STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056194	A. Building B. Wing	03/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Gardens Convalescent Hospital	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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on interview and record review, the facility failed to: -Obtain informed consent (a process during which residents or caregivers are educated regarding the potential risks and benefits of medication therapy) from the resident or their responsible party (RP - a person delegated to make medical decisions for the resident in the event they are unable to do so) prior to treatment in two of five residents sampled for unnecessary medications (Resident 26 and Resident 10). -Obtain informed consent from the resident or RP after increasing the dose of aripiprazole (a medication used to treat mental illness) in one of five residents sampled for unnecessary medications (Resident 43). The deficient practices of failing to obtain informed consent prior to initiating treatment or increasing the dose of psychotropic (medications that affect brain activities associated with mental processed and behavior) medications could have prevented Residents 26, 10, and 43 from exercising their right to decline treatment with psychotropic medications. This increased the risk that Residents 26, 10 and 43 could have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to psychotropic medications leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Cross Reference F758 Findings: a. A review of Resident 26's Admission Record dated 3/2/25, indicated he was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including schizophrenia (a mental illness characterized by hearing or seeing things that are not there) and bipolar disorder (a mental health condition that causes extreme mood swings from emotional highs [mania] to deep lows [depression]). A review of Resident 26's History and Physical (H&P - a record of a comprehensive physician's assessment) dated 1/22/25, did not indicate whether this resident had the capacity to understand and make decisions. (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 03/02/2025
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 26's Order Summary Report (a summary of all current physician orders), dated 3/2/25 indicated Resident 26's attending physician prescribed divalproex (a medication used to treat mental illness) ER 250 milligram (mg - a unit of measure for mass) capsules to take three capsules by mouth two times a day for bipolar disorder manifested by rapid fluctuations of emotions ranging from calmness to anger on 12/27/24. A review of Resident 26's available informed consent documentation and clinical record indicated there was no documentation that Resident 26 or any responsible party received education regarding the risks and benefits of divalproex prior to its initiation on 12/27/24. A review of Resident 43's Admission Record, dated 3/2/25, indicated she was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental illness characterized by hearing or seeing things that are not there and extreme mood swings from emotional highs [mania] to deep lows [depression].) A review of Resident 43's H&P, dated 3/1/25, did not indicate whether this resident had the capacity to understand and make decisions. A review of Resident 43's psychiatric note (a medical progress assessment written by a psychiatric care provider) dated 1/21/25, indicated Resident 43's dose of aripiprazole was decreased from 10 mg twice daily to 10 mg at bedtime. A review of Resident 43's Medication Administration Record (MAR - a monthly record of medications administered and monitoring documented for a resident) for January and February 2025 indicated Resident 43 received aripiprazole 10 mg at bedtime between 1/21/25 and 2/16/25. Further review of the MAR indicated she was hospitalized between 2/17/25 and 2/20/25. A review of Resident 43's Order Summary Report dated 3/2/25 indicated Resident 43's attending physician prescribed aripiprazole 20 mg via gastrostomy tube (g-tube - a tube surgically implanted into the stomach for administration of medications and nutrition) at bedtime for schizoaffective disorder manifested by suspiciousness and auditory hallucinations on 2/20/25 when she was readmitted from the hospital. A review of Resident 43's available informed consent documentation and clinical record indicated there was no documentation that Resident 43 or any responsible party received education regarding the risks and benefits of the increased dose of aripiprazole on or after 2/20/25. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/02/25 at 11:36 AM with the Director of Nursing (DON), the DON stated Resident 43's psychiatrist decreased her dose of aripiprazole to 10 mg at bedtime in January, but she was currently receiving 20 mg at bedtime. The DON stated Resident 43 was recently readmitted from the hospital and upon readmission, the facility continued the 20 mg dose per a hospital discharge order instead of the 10 mg dose she was receiving earlier. The DON stated the February MAR indicated no increase in behaviors for this resident and the clinical record contained no other clinical justification for the increase in dosage, so the increase in dosage was likely unintentional. The DON stated this would also explain why the facility failed to obtain informed consent for the increased dose of aripiprazole. The DON stated, as a result, Resident 43 has been receiving more aripiprazole than intended since 2/20/25. The DON stated this increased Resident 43's risk of developing adverse effects related to antipsychotic medication including movement disorders, drowsiness, dizziness, or blurry vision which may contribute to a decline in her quality of life. During an interview on 3/2/25 at 11:52 AM, the DON stated the facility failed to obtain informed consent prior to initiating therapy with divalproex for Resident 26. The DON stated the facility was required to obtain informed consent prior to use for any medication used to treat behavioral issues, whether it is a psychotropic medication or not. The DON stated informed consent may have been missed for Resident 26's divalproex because it was not a traditional psychotropic medication. The DON stated this increased the risk that Resident 26 might not have been able to exercise his right to opt out of treatment with divalproex and its risk of adverse effects such as drowsiness and dizziness which could lead to a decline in his quality of life. A review of the facility's policy titled, Psychotropic medication Use, revised July 2022, indicated When determining whether to initiate, modify, or discontinue medication therapy, the IDT conducts an evaluation of the resident. The evaluation will attempt to clarify whether . the actual or intended benefit of the medication is understood by the resident/representative. Residents (and/or representatives) have the right to decline treatment with psychotropic medications. The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives. 46144 b. During a review of Resident 10's Admission Record, the Admission Record indicated Resident 10 was admitted to the facility on [DATE]. Resident 10's diagnoses included encephalopathy (brain disorder disease or damage that affects your brain's function or structure), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and post-traumatic stress disorder ([PTSD]- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event). During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 1/7/2025, the MDS indicated Resident 10's cognition (ability to learn, reason, remember, understand, and make decisions) was intact. The MDS indicated Resident 10 required substantial assistance for showering, dressing, and toileting hygiene. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Physician's Orders titled, