STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056476	A. Building B. Wing	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rosewood Care Center	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49091 Based on interview, and record review, the facility failed to provide an accurate Minimum Data Assessment (MDS- an assessment used to guide plan of care) for one of 20 sampled residents (Resident 392) for Resident 392's Hospice (the provision of care, comfort, and quality of life of a person with a serious illness who is approaching the end of life) care status. This deficient practice resulted in reflecting inaccurate care status for Resident 392 and had the potential for Resident 392 to receive care that was not appropriate to his medical, functional and/or psychosocial needs. Findings: During a review of Resident 392's Admission Record dated 9/28/23, the record showed Resident 392 was admitted to the facility on [DATE] with a diagnosis of Palliative Care (focused care providing relief of discomfort). During a record review of Resident 392's physician orders document titled, Order Details dated 9/6/23, the record showed Resident 392 was ordered to the care of Hospice (the provision of care, comfort, and quality of life of a person with a serious illness who is approaching the end of life) Care Services for End Stage Vascular Dementia (changes to memory, thinking and behavior resulting from damaged blood vessels in the brain). During an interview and record review with the Minimum Data Set Coordinator 1 (MDSC1) on 9/27/23 at 9:15 a.m., Resident 392's admission MDS assessment dated [DATE] was reviewed. MDSC1 stated Section O of the MDS assessment did not indicate if Resident 392 was under Hospice Care. MDSC1 stated the facility's regional Registered Nurse (RN) completed Resident 392's MDS assessment. MDSC 1 stated the RN was usually not onsite at the facility. The MDSC 1 stated that he and Minimum Data Set Coordinator 2 (MDSC 2) reviewed Resident 392's MDS assessment for accuracy, however Resident 392's admission MDS assessment was missed. MDSC1 stated the facility's failure to code Resident 392 as being under Hospice care resulted in inaccuracy of Resident 392's MDS assessment.

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44771 Based on observation, interview and record review, the facility failed to administer medications below a five percent (5%) error rate when: 1. A Licensed Vocational Nurse (LVN 1) did not administer sertraline (a drug used to treat depression; a mental health disorder associated with low mood) 100mg and lidocaine patch (a patch used for temporary pain relief) 4% to one (Resident 31) of 19 sampled residents. 2. A second Licensed Vocational Nurse (LVN 2) did not administer chlorhexidine mouthwash (a prescribed mouthwash that decreases bacteria in the mouth) to one (Resident 83) out of 19 sampled residents. These errors have resulted in Resident 31 and 83, not receiving medication as prescribed by their physicians. Findings: 1. During a concurrent observation and interview on 9/26/23 at 8:10 a.m. with Licensed Vocational Nurse (LVN 1), LVN 1 was observed preparing medications for Resident 31. LVN 1 stated there was no more lidocaine patch 4% and no sertraline 100mg in the medication cart so she is unable to give those medications. LVN 1 stated Resident 31's sertraline was reordered on 9/24/23, but was not available. During a concurrent interview and record review on 9/26/23 at 11:53 a.m., with LVN 1, Resident 31's physician orders were reviewed. The physician orders indicated sertraline 100mg, give 1 tablet by mouth daily for depression m/b (manifested by) sad facial expression. LVN 1 stated if Resident 31 did not receive sertraline, potential consequences include becoming more sad or anxious. 2. During a concurrent observation and interview on 9/26/23 at 11:43 a.m., Licensed Vocational Nurse (LVN 2) was observed preparing six medications for Resident 83. LVN 2 looked through Medication Cart 1, and stated she was unable to find Resident 83's Chlorhexadine mouthwash so she would not be able to give it. During a concurrent interview on 9/28/23 at 9:17 a.m., with Director of Nursing (DON), the DON stated resident medication lists are located in the Cubex (an automatic medication dispensing machine) and the Cubex has most routine medications. The DON stated there is no reason for residents not to get routine medications and that not giving a medication as ordered is considered a medication error. During a review of the facility's policy and procedure titled, Medication Errors, dated [DATE], indicated a medication error is defined as administration to a resident .omission of the prescribed medication .

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44771 Based on observation, interview, and record review, the facility failed to ensure that biologicals were labeled and stored according to professional standards when 1. Aluminum packages of 55 vials of ipratropium-albuterol inhalation solution were left open to air and light 2. A vial of timolol maleate ophthalmic solution was unlabeled and undated. This failure had the potential to result in administering ineffective medications to residents which could lead to residents health care needs being unmet and potential hospitalization . Findings 1 . During a concurrent medication storage observation and interview on 9/27/23 at 11:15 a.m., with Registered Nurse (RN 1), four aluminum packages were observed unrolled and left open and without open dates at Station 1's Medication Cart 2. Inside the four aluminum packages were a total of 55 vials of ipratropium-albuterol 0.5-2.5 (3) mg/3mL (a combination of two medications given through a mask to help open the airway in lungs) solution. RN 1 stated that this medication needs to be protected from light. RN 1 stated that if exposed to light, the medication could lose effectiveness and residents could have breathing issues since this medications helps open the airway. During an interview on 9/28/23 at 10:42 a.m., with Pharmacy Consultant (PC), PC stated the expectation is for Duoneb (the brand name for ipratropium-albuterol) to be preserved in foil packaging, following manufacturer guidelines. PC stated the foil packaging is to protect the integrity of the medication. During a review of the manufacturer's storage guidelines, dated [DATE], the guidelines indicated that vials should be protected from light before use, therefore, keep unused vials in the foil pouch or carton. During a review of facility's policy and procedure titled, Medication Storage in the Faciity, dated April 2008, indicated Medications and biologicals are stored .following manufacturer's recommendations . 2. During a concurrent medication storage observation and interview on 9/27/23 at 10:42 a.m., with Registered Nurse (RN 1), one vial of timolol maleate (a medication to decrease the pressure in the eye to prevent blindness) had no label and no open date at Station 1's Medication Cart 1. RN 1 stated that once opened, eye drops are good for 28 days so there should be an open date to let nurses know how long the bottle has been open. During an interview on 9/28/232 at 8:54 a.m., with Director of Nursing (DON), the DON stated eye drops need to have open dates. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure titled Medication Ordering and Receiving from Pharmacy (undated), indicated .e.g. eye drops .B. each prescription medication label includes: 1) resident name .5) prescriber's name, 6) date dispensed, 7) expiration date of medication .

