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	10/17/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 36038 Based on observation, interview, and record review, the facility failed to ensure dignity was provided for two of two residents reviewed for dignity (Residents 2 and 27) when: 1. The Certified Nursing Assistant (CNA) did not provide assistance and allowed Resident 2 to soil herself; and 2. Resident 27's lunch tray was not provided at the same time as the other residents. These failures had the potential to affect Residents 2 and 27's self-worth and self-esteem. Findings: 1. On October 16, 2024, at 4 p.m., during an observation inside Resident 2's room, Resident 2 stated, she needed assistance to go to the bathroom. CNA 1 came in and Resident 2 requested assistance to go to the bathroom. CNA 1 told Resident 2 to use her incontinence pad and he would change it later. On October 16, 2024, a review of Resident 2's Admission Record indicated, Resident 2 was admitted to the facility August 16, 2021, with diagnoses which included Alzheimer's disease (a brain disorder that affects memory). On October 16, 2024, a review of Resident 2's Care plan indicated .Focus- The Resident has Bowel incontinence r/t (related to) Dementia (forgetfulness), cognitive impairment .Interventions .Provide bedpan/bedside commode . On October 17, 2024, at 3:22 p.m., during an interview with CNA 1, CNA 1 stated, when Resident 2 asked for assistance to go to the bathroom, the expectation was to offer toileting and or provide a bed pan to Resident 2. CNA 1 stated he should have assisted Resident 2 to the bathroom or offered the resident a bed pan, rather than telling her to soil in her incontinence pad. On October 17, 2024, at 3:49 p.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated the staff providing continence care should first offer the resident assistance to use the toilet or to offer a bedside commode or a bedpan. The ADON stated allowing the resident to soil herself in her incontinence pad, was a dignity issue. (continued on next page)

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
	056315	A. Building B. Wing	10/17/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44270 2. On October 14, 2024, at 12:33 p.m., an observation was conducted in the dining room for Resident 27. Resident 27 was observed to be seated at a table with two other residents, who were served their meals and began eating. Resident 27 did not receive his lunch for approximately twenty minutes and was watching the other two residents eat. On October 14, 2024, at 12:34 p.m., an interview was conducted with Resident 27. Resident 27 stated I don't know where my lunch is, looking at the other resident food makes me feel more hungry. On October 14, 2024, at 12:36 p.m., an interview was conducted with LVN 1. LVN 1 stated Resident 27's meal was not served along with the other residents' meals and that food should be served to residents sitting at the same table, so that they are not watching other residents eat and to preserve their rights and dignity. LVN 1 stated Resident 27 should have been served with the other residents. On October 16, 2024, at 12:09 p.m., an interview was conducted with the Registered Dietitian (RD). The RD stated residents seated together are expected to receive their meals at or around the same time to maintain their preferences and dignity. The RD stated serving meals separately could make residents feel left out and affect their sense of dignity. A review of the facility Policy and Procedure titled, Quality of Life - Dignity, dated February 2020, indicated, . Each resident shall be cared for in a manger that promotes and enhances his or her sense of well-being, level or satisfaction with life, feeling of self-worth and self esteem .Residents are treated with dignity and respect at all times .

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	10/17/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44505 Based on observation, interview, and record review, the facility failed to follow and conduct a self-administration assessment for one of two residents reviewed for self-administration of medication (Residents 34). This failure had the potential to result in an unsafe administration of medication for Resident 34. Findings: 1.On October 14, 2024, at 9:25 a.m., during a concurrent observation and interview inside Resident 34's room. Resident 34 was observed sitting in bed. Two clear cups containing a clear gel was observed on top of Resident 34's bedside table. Resident 34 stated the clear get was an A&D ointment (medication used to treat minor skin irritations). Resident 34 further stated he self-administered the ointment for his scratches on his arms, and the licensed nurses were aware. On October 14, 2024, at 11:00 a.m., Resident 34's record was reviewed. Resident 34 was admitted to the facility on [DATE]. Further review of Resident 34's medical records indicated Resident 34 was not assessed for self-administration of medication. On October 14, 2024, at 3:50 p.m., during an interview with Licensed Vocational Nurse (LVN 2), LVN 2 stated Resident 34 should have been assessed for self-administration of medication before he is allowed to self-administer. A review of the facility policy and procedure titled, Self-Administration of Medication, dated February 2021, indicated, .Residents have the right to self-administer medications .upon the request of the resident, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident .

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	10/17/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36038 Based on interview and record review, the facility failed to report an allegation of physical abuse involving Residents 30 and 310 to the California Department of Public Health (CDPH) immediately, and no later than two hours after the allegation was made, for two of two residents reviewed for abuse (Residents 30 and 310). This failure had the potential to delay the implementation of appropriate action and protection for the residents, placing them at risk for further abuse. Findings: On October 14, 2024, a review of Resident 310's Admission Record, indicated, Resident 310 was admitted to the facility on [DATE], with diagnoses which included anxiety (feeling of fear, dread, and uneasiness). During a review of Resident 310's Change in Condition, dated October 13, 2024, indicated, .Resident stated another resident (Resident 30) .allegely (sic) bumped into her wheelchair with her walker intentionally. Resident she feels threatened by this resident and due to this incident, resident is now undergoing emotional distress . On October 17, 2024, at 2:41 p.m., during an interview, with Registered Nurse (RN) 1, RN 1 stated over the weekend, Resident 310 approached her and reported that Resident 30 had looked at her and purposefully hit her with her wheelchair. RN 1 stated she then reported the incident to the Director of Nursing (DON) and the Administrator. On October 17, 2024, at 6:49 p.m., during a concurrent interview and review of Resident 310's Change in Condition with the Assistant Director of Nursing (ADON), the ADON stated Residents 30 and 310 had an alleged physical altercation on October 13, 2024. The ADON stated that all staff were mandated reporter, and they should have reported the incident immediately, within 2 hours. During a review of facility policy and procedure titled, ABUSE PROHIBITION & PREVENTION POLICY AND PROCEDURE, dated August 2022, indicated .Reporting .The facility will report allegations of abuse . Immediately-no later than 2 hours .to State Survey Agency .

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	10/17/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47202 Based on observation, interview and record review, the facility failed to ensure the plan of care (POC) was updated for one of 21 residents reviewed (Resident 83). This failure resulted in the licensed nurse being unaware of Resident 83's current condition and POC. Findings: On October 16, 2024, at 8:09 a.m., during the medication administration observation with Licensed Vocational Nurse (LVN) 4 a Contact Precaution (measures used to prevent the spread of infections) sign was observed outside Resident 83's room. LVN 4 entered and exited the room, provided care, and administered oral medications to Resident 83 without donning (putting on) and doffing (taking off) PPE (Personal Protective equipment - equipment worn to prevent exposure and spread of illness and infection) On October 16, 2024, at 9:35 a.m., during an interview with LVN 4, she stated she did not know the reason Resident 83 was on contact precautions. On October 16, 2024, Resident 83's record was reviewed. Resident 83 was admitted to the facility on [DATE], with diagnosis which included sepsis (life threatening complication of an infection). A review of Resident 83's History and Physical, dated July 24, 2024, indicated Resident 83 had the capacity to understand and make decisions. A review of Resident 83's Progress Notes, dated October 7, 2024, indicated, .Res (sic) (resident) .Readmit from (name of hospital) .Res admitted back to (name of facility) .(name of provider) made aware regarding res arrival and order to carry out all discharge order from hospital . A review of Resident 83's Hospital Records indicated the following: - Dated October 6, 2024, indicated, .Discharge Summary: DC (discharge) Dx (diagnosis) .Klebsiella CRE (Carbapenem Resistant Enterobacteriacaeae - a bacteria resistant to antibiotics [medication use to treat infections])) Bacteremia . - Dated October 2, 2024, indicated, .Culture Urine .Result: .Carbapenem Resistant Enterobacteriacaeae (CRE) Detected .Patient requires Contact Isolation . A review of Resident 83's Care Plan dated October 7, 2024, indicated Resident 83's POC was not updated or revised to address the new diagnosis of CRE Bacteremia in the Urine. (continued on next page)

