief. CNA 3 stated the staff were aware of the residents' concerns and complaints regarding call light response and timely brief change but, We are always shorthanded. CNA 3 stated sometimes the residents were soiled with their feces and urine. During an interview with CNA 4 on 7/2/25 at 2:31 P.M., CNA 4 stated the 1:1 monitoring of one resident was a hustle because it takes away our time to watch our designated residents. Sometimes the residents want to go to the bathroom, but we are not there. CNA 4 stated that was 30 minutes to an hour away from the other residents. CNA 4 stated the CNAs were also to provide showers when there was no one assigned to do the task. CNA 4 stated most of his assigned residents wondered where he had been and had to wait 30 minutes to an hour. A review of the facility's resident council meeting minutes from April to June 2025 indicated the following: - May 2025, per the meeting minutes, five residents voiced their concerns that they waited an hour for their call lights to be answered. - June 2025, per the meeting minutes, one resident voiced a concern that staff just passed by when she needed some assistance to go to activities or needs to be attended. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint review of the facility's actual staffing information for June 2025 and an interview with the Director of Staff Development (DSD) on 7/2/25 at 2:59 P.M., the DSD stated there were days they were short-staffed, especially when there were call ins during the weekends. The DSD stated on 6/1/25, 6/15/25 and 6/22/25, the actual staffing was below what was expected to be able to provide at least a minimum of care to the residents. The DSD also stated CNAs were assigned to do 1:1 monitoring of a resident. The DSD stated it was a 30-minute rotation. The DSD stated each CNA had assigned nine to ten residents. The DSD stated if one CNA was to do the 1:1 rotation, one CNA would have to take care of approximately 18-20 residents at a given time. The DSD stated there were complaints from the residents and the CNAs but had gotten no response from the Interdisciplinary team (IDT). The DSD stated it should have been addressed for residents' safety. The DSD stated it was true there was no shower person to provide showers to the residents and the CNAs assigned to the residents were responsible to provide the residents showers. The DSD stated, I know we are protecting the one patient but neglecting the rest of residents. During a joint interview with the Administrator (ADM) and the Director of Nursing (DON) on 7/2/25 at 3:31 P. M., the ADM and the DON stated the 1:1 monitoring was working for the resident. The DON stated the management had not received any complaints related to residents' care. The ADM and the DON were not aware the CNAs were providing showers to their assigned residents, in addition to doing the 1:1 rotation. The ADM and the DON stated there was a shower lady and did not think the shower person was not able to provide showers at the time being. The DON stated moving forward, the expectation was to ensure the CNAs were present to take care of the residents for safety. A review of the facility's policy titled, Staffing, Sufficient and Competent Nursing, revised 4/25, indicated, Our facility provides sufficient numbers of nursing staff .to provide nursing and related care and services for all residents in accordance with resident care plans .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 .