

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056476	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2025
NAME OF PROVIDER OR SUPPLIER Windsor Rosewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1911 Oak Park Boulevard Pleasant Hill, CA 94523	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the Responsible Party (RP is the person designated as being responsible for another person's medical and financial decisions) of Resident 1 ' s change of condition (COC).</p> <p>This failure resulted in Resident 1 ' s RP being uninformed and unaware of Resident 1 ' s COC.</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record, dated 5/21/25, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit (communication difficulties)and aphasia (a language disorder that affects the ability to communicate).</p> <p>Review of Resident 1 ' s Minimum Data Set (an assessment tool) dated 4/22/25, indicated he had a brief interview for mental status or BIMS of 0 (BIMS score of 0-7 indicates severe cognitive impairment).</p> <p>During a review of the clinical record for Resident 1, the progress notes documented by Registered Nurse (RN) 1 dated 2/19/25 at 8:46 a.m., indicated, Right foot big toe have a foul smell. Will be referred to Podiatry(Podiatry is a branch of medicine that focuses on the diagnosis, treatment, and prevention of disorders of the feet, ankles and lower legs).</p> <p>During a concurrent joint interview and record review with the Director of Nursing (DON) and RN 1 on 5/21/25 , at 1:16 p.m., RN 1 and DON could not find the documentation that Resident 1 ' s RP was informed of the resident ' s foul smelling right big toe. RN 1 acknowledged she could not recall that she informed Resident 1 ' s RP about the the resident's toe.</p> <p>During an interview with the DON on 5/21/25 at 1:36 p.m., DON stated the facility had to notify the physician and the RP if there was a COC.</p> <p>(continued on next page)</p>

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: 056476	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2025
NAME OF PROVIDER OR SUPPLIER Windsor Rosewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1911 Oak Park Boulevard Pleasant Hill, CA 94523	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Change of Condition: Notification of, dated 8/25/21 the P&P indicated, I. Purpose: To ensure residents, family, legal representatives, and physicians are informed of changes in the resident ' s condition. II. Policy: A facility must immediately inform the resident, consult with the Resident ' s physician . and notify, consistent with his/her authority, Resident Representative where there is: . A significant change in the Resident ' s physical, mental or psychosocial status . A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment .or to commence a new form of treatment) .</p>		