STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056315	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Cypress Gardens	9025 Colorado Avenue Riverside, CA 92503

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46145 Based on interview and record review, the facility failed to notify the Resident Representative (a person assigned by the resident to make medical decisions in the event the resident is unable), when a new medication Lorazepam (a medication used to manage feelings of anxiety [feeling of worry, nervousness, or unease about something]) was added to the resident's medication regimen, for one of three sampled residents (Resident 1). This failure had the potential for the Resident 1's Representative to be unaware of Resident 1's care which could affect the resident's health and safety. Findings: On July 23, 2024, at 8:20 a.m., an unannounced visit was made to the facility to investigate a resident rights issue. On July 23, 2024, at 12:35 p.m., an interview was conducted with Resident 1's Representative (RR), who stated, the resident appeared drugged, when she visited him, and was concerned the resident was being over medicated. The RR further stated, at that time, she had not been notified by the facility that Resident 1 was started on new medications. A review of Resident 1's medical record, titled, Face Sheet, indicated, the resident was readmitted to the facility on [DATE], with a diagnosis of kidney cancer, under hospice (End of life) care, with a Brief Interview for Mental Status (a cognitive assessment) score of 06 (severely cognitively impaired). Further review of Resident 1's record, indicated, Resident 1 had appointed a representative as a health care decision maker. A review of Resident 1's Physician Orders, dated June 2, 2024, indicated, .LORazepam Oral Tablet 1 MG (milligram) (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for anxiety . A review of Resident 1's PSYCHOTROPIC (medication that affects the mind, emotions, and behavior) MEDICATION ADMINISTRATION DISCLOSURE, dated June 2, 2024, indicated, Resident 1 signed the form, consenting to Lorazepam being added to his medication regimen. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 1's record indicated, there was no documented evidence Resident 1's Representative was notified. On June 24, 2024, at 1:28 p.m., an interview was conducted with the Assistance Director of Nursing (ADON), who stated, if a resident has appointed a representative, and a new medication is added to the resident's medication regimen, the facility should notify the representative of the new medication orders. On June 25, 2024, at 11:56 a.m., a concurrent interview and review of Resident 1's Ativen consent form with the Director of Nursing (DON) were conducted. The DON stated, resident had an appointed representative, in the event he was deemed incapacitated to make his own medical decisions. The DON further stated, there was no documentation Resident 1's Representative was notified of resident's new anti-anxiety medication Ativan, after resident consented to adding the medication to his regimen, on June 2, 2024. A review of the facility's Policy & Procedure, titled, Health, Medical Condition and Treatment Options Informing Residents of, revised February 2021, indicated, . 1. Each resident is informed of his/her total health status and medical condition, including diagnosis treatment recommendations and prognosis, in advance of treatment and on an on-going basis. If a resident has an appointed representative, the representative is also informed .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 46145 Based on interview and record review, the facility failed to follow-up on a Letter of Agreement ({LOA}- an agreement of provided services between the facility and an uncontracted company), for hospice (End of life care) for one of three sampled residents (Resident 1). This failure resulted in the inability for Resident 1 to change hospice services, to a hospice of their choice. Findings: On July 23, 2024, at 8:20 a.m., an unannounced visit was made to the facility to investigate a resident rights issue. On July 23, 2024, at 12:35 p.m., an interview was conducted with Resident 1's Representative (RR - a person assigned to make medical decisions in the event the resident is unable), who stated, the resident was on hospice care at the facility. The RR stated the facility told them they could use any hospice of their choice. The RR stated, they found a new hospice and they wished to change Resident 1's care too. The RR stated, the new hospice had reached out to the facility for approval, and representative/new hospice had not received a response from the facility. The RR stated it had been over a month since the request. A review of Resident 1's medical record, titled, Face Sheet, indicated, resident was readmitted to the facility from GACH (General Acute Care Hospital) on June 1, 2024, with a diagnosis of kidney cancer, under hospice care. Resident 1 had a Brief Interview for Mental Status (a cognitive assessment) score of 7 (severe cognitive impairment). On July 23, 2024, at 1:24 p.m., an interview was conducted with the Director of Nursing (DON), who stated, residents can choose the services of any hospice they prefer. The DON stated, if the hospice is not contracted with the facility, a LOA from the uncontracted hospice, would be sent to the facility's corporate office for approval. The DON further stated, she did not know the status of Resident 1's LOA, as the Administrator (Admin) is responsible for following-up on the approval of the LOA with facility's corporate office. A review of Resident 1's progress notes, dated, June 13, 2024, at 9:56 a.m., by the Social Services Assistant (SSA), indicated, . SSA received a call from (Resident 1's) (Representative) stating she would like to change (Resident's) hospice company . SSA will make SSD (Social Services Director) aware . On July 23, 2024, at 3:51 p.m., an interview was conducted with the SSD, who stated, approximately one month prior, SSA had reported to her, that Resident 1's Representative wanted to change hospice companies. The SSD stated she reported this to Admin, who is responsible for sending, and following up, on a LOA. The SSD further stated, she did not document her conversation with Admin, and did not know the status of LOA. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On July 24, 2024, at 1:50 p.m., an interview was conducted with Admin, who stated, the process for a resident to change hospice care to an uncontracted hospice, requires an approved LOA from corporate. The Admin stated, he is responsible for sending and following up on LOA's with corporate. The Admin verified, he sent Resident 1's LOA to corporate office on approximately, June 15, 2024, and had not followed-up on the LOA, until July 23, 2024. The Admin stated, he had been out of the country part of that time, he had not designated the task to other staff members in his absence. The Admin further stated, To be honest, I hadn't thought about it. A review of the facility's Policy & Procedure, titled, Hospice Program, revised, 2017, indicated, . Our facility has designated (Social Service), to coordinate care provided to the resident by our facility staff and the hospice staff . 14. Coordinated care plan will reflect the resident's goals and wishes, as stated in his or her advance directives and during ongoing communication with the resident or representative, including: a. Palliative goals and objectives .