STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555060	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER: Windsor the Ridge Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 350 Iris Drive Salinas, CA 93906	

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** 44583 Based on interview, and record review, the facility failed to update the fall care plan for one of 8 residents (Resident 84) when interdisciplinary team (IDT, team composed of members from different departments involved in resident's care) did not review and revised Resident 84's fall risk care plan with subsequent falls. This failure resulted in Resident 84's two more subsequent falls. Findings: Review of Resident 84's Admission Record indicated, Resident 84 was admitted to the facility with diagnoses including displaced intertrochanteric fracture of right femur (broken thigh bone), Alzheimer's disease (a progressive disease that destroys memory and mental functions), fall on same level from slipping, tripping, and stumbling, and cognitive communication deficit (problems with a person's ability to think, learn, remember, use judgement, and make decisions). Review of Resident 84's Minimum Data Set (MDS, an assessment tool) Significant change in status and 5-day scheduled assessment, dated 2/10/2024, indicated Resident 84's Brief Interview for Mental Status (BIMS, an assessment to test a person's cognition level) was 9, [a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact] which indicated Resident 84 had moderately impaired cognition. Further review of Resident 84' MDS indicated, Resident 84 had fallen in the past month and had a fracture related to the fall. Review of Resident 84's Change in Condition Evaluation dated 2/3/2024, indicated, Resident 84 had an unwitnessed fall and was sent out to the hospital for possible injury evaluation. There was no documentation the IDT reviewed and revised Resident 84's fall risk care plan when Resident 84 returned from hospitalization . Review of Resident 84's Interdisciplinary Fall dated 2/13/2024, indicated, Resident 84 had another unwitnessed fall on this date, inside the restroom. Further review indicated, Care plan updated to prevent recurrence. There were no new fall risk interventions tried since 2/13/2024 to prevent further falls. (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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(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	Review of Resident 84's Interdisciplinary Fall dated 3/19/2024, indicated, Resident 84 had a witnessed fall on this date, inside her room. Further review indicated, Resident 84 was walking into her room with the used of the four wheeled walker (4WW, an assistive device that gives support to maintain balance or stability while walking), attempted to turn but lost her balance. The record indicated, Care plan updated to prevent recurrence. There were no new fall risk interventions dated 3/19/2024. During a concurrent interview and record review on 3/28/2024 at 10:33 a.m. with the Director of Staff Development (DSD), Resident 84's fall risk care plan was reviewed. The DSD confirmed Resident 84 was a fall risk and had fallen in the facility. The DSD further confirmed the fall risk care plan was not updated when Resident 84 fell on [DATE] and 3/19/2024. During a review of the facility's policy and procedure (P&P) titled, FALLS MANAGEMENT, revised 11/2012, the P&P indicated, Recent falls will be reviewed daily by a designated facility fall team, to evaluate cause, determine additional strategies as needed to prevent recurrence for each resident and further revise the care plan .

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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** 44583 Based on observation, interview and record review, the facility failed to ensure fall management policy and procedure were implemented for one of eight residents (Resident 84) when: fall risk assessment was not performed when Resident 84 had a significant change in status and the interdisciplinary team (IDT, team composed of members from different departments involved in resident's care) did not develop and implement appropriate new interventions after a fall. These failures resulted in Resident 84's subsequent falls and had a potential to sustain serious injuries. Findings: 1a. Review of Resident 84's Admission Record indicated, Resident 84 was readmitted to the facility on [DATE] with diagnoses including displaced intertrochanteric fracture of right femur (broken thigh bone), Alzheimer's disease (a progressive disease that destroys memory and mental functions), fall on same level from slipping, tripping, and stumbling, and cognitive communication deficit (problems with a person's ability to think, learn, remember, use judgement, and make decisions). Review of Resident 84's minimum data set (MDS - an assessment tool) Significant change in status and 5-day scheduled assessment, dated 2/10/2024, indicated Resident 84's brief interview for mental status (BIMS - an assessment to test a person's cognition level) was 9 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact), which meant Resident 84 had moderately impaired cognition. Further review of Resident 84' MDS indicated, Resident 84 had fallen in the past month and had a fracture related to the fall. Review of Resident 84's Interdisciplinary Fall dated 2/5/2024, indicated, Resident 84 had an unwitnessed fall on 2/3/2024. Further review indicated, Resident has a cut to the right side of her head. Writer administered pressure with towel to control the bleeding. Resident complained of pain to her head and hip .Resident was able to verbalize that she was attempting to grab clothes from the drawer and accidentally slipped. Resident 84 was sent out to the hospital for further evaluation. Further review indicated there was no documentation the IDT reviewed Resident 84's fall risk care plan and there were no new appropriate fall interventions developed and implemented when Resident 84 returned from hospitalization . Review of Resident 84's Interdisciplinary Fall dated 2/13/2024, indicated, Resident 84 had another unwitnessed fall on this date, inside the restroom. Further review indicated, Resident was sitting on the floor both legs extended in front of her .IDT: Resident is alert and oriented x2 [to person and place], with dx [diagnosis] ALZHEIMER'S DISEASES. Resident is impulsive and fails to use the call light. Resident has been encouraged multiple times of the use of call light. Resident does have BSC [bedside commode, a portable toilet positioned beside the bed] next to her bed. Bed is placed in lowest position for safety. No appropriate new interventions were developed and implemented after the fall. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 84's Interdisciplinary Fall dated 3/19/2024, indicated, Resident 84 had a witnessed fall on this date, inside her room. Further review indicated, Resident 84 was walking into her room with the used of the four wheeled walker (4WW, an assistive device that gives support to maintain balance or stability while walking), attempted to turn but lost her balance. IDT Recommendations were rehab (physical therapy [PT] or occupational therapy [OT]) referral, care plan updated to prevent recurrence, and resident education provided. Upon review, none of these interventions were implemented. During an observation at the hallway on 3/24/2024 at 2:52 p.m., Resident 84 was observed walking with the use of her 4WW. At 3:21 p.m., in Resident 84's room, Resident 84 was observed lying in bed, bed was not in lowest position, and floor mat was placed at the left side of the bed. During an interview with licensed vocational nurse K (LVN K) on 3/27/2024 at 1:54 p.m., LVN K stated nurses were doing the fall risk assessment upon admission only. LVN K further stated it was important to do the fall risk assessment for staff to know the resident's baseline. During a concurrent interview and record review with minimum data set coordinator (MDSC) on 3/27/2024 at 2:21 p.m., MDSC reviewed Resident 84's fall risk assessment dated [DATE]. MDSC confirmed there were no fall risk assessment completed when Resident 84 was readmitted on [DATE] and when Resident 84 had a significant change of condition MDS on 2/10/2024. MDSC stated there should have been a fall risk assessment completed when Resident 84 had a significant change of condition. During a concurrent interview and record review with director of staff development (DSD) on 3/28/2024 at 10:58 a.m., DSD reviewed Resident 84's fall risk assessment dated [DATE]. DSD confirmed there was no fall risk assessment completed when Resident 84 was readmitted on [DATE]. DSD stated fall risk assessment should be completed upon resident's admission and whenever there was a change in resident's condition. During a review of the facility's policy and procedure titled, FALLS MANAGEMENT, date revised 11/2012, indicated, Residents will be assessed for fall risk and interventions will be implemented to reduce the risk of falls .Residents' fall risk will be re-assessed with each significant change of condition MDS, and each comprehensive MDS . 1b. During another observation in Resident 84's room on 3/25/2024 at 10:28 a.m., Resident 84 was seated at the edge of bed, floor mats were position on both sides of the bed and bed was not in the lowest position. During a concurrent observation and interview with licensed vocational nurse G (LVN G) on 3/27/2024 at 10:35 a.m., in Resident 84's room, Resident 84 was not in the room. LVN G confirmed there were floor mats on both sides of the bed. LVN G did not confirm the floor mats were a trip hazard especially when Resident 84 was walking inside the room. During a concurrent interview and record review with physical therapist (PT) on 3/27/2024 at 3:36 p.m., PT reviewed Resident 84's PT and OT's notes on February and March 2024. PT confirmed there was no post fall screen completed when Resident 84 fell on [DATE] since Resident 84 was still on therapy. PT further confirmed there was no PT or OT screen completed when Resident 84 fell on [DATE]. PT stated when asked about the use of floor mats on both sides of Resident 84's bed, it might be a trip hazard. I will talk to nurses. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with DSD on 3/28/2024 at 10:33 a.m., DSD reviewed Resident 84's fall documentations on 2/3, 2/13 and 3/19/2024 and Resident 84's fall risk care plan. DSD confirmed Resident 84 had diagnosis of Alzheimer's disease and Resident 84 never called for help even with frequent reminders. DSD confirmed Resident 84's fall risk care plan did not have appropriate new fall interventions when Resident 84 fell on ,d+[DATE] and 3/19/2024. During a review of the facility's policy and procedure titled, FALLS MANAGEMENT, date revised 11/2012, indicated, Recent falls will be reviewed daily by a designated facility fall team, to evaluate cause, determine additional strategies as needed to prevent recurrence .