

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 04/22/2024
NAME OF PROVIDER OR SUPPLIER Windsor Gardens Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 915 S. Crenshaw Blvd. Los Angeles, CA 90019	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261</p> <p>Based on interview and record review, the facility staff failed to ensure physician (MD) was notified concerning the change of conditions (COC/CIC) for two of two sampled residents (Residents 3 and 6) when:</p> <ol style="list-style-type: none"> 1. Resident 3 had multiple episodes of refusing medications. 2. Resident 6 complained of feeling weak. <p>These deficient practices had the potential to result in possible delayed provision of necessary care and services to Resident 3 and 6.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 3's Admission Record indicated Resident 3 was admitted to the facility on [DATE], with diagnoses including periprosthetic fracture (broken bone around the implants) around internal prosthetic (artificial device that replaces a missing body part) left hip joint, chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe) and diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]). <p>A review of Resident 3's Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 3/13/2024, indicated Resident 3 had an intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and required maximal assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene).</p> <p>A review of Resident 3's Medication Administration Record (MAR) dated from 4/1/2024 to 4/30/2024, indicated the following refusals of medications:</p> <p>Amlodipine Besylate (blood pressure medication) 10 milligram (mg), one tablet by mouth (PO) one time a day (QD-daily), refused on 4/1/2024, 4/3/2024-4/6/2024, 4/8/2024-4/11/2024, 4/13/2024-4/18/2024.</p> <p>(continued on next page)</p>

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Apixaban (anti-blood clot medication) 2.5 mg, one tablet PO twice a day (BID), refused on 4/1/2024 (morning and evening shifts), 4/3/2024-4/4/2024 (morning and evening shifts), 4/5/2024 (morning shift), 4/6/2024 (morning shift), 4/8/2024-4/10/2024 (morning shifts), 4/12/2024 (evening shift), 4/13/2024 (morning shift), 4/14/2024-4/17/2024 (morning and evening shifts), and 4/18/2024 (morning shift).</p> <p>Fexofenadine hydrochloride (HCL) (anti-allergy medication) 180 mg, one tablet PO QD, refused on 4/1/2024, 4/3/2024- 4/6/2024, 4/8/2024-4/11/2024, 4/14/2024-4/18/2024.</p> <p>Januvia (diabetic medication) 100 mg, one tablet PO QD, refused on 4/1/2024-4/4/2024, 4/6/2024-4/8/2024, 4/10/2024-4/17/2024.</p> <p>Losartan Potassium (blood pressure medication), one tablet PO QD, refused on 4/1/2024-4/6/2024, 4/8/2024-4/11/2024, 4/13/2024-4/17/2024.</p> <p>During an interview with Licensed Vocational Nurse 3 (LVN 3) on 4/18/2024 at 2:32 p.m., LVN 3 stated Resident 3 had been refusing most of her scheduled medications. LVN 3 stated she [LVN 3] had not completed any COC or MD notifications for Resident 3's refusals of medications. LVN3 stated they [nurses] are supposed to notify MD, do a COC documentation, and revise care plan for the refusals.</p> <p>During an interview with Interim Director of Nursing (IDON) on 4/19/2024 at 12:33 p.m., IDON stated the facility should monitor the refusals of medications and notify MD/start a COC documentation and care planning for the refusal.</p> <p>A review of facility's policy and procedures (P&P), titled, Change in Condition: Notification of, reviewed on 12/14/2023, indicated facility would ensure that residents, family, legal representatives, and physicians are informed of changes in resident's condition.</p> <p>A review of facility's P&P, titled, Requesting, Refusing and/or Discontinuing Care or Treatment, reviewed on 12/14/2023, indicated that a healthcare practitioner will be notified of refusal of treatment.</p> <p>2. A review of Resident 6's Admission Record indicated Resident 6 was originally admitted to the facility on [DATE], was readmitted on [DATE], with diagnoses including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), protein calorie malnutrition (lack of sufficient nutrients in the body) and seizure (a sudden, uncontrolled electrical disturbance in the brain).</p> <p>A review of Resident 6's MDS, dated [DATE], indicated Resident 6 had an intact cognition for daily decision-making and required moderate to maximal assistance from staff for ADLs.</p> <p>During an interview with Resident 6 on 4/18/2024 at 1:27 p.m., Resident 6 stated she might have an episode of seizure or was feeling very weak on 4/15/2024. Resident 6 stated LVN 2 was assigned and made aware regarding the COC.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review with LVN 2 on 4/19/2024 at 12:49 p.m., Resident 6's medical chart (COC/CIC, and progress notes) from 4/1/2024 to 4/18/2024 were reviewed. The record review indicated there were no documentations for Resident 6's complaint of feeling weak. LVN 2 stated he was working on 4/15/2024 and was assigned to Resident 6. LVN 2 also stated Resident 6 complained of feeling very weak on 4/15/2024. LVN 2 stated he was supposed to notify the MD, document the COC/CIC per facility policy.