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	10/17/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 16, 2024, at 10:43 a.m., during an interview and review of Resident 83's medical records with the Infection Preventionist (IP), she stated a POC should be updated whenever residents had changes in condition, receives new orders or returns from the hospital. The IP stated the POC should be updated to reflect specific concerns and interventions, for staff to provide appropriate care. The IP stated Resident 83 was hospitalized on [DATE] and readmitted back in the facility on October 7, 2024, with new diagnosis of CRE in the urine and a physician order to place resident on contact isolation. The IP stated she did not update Resident 83's POC upon resident readmission. The IP further stated she should have updated Resident 83's POC upon readmission and should have been revised. On October 16, 2024, at 12:34 p.m., during an interview and review of Resident 83's medical records with the Director of Nursing (DON), she stated, the IDT (Interdisciplinary Team - a group of people from different disciplines who work together to plan care for a resident) was responsible to update the POC to reflect a resident's specific areas of concerns and for staff to know what patient-centered care and intervention to provide the resident. The DON stated the IP and IDT should have updated Resident 83's POC upon readmission to the facility on [DATE]. A review of the facility policy and procedure titled, Care Plan Comprehensive, dated August 25, 2021, indicated, .The Interdisciplinary Team is responsible for evaluation and updating of care plans .When the resident has been readmitted to the facility from hospital stay .

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	10/17/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44505 Based on observation, interview, and record review, the facility failed to ensure that two out of three residents reviewed for quality of care (Residents 34 and 55) had a physician's order for medication administration. This failure had the potential to result in medical complications and unforeseen side effects related to unprescribed medications. Findings: 1. On October 14, 2024, at 9:25 a.m., during a concurrent observation and interview inside Resident 34's room. Resident 34 was observed sitting in bed. Two clear cups containing a clear gel was observed on top of Resident 34's bedside table. Resident 34 stated the clear gel was an A&D ointment (medication used to treat minor skin irritations). Resident 34 further stated he self-administered the ointment for his scratches on his arms, and the licensed nurses were aware. On October 14, 2024, at 11:00 a.m., Resident 34's record was reviewed. Resident 34 was admitted to the facility on [DATE]. Further review of Resident 34's Order Summary Report, for the month of October 2024, indicated Resident 34 did not have a physician order for A&D ointment. On October 14, 2024, at 3:50 p.m., Licensed Vocational Nurse (LVN 2) was interviewed. LVN 2 stated there should be a physician order for the ointment. LVN 2 stated Resident 34's A&D ointment did not have a physician order. 47202 2. On October 14, 2024 at 10:30 a.m., during a concurrent observation and interview in Resident 55's room, Resident 55 was observed sitting in his wheelchair. A bottle of Eye Drops medication was observed on Resident 55's bedside table. Resident 55 stated, a friend brought in the eye drops and he used it multiple times a day for dry eyes while in the facility. On October 14, 2024, Resident 55's medical records were reviewed. Resident 55 was admitted to the facility on [DATE]. During a review of Resident 55's Minimum Data Set (MDS - an assessment tool), dated September 4, 2024, indicated Resident 55 had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). A review of Resident 55's Order Summary Report, for the month of October 2024, indicated Resident 55 did not have an order for the eye drops medication. (continued on next page)

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	10/17/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 14, 2024 at 10:35 a.m., during a concurrent observation, interview, and review of Resident 55's Order Summary Report, with the Director of Nursing (DON), she stated Resident 55 had a bottle of eye drops on the bedside table. The DON stated Resident 55 did not have a physician order for eye drops and the medication. The DON stated the eye drops should have a physician order prior to administration. A review of the facility policy and procedure titled, .Medication Administration-General Guidelines ., dated October 2017, indicated, .Medications are administered in accordance with written orders of the attending physician .