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42922 Based on observation, interview and record review, the facility failed to ensure the dietary staff stored and prepared food under sanitary conditions for 89 of 97 residents whose food were prepared in the kitchen. These deficient practices placed the residents at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages). Findings: During an initial tour of the kitchen with the Dietary Supervisor (DS) on [DATE] at 9:40 A.M., the following were observed: - A jar of Kikkoman soy sauce had a use by date of [DATE]. - A 4.5lb container of sweet and sour sauce did not have an open date and a use by date. - A one-gallon jar of mayonnaise had no open date and use by date. - Four dented cannisters of oats with ill-fitting lids were on the emergency supply shelf. - There were hamburger patties in the freezer with an expiration date of [DATE]. - Enchiladas in the freezer had an expiration date of [DATE]. - Ten pounds of ground beef in the freezer had a use by date of [DATE]. - Five pieces of bell pepper and two containers of strawberries in the refrigerator were rotten. - An open pack of American cheese did not have an open date and a use by date. - A pack of lemon bars had an expiration date of [DATE]. - Farina Hot Meal Cereal had an expiration date of [DATE]. - The following food items in the Unit 2 refrigerator did not have use by dates: ten pounds diced chicken, cooked turkey breast, a bag of meat balls, a bag of breaded fish. During an interview on [DATE] at 9:40 a.m., the DS stated expired food items and other food items that were not consumed before the use by date should be discarded because these could be a source of foodborne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's undated policy titled: Labeling and Dating of Food indicated: all food will be dated, labeled, and prepared for storage to prevent contamination, deterioration, and dehydration .

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 47400 Based on observation, interview, and record review, the facility failed to provide no less than 80 square feet per resident for 18 of 51 rooms (Rooms 103, 105, 109, 111, 112, 114, 115, 118, 123, 124, 200, 201, 202, 203, 204, 206, 208, and 210). This failed practice had the potential to result in lack of sufficient space for staff to deliver care and provide storage space for resident belongings. Findings: During the initial tour on 9/28/23 at 9:30 a.m., the living space for Rooms 103, 105, 109, 111, 112, 114, 115, 118, 123, 124, 200, 201, 202, 203, 204, 206, 208, and 210 were observed as follows: Room [103] had 2 beds and measured 149.58 square feet, providing 74.79 square feet per resident. Room [105] had 2 beds and measured 145.12 square feet, providing 72.55 square feet per resident. Room [109] had 2 beds and measured 149.62 square feet, providing 74.79 square feet per resident. Room [111] had 2 beds and measured 151.77 square feet, providing 75.88 square feet per resident. Room [112] had 2 beds and measured 153.54 square feet, providing 76.77 square feet per resident. Room [114] had 2 beds and measured 151.39 square feet, providing 75.69 square feet per resident. Room [115] had 2 beds and measured 152.39 square feet, providing 76.19 square feet per resident. Room [118] had 2 beds and measured 149.62 square feet, providing 74.79 square feet per resident. Room [123] had 2 beds and measured 152.13 square feet, providing 76.06 square feet per resident. Room [124] had 2 beds and measured 156.74 square feet, providing 78.37 square feet per resident. Room [200] had 2 beds and measured 151.39 square feet, providing 75.69 square feet per resident. Room [201] had 2 beds and measured 151.39 square feet, providing 75.69 square feet per resident. Room [202] had 2 beds and measured 152.13 square feet, providing 76.06 square feet per resident. Room [203] had 2 beds and measured 154.68 square feet, providing 77.34 square feet per resident. Room [204] had 2 beds and measured 146.84 square feet, providing 73.42 square feet per resident. Room [206] had 2 beds and measured 150.26 square feet, providing 75.13 square feet per resident. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Room [208] had 2 beds and measured 149.38 square feet, providing 74.69 square feet per resident. Room [210] had 2 beds and measured 151.39 square feet, providing 75.69 square feet per resident. Residents in the affected rooms by observation, had privacy, storage space for personal belongings and there were no complaints received from those residents. The facility's staff were observed to be able to provide nursing services to meet the individual needs of each resident within those affected rooms. During the group interview on 9/28/23 at 11:00 a.m., the residents stated they had no issues with their private space and had enough room for their personal items. There were no negative consequences attributable to the decreased space (less than 80 square feet) in Rooms 103, 105, 109, 111, 112, 114, 115, 118, 123, 124, 200, 201, 202, 203, 204, 206, 208, and 210. During the entrance conference on 9/25/23 at 09:40 a.m., the facility's administrator (ADM) stated the facility would be requesting room waivers for Rooms 103, 105, 109, 111, 112, 114, 115, 118, 123, 124, 200, 201, 202, 203, 204, 206, 208, and 210.