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 07/02/2024
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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43851 Based on interview and record review, the facility failed to report an injury of unknown origin to the State Survey Agency (SSA) within two hours for one of two sampled residents (Resident 1). Resident complained of pain to right upper leg which resulted in a fracture. This deficient practice resulted in a delay of an onsite inspection by the SSA and had potential for ongoing injuries for Resident 1. Findings: A review of Resident 1's Admission Record indicated the facility readmitted the resident on 1/5/2023 with diagnoses that included dementia, schizoaffective disorder (a mental health problem where you experience psychosis [a mental disorder characterized by a disconnection from reality] as well as mood symptoms), generalized anxiety disorder (a feeling of fear, dread, and uneasiness), and cognitive communication deficit (a disorder that affects a person's ability to communicate). A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 4/8/2024, indicated the resident had severely impaired cognition (problems with the ability to think, understand, and reason) and had behavioral symptoms not directed towards others (physical symptoms such as hitting or scratching self, pacing, rummaging, or verbal/vocal symptoms likes screaming, and disruptive sounds) that occurred one to three days per week. The MDS indicated Resident 1 required supervision or touching assistance with eating, required partial/moderate assistance with upper body dressing, and required substantial/moderate assistance with personal hygiene. The MDS indicated Resident 1 was always incontinent of urine and bowel, and Resident 1 was taking antipsychotic, antianxiety, and antidepressant medications. A review of Resident 1's Change of Condition form dated 6/18/2024 at 2 PM, indicated the Certified Nursing Assistant (CNA) reported to the Charge Nurse (CN) that while attempting to transfer the resident to the shower chair he said pain and rubbed his right leg. The COC form indicated with the CN at bedside, the CNA touched Resident 1's leg to help him sit up and the resident showed signs of mild pain. There was no discoloration, bruising, edema, or bleeding noted. Resident 1 received acetaminophen (Tylenol, a mediation used to treat mild pain) which was effective. A review of Resident 1's Physician's Order dated 6/18/2024, indicated the resident was to have an x-ray of the right femur due to pain. (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 07/02/2024

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Windsor Gardens Convalescent Hospital	915 S. Crenshaw Blvd. 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Radiology Results Report reported 6/19/2024 at 9:52 AM, indicated the resident's right femur (thighbone) had an acute subcapital fracture. A review of the Physician's Order dated 6/19/2024 indicated to transfer Resident 1 to GACH 1 for further evaluation due to abnormal x-ray results. A review of GACH 1's History and Physical (H&P) Note dated 6/19/2024 at 4:27 PM, indicated Resident 1 was brought in from the facility secondary to acute hip pain. The note indicated on arrival Resident 1 was evaluated and noted to be agitated, confused, and unable to provide information. The note indicated multiple attempts to contact the facility were made for further information but were to no avail. The note indicated the x-ray was noted with displaced and angulated right femoral neck fracture (a broken neck of the right thighbone). The H&P note indicated Resident 1 was admitted for further management and follow-up. A review of GACH 1 ' s Operative Report dated 6/20/2024, indicated Resident 1 had a right hip bipolar replacement (a surgical procedure that replaces the head of a damaged femur with an implant designed to stabilize the femur and restore hip function) on 6/20/2024. A review of a letter from the facility to the Department of Public Health (DPH) dated 6/20/2024, indicated on 6/18/2024 at 2 PM, Certified Nursing Assistant (CNA) touched Resident 1 ' s right lower extremity to help them sit up and the resident started grimacing (having a look of pain). The CNA asked Resident 1 if they were in pain and the resident stated yes. The letter indicated Resident 1 was not able to rate his pain due to impaired cognition. Upon nurse assessment the resident started grimacing when their right lower extremity was touched. The letter indicated no bleeding, redness, edema, or skin discoloration was noted on Resident 1's right lower extremity. The letter indicated when the CN asked what happened, Resident 1 was unable to provide a description of how and when this happened. Acetaminophen was given to Resident 1 and was deemed