

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  11/25/2025
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 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.  (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to adequately monitor and supervise one of three sampled residents, Resident 23, who repeatedly left the premises without the facility's knowledge. This failure posed risks to Resident 23's health and safety, including heat or cold exposure, being struck by a vehicle, dehydration, and other medical complications, potentially affecting their overall well-being. Findings: Review of Resident 23's admission record indicated, was readmitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (high blood sugar) with other skin complications, hypertension (high blood pressure), alcohol dependence, depression, muscle weakness, and other abnormalities of gait and mobility. Review of Resident 23's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/13/25 indicated a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 4, which means severe cognitive (thought process) impairment. The MDS indicated Resident 23's functional abilities and mobility required set-up help. Review of Resident 23's care plan dated 7/8/25 indicated, [Resident 23] has impaired/decline in cognitive function or impaired thought processes related to: -Illiterate, unable to read or write -Impaired decision making AEB: BIMS of 4-indicates severe cognitive impairment. During a concurrent interview and record review on 9/25/25 at 4:12 PM with the Assistant Director of Nursing (ADON), Resident 23's elopement assessment dated [DATE] was reviewed. The elopement assessment indicated a score of 3 which means at risk for elopement. The ADON also reviewed Resident 23's elopement care plan indicating at risk for elopement as evidenced by (AEB) exit seeking behavior and history of elopement and was initiated on 7/11/25. The ADON stated a wander guard was put in place on 7/11/25 as intervention for resident's exit seeking behavior. During an interview on 9/25/25 at 4:32 PM, the Director of Nursing (DON) stated that Resident 23 exited the facility through the sliding door in his room without staff knowledge on 7/19/25. The DON stated Resident 23 was then found walking closed to his ex-wife's apartment. Per DON, interventions implemented after this incident included increased supervision and 1:1 supervision on certain days. The DON was asked what increased supervision and 1:1 supervision on certain days means. The DON was not able to explain and provide documentation that these interventions were implemented. The DON stated, just increased supervision of the resident. Review of Resident 23's elopement care plan initiated on 7/19/25 and revised on 8/28/25 indicated, [Resident 23] has increase supervision-initiated r/t leaving the facility without staff knowledge. The care plan indicated interventions including, Ensure bedroom screen door is locked at all times. Initiated increased supervision and monitoring . Monitor and document behaviors and triggers that may lead to elopement. Monitor wander guard #36 placement and functioning. Review of Resident 23's Activities Progress Note dated 9/5/25 indicated, At 1545, resident attempted to leave the facility but was redirected and convinced to return inside. Wanderguard was removed and not on LW when sighted leaving. Wanderguard was found (#36) and was placed back onto LW. RP was connected and agreed to pick up resident to run errands in order to decrease exit-seeking behaviors. Resident is on Q 1 hour monitoring location until further notice. Review of Resident 23's Interdisciplinary Care Conference dated 9/5/25 indicated, Resident 23 was observed with exit-seeking behavior during the morning shift, verbalizing wanting to leave the facility to visit his daughter and grandchildren. Recommendations: Increased supervision by staff. Wanderguard, intact, functioning, and location in place. Review of Resident 23's eINTERACT Change in Condition Evaluation - V 5.1 dated 9/13/25 indicated, At approximately 18:30 PM, the resident exited the facility without staff knowledge. Elopement (A situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision) protocol was immediately initiated, staff conducted thorough search in each resident room. outside the facility surrounding and resident was not located, 911 was called and report the elopement incident, all documents and description of resident were provided, MD and RP aware. Admin and DON notified. During an interview on 9/25/25 at 3:26 PM, Registered Nurse (RN) 1 stated that on 9/13/25 at 6:30 PM, he noticed Resident 23 was not in his bed nor inside the facility. RN 1 stated they were not able to find Resident 23 so he called 911 (emergency services) and notified the responsible party and the Administrator. During further interview, RN 1 stated that Resident 23 had his wander guard (a technology system used in facilities like hospitals and senior living homes to prevent residents at risk of wandering from leaving a secure area) on his left wrist but nobody heard the alarm when resident left. RN 1 also stated that they did not find Resident 23's wander guard in the facility. RN 1 further</p>		