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	10/17/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44505 Based on observation, interview, and record review, the facility failed to ensure the care plan intervention for fall was implemented for one of one resident reviewed for fall (Resident 209). This failure had the potential to increase the risk of further falls or injury for Resident 209. Findings: On October 16, 2024, at 11:30 a.m., during an observation, Resident 209 was inside his room, lying in bed with no floor mat in place. A review of Resident 209's Admission Record, indicated, Resident 209 was admitted to the facility on [DATE], with diagnoses that included altered mental status and unsteadiness on feet. A review of Resident 209's care plan, dated June 30, 2024, indicated, Resident is at risk for falls r/t (related to) history of falls .Interventions: fall mats (equipment used to protect patients from serious injuries) . On October 16, 2024, at 12:15 p.m., during a concurrent observation and interview with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 209 was a fall risk and had an order and care plan intervention for a floor mat. LVN 3 stated Resident 209 did not have a floor mat placed at the bedside. On October 17, 2024, at 3:15 p.m., during an interview with the Registered Nurse (RN) 2. RN 2 stated following Resident 209's previous falls, a floor mat was implemented as one of the interventions. RN 2 further stated Resident 209 should have a floor mat at the bedside to prevent injury in the event of a fall. The facility policy and procedure, titled, Care Plan Comprehensive dated August 25, 2021, indicated, .the comprehensive care plan includes the following .the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being .identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident .

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	10/17/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44505 Based on observation, interview, and record review, the facility failed to ensure that proper care and treatment services for oxygen (O2) were provided for two of three sampled residents (Residents 34 and 59) when: 1. Oxygen tubing for Residents 34's and 59's was not date-labeled. 2. Resident 59 did not have a physician's order for oxygen therapy. These failures had the potential to place Residents 34 and 59 at risk of respiratory infection and unnecessary respiratory care. Findings: 1a. On October 14, 2024, at 10:18 a.m., Resident 34 was observed sitting in bed with a nasal cannula (a device used to deliver oxygen) attached to his nose with oxygen set at two liters per minute (LPM- unit of measurement). Resident 34's nasal cannula tubing was not date-labeled. A review of Resident 34's Order Summary Report for the month of October 2024, indicated, May have PRN (as needed) O2 on 2L (two liters) for SOB as needed. On October 14, 2024, at 3:30 p.m., during an observation and interview with the Licensed Vocational Nurse (LVN 2) in Resident 34's room, LVN 2 stated Resident 34's NC tubing was not date-labeled. LVN 2 further stated that she did not know when the NC tubing was last replaced. 1b. On October 14, 2024, at 11:07 a.m., during an observation, Resident 59 was observed lying in bed with a NC attached to a running oxygen concentrator (medical device used to deliver oxygen) set at 1 LPM. On October 14, 2024, at 4:20 p.m., during an observation and interview with LVN 4 in Resident 59's room, LVN 4 stated Resident 59's NC tubing was not labeled with the date. LVN 4 stated the NC tubing should be date-labeled, for infection control. On October 17, 2024, at 3:09 p.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated, the oxygen tubing should be dated, for infection control, that's the expectation. 2. On October 14, 2024, at 11:07 a.m., during an observation, Resident 59 was observed lying in bed with a NC attached to a running oxygen concentrator set at 1 LPM. On October 14, 2024, at 11:07 a.m., during an interview with Resident 59, Resident 59 stated she used oxygen as needed to help her with her breathing. (continued on next page)

