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	12/11/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to accurately code a fall incident on the Minimum Data Set (MDS - a federally mandated resident assessment tool) for one of three sampled residents (Resident 4).This deficient practice placed Resident 4 at risk for ineffective care planning, monitoring of fall risks and inaccurate health status sent to the federal database. Findings:A review of Resident 4's admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses which included history of Paroxysmal Atrial Fibrillation(an irregular and often very rapid heart rhythm).A record review of Resident 4's clinical chart indicated: - Resident 4's Intradisciplinary (IDT) note dated 10/14/25 1357 (1:57 P.M.) indicated, . fall incident: 10/12/25 11:00 AM.Reported unwitnessed fall when res. Noted by LN sitting at bedside, remains on same baseline orientation.- Resident 4's progress note dated 10/12/25 11:38 (11:38 A.M.) indicated, .LN found resident on the floor sitting on her bottom, bed noted at lowest position, Resident stated sheg got up but slipped and she fell on he [sic] bottom.- Resident 4's quarterly MDS assessment dated [DATE] Section J1800 indicated, Fall was coded 0.No.- Resident 4's care plan initiated 8/29/25 Created 8/29/25 and revised 11/6/25 indicated, .Risk for falls.On 12/11/2025 at 2:11 P.M., an interview and record review was conducted with the Minimum Data Set Nurse (MDSN). The MDSN stated this was not accurately coded and should have been coded as yes because Resident 4 had a fall incident on 10/12/25. The MDSN stated it was important that Resident 4's MDS to be accurate because the MDS drives the care planning to be personalized for Resident 4 and to update care interventions and monitoring for falls and safety risks. The MDSN stated she had to modify Resident 4's quarterly MDS dated [DATE] and re-send to the federal database to provide accurate information for Resident 4's health status and to reflect accurate quality measures of the facility.On 12/11/2025 at 4 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectations was for the MDSN to accurately code the MDS according to the RAI for all residents because this information was sent to the federal database and was important to personalize the plan of care for falls and safety risks.A review of Centers for Medicare and Medicaid Services (CMS, a federal agency) RAI Manual 3.0 October 2025, (Page J-35) J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent .0.No 1. Yes.

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

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	12/11/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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	055954	A. Building B. Wing	12/11/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to follow proper infection control procedures for one of five sampled residents (Resident 1) to prevent the spread of pediculosis (lice-tiny, parasitic insects [about the size of a sesame seed] that feed on blood in the scalp/skin and cause intense itching that can lead to open sores and infection) when the facility failed to assess, screen, or monitor exposed former and new roommates during a room change.This deficient practice placed four residents (Resident 1's roommates) at risk for undetected lice and possible outbreaks (further spread) in the facility.Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included history of Cervical Disc Disorder (injuries to a disc [shock absorber between the bones in your neck], or multiple discs, located between the cervical [seven small bones that make up your neck] bones).A record review of Resident 1's clinical chart indicated: - Resident 1's Nurses Progress note on 11/14/2025 at 8:33 (6:33 P.M.) indicated, .Resident c/o itchy scalp. Noted w/ head lice. No rashes to scalp, no open areas. NP [Nurse Practitioner] [NP Name]on site made aware w/ new order for Permethrin 1% to be applied to hair/scalp. Dtr [daughter] [Family Member Name] at bedside aware and supplied Permethrin shampoo 1% .- Resident 1's care plan initiated 11/14/25 indicated, .The resident c/o [complain of] of itchy scalp.Give permethrin 1% [medication used to treat lice] as PPX [prophylaxis] r/t [related to] head lice.On 12/9/25 at 12:11 P.M., an interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 1 had lice and was treated with Permethrin (lice shampoo) cream shampoo as ordered by the Nurse Practitioner (NP). LN 1 stated he was the nurse assigned to Resident 1 (room [ROOM NUMBER]) when he discovered lice on Resident 1 by Resident 1's family member. LN 1 stated that Resident 1 was transferred to a different room (from room [ROOM NUMBER] to room two) and had two roommates in each room. LN 1 stated that he was unable to find documentation if Resident 1's former roommates (room [ROOM NUMBER]) or new roommates (room two) were assessed and/or monitored for lice during Resident 1's treatment for lice. LN 1 stated isolation/contact (everyone coming into a resident's room is asked to wear a gown and gloves) precautions were not initiated during Resident 1's treatment for lice and stated contact precautions should have been in place to prevent lice infestation to Resident 1's roommates. LN 1 stated lice was highly contagious and can cause itching and spread through personal items that can cause open sores and infection.On 12/9/25 at 12:27 P.M., an interview and record review was conducted with LN 2. LN 2 stated she was Resident 1's nurse when Resident 1 moved from room [ROOM NUMBER]. LN 2 stated Resident 1 had lice that and treatment for lice continued during the room change. LN 2 stated that Resident 1 had two new roommates (room two) and had two former roommates (room [ROOM NUMBER]) during the room change. LN 2 stated they did not initiate contact precautions for Resident 1 during the treatment for the lice and was unable to find documentation that her new roommates in room two were monitored and/or assessed for lice. LN 2 stated Resident 1's roommates (room [ROOM NUMBER] and room two) should have been monitored for lice because lice was highly contagious and could spread if not contained properly by necessary precautions.On 12/9/25 at 2:30 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated they adhered to the Centers for Disease Control and Prevention (CDC) guidelines with lice and further stated lice is contagious and could cause infections from open sores due to itching. The DON stated, normally put a sign on the door and keep resident (Resident 1) on precautions for lice, but I guess that didn't happen this time for contact precautions. The DON stated, we did not monitor [Resident 1's Name] roommates for lice when she moved from room [ROOM NUMBER] to room [ROOM NUMBER] and should have also monitored them but at that time we didn't have any free beds for contact isolation. The DON acknowledged CDC guidelines for lice recommendation precautions for lice is 24 hours contact/isolation. The DON further stated, 'we should have checked everyone who shared the rooms, but I don't see that it was done.According to the Centers for Disease Control and Prevention (CDC) Appendix A at https://www.cdc.gov/infection-control/hcp/isolation-precautions/appendix-a-type-duration.html .Pediculosis (lice) requires Contact plus Standard [handwashing] Precautions until 24 hours after initiation of effective therapy .A review of the facility's policy and procedure titled, Procedure: Pediculosis (Body, Head, Pubic Lice) dated 3/6/2023, indicated .Interdisciplinary team to implement measures to eliminate infestation and prevent spread to others