</p> <p>During an interview with IDON on 4/19/2024 at 12:33 p.m., IDON stated the facility should notify the MD with documentation properly done when a resident complains of weakness.</p> <p>A review of facility's P&P, titled, Change in Condition: Notification of, reviewed on 12/14/2023, indicated facility would ensure that residents, family, legal representatives, and physicians are informed of changes in resident's condition.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261</p> <p>Based on interview and record review, the facility failed to ensure prompt attempt was made to resolve grievances for one of two sampled resident (Resident 4).</p> <p>This deficient practice violated Resident 4's right to have grievance addressed.</p> <p>Findings:</p> <p>A review of Resident 4's Admission Record indicated Resident 4 was originally admitted to the facility on [DATE], and was readmitted on [DATE] with diagnoses including neuropathy (weakness, numbness, and pain from nerve damage usually in the hands and feet), asthma (respiratory condition marked by spasms in the bronchi of the lungs, causing difficulty in breathing) and obesity (a disorder involving excessive body fat that increases the risk of health problems).</p> <p>A review of Resident 4's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/7/2024, indicated Resident 4's cognitive (relating to mental action or process of acquiring knowledge and understanding) skills for daily decision-making was intact. Resident 4 required supervision from staff for activities of daily living (ADLs- bed mobility, transfer, dressing, and toilet use).</p> <p>A review of Resident 4's Grievance/Complaint Investigation Report (GCIR) dated 3/23/2024, indicated Resident 4 had concerns on missing items, totaling \$87.02., GCIR also indicated, on 3/25/2024, the cost of Resident 4's items would be reimbursed.</p> <p>During an interview with Resident 4 on 4/18/2024 at 1:02 p.m., Resident 4 stated she had missing items from her room and facility had notify her that facility would reimburse the missing items. Resident 4 stated that it had been more than 3 weeks and she [Resident 4] still had not received the reimbursement.</p> <p>During an interview with Social Service Department Staff (SSD) on 4/19/2024 at 12:25 p.m., SSD stated the facility was still waiting from the corporate to provide them the money. SSD also stated that it was unacceptable for Resident 4 to wait too long.</p> <p>During an interview with Interim Director of Nursing (IDON) on 4/19/2024 at 12:33 p.m., IDON stated that 3 weeks' worth of wait was too long for Resident 4 to get the reimbursement money.</p> <p>A review of facility's policy and procedures (P&P), titled, Grievances/Complaints, Recording and Investigating, reviewed on 12/14/2023, indicated that the grievance/complaint investigation report form will be filed within a timely manner.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261</p> <p>Based on interview and record review, the facility staff failed to develop and implement a comprehensive care plan that met the care/services based on the resident's individual assessed needs for one of 12 sampled residents (Resident 3) by failing to ensure Resident 3's episodes of refusing medications were care planned.</p> <p>This deficient practice had the potential to result negative impact on Resident 3's health and safety, as well as the quality of care and services Resident 3 received.</p> <p>Findings:</p> <p>A review of Resident 3's Admission Record indicated Resident 3 was admitted to the facility on [DATE], with diagnoses including periprosthetic fracture (broken bone around the implants) around internal prosthetic (artificial device that replaces a missing body part) left hip joint, chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe) and diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]).</p> <p>A review of Resident 3's Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 3/13/2024, indicated Resident 3 has an intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and needing maximal assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene).</p> <p>A review of Resident 3's Medication Administration Record (MAR) dated from 4/1/2024 to 4/30/2024, indicated the following refusals of medications:</p> <p>Amlodipine Besylate (blood pressure medication) 10 milligram (mg), one tablet by mouth (PO) one time a day (QD-daily), refused on 4/1/2024, 4/3/2024-4/6/2024, 4/8/2024-4/11/2024, 4/13/2024-4/18/2024.</p> <p>Apixaban (anti-blood clot medication) 2.5 mg, one tablet PO twice a day (BID), refused on 4/1/2024 (morning and evening shifts), 4/3/2024-4/4/2024 (morning and evening shifts), 4/5/2024 (morning shift), 4/6/2024 (morning shift), 4/8/2024-4/10/2024 (morning shifts), 4/12/2024 (evening shift), 4/13/2024 (morning shift), 4/14/2024-4/17/2024 (morning and evening shifts), and 4/18/2024 (morning shift).</p> <p>Fexofenadine hydrochloride (HCL) (anti-allergy medication) 180 mg, one tablet PO QD, refused on 4/1/2024, 4/3/2024- 4/6/2024, 4/8/2024-4/11/2024, 4/14/2024-4/18/2024.