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	10/17/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 59 Admission Record, indicated, Resident 59 was admitted to the facility on [DATE], with multiple diagnoses that included asthma (a chronic lung disease making it difficult to breathe) and anxiety (a feeling of fear, dread, and uneasiness). A review of Resident 59's record, Order Summary Report, for the month of October 2024, indicated, Resident 59 did not have a physician's order for the use of oxygen. On October 14, 2024, at 4:08 p.m., during an interview with LVN 2, LVN 2 stated she could not find a physician's order for oxygen in Resident 59's records and there should be one. On October 17, 2024, at 3:15 p.m., during an interview with the Assistant Director of Nursing (ADON). The ADON stated, there should be a physician's order for the use of oxygen. A review of the facility's policy and procedures titled, Oxygen Administration, dated April 2007, indicated, . verify that there is a physician's order for this procedure. Review the physician's order for oxygen administration .

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	10/17/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47202 Based on observation, interview, and record review, the facility failed to ensure expired medications were discarded and not readily available for use when multiple oral medications were observed in the medication cart. This failure had the potential to result in the administration of expired medications to residents. Findings: On October 16, 2024, at 2:42 p.m., during a concurrent observation and interview with Licensed Vocational Nurse (LVN) 5 of the medication cart in Station One, the following were observed: - Gabapentin (medication use to treat nerve pain and seizures) 100 mg (milligram - unit of measurement) capsule with an expiration date of May 21, 2024. - Tramadol HCL (Narcotic - a drug that can cause insensibility or stupor) 50 mg tablet with an expiration date of October 9, 2024. - Dicyclomine (medication use to treat abdominal pain and spasm) 20 mg tablet with an expiration date of October 12, 2024. LVN 5 stated expired medication should be removed from the medication cart and destroyed or given to the Director of Nursing (DON) for disposal if the medication is a narcotic. LVN 5 stated Gabapentin, Tramadol and Dicyclomine medications were expired and should have been discarded, for resident safety. On October 16, 2024, at 4:45 p.m., during an interview with the Assistant Director of Nursing (ADON), she stated expired medications should be removed from the medication carts, not readily available for use, and disposed of in the destruction bucket. The ADON stated, licensed nurses should check the medication carts each shift to remove expired medication, ensuring resident safety and preventing the administration medications, which could lead to adverse reactions. The facility's policy and procedures titled, Medication Storage in the Facility, dated April 2008, indicated, . Outdated, contaminated or deteriorated medication .are immediately removed .disposed of according to procedures for medication disposal .

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	10/17/2024

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 36038 Based on observation, interview, and record review, the facility failed to ensure two dietary staff members were able to provide proper nutrition services for a population of 95 residents who eat in the facility when: 1. The Dietary Aide was unable to accurately demonstrate the concentration of the chlorine sanitizing solution (solution used killing bacteria on food contact surfaces); and 2. The [NAME] was unable to verbalize proper cool down process for food. These failures had the potential to expose residents to foodborne illnesses (illnesses resulting from eating contaminated food). Findings: 1. On October 16, 2024, at 9:09 a.m., a concurrent observation, interview, and review of the manufacturer's instruction for the chlorine test paper were conducted with the Dietary Aide (DA). The DA was observed testing the concentration of the chlorine sanitizing solution. The DA obtained a test strip from the chlorine test paper container, dipped the strip into the chlorine sanitizing solution for five seconds, and then compared the strip to a color chart on the container. The DA read the color chart and stated the concentration was 200 ppm (parts per million - unit of measurement). The DA stated the normal chlorine concentration should be at 50 -100 ppm. The DA stated the manufacturer's instructions were to dip and remove quickly, blot immediately with paper towel and compare to color chart at once. The DA further stated she did not follow the instructions on the chlorine test strip label. On October 17, 2024, at 8:37 a.m., during an interview with the Registered Dietician (RD), the RD stated when the kitchen staff should follow the manufacturer's instructions for testing the sanitizing solution, and if not followed, there was a potential for foodborne illness. The RD further stated the dietary staff should have followed the manufacturer's instruction. During a review of facility document titled SANITIZATION, dated November 2022, indicated .Dishwashing. Low Temperature Dishwasher (Chemical Sanitization) .The chemical solution is maintained at the correct concentration, based on periodic testing .according to manufacturer's guidelines . 2. On October 16, 2024, at 3:42 p.m., during an interview with the Cook, the [NAME] stated the cool down process involved placing warm food directly into the refrigerator for five hours. The [NAME] stated the cool down process should reduce the food temperature from 140 to 70 degrees Fahrenheit (F) in 3 hours and from 70 to 40 degrees F in two hours, for a total of five hours. The [NAME] stated, he asked the DM regarding the cool down process and confirmed that he was not able to verbalize the proper cool down process for both warm and ambient temperature foods. (continued on next page)

