STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Post-Acute Care Center of Hayward	25919 Gading Road Hayward, CA 94544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 45875 Based on interviews and record review, the facility failed to ensure the Resident Representative (RR) was notified of changes in condition and treatment of one (Resident 1) of three sampled residents, when: 1. Resident 1 developed an unstageable pressure injury and the wound progressed to a Stage 4 pressure injury and received wound debridement (process of removal of dead (necrotic) or infected skin tissue to help a wound heal) multiple times as part of the treatment plan. 2. Resident 1 ' s Physician was not notified and updated on the progress of wound from skin shear to Stage IV pressure injury (a pressure injury develops when one or more layers of skin and tissue are damaged from continuous pressure to the area. The depth of skin and tissue damage determines the stage of the pressure ulcer, which is on a scale of stage I to stage IV, stage IV the deepest ulcer, including damaged skin and muscle down to the level of bone). This deficient practice prevented Resident 1 ' s RR from exercising his rights to participate in her plan of care. This failure also caused Resident 1 ' s Physician being uninformed and unaware of Resident 1 ' s change in condition. Findings: 1.During a record review of Admission Record, printed on 4/12/24, the Admission Record indicated Resident 1 was admitted to the facility in July 2023. The Admission Record indicated that Resident 1 has medical diagnoses to include hemiplegia (loss of muscle function on one side of body) affecting left dominant side, weakness, and multi-system degeneration of the autonomic nervous system (a condition of the nervous system that causes gradual damage to nerve cells in the brain and affects balance, movement, and the autonomic nervous system, which controls several basic functions). During a record review of Resident 1 ' s Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), Section C, dated 1/17/24, showed Resident 1 ' s Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident ' s cognitive status in regard to attention, orientation, and ability to register and recall information)score was 2 out of 15, indicating severely impaired mental status. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 1 ' s physician notes titled, SNF Visit Notes, the physician notes indicated the patient does not have capacity to make decisions and Son is DPOA (durable power of attorney for health care is a legal document that gives another person the authority to make a medical decision for an individual). During a record review of Resident 1 ' s, Surgical wound notes, titled, Surgical Consult, dated 12/20/23, the wound notes indicated Resident 1 had an unstageable pressure injury at coccyx and the wound was debrided. During a concurrent interview and record review on 4/11/24 at 2:59 p.m. with Director of Nursing (DON), Resident 1 ' s Progress Notes and Care Conference Notes were reviewed. DON stated Resident 1 had a pressure injury wound and was treated and followed by the wound doctor (MD). DON stated the most recent care conference was conducted on 2/2/24. DON stated the care conference notes do not provide any information regarding the pressure injury wound or treatment to the RR. DON stated she has never talked to RR regarding the pressure injury so far. DON stated she was not able to provide any information or find any documentation if any staff from facility notified the RR when the wound progressed to stage 4. During an interview on 4/12/24 at 10:30 a.m., with RR, RR stated he is the responsible party for Resident 1, and he was never informed about the pressure injury and the progress to a stage IV pressure injury. RR stated he attended a care conference in February 2024, but no information was provided regarding the pressure injury or treatment. RR also stated as he was involved in care and in communication with the facility. RR stated he only found out about the pressure injury when Resident 1 was sent out to the hospital in April and was shocked. During a concurrent interview and record review on 4/17/24 at 11:53 a.m. with Assistant Director of Nursing (ADON), Resident 1 ' s, Surgical Consult Notes from MD, dated 12/20/23, were reviewed. The wound notes indicated Resident 1 has an unstageable pressure injury at coccyx and the wound was debrided. ADON reviewed Resident 1 ' s clinical chart and stated she could not find any documentation regarding a change in condition or notification to RR. During an interview and record review on 4/17/24 at 12:04 p.m., with Assistant Director of Nursing (ADON), Resident 1 ' s, Surgical Consult Notes from MD, dated 1/10/24, were reviewed. The wound notes indicated Resident 1 has Stage IV pressure injury at coccyx and wound was debrided. ADON stated she could not find any documentation regarding a change in condition or notification to RR. ADON also stated a change in condition documentation should have been done and family should be notified about the condition, treatment, and procedures done. During an interview on 4/23/24 at 10:51 am. with Director of Nursing (DON), DON stated when MD makes a change in wound staging, they must do a COC documentation and notify the attending physician (AP) and family. DON stated it is important to notify the family regarding the plan of care and to monitor Resident progress. During a review of the facility ' s policy and procedure (P&P) titled, Change of Condition, Resident, revised in November 2017, the P&P indicated Procedure .4. Keep the resident notified (If cognitively able to understand) and notify the resident representative of the change of condition, new physician orders, and/or the need to seek acute medical intervention. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent interview and record review on 4/17/24 at 2:55 p.m. with NP, Resident 1 ' s clinical chart and surgical notes were reviewed. NP stated they initially made referral to MD when Resident 1 was noted with a skin shear at coccyx area. NP stated MD was following the wound since then. NP stated their team was not aware that the wound had progressed to a stage IV. NP also stated they expect the facility to provide communication regarding residents if there is change in condition. NP stated when they are not notified, they miss the chance to do any intervention if needed. During an interview on 4/23/24 at 10:51 am. with Director of Nursing (DON), DON stated when MD makes a change in wound staging, they must do a COC documentation and notify the AP and family. DON stated the facility had a binder system for communication update on Resident condition to the AP. DON stated treatment Nurse should also be notifying the MD or NP regarding the progress in the wound. During a review of the facility ' s P&P titled, Change of Condition, Resident revised in November 2017, the P & P indicated Procedure .2. After assuring the resident ' s safety, notify the resident ' s physician of the clinical findings and note/implement new orders given by the physician. Include information regarding the resident ' s allergies, advanced directives, or level of care wishes, etc., and any other pertinent information as it pertains to the change of condition, when reviewing the change of condition with the physician.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45875 Based on interviews and record review, the facility failed to provide treatment consistent with professional standards to promote healing of a pressure ulcer for one (Resident 1) of three sampled residents when: 1. Resident 1 did not have a physician ' s order for wound treatment and no wound treatments were documented on treatment administration record from 1/25/24 to 2/22/24. 2. Resident 1 ' s weekly skin assessment was not completed and accurately documented for multiple months. This deficient practice placed Resident 1 at risk for worsening existing pressure ulcer and slow healing of a stage IV pressure injury (a localized damage to the skin and/ or underlying soft tissue, usually over a bony area, or related to a medical or other device). Findings: 1.During a record review of Admission Record, printed on 4/12/24, the Admission Record indicated Resident 1 was admitted to the facility in July 2023. The Admission Record indicated that Resident 1 has medical diagnoses to include hemiplegia (loss of muscle function on one side of body) affecting left dominant side, weakness, and multi-system degeneration of the autonomic nervous system (a condition of the nervous system that causes gradual damage to nerve cells in the brain and affects balance, movement, and the autonomic nervous system, which controls several basic functions). During a record review of Resident 1 ' s Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), Section C, dated 1/17/24, showed Resident 1 ' s Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident ' s cognitive status in regard to attention, orientation, and ability to register and recall information)score was 2 out of 15, indicating severely impaired mental status. During a concurrent interview and record review on 4/11/24 at 2:49 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1 ' s Treatment Administration Record (TAR, a documentation of wound treatment) was reviewed. LVN 1 stated there was no documentation of wound treatment from 1/25/24 to 2/22/24. During a concurrent interview and record review on 4/1/7/24, at 11:40 a.m., with Assistant Director of Nursing (ADON) and Medical Records Director (MRD), Resident 1 ' s Physician Orders and TAR were reviewed. MRD and ADON confirmed there were no doctors order for wound treatment and no wound treatment was documented from 1/25/24 to 2/22/24 for Resident 1 ' s pressure injury. During a concurrent interview and record review on 4/17/24 at 11:49 a.m. with ADON, Resident 1 ' s surgical wound notes, titled Surgical Consult, were reviewed. The notes indicated on 1/24/24, dressing used on wound to be Silvadene, Calcium alginate a dry dressing for the wound. The wound notes dated 1/31/24 , 2/7/24, 2/14/24 indicate dressing used on the wound to be calcium alginate with honey and dry dressing on the wound. ADON stated the treatment nurse usually puts in the treatment order for wound treatment at the facility as per wound physician orders. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with ADON on 4/17/24 at 1:15 p.m. with ADON, ADON stated it is crucial to follow physician orders unless it is contra- indicated. ADON stated the doctor ' s orders are followed to ensure there are no ill-effects to the resident. During a review of the facilities, Policy and Procedures (P&P) titled, Administering Medications, revised in April 2019, the P&P indicated, Policy interpretation and implementation .24. Topical medications used in treatments are recorded on the Resident ' s treatment record (TAR). 2.During a concurrent interview and record review on 4/23/24 at 10:59 a.m. with Director of Nursing (DON), Resident 1 ' s weekly nursing skin assessment, titled Body Check. X- V2, were reviewed from January 2024 to March 2024. DON stated she could only find weekly skin assessments for 1/22/24, 1/29/24, 2/22/24, 3/22/24. DON stated it is important to do weekly skin assessments and document accurately to check if the patient has any skin issues and if there are any changes. During an interview and record review on 4/23/24 at 11:00 a.m. with MRD, Resident 1 ' s weekly skin assessment records were reviewed. MRD stated there is a schedule for weekly skin assessment for all residents and on the scheduled day nurses would document weekly assessment and summary. MRD stated as per Resident 1 ' s skin assessment schedule there is missing weekly nursing skin assessments on 1/8/24, 1/15/24, 2/1/24 ,2/8/24, 2/15/29, 2/29/24, 3/1/24, 3/8/24, 3/15/24, 3/29/ 24 for 2024. Resident 1 did not have weekly nursing skin assessment documentation for 10 weeks between January 2024 to March 2024. During a review of facilities P&P titled, Skin integrity Management, dated 5/26/21, the P&P indicated Procedure 3. Identify patient ' s skin integrity status and need for prevention intervention or treatment modalities thorough review of all appropriate assessment information. 3.1. Perform skin inspection on admission/re-admission and weekly. Document on treatment Administration Record (TAR) or in Point click care (PCC, electronic medical record).