| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056315 | A. Building<br>B. Wing | 08/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Windsor Cypress Gardens | 9025 Colorado Avenue<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>(continued on next page) |

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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, it has been determined that the facility did not ensure that wound and skin documentation accurately reflected the conditions of the residents during daily and weekly assessments, in accordance with current professional standards of practice, for all four sampled residents (Residents 1, 2, 3, and 4). This failure had the potential to result in inadequate monitoring of wounds and skin integrity. missed changes in condition, and delayed interventions, placing residents at risk for complications and worsening existing conditions. Findings: On July 31, 2025, a review of Resident 1's record was conducted. Resident 1 was admitted to the facility on [DATE], and discharged on June 30, 2025, with diagnoses which included cerebral infarction (portion of the brain with debilitated or weakened function) and unspecified convulsions (uncontrolled shaking of the body). A review of the History and Physical, dated June 29, 2025, indicated Resident 1 has the capacity to make decisions.A review of Resident 1's Body Check indicated:-June 27, 2025, .completed with skin issues.scab to right antecubital 0.5 cm x 0.5 cm (centimeters - unit of measurement) .scab to right dorsal foot.discoloration to right buttock.right deficit r/t (related too) CVA (cerebral vascular accident) .scar tissue to right anterior forearm.; and -July 11, 2025, .MASD (moisture associated skin damage-skin irritation caused by prolonged exposure to moisture, leading to inflammation and potential skin breakdown) to buttocks-ongoing tx (treatment) administered.redness to right antecubital. self-inflicted scratches to right upper back. Scabbed 100%. No bleeding. No redness.A review of Resident 1's Weekly Documentation, dated July 8, 2025 (for July 5, 2025), and July 19, 2025 (for July 19,2025), indicated no skin issues. In addition, there was no documented evidence that the weekly documentation identified an ongoing status of the residents' skin condition. A review of Resident 1's Daily Documentation from July 1, 2025, to July 19, 2025, indicated the following: .July 6, 2025.skin integrity.resident has a wound. YES.see current Tx (treatment) .July 7, 2025.skin integrity.resident has a wound.YES.see Tx plan.July 12, 2025.skin integrity.resident has a wound.YES.see Tx records.7/26/2025.skin integrity.resident has a wound. No.No comments There was no documentation that the nurse's daily documentation identified current skin conditions with ongoing treatments. A review of Resident 1's Change of Condition, (COC) dated July 4, 2025, at 9:57 p.m., indicated, .resident noted with open area to coccyx. No discharge noted. Resident denies pain.provider recommendations.monitor.A review of Resident 1's Order Summary Report dated July 4, 2025, indicated: .cleanse coccyx open area with NS (normal saline solution). Pat dry. Apply TAO [Triple antibiotic ointment]. Leave open to air every shift for 14 days.; and .monitor discoloration to right buttocks x 14 days. Then re-eval. Notify MD of any new COC .Further review of Resident 1's nursing documentation did not consistently mention the coccyx wound noticed on July 4, 2025.On July 31, 2025, at 12:20 p.m., during observation and interview, Resident 3 was alert and lying in bed with his left leg resting on the bed. Resident 3 mentioned he was recently admitted after foot surgery and that he had his first wound treatment from the wound specialist. He noted that nurses were not yet treating his wounds, but he was receiving mobility therapy. The left foot had several metal pins and a stabilization device, with clean and dry wound edges, showing no signs of bleeding or drainage. A review of Resident 3's record was conducted. Resident 3 was admitted to the facility on [DATE], with diagnosis which included fracture (broken) left foot with routine healing, non-pressure chronic ulcer of other parts of unspecified foot with unspecified severity. A review of Resident 3's Minimum Data Set (MDS - an assessment tool), dated July 30, 2025, indicated a BIMS (Brief Interview of Mental Status) score of 15 (cognitively intact). A review of Resident 3's Body Check dated July 17, 2025, indicated, Resident 1 had multiple wound issues, including a diabetic foot ulcer (DFU - open sore or wound on the foot) to the left great toe and an external fixation device with pins. A review of Resident 3's Daily Documentation from July 30, 2025, indicated No wound, with no descriptive notes. There was no documentation that the nurse's daily documentation identified current skin conditions with ongoing treatments. A review of Resident 3's Care Plan initiated July 29, 2025, indicated: .LLE ste [site] with multiplanar external fixation device 25 pins.interventions.administer treatments as ordered by MD [medical doctor] .treatment nurse to evaluate every week.keep site clean and dry.report any signs of infection to MD. DFU treatments to left great toe. interventions.administer treatments as ordered by MD.treatment nurse to evaluate every week.keep site clean and dry.report any signs of infection to MD.Further review of Resident 3's record indicated there was no evidence in