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	10/17/2024

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On October 16, 2024, at 3:55 p.m., during an interview with the Dietary Manager (DM) stated the cool down process should reduce the food temperature from 140 to 70 degrees F within two hours and from 70 to 40 degrees F in four hours. The DM stated if the cool down process is not conducted correctly there is a potential for food borne illness. The DM further stated he expected the staff to know the cool down process. During a review of the facility undated policy and procedure titled Food Preparation and Service indicated . Food and nutrition services employees prepare distribute and serve food in a manner that complies with safe food handling practices .Rapid Cooling .Potentially hazardous foods are cooled rapidly. This is defined as cooling from 135 F- 70 F within 2 hours and then to a temperature of 41 F or below within the next 4 hours. The total cooling time between 135 F and 41 F is not to exceed 6 hours .

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	10/17/2024

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36038 Based on observation, interview, and record review, the facility failed to ensure that food brought by visitor and family members was not expired and was safe for consumption. This failure had the potential for the residents to be exposed to foodborne illness. Findings: On [DATE], at 8:40 a.m., a concurrent observation of residents' food refrigerator and interview with Assistant Director of Nursing (ADON) were conducted. Food items in a freezer bag, belonging to Resident 26 were observed in residents' food refrigerator. The following food items were noted: a. Eight cooked hot dogs placed in four ziplock bags, not date-labeled; b. One piece of croissant bread with a discard date of [DATE]; c. One turkey provolone and pesto ciabatta sandwich, labeled enjoy by [DATE]; and d. One egg sandwich with a discard date of [DATE]. The ADON stated, these food items should have been discarded and it would be unsafe to serve the food to the resident due to potential for foodborne illness. During a review of undated facility policy and procedure titled Foods Brought by Family/Visitors indicated . Food brought to the facility is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents .Perishable foods are stored in resealable containers . Containers are to be labeled with resident's name, the item and the 'use by' date. The nursing staff will discard perishable foods on or before the 'use by' date .

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	10/17/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47202 Based on interview and record review, the facility failed to ensure a physician order was transcribed into the resident's electronic medical record (EMR) for one of 21 residents reviewed (Resident 83). This failure had the potential to affect Resident 83's overall health and well-being. Findings: Resident 83's Admission Record was reviewed. Resident 83 was admitted to the facility on [DATE], with diagnosis which included sepsis (life threatening complication of an infection). A review of Resident 83's Order Summary Report for the month of October 2024, indicated Resident 83 did not have a physician order for contact isolation (a type of precaution to prevent the spread of infectious agents that can be transmitted through direct or indirect contact). On October 16, 2024, at 10:43 a.m., during an interview and review of Resident 83's Order Audit Report with the Infection Preventionist (IP), she stated, upon receipt of a physician order, the order should be transcribed into the resident medical record at the time the order was received. The IP stated she spoke with the physician on October 7, 2024, and received an order to place Resident 83 on Contact Isolation for CRE (Carbepenem-resistant Enterobacteriaceae - a group of bacteria that are resistant to a class of antibiotics [to treat severe infection]) in the urine. The IP further stated she did not transcribe the physician order in the resident's medical records. The IP stated she should have transcribed the physician order in a timely manner to ensure staff were aware of the current orders for resident care. On October 16, 2024, at 12:34 p.m., during an interview and review of Resident 83's medical records with the Director of Nursing (DON), she stated, physician orders should be reflected and transcribed in the resident medical records at the time the order was received or within four hours. The DON further stated the IP should have transcribed the physician order on October 7, 2024 after receipt of the physician order. A review of the facility policy and procedure titled, Physician Orders, dated March 22, 2022, indicated, .This will ensure that all physician orders are complete and accurate .The order is transcribed onto the physician order form at the time the order is taken .