effective. The MD was notified and ordered an x-ray of the right lower extremity due to pain. The letter indicated the x-ray result was received on 6/19/2024, indicating an acute fracture. The letter indicated Resident 1 ' s MD was notified of the results and ordered to transfer the resident to GACH 1 for further evaluation. The letter indicated the Administrator was notified on 6/19/2024 at 10:30 AM. The letter indicated the Administrator reported the incident to DPH on 6/20/2024 at 10:28 AM. The letter indicated Resident 1 ' s cause of injury was unknown and there were no known witnesses. The letter indicated the investigation was ongoing. A review of a fax confirmation of the letter from the facility to DPH dated 6/20/2024, indicated DPH received the reporting of Resident 1 ' s injury of unknown origin on 6/20/2024 at 11:57 AM. During a telephone interview on 7/2/2024 at 12:55 PM, LVN 2 stated on 6/19/2024 she was the desk nurse. LVN 2 stated Resident 1 stated he was having pain and was given Tylenol. LVN 2 stated she informed the Administrator, Director of Nursing (DON), and Resident 1 ' s MD of the resident ' s x-ray results when the results were received. LVN 2 stated the incident was so unexpected, they did not know how it happened. LVN 2 stated Resident 1 liked to walk around and wandered looking for food. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/2/2024 at 4:25 PM, the COC form dated 6/19/2024 at 12:40 PM and the fax confirmation dated 6/20/2024 at 11:57 AM were reviewed with the DON. The DON stated it turned out Resident 1 had fracture. The DON stated Resident 1 was sent out the same day to GACH 1. The DON stated she was notified of Resident 1 ' s fracture and stated she could not recall when she was notified. The DON stated she did not know how Resident 1 developed the fracture and stated the resident ' s injury was of an unknown origin. The DON reviewed the COC form dated 6/19/2024 and stated staff knew of Resident 1 ' s fracture at 12:40 PM. The DON stated the fax confirmation indicated the Department of Public Health (DPH) was notified of Resident 1 ' s injury of unknown origin on 6/20/2024 at 11:57 AM. The DON stated there was a delay in reporting the injury to DPH, it was reported more than 2 hours later. The DON stated a delay in reporting could potentially cause a delay in investigating the injury which could lead to further injury to the resident. During an interview on 7/2/2024 at 5:09 PM, the COC form dated 6/19/2024 at 12:40 PM and the fax confirmation dated 6/20/2024 at 11:57 AM were reviewed with the Administrator (ADM). The ADM stated he was made aware of Resident 1 ' s fracture on 6/20/2024 but indicated the resident ' s fracture was found on 6/19/2024. The ADM stated a fracture was a serious bodily injury. The ADM stated injury of unknown origin should have been reported to DPH and the ombudsman (a representative who assist residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences) in two hours as indicated in the facility ' s policy. A review of the facility ' s policy and procedure titled, Abuse Prohibition Policy and Procedure, reviewed 2/23/2021, indicated Report allegations involving neglect, exploitation, or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of property no later than two (2) hours after the allegation is made if the vent results in serious bodily injury. Serious bodily injury is reportable. Only an investigation can rule out abuse, neglect, or mistreatment. Serious bodily injury is defined as an injury involving extreme physical pain, involving substantial risk of death, involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization , or physical rehabilitation .Notify local law enforcement, ombudsman, licensing district office, licensing boards, registries and other agencies as required.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1), who had diagnosis of Dementia (loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that the loss interferes with a person's activities of daily living), had a history of wandering (a common behavior in those with dementia, walking aimlessly with no real place to go and becoming confused with their location), and was a risk for falls, was provided with the necessary care and services by failing to: -Develop a comprehensive care plan for Resident 1's diagnosis of Dementia, including supervision to prevent injury. -Complete a wandering assessment and fall risk assessment quarterly. As a result, on 6/19/2024, Resident 1 complained of pain to the right femur (thighbone), resulting in an acute subcapital fracture (a sudden broken neck of the right thighbone) of unknown origin. Resident 1 was transferred to the General Acute Care Hospital (GACH) where surgery was performed on 6/20/2024. Findings: A review of Resident 1's Admission Record indicated the