| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056194 | A. Building<br>B. Wing | 03/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Windsor Gardens Convalescent Hospital | 915 S. Crenshaw Blvd.<br>Los Angeles, CA 90019 |

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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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43321<br><br>Based on observation, interview, and record review the facility failed to provide the necessary assessments, care, and services for one of three residents (Resident 1) to prevent falls, by failing to ensure two staff transferred Resident 1 from wheelchair (WC) to bed. On 2/25/2024, certified nurse assistant 1 (CNA 1) attempted to transfer Resident 1 from a WC to a bed without the assistance of another staff member.<br><br>As a result, on 2/25/2024, Resident 1 fell from the WC onto the floor sustaining right eye injury. Resident 1 required emergent transfer to general acute care hospital 1 (GACH 1) via 911 (emergency response telephone number). GACH 1 diagnosed Resident 1 with right orbital (bony cavity that contains the eyeball) displaced fracture (two or more breaks in the bone surrounding the eye causing improper alignment), right retrobulbar hematoma (a collection of blood within the bony orbit and behind the eyeball) with proptosis (bulging) and right periorbital (around the eye) hematoma (clotted blood usually caused by broken blood vessel). On 2/25/2024 was transferred to GACH 2, a trauma center (higher level of care) for emergent ophthalmology (a branch of medicine that deals with the structure, functions, and diseases of the eye) consult. GACH 2 performed canthotomy (a surgical procedure where the lateral corner of the eye is cut to relive the fluid pressure inside or behind the eye) to Resident 1's right eye.<br><br>Findings:<br><br>A review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 2/2/2024 with diagnoses including dementia (progressive loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Parkinson's disease without dyskinesia (movement disorder), with fluctuations, open angle glaucoma of the left eye (ongoing progressive and irreversible increased pressure in the eye causing progressive visual loss), osteoarthritis (condition of the breakdown of joint cartilage and the underlying bone causing pain and stiffness especially to hips, knees and thumb joint), and history of falling.<br><br>A review of Resident 1's Prior Stay Assessment- V2 form dated 2/2/2024, indicated Resident 1 had not been admitted to a skilled nursing facility (SNF) in the last 60 days and was authorized for respite care (short term) at the facility from 2/2/2024 to 2/23/2024.<br><br>(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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056194 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/06/2024 |
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| NAME OF PROVIDER OR SUPPLIER Windsor Gardens Convalescent Hospital | | STREET ADDRESS, CITY, STATE, ZIP CODE 915 S. Crenshaw Blvd. Los Angeles, CA 90019 | |

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

A review of Resident 1's Physician Order dated 2/2/2024, indicated physical therapy (PT - the care provided to a patient promote, maintain, or restore health through patient education, physical intervention, disease prevention, and health promotion) and occupational therapy (OT - the use of occupation and meaningful activities with specific goals to help people of all ages prevent, lessen, or adapt to disabilities) to evaluate Resident 1.

A review of Resident 1's Lift Transfer Resposition-V2 form dated 2/3/2024, indicated Resident 1 was not able to transfer independently or without supervision. The Lift Transfer Reposition form indicated Resident 1 was not able to bear weight on both legs. The Lift Transfer Reposition form indicated Resident 1 required a total lift (machine used when a resident needs complete assistance to transfer between surfaces) and required two staff for repositioning in bed.

A review of Resident 1's care plan titled Resident is at risk for fall/injury r/t (related to) poor balance, Parkinson's disease, hx (history) of fall, use of medications such as (psychotropic [medications that affect the nervous system], analgesic [medications that treat pain and inflammation]), initiated on 2/5/2024, indicated interventions included staff to prevent falls by anticipating and meeting Resident 1's needs. The care plan did not indicate Resident 1's specific needs.

A review of Resident 1's MDS dated [DATE], indicated Resident 1's cognition (the mental ability to make decisions of daily living) was not intact. The MDS indicated Resident 1 had not attempted to move from sitting to lying position in bed, lying to sitting on side of the bed, and sitting to standing position due to medical condition or safety concerns. The MDS indicated Resident 1 was dependent on two or more staff to transfer from chair to bed and vice versa. The MDS indicated Resident 1 used a WC for mobility (movement).

A review of Resident 1's care plan titled Resident is at risk for fall/injury r/t to poor balance, Parkinson's disease, hx of fall, use of medications such as (psychotropic, analgesic) revised on 2/12/2025, indicated Resident 1 was at risk for fall/injury. The care plan interventions included to ensure staff followed facility's fall protocol. However, the care plan did not include the facility's fall protocol.