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	10/17/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44505 Based on observation, interview, and record review, the facility failed to ensure proper infection control measures were implemented when: 1. The Licensed Vocational Nurse (LVN 1) did not change gloves and perform hand hygiene during wound care for one of one resident reviewed for pressure injury (Resident 67). 2. Two clean linen closets were not kept clean. 3. A licensed nurse did not wear PPE (Personal Protective Equipment- equipment use to protect against infection or illness) in transmission based precaution room (room used to isolate residents). These failures had the potential to result in cross-contamination, increasing the spread of infection to an already vulnerable population of residents in the facility. Findings: On October 15, 2024, at 9:45 a.m., during a wound care observation in Resident 67's room, with LVN 1, LVN 1 removed and discarded the soiled wound dressing (a type of bandage used to cover a wound) and proceeded to clean Resident 67's wound with normal saline (a sterile solution of salt in water). LVN 1 did not change gloves and perform hand hygiene during the procedure. On October 15, 2024, at 10:35 a.m., during an interview with LVN 1. LVN 1 stated, he did not change his gloves or perform hand hygiene after discarding the soiled wound dressing and before cleaning Resident 67's wound. LVN 1 stated he should have changed gloves and washed his hands after removing the soiled dressing. LVN 1 further stated he did not follow proper infection control practices. On October 17, 2024, at 3:10 p.m., during an interview with the Assistant Director of Nursing (ADON), she stated, LVN 1 should have changed gloves and performed hand hygiene after removing Resident 67's soiled wound dressing to prevent cross-contamination and infection. A review of Resident 67's Admission Record indicated Resident 67 was admitted to the facility on [DATE], with diagnoses which included Stage 4 pressure ulcer (bed sore over bony areas that goes through the skin and deeper layers reaching muscle, tendons or even bone) of left hip. The facility Policy and Procedure titled, Wound Care, dated April 2, 1996, indicated, .the purpose of this procedure is to provide guidelines for the care of wounds to promote healing .wash and dry your hands thoroughly .put on exam gloves .remove soiled dressing .pull gloves over dressing and discard .wash and dry your hands .put on gloves .clean the wound according to the order .apply treatment as indicated . 2. On October 15, 2024, at 9:15 a.m., during a concurrent observation and interview with the House Keeping Laundry Supervisor (HLS), the following were observed: (continued on next page)