facility readmitted the resident on 1/5/2023 with diagnoses that included dementia, schizoaffective disorder (a mental health problem where you experience psychosis [a mental disorder characterized by a disconnection from reality] as well as mood symptoms), generalized anxiety disorder (a feeling of fear, dread, and uneasiness), and cognitive communication deficit (a disorder that affects a person's ability to communicate). A review of Resident 1's Fall Risk assessment dated [DATE], indicated the resident was at moderate risk for falls, was taking psychotropic (medication used to treat psychosis, a collection of symptoms that affect the mind, where there has been some loss of contract with reality) and cathartic (medication that increases the passage of stool) medication. The assessment indicated Resident 1 had inadequate vision and was frequently incontinent (unable to control urine or stool). There were no further documented Fall Risk Assessments after 10/8/2023. A review of Resident 1's Wandering Risk assessment dated [DATE] indicated the resident was at high risk for wandering as resident was disoriented, exhibited/expressed fear and/or anxiety, did not understand their surroundings, and did not understand what was being said due to language or cognition. Resident 1 had a diagnosis of dementia with psychosis, was taking antipsychotics (medications to treat psychosis), antidepressants (medication to treat major depressive disorder), and anti-anxiety (medication to treat anxiety) medication. Resident 1 was a known wanderer and had a history of wandering. There were no further documented Wandering Risk Assessments after 10/8/2023. (continued on next page)

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 4/8/2024, indicated the resident had severely impaired cognition (problems with the ability to think, understand, and reason) and had behavioral symptoms not directed towards others (physical symptoms such as hitting or scratching self, pacing, rummaging, or verbal/vocal symptoms likes screaming, and disruptive sounds) that occurred one to three days per week. The MDS indicated Resident 1 required supervision or touching assistance with eating, was always incontinent of urine and bowel, and Resident 1 was taking antipsychotic, antianxiety, and antidepressant medications. The MDS further indicated Resident 1 had a diagnosis of Non-Alzheimer's Dementia. A review of Resident 1's Impaired Cognitive Function care plan dated 4/20/2024, indicated this was related to impaired decision making. The care plan interventions indicated to administer medications as ordered, communicate with the resident/family/caregivers regarding the resident's capabilities and needs, engage the resident in simple structured activities that avoid overly demanding tasks and to keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. The care plan did not include monitoring the resident's whereabouts or supervision. A review of Resident 1's Care Plan dated 4/20/2024, indicated the resident was at risk for falls related to poor communication/comprehension (the capability to understand), use of medication such as psychotropics, impaired visual function, unsteady gait (unstable walking pattern), poor balance/body control, and confusion. The care plan interventions included to anticipate and meet Resident 1's needs, and to monitor the resident for behaviors due to multiple falls. A review of Resident 1's care plan reviewed 4/20/2024, indicated Resident 1 was noted to be ambulating without assistance in the hallways. The care plan interventions included to provide stand-by assistance whenever possible while the resident was ambulating. The interventions did not include supervision. There was no care plan for Dementia found in Resident 1's medical record. A review of Resident 1's Medication Administration Record dated 6/1/2024 - 6/30/2024, indicated the resident's behavior of wandering from room to room was monitored and the number of episodes were recorded every shift. The MAR indicated Resident 1 had a total of 87 episodes of wandering from 6/1 - 6/19/2024. The MAR further indicated Resident 1 received 37 doses of Namenda 10 mg (used to treat dementia). A review of Resident 1's Change of Condition form dated 6/18/2024 at 2 PM, indicated the Certified Nursing Assistant (CNA) reported to the Charge Nurse (CN) that while attempting to transfer the resident to the shower chair he said pain and rubbed his right leg. The COC form indicated with the CN at bedside, the CNA touched Resident 1's leg to help him sit up and the resident showed signs of mild pain. There was no discoloration, bruising, edema, or bleeding noted. Resident 1 received acetaminophen (Tylenol, a mediation used to treat mild pain) which was effective. A review of Resident 1's Physician's Order dated 6/18/2024, indicated the resident was to have an x-ray of the right femur due to pain. A review of Resident 1's Radiology Results Report reported 6/19/2024 at 9:52 AM, indicated the resident's right femur (thighbone) had an acute subcapital fracture. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Physician's Order dated 6/19/2024 indicated to transfer Resident 1 to GACH 1 for further evaluation due to abnormal x-ray results. A review of GACH 1's Radiology Department Note dated 6/19/2024 at 3:13 PM, indicated Resident 1 had a Computed Tomography (CT - diagnostic imaging procedure that uses a computer linked x-ray machine to create detailed images of the inside of the body) of the abdomen and pelvis. The CT scan indicated a recent mildly displaced and impacted subcapital fracture of the right femoral neck with apex anterior angulation (a broken neck of the right thighbone). A review of GACH 1's History and Physical (H&P) Note dated 6/19/2024 at 4:27 PM, indicated Resident 1 was brought in from the facility secondary to acute hip pain. The note indicated on arrival Resident 1 was evaluated and noted to be agitated, confused, and unable to provide information. The note indicated multiple attempts to contact the facility were made for further information but were to no avail. The note indicated the x-ray was noted with displaced and angulated right femoral neck fracture (a broken neck of the right thighbone). The H&P note indicated Resident 1 was admitted for further management and follow-up. A review of GACH 1's emergency room Template Note dated 6/19/2024 at 5:19 PM, indicated Resident 1 was brought in by ambulance from the facility for injury of unknown origin of right hip fracture. The note indicated Resident 1 was to have an orthopedic consult (be seen by a physician who specializes in injuries of the musculoskeletal system) for surgical repair. A review of GACH 1's Operative Report dated 6/20/2024, indicated Resident 1 had a right hip bipolar replacement (a surgical procedure that replaces the head of a damaged femur with an implant designed to stabilize the femur and restore hip function) on 6/20/2024. During an interview on 7/1/2024 at 1:39 PM, Certified Nursing Assistant (CNA) 1 stated on 6/18/2024 at around 7:15 AM she came in and asked Resident 1 if they wanted to get ready for breakfast. CNA 1 stated she was trying to position Resident 1, but the resident was saying ouch pain and pointed to their right leg. CNA 1 stated Resident 1 was saying pain, so she did not move the resident and instead put the head of the bed up and gave him breakfast. CNA 1 stated at 8 AM that day she reported to her charge nurse (Licensed Vocational Nurse [LVN] 5) that Resident 1 was having pain. CNA 1 stated Resident 1 was not crying. CNA 1 stated the next day (6/19/2024), Resident 1 was screaming, and saying help me there's pain. CNA 1 stated, I asked him if anyone hit him and he said no, I asked him if he bumped into something he said no, he just kept saying he was in pain. CNA 1 stated she was not working on the Sunday or Monday before 6/18/2024 and did not know if anything happened to Resident 1 on those dates. CNA 1 stated Resident 1 can stand and walk, but indicated the resident needed some assistance with walking. CNA 1 stated sometimes Resident 1 liked to move fast around the facility in the wheelchair. CNA 1 stated Resident 1 wandered a lot. Phone interviews were attempted to contact LVN 5, who was assigned to Resident 1 on 6/18/2024, but the LVN could not be reached. During an interview on 7/2/2024 at 9:55 AM, the Activities Director (AD) stated she was very familiar with Resident 1, the resident was confused at times and stated the resident liked to go around the facility in his wheelchair. The AD stated sometimes Resident 1 liked to go fast in his wheelchair the staff would have to remind him to slow down. The AD stated Resident 1 would wander around the facility a lot. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/2/2024 at 10:59 AM, LVN 1 stated she was working on 6/16/2024 and 6/17/2024 and was taking care of Resident 1. LVN 1 stated Resident 1 would sometimes stand and get up on their own, wander and ambulate on their own. LVN 1 also stated Resident 1 liked to maneuver themselves around the facility in their wheelchair fast, was independent and did not need much supervision. During a telephone interview on 7/2/2024 at 12:55 PM, LVN 2 stated she was the desk nurse on 6/19/2024 and she informed the Administrator, Director of Nursing (DON), and Resident 1's MD of the resident's x-ray results indicating a fracture. LVN 2 stated Resident 1 did not require much supervision because he was independent and could walk without assistance. LVN 2 stated Resident 1 liked to walk around and wandered looking for food. During a telephone interview on 7/2/2024 at 1:18 PM, CNA 3 stated she was familiar with Resident 1. CNA 3 stated Resident 1 would frequently walk around the facility independently. During a telephone interview on 7/2/2024 at 1:27 PM, LVN 3 stated Resident 1 did not require supervision, was very independent, and could walk. LVN 3 stated Resident 1 liked to walk around the facility. During a concurrent interview and record review on 7/2/2024 at 3:39 PM, Resident 1's medical record was reviewed with Minimum Data Set Nurse (MDSN) 1. MDSN 1 stated she was familiar with Resident 1 and the resident was not that alert. MDSN 1 stated the MDS indicated Resident 1 had dementia and was taking Namenda for dementia. MDSN 1 stated Resident 1 did not have a care plan that focused on dementia and indicated there was also no care plan for Namenda. MDSN 1 stated a resident with dementia needs a lot of reminders, residents tend to wander so it was important to keep an eye on them. MDSN 1 stated it was important to have a care plan for dementia because care plans formulate a plan of care for addressing the needs of the resident. The MDSN 1 further stated the care plan guided staff on how to attend to those needs. MDSN 1 stated care plans should be resident specific. During a concurrent interview and record review on 7/2/2024 at 4:25 PM, Resident 1's care plan, fall risk assessment dated [DATE], and wandering risk assessment dated [DATE] were reviewed with the DON. The DON stated Resident 1 was always on the go pushing their wheelchair. The DON stated Resident 1 would get confused, had dementia, a cognitive communication deficit, and psychiatric issues. The DON verified Resident 1 did not have a care plan that focused on dementia and that the last fall and wandering risk assessments were completed on 10/8/2023. The DON stated the risk assessments help determine what interventions were needed to help prevent injuries from falls or wandering. The DON stated residents who are confused, or wander should have some supervision to ensure they do not injure themselves. The DON stated not having a care plan and not completing the risk assessment quarterly could have put the resident at risk for not getting the care they needed. The DON further stated Resident 1 should have had a care plan for dementia and should have a fall risk assessment and wandering risk assessment done quarterly. The DON stated care plans were important for staff to know what care to give residents and what type of outcomes they should be looking for. The DON stated Resident 1 approached things in a different manner than someone with a different mental status. During an interview on 7/2/2024 at 5:09 PM, the Administrator (ADM) stated the facility did not have a policy for fall risk assessments and wandering risk assessments. The ADM stated according to point click care (PCC, an electronic health record system used for documentation) the fall risk assessment and wandering risk assessment are to be done quarterly. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Care Plan, Baseline and Comprehensive, revised 11/2017, indicated to develop, upon admission and following completion of the Admission Nursing Assessment, and interim and comprehensive care plan for the resident. A comprehensive person-centered care plan consistent with residents rights will include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive assessment care plan must describe the following: Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Any services that would otherwise be required but are not provided due to the resident's exercise of rights including the right to refuse treatment. If applicable, any services provided as a result of PASSAR recommendations as well as rationale if facility disagree with the findings of the PASSAR. Goals for admission and desired outcomes. Resident preferences and potential for future discharge including appropriate referrals. Discharge plans as appropriate. The comprehensive care plan will be completed per RAI guidelines. A review of the facility's policy and procedure titled, Care of a Resident with Dementia & Behavior Assessment, revised 6/2017, indicated the resident will be assessed, and care plan developed based on an individualized holistic approach. Resident's showing signs of problematic behavior will be identified and managed appropriately. Residents will have minimal complications associated with the management of problematic behavior. The staff will identify and discuss with the practitioner situations where non-pharmacologic approaches are indicated and will institute such measures to the extent possible. A review of the facility's policy and procedure titled, Fall management effective 5/26/2021, indicated patients will be assessed for falls risk as part of the nursing process. Those determined to be at risk will receive interventions to reduce risk and minimize injury.