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	12/17/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff provided timely incontinence care consistent with the resident's care needs for one of two sampled residents (Resident B).This failure resulted in Resident B remaining in a soiled brief for approximately an hour, placing the resident at risk for skin breakdown, infection, discomfort, and compromised dignity.Findings:A review of Resident B's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses which included hereditary spastic paraplegia (weakness with stiffness of legs).A review of Resident B's Minimum Data Set (MDS - an assessment tool), dated October 31, 2025, indicated:- Brief Interview for Mental Status (a standardized cognitive screening tool) score of 15 (cognitively intact).- Functional Abilities-Self Care-Toileting Hygiene-Substantial /Maximal assist [Helper does more than half the effort Bladder-Urinary Continence-Always incontinent.On November 19, 2025, at 4:12 p.m., during an observation in Resident B's room, a strong urine odor was noted. In a concurrent interview with Resident B, Resident B stated she had been changed at approximately 3 p.m., became wet again about 30 minutes later, and remained wet despite notifying staff. On November 19, 2025, during a concurrent observation and interview with CNA 1, the following was observed:-At 4:15 p.m., CNA 1 stated Resident B was wet. CNA 1 was observed to leave Resident B's room without providing incontinence care or explanation to the resident. -At 4:30 p.m., CNA 1 was observed to return to Resident B's room and stated he would change the resident. CNA 1 was observed placing a clean brief on the bedside table and exiting the room again without providing incontinence care. -At 4:33 p.m., CNA 1 returned to Resident B's room and provided incontinence care, approximately one hour after Resident B reported being wet and notifying staff. On November 19, 2025, at 4:40 p.m., an interview with Licensed Vocational Nurse (LVN) was conducted. LVN stated CNAs were required to provide incontinence care every two hours and as needed, and if delayed, staff were expected to communicate this to the resident. On December 2, 2025, at 1:33 p.m., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation was for the CNA to provide incontinence care every two hours and as needed, and not doing so placed residents at risk for skin breakdown and infection. A review of the facility policy and procedure titled Dignity, dated February 2021, indicated .Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents.promptly responding to a resident request for toileting assistance.

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
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the timely reordering and availability of a prescribed controlled pain medication (oxycodone) for one of three sampled residents (Resident A). This failure resulted in a missed scheduled dose when the medication was not available, placing the resident at risk for unmanaged pain. Findings:On November 17, 2025, at 11 a.m., an unannounced visit to the facility to investigate a quality-of-care issue.A review of Resident A's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses which included chronic gout (2 or more gout attacks [redness and swelling of affected joint]). A review of Resident A's History and Physical Examination, dated May 31, 2025, indicated Resident A has decision making capacity.A review of Resident A's Physician Order, dated June 24, 2025, indicated .Oxycodone HCl Oral Tablets 5 MG (milligram- unit of measurement) Give 2 tablets by mouth every 4 hours for pain mgmnt (management).On November 17, 2025, at 12:52 p.m., an interview was conducted with Resident A. Resident A stated the scheduled dose of routine Oxycodone (powerful pain killer use for moderate to severe pain) was not administered sometime during the last week of June 2025. A review of Resident A's Medication Administration Record (MAR) from June to July 2025 for oxycodone indicated on June 26, 2025, at 12 p.m., oxycodone was not administered, and a nursing note dated the same day documented that the medication was not given because it was not available. A review of Resident A's Refill Request Form and pharmacy delivery receipt indicated that a refill request for oxycodone 5 mg was submitted on June 19, 2025, and 48 tablets were delivered on June 21, 2025.A review of the physician's order indicated that, based on the prescribed dosing schedule, the 48-tablet supply would have been completed on or about June 25, 2025. Further review of Resident A's record indicated no documentation that the licensed nurse requested a refill for oxycodone on or before June 25, 2025. On November 17, 2025, at 4:10 p.m., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the facility practice was to make sure that medications were given as ordered and the licensed nurse were expected to request refill when approximately three doses remain. On November 25, 2025, at 1:21 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated she did not administer the oxycodone on June 26, 2025, at noon because the medication was not available. LVN 1 stated when narcotic medication such as oxycodone runs out, she gets it from the emergency kit. LVN 1 further stated there was no oxycodone available in the emergency kit at that time. On November 28, 2025, at 9:22 a.m. a concurrent interview and record review was conducted with LVN 2. LVN 2 stated that 48 tablets of oxycodone 5 mg, delivered on June 21, 2025, would last approximately four days based on the prescribed dose of two tablets every four hours (six doses per day). LVN 2 stated, based on this dosing schedule, the medication supply would have been completed on or about June 25, 2025. LVN 2 stated licensed nurse should request refills when approximately six tablets remain. LVN 2 further stated when refill medications were not available, residents may experience uncontrolled and escalating pain, and that effective pain management was important. On December 2, 2025, at 1:33 p.m., an interview with the Director of Nursing (DON) was conducted. The DON stated the licensed nurse are expected to request medication refill from the pharmacy when three pills remain in the resident's supply.A review of the facility policy document titled Administering Medications, dated April 2019 indicated, .Medications are administered in accordance with prescriber orders.A review of the facility document titled Refill Request, dated June 19 indicated .Best Practice: Fax refill request 3-5 days prior to supply depletion.