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	10/17/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Inside Clean Linen Closet #1, the floor contained two unused adult diapers, a towel, a gown, a pad, and a pillowcase. b. Inside Clean Linen Closet #2, the floor was littered with a mask, towel, pencil, pillowcases, bedsheet, body lotion bottle, two dirty gloves, hangers, and three pieces of paper. The HLS stated, this is a clean area; the clean linen closets are used to store laundered linens and should be kept clean and tidy, with nothing on the floor. On October 17, 2024, at 3:15 p.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated Clean Linen Closets #1 and #2 should be clean and organized, for infection prevention. A review of the facility policy and procedure titled, Infection Prevention and Control Program, dated September 18, 2023, indicated, .an infection prevention and control program are established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . 47202 3. Resident 83's Admission record was reviewed. Resident 83 was admitted to the facility on [DATE], with diagnosis which included sepsis (life threatening complication of an infection). A review of Resident 83's History and Physical, dated July 24, 2024, indicated Resident 83 had the capacity to understand and make decisions. A review of Resident 83's Order Summary, dated October 7, 2024, indicated, .May have Contact Isolation Precaution (measures use to prevent the spread of infections) q (sic) (every) shift .Dx (Diagnosis): CRE (Carbapenem Resistant Enterobacterales - a bacteria resistant to antibiotics [medication use to treat infections]) Bacteria in urine . A review of Resident 83 Care Plan, revised October 16, 2024, indicated, .Patient .has an actual .infection with .CRE bacteremia in urine culture .Interventions: Contact Precautions: PPE (gown and gloves), put on before every room entry and remove before exit . On October 16, 2024, at 8:09 a.m., during the medication administration observation with License Vocational Nurse (LVN) 4, a Contact Precaution sign was observed outside Resident 83's room. LVN 4 entered and exited the room, provided care, and administered oral medications to Resident 83 without donning (putting on) PPE. On October 16, 2024, at 9:35 a.m., during an interview with LVN 4, she stated Resident 83 was on contact precaution and she did not know the reason. LVN 4 further stated she provided care and administered medication to Resident 83 and did not wear PPE. LVN 4 stated she should have worn gloves and gown (PPE) to prevent the spread of pathogens (germs) and protect the facility residents from infection. (continued on next page)

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	10/17/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On October 16, 2024, at 9:52 a.m., during an interview and review of Resident 83's Order Summary, with the Infection Preventionist (IP), she stated Resident 83 was on contact isolation precaution for CRE in the urine. The IP further stated LVN 4 should have worn PPE before providing care to Resident 83 to prevent the spread of infection to other residents in the facility. A review of policy and procedure titled, Isolation - Categories of Transmission-Based Precautions, dated September 2022, indicated, .Contact Precautions .Staff and visitors wear gloves when entering the room . Staff and visitors wear a disposable gown upon entering the room . A review of policy and procedure titled, Infection Prevention and Control Program, dated September 18, 2023, indicated, .Is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .

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	10/17/2024

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 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44505 Based on observation, interview, and record review, the facility failed to ensure one bedroom (room [ROOM NUMBER]) did not accommodate more than four residents. This failure had the potential to affect the health and safety of the residents residing in this room. Findings: On October 14, 2024, at 9:43 a.m., during the initial tour of the facility, room [ROOM NUMBER] was observed to have five residents (Residents 37, 51, 76, 78, 210) assigned to the room. A record of the facility's room size was reviewed and indicated room [ROOM NUMBER] measured 440.94 square feet (sq ft) (length-in feet X width-in feet), 20 feet and 9 inches by 21 feet and 2 inches. The square footage allows 88.18 sq ft per resident. During the facility survey from October 14, 2024, to October 17, 2024, no adverse effects that would affect the quality of life of the residents were observed. Residents in room [ROOM NUMBER], who were interviewable, stated they were comfortable in the room and no desire to change rooms. A continuation of room waiver is recommended.

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	10/17/2024

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 36038 Based on observation, interview, and record review, the facility failed to ensure the resident's call light was functioning at all times, for one of two residents reviewed for environment (Resident 67). This failure had the potential for Resident 67 to not be able to call for assistance when needed. Findings: On October 17, 2024, at 9:09 a.m., during a concurrent observation and interview of Resident 67 in his room, Resident 67 stated his call light was not working. Resident 67 pressed the call button, the light near the bed did not activate nor the dome light found outside the resident room. On October 17, 2024, at 9:10 a.m., during a concurrent observation and interview with Certified Nurse Assistant (CNA) 2. CNA 2 tested Resident 67's call light and stated the resident's call light was not working. CNA 2 stated Resident 67 used his call light to request for assistance and the call light should be fixed right away. During a review of facility policy and procedure titled Answering the Call Light, dated September 2022, indicated .Be sure that the call light is .functioning at all times .