A review of Resident 1's Change in Condition (COC - a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domain that without intervention, the deviation could lead to significant complications including death) Evaluation form dated 2/25/2024 at 8 p.m., indicated that on 2/25/2024 at 7:40 p.m., Licensed Vocational Nurse 1 (LVN 1), CNA 1, and CNA 2 entered Resident 1's room and saw Resident 1 on the floor with the face down between a window and a bed. The COC indicated LVN 1 observed Resident 1's right eyebrow was cut and bleeding, and the resident's right eyelid was bruised and swollen. The COC indicated LVN 1 asked Resident 1, are you ok and Resident 1 stated, yes. The COC indicated LVN 1 called 911, Resident 1 was transported to GACH 1, and resident's family member 1 (FM 1) was notified.

A review of Los Angeles Fire Department (LAFD) Patient Care Report (form emergency transport uses to document assessment and care) dated 2/25/2024 at 7:51 p.m., indicated Resident 1 was picked up and transported to a GACH after a mechanical (external force and or no underlying cause) fall while staff was assisting Resident 1 back to bed. The LAFD patient care report indicated Resident 1 was alert and stable for transport.

(continued on next page)

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of GACH 1 Emergency Department (ED) Summary Report dated 2/25/2024, indicated Resident 1 arrived with a large right periorbital hematoma.<br><br>A review of GACH 1 Computerized Tomography Scan (CT - medical imaging technique used to obtain detailed internal images of the body) of maxillofacial (portion of the face from the upper jaw) structures dated 2/25/2024, indicated Resident 1 had, markedly displaced fracture of the right inferior (lower) orbital (eye socket) wall with protrusion of extraconal (sticking out of eye socket) fat through the orbital floor defect. Large right periorbital hematoma with retrobulbar (behind the eyeball) hemorrhage and severe proptosis (bulging from natural position) of the right globe (eye eyeball) and stretching of the right optic nerve (relays messages from your eyes to the brain to create visual images) and extraocular (outside the eye) muscles. Urgent surgical assessment recommended for further management.<br><br>A review of Resident 1's ED (emergency department) Summary Report dated 2/26/2024 (no time), indicated a call was placed to GACH 2 trauma center on 2/25/2024 at 11:44 p.m., for immediate consultation with ophthalmology for possible lateral canthotomy and facial surgeons. Resident 1 was accepted and transferred to GACH 2 on 2/26/2024 at 12 a.m. The ED summary report under, medical decision making and documented by ED physician, indicated, After evaluation, it is my medical judgement that given patient's medical history, current needs, the medical predictability, and concern that something adverse (negative outcome) is going to happen to the patient given the results of his work up, if they (Resident 1) are not admitted . The complexity required for the (Resident 1's) care, the time requirement for diagnostic procedure and services needed for the patient [Resident 1], the patient will need at least two midnight stays. The ED summary report indicated Resident 1 was treated with Tylenol for pain, updated tetanus injection (vaccine to prevent lock jaw/painful muscle contractions), and ice packs applied to the right eye. Resident 1 received Unasyn (antibiotic - medication to prevent/treat infections)) intravenous (IV - inside a vein) for the facial fractures.<br><br>During an interview on 2/27/2024 at 8:44 a.m., FM 1 stated the skilled nursing facility (SNF) admitted Resident 1 for respite care for three weeks. FM 1 stated, I was in shock when I got the call (telephone) Sunday night (2/25/2024) that [Resident 1] fell , had a lot of bleeding, and was taken by 911 to the hospital. FM 1 stated, FM 1 contacted the SNF for clarification about Resident 1's fall. FM 1 stated that a nurse (unidentified) told FM 1 that Resident 1 fell when the aid (CAN 1) was transferring Resident 1 from the WC to bed. FM 1 stated, we went to the hospital (GACH 1), and [Resident 1's] right eye was getting larger. The doctor told us they (GACH 1) needed to transfer [Resident 1] to a higher level of care trauma center stat (immediately). FM 1 stated GACH 1 transferred Resident 1 to GACH 2, a trauma center, on 2/25/2024. FM 1 stated, they had to drain blood from [Resident 1] eye and GACH 2 was deciding whether to proceed with reconstructive surgery Resident 1's right eye. FM 1 stated GACH 2 admitted Resident 1 to the intensive care unit (ICU - a unit in a hospital that provides critical care and life support for acutely ill and injured patients), and that Resident 1 received blood transfusion. FM 1 stated Resident 1, is unable to see out of the right eye and that GACH was trying to save the right eyeball. FM 1 stated Resident 1's eyeball detached and was on the side as opposed to being in the right eye socket. FM 1 stated Resident 1 was not able to remember what happened regarding the fall.