daily documentation that the current wounds and treatment were consistently recorded.On July 31, 2025, at 12:30 p.m., during observation and interview, Resident 2 |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to conduct an ongoing monitoring and supervision for use of bed rails for four of six residents reviewed, (Residents 1, 2, 5 and 6)This had the potential to cause Residents 1, 2, 5, and 6 to be at risk for entrapment or injury for falls.Findings:On July 31, 2025, Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], readmitted [DATE], and discharged on July 22, 2025, with a diagnosis which included hemiplegia and hemiparesis following cerebral infarction (loss of function of one side of the body with brain dysfunction) affecting the right dominant side, and traumatic brain injury.A review of the History and Physical dated March 13, 2025, indicated, .Resident 1 does not have capacity to understand and make decisions.A review of the Physicians order dated June 14, 2023, indicated, .side rail one half x 2 up in bed as enabler to assist with bed mobility -nonrestraint.active.A review of the Bed safety assessment dated July 21, 2023, indicated, .Res currently has 1/4 rails for mobility and positioning.A review of assessments records for Resident 1 did not indicate documented bed safety assessment for Resident 1 after July of 2023 or prior to his discharge on [DATE].A review of the Change of Condition dated July 14, 2025, indicated, .07/14/2025 3:15 a.m., .Resident seen sitting on side of bed with (R) arm inside rail. RN (Registered Nurse) supervisor provided head to toe assessment with excoriation noted to (R) side of back upper and lower & (R) arm.MD (physician) notified with orders in place. Recommendation is for resident to have bed in low position for safety measures and cont. (continue) with call light within reach.A review of the Nurse Progress Note, dated July 15, 2025, at 3:15 a.m. indicated, .resident was found on the floor in his room. this writer immediately proceeded to resident's room to assess the situation.3:17 upon entry, resident was observed lying on the floor next to his bed on the right side. The resident was found in a semi-fetal position with his right arm caught within the side rail. environmental safety checks performed: bed observed in low position with right side rail up, left side rail down. floor free of clutter or liquid. lighting adequate. The call light was on the bed but not activated by resident. call light noted on in room for resident's roommate.3:19 rn supervisor initiated head-to-toe assessment.noted superficial excoriations to the right lateral arm and right mid-back region. no active bleeding. no hematoma, swelling, or visible deformities noted. resident denied pain verbally and also responded nonverbally by shaking head no when asked if he had pain to back, arm, hips, or head.3:22 range of motion assessment conducted.resident able to move lue (left upper extremity) and lle (left lower extremity) extremities within baseline with no signs of guarding, facial grimace, or vocal complaints of pain. passive range of motion provided to rue (right upper extremity) and rle (right lower extremity) no signs of guarding, facial grimace, or vocal complaints of pain. no decrease in strength noted outside of resident's baseline. neurologically, resident alert and oriented to self and place within place. skin warm and dry. respirations even and unlabored.3:25 hours: vital signs obtained. (vital signs were within normal limits according to the record) .3:27: pa (physician assistant) notified of incident.neurologic monitoring protocol per fall policy. fall risk precautions maintained.3:30.resident safely assisted back to bed. repositioned for comfort. call light placed within reach. bed in lowest position, brakes engaged. floor mats are implemented for safety. resident remains without signs of distress at this time. no signs of acute change in condition.3:35 responsible party and spouse.notified via phone of fall incident and current condition.5:04 . provider responded with new orders for stat xrays to rt (right) forearm, rt shoulder and pelvis.A review of the IDT (interdisciplinary team) meeting notes, dated July 14, 2025, indicated, .Cognitive changes since last review: No.Communication/speech/hearing pattern changes since last review: No. Physical functioning changes since last review: No. Spouse present. New or interim disease/conditions/infections that impact the resident's ability to care for self and adds a risk for care/treatment: fall 7/14/25 minor injury 7/11/2025. Rehab Screen note. Rehab Screen: Current Therapy Orders or Restorative Programs: Restorative Program.Areas reviewed: No changes in function since last assessment.Comments: RNA has reported R hip pain in Pt but family has not expressed any concerns and states pain is chronic. Pt has no active ROM of RUE and RLE and may be at baseline function. There is no need for therapy at this time as pt maintains RNA program.Evaluation order requested: No evaluation indicated.Further review of the IDT notes indicated no documentation that the IDT discussed the need for an assessment and/or evaluation of the use of side rails for Resident 1 for the year of 2024, and after the fall that occurred on July 14, 2025.A review of the Care Plan, Risk for injury related to side rail use, initiated April 20, 2021, revision July 11, 2023, and then again December 7, 2023, indicated, .Goal, Resident will not have |