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	12/31/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 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 review, the facility failed to ensure one of three sampled residents (Resident 1) was discharge to a safe and appropriate setting. The facility did not verify that the receiving environment could meet the resident's care needs and discharged the resident to an unlicensed room and board (a living accommodation where individuals are offered a place to stay along with meals).These failures resulted in Resident 1 remaining confined to the kitchen area at the room and board, as the resident could not maneuver stairs or access the restroom on his own. Two days later, Resident 1 was transferred to the General Acute Care Hospital (GACH).Findings:On December 30, 2025, at 10:47 a.m., an unannounced visit to the facility to investigate an unsafe discharge issue. A review of Resident 1's admission Record, indicated resident was admitted on [DATE], and discharged on December 17, 2025, with diagnoses including chronic gout (a complex form of arthritis caused by too much uric acid that crystallizes and is deposited in joints), pneumonia (infection in the lungs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and acute kidney failure (occurs when the kidneys suddenly become unable to filter waste products from the blood).A review of Resident 1's History and Physical, dated November 14, 2025, indicated resident had the capacity to understand and make decisions.On December 30, 2025, at 11:18 a.m., an interview was conducted with the Director of Rehabilitation (DOR). The DOR stated that Resident 1 received physical and occupational therapy for strengthening and required a grab bar to transfer from the bed to a wheelchair. However, the DOR stated Resident 1 could propel himself in a wheelchair without assistance.On December 30, 2025, at 12:56 p.m., a telephone interview was conducted with the Room and Board Manager (RABM). The RABM stated Resident 1 was admitted on [DATE], arriving in a wheelchair and remaining in the kitchen area as he could not go up the steps. The RABM stated Resident 1 could not transfer from the wheelchair to the bed or climb stairs independently. The RABM stated due to car trouble, the RABM could not assess him in person and conducted a phone interview, during which Resident 1 claimed he could care for himself. The RABM contacted Adult Protective Services (APS) for placement assistance, and Resident 1 stayed in the kitchen for two days before being transferred to the hospital.On December 31, 2025, at 11:16 a.m., an interview was conducted with the Certified Nursing Assistant, (CNA). The CNA stated Resident 1 required one- or two-person assistance for transfers, toileting, and bathing and exhibit verbal threats toward staff. On December 31, 2025, at 11:30 a.m., an interview was conducted with the facility's Case Manager (CM). The CM stated Resident 1 was homeless prior to admission and that they applied for recuperative care and Resident 1 had been denied. The CM stated room and board placement requires independence in most activities of daily living (ADL). The CM stated Resident 1 required assistance with ADLs. On December 31, 2025, at 12:02 p.m., an interview was conducted with the SSD. The SSD stated she was working with a third-party placement coordinator for Resident 1's placement. The SSD stated a third-party placement coordinator came and assessed Resident 1 several times prior to Resident 1's discharge on [DATE]. The SSD denied that she had any communication with the RABM prior to Resident 1's discharge. On December 31, 2025, at 1:27 p.m., a telephone interview was conducted with the third-party Business Development Director (BDD). The BDD stated that he was working with the facility for Resident 1's placement. The BDD stated he provided room and board contact information to Resident 1. The BDD stated he met Resident 1 in person and was unaware of the care needs for Resident 1. On December 31, 2025, at 1:52 p.m., a telephone interview was conducted with the Enhanced Case Manager (ECM) with the [name of foundation]. The ECM stated that the foundation assists unhoused people with housing, healthcare, and personalized support. The ECM stated that he was assisting the facility with a safe discharge for Resident 1. The ECM stated that Resident 1 did not meet the criteria for room and board placement because Resident 1 was unable to perform activities of daily living without assistance. The ECM stated that Resident 1 was discharged from the facility on December 17, 2025.On December 31, 2025, at 2:31 p.m., an interview was conducted with the facility's Director of Nursing, (DON). The DON stated the room and board manager should assess the resident in person prior to discharge and social services should arrange the discharge after acceptance. On January 13, 2026, at 2:01 p.m., an interview was conducted with the Administrator (Adm) and the Interdisciplinary Team (DON, SSD, and Physical Therapist). -The Adm stated a resident could be discharged to a room and board if they were high functioning, meaning the resident could perform most activities independently;-The SSD stated she provided the third-party representative with a