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of Resident 2 (Resident 1's roommate) admission record indicated the facility admitted Resident 2 on 2/23/2024 with diagnoses including lumbar vertebra fracture (broken lower back bone), abdominal aortic aneurysm (enlargement of the aorta, the main blood vessel that delivers blood to the body), hyponatremia (low sodium), hypertension (high blood pressure), difficulty walking, and generalized weakness.<br><br>A review of Resident 2's MDS dated [DATE], indicated Resident 2's cognition was intact.<br><br>During an interview on 2/27/2024 at 1:05 p.m. Resident 2 stated he recalled a nurse (did not state which nurse) was wheeling Resident 1 to the left side of the room next to the sliding glass door when all of sudden Resident 2 heard the nurse howl (loud cry) and saw Resident 1 lying on the floor. Resident 2 stated, [Resident 1] must have hit his head on the bedside table that was on that side of the bed. Resident 2 stated several staff came in and helped Resident 1 back into the WC. Resident 2 stated Resident 1, had a little bit of bleeding on the right eye. Resident 2 denied witnessing Resident 1's actual fall but did see the nurse behind Resident 1's WC. Resident 2 confirmed and stated there was only one nurse in the room at the time Resident 1 fell .<br><br>During an interview on 2/27/2024 at 1:25 p.m. CNA 3 stated, CAN 3 was Resident 1's regular CNA I since Resident 1's admission. CNA 3 stated Resident 1 was alert and able to make needs known, could not walk and needed two people to transfer and because, I cannot do it [transfer Resident 1] myself. CNA 3 stated, I help [Resident 1] with transfers because the resident is not strong enough to help with transfers. I always call for help because the resident may fall. CNA 3 stated there were no fall pads (mats) on the floor for Resident 1.<br><br>During an interview with CNA 4 on 2/27/2024 at 2:59 p.m. CNA 4 stated CNA 4 has provided cared to Resident 1, and that Resident 1 requires two staff for transfers because Resident 1 was stiff, had tremors, could not stand, and was a fall risk.<br><br>During an interview with CNA 2 on 2/27/2024 at 3:14 p.m. CNA 2 stated, that on 2/25/2024, CNA 4 found Resident 1 already on the floor and did not witness the actual fall. CNA 4 stated Resident 1 was lying on the right side of the bed, facing the bed and was in between the sliding glass door and the bed. CNA 4 stated CNA 1 went to CNA 2 panicking and told CNA 2 that CNA 4 had someone (Resident 1) fall. CNA 2 followed CNA 4 to the room and saw Resident 1 on the floor. CNA 2 stated the WC was next to the foot of the bed, in between the bed and the sliding glass door and facing a dresser located straight ahead. CNA 2 stated the WC was next to the bed because CNA 4 was trying to get Resident 1 back in bed. CNA 2 stated Resident 1's right eyebrow was cut and dripping blood. CNA 2 stated CNA 2 always uses two people when transferring Resident 1 from bed to WC. CNA 2 stated Resident 1, was a fall risk that is why we always used two people to transfer the resident. CNA 2 stated Resident 1 had a yellow wrist band (fall risk band) and was total care (dependent).<br><br>During an interview with assistant Director of Staff Development (ADSD) on 2/27/2024 at 4:04 p.m., ADSD stated, CNA 1 approached ADSD on 2/26/2024 (a day after the incident) and informed ADSD that on 2/25/2024 Resident 1 fell . ADSD stated CNA 1 said, the last time I transferred the resident alone, there was no problem but when I tried to transfer him yesterday, he fell . The ADSD stated CNA 1 was not Resident 1's regular CAN and that all the nurses in the facility know to call for help when transferring a resident including Resident 1. ADSD stated Resident 1's fall could have been prevented if CNA 1 called for help. ADSD stated Resident 1 was stiff and staff have to be careful. ADSD stated CNA 1 was not familiar with the resident and should have asked for help.