</p> <p>Januvia (diabetic medication) 100 mg, one tablet PO QD, refused on 4/1/2024-4/4/2024, 4/6/2024-4/8/2024, 4/10/2024-4/17/2024.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Losartan Potassium (blood pressure medication), one tablet PO QD, refused on 4/1/2024-4/6/2024, 4/8/2024-4/11/2024, 4/13/2024-4/17/2024.</p> <p>A review of Resident 3's care plan, indicated missing care plans for Resident 3's refusal of medications.</p> <p>During an interview with Licensed Vocational Nurse 3 (LVN 3) on 4/18/2024 at 2:32 p.m., LVN 3 stated Resident 3 had been refusing most of her scheduled medications. LVN 3 stated she had not done any COC (change of condition) or MD notifications for Resident 3's refusals of medication. LVN3 stated they [nurses] are supposed to notify MD, complete a COC documentation, and do a care plan for the refusals of medication.</p> <p>During an interview with Interim Director of Nursing (IDON) on 4/19/2024 at 12:33 p.m., IDON stated the facility should monitor the refusals of medications and notify MD/start a COC documentation and care plan for the refusal.</p> <p>A review of facility's policy and procedures (P&P), titled, Care Plans, Comprehensive Person-Centered, reviewed on 12/14/2023, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. P&P also indicated that refusals are also documented in the resident's clinical record in accordance with established policies.</p> <p>A review of facility's P&P, titled, Requesting, Refusing and/or Discontinuing Care or Treatment, reviewed on 12/14/2023, indicated that if the decision to refuse or discontinue treatments results in significant change in condition, an appropriate change will be made to the resident's care plan.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261</p> <p>Based on observation, interview and record review, the facility failed to timely administer medications per facility policy to one of one sampled resident (Resident 11).</p> <p>This deficient practice had the potential to result in medication ineffectiveness and place Resident 11 at risk for unsafe, and improper medication administration use.</p> <p>Findings:</p> <p>A review of Resident 11's Admission Record indicated Resident 11 was admitted originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including hemiplegia (paralysis on one side of the body), hemiparesis (weakness on one side of the body) and diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]).</p> <p>A review of Resident 11's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/27/2024, indicated Resident 11's cognitive (relating to mental action or process of acquiring knowledge and understanding) skills for daily decision-making was severely impaired and required maximal assistance from staff for activities of daily living (ADLs- bed mobility, transfer, dressing, and toilet use).</p> <p>A review of Resident 11's Medication Administration Audit Report, dated 4/19/2024, indicated a scheduled medication administration at 9:00 a.m. for the following medications:</p> <p>Amlodipine Besylate (antihypertensive medication) 5 milligram (mg) one tablet by mouth (PO) one time a day (QD)</p> <p>Carvedilol (antihypertensive medication) 6.26 mg one tablet PO twice a day (BID)</p> <p>Irbesartan (antihypertensive medication) 300 mg one tablet PO QD</p> <p>Namenda (anti-dementia [a chronic or persistent disorder of the mental processes caused by brain disease] medication) 10 mg one tablet PO QD</p> <p>Heparin Sodium injection (anti-blood clot medication) 5000 unit/milliliter (unit/ml) inject 1 ml subcutaneously (insertion of medications beneath the skin) every 12 hours</p> <p>Plavix (anti-blood clot medication) 75 mg 1 tablet PO QD</p> <p>Multivitamin-Minerals (supplement) 1 tablet PO daily</p> <p>A review of Resident 11's Medication Administration Audit Report, dated 4/19/2024, indicated the medication administration was recorded at 10:35 to 10:38 a.m. for the following medications:</p> <p>Amlodipine Besylate 5 mg one tablet by PO QD</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Carvedilol 6.26 mg one tablet PO BID</p> <p>Irbesartan 300 mg one tablet PO QD</p> <p>Namenda 10 mg one tablet PO QD</p> <p>Heparin Sodium injection 5000 unit/ml inject 1 ml subcutaneously every 12 hours</p> <p>Plavix 75 mg 1 tablet PO QD</p> <p>Multivitamin-Minerals 1 tablet PO daily</p> <p>During a concurrent medication administration observation and interview with Licensed Vocational Nurse 2 (LVN 2) on 4/19/2024 at 10:18 a.m., Resident 11 received all the ordered 9:00 a.m., scheduled medications from LVN2. LVN2 stated the medication administration should be done within one hour before and after of the prescribed time. LVN2 stated he was busy in the morning and was barely able to provide the medications to Resident 11.</p> <p>During an interview with Interim Director of Nursing (IDON) on 4/19/2024 at 12:33 p.m., IDON stated that scheduled medications should be administered an hour before and an hour after from the scheduled time.</p> <p>A review of facility's policy and procedures (P&P), titled, Administering Medications, reviewed on 12/14/2023, indicated that medications are administered within one hour before and after of their prescribed time.</p>