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview with the physical therapist (PTS) on 2/27/2024 at 4:30 p.m. PTS stated on 2/5/2024, both the PTS and occupational therapist (OT- is a healthcare provider who helps you improve your ability to perform daily tasks) stated Resident was weak and needed a lot of help when sitting up and with transfers. PTS stated PTS had recommended that staff use a lifting device when transferring Resident 1, and for two people to assist when transferring Resident 1. PTS stated PTS further stated Resident 1 was a fall risk because of poor balance and strength.<br><br>During an interview CNA 1 on 2/28/2024 at 1:30 p.m., CNA 1 stated that on 2/25/2024, CNA 1 was assigned Resident 1. CNA 1 stated that on 2/25/2024 at around 7 p.m., Resident 1 fell when CNA 1 was trying to transfer Resident 1 back to bed without assistance. CNA 1 stated, I saw [Resident 1's] eye towards me moving. I ran into the hallway to get help. CNA 1 stated CNA 2 and LVN 1 came into the room. CNA 1 stated Resident 1 had swelling around the right eye and LVN 1 called 911. CNA 1 stated that on one occasion, someone (unidentified) assisted CNA 1 to transfer Resident 1. CNA 1 stated CN 1 did not know Resident 1 was a fall risk and did not recall seeing a yellow band (fall risk band) on the resident. CNA 1 confirmed and stated two people are needed to transfer Resident because it was the facility's policy.<br><br>During an interview on 2/28/2024 at 2:20 p.m., LVN 1 confirmed and stated LVN 1 was working on 2/25/2024 and at 7 p.m. LVN 1 stated Resident 1 was sitting in a WC and told CNA 1 that Resident 1 was ready to go back to bed and to get another CNA to help with transferring the resident back to bed. On 2/25/2024 at around 7:40 p.m., LVN 1 stated, I heard a CNA scream and immediately followed [CNA 1 and CNA 2] into [Resident 1's] room and saw [Resident 1] lying on floor, face down in between the bed and the sliding glass door. LVN 1 stated Resident 1 had some bleeding and swelling to the right eye and was not able to open the right eye. LVN 1 stated LVN 1 instructed CNA 1 to apply ice, the bleeding stopped, the paramedics (medical professionals who specialize in emergency treatment) arrived approximately 15 minutes after the fall and transported Resident 1 to GACH 1. LVN 1 stated the way Resident 1, was positioned on the floor, looked like [CNA 1] was attempting to put the resident back to bed. LVN 1 stated CNA 1 told LVN 1 that CNA 1 was trying to put Resident 1 back to bed. LVN 1 stated Resident 1 was dependent for transfers, required two people to assist at all times, and that it is our policy (two persons to assist with transfers).<br><br>During an interview with the Director of Nursing (DON) on 2/28/2024 at 6:52 p.m., the DON confirmed and stated the facility did not perform/conduct fall risk assessment for Resident 1. The DON stated Resident 1's fall could have been avoided if two staff were present to assist with the transfer.<br><br>A review of the facility's Inservice Attendance Record Sign in Sheet dated 2/29/2024, regarding the subject of the in-service, indicated, Transfer assist, fall management/prevention transfer assistance IE: 2 person for Hoyer lift (mechanical lifting device) . Staff to identify 1 (one) person or two persons assist and for Hoyer lift always two persons assist at all times.<br><br>A review of the facility's Safe patient handling lesson plan (no date), regarding CNA- Safely Moving Residents-Lifting and Transferring, indicated, general lifting and transferring tips to help the residents safe included, use teamwork by asking your teammates for help and talking with them about what you do as you plan and while doing it.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of the facility's policy and procedures (P&P), Fall Management effective 5/26/2021, indicated, patients will be assessed for fall risk as part of the nursing assessment process. This determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. Procedure:<br><br>Identify patient's fall risk by reviewing the nursing documentation.<br><br>Communicate patient's fall risk status to care givers.<br><br>Develop individualized plan of care.<br><br>Review and revise care plan as indicated. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>43321<br><br>Based on interview and record review the facility failed to give Carbidopa/Levodopa 25-100 mg (milligrams) po (by mouth) four times a day for Parkinson ' s disease without dyskinesia, with fluctuations (a progressive disease of the nervous system marked by tremors, muscle stiffness, and slow, imprecise movements- without dyskinesia- unwanted movements such as rapid jerking, muscle spasms and rhythmic, dance like movements) on 2/22/2024 and 2/23/2024 for one of three sampled residents, Resident 1.<br><br>This deficient practice may have placed Resident 1 at risk for falls.<br><br>Findings:<br><br>A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 2/2/2024 with diagnoses including Unspecified Dementia (progressive loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Parkinson ' s disease without dyskinesia, with fluctuations, Open Angle Glaucoma of the left eye (a chronic progressive and irreversible buildup of increased pressure in the eye causing progressive loss of peripheral vision, followed by central visual field loss), Osteoarthritis (condition of the breakdown of joint cartilage and the underlying bone causing pain and stiffness especially to hips, knees and thumb joint), Atrial Fibrillation (irregular heart beat), Hypothyroidism (condition in which the thyroid gland does not produce enough thyroid hormone), Hypotension (low blood pressure), Benign Prostatic Hypertrophy (enlarged prostate gland), Dysphagia (difficulty swallowing), carpal tunnel syndrome of upper limbs (a numbness and tingling in the hands and arms caused by a pinched nerve in the wrist) and history of falling.<br><br>A review of Resident 1 ' s Minimum Date Set (MDS - a standardized assessment care screening tool) dated 2/9/2024 indicated Resident 1 ' s cognition (the mental ability to make decisions of daily living) was not intact. The MDS indicated Resident 1 had not attempted to move from sitting to lying position in bed, lying to sitting on side of the bed, sit to stand and walking 10 feet due to medical condition or safety concerns. The MDS indicated Resident 1 was dependent on facility staff for chair to bed transfers (the ability to transfer to and from bed to chair or wheelchair) meaning helper does all the effort. The MDS indicated Resident 1 required the assistance of 2 or more helpers for mobility and transfers. The MDS indicated Resident 1 used a mobility device (Wheelchair).<br><br>A review of Resident 1 ' s physician order dated 2/2/2024 indicated Carbidopa/Levodopa oral tablet 25-100mg give 1 tablet by mouth four times a day for movement disorder to be given at 6am, 10am 2pm, 5pm.<br><br>A review of Resident 1 ' s Medication Administration Record (MAR) dated 2/22/2024 and 2/23/2024 timed at 6:00 a.m. indicated NN or see nurse ' s notes.<br><br>A review of Resident 1 ' s nursing progress note dated 2/22/2024 indicated the medication was re-ordered.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident 1 ' s nursing progress note dated 2/23/2024 indicated the nurse was waiting for pharmacy to deliver the medication.<br><br>During an interview on 2/27/2024 at 8:44 a.m. FM 1 stated, I questioned whether they were giving him his Parkinson ' s medication because that can have an impact on movement, and I was told they have some odd policy of two-hour window to give medication. He is supposed to receive carbidopa-levodopa (combination medication used to treat Parkinson-like symptoms such as shakiness, stiffness and difficulty moving) four times a day for Parkinson ' s. FM 1 was asked how this was related to the fall and stated, The medication could impact ability to control movements and if not taken the resident could not sense a fall and brace himself for impact.<br><br>During an interview on 2/28/2024 at 3:30 pm the Licensed Vocational Nurse (LVN) 2 stated on 2/23/2024 Resident 1 did not receive the 6:00 a.m. dose of Carbidopa/Levodopa because she (LVN 2) was waiting on the medication to be delivered from pharmacy. LVN 2 stated, the facility process is to re-order medications when there are 5 pills left to ensure it is available to give. LVN 2 did not know why it was not re-ordered and stated it was important to make sure the medication was available to prevent any complications.<br><br>During an interview on 2/28/2024 at 3:57 p.m. LVN 3 stated she remembered one day the week prior to interview date the Carbidopa/Levodopa was not available for the 6:00 a.m. dose. LVN 3 stated the medication was requested from pharmacy but did not know why it was not requested sooner. LVN 3 stated it was important to have the Carbidopa/Levodopa to ensure the resident received his proper medications.<br><br>During an interview on 2/28/2024 at 4:35 p.m. the director of nursing (DON) stated Resident 1 ' s medications were supplied by a Government Agency, and they should have been available. The DON did not know the reason the medication was not available on 2/22/2024 and 2/23/2024 but stated, it should be ordered a head of time to ensure it is available.<br><br>A review of the facility policy and procedure titled, Medication Administration Schedule dated 12/14/2023 indicated . scheduled medications are administered within one (1) hour of their prescribed time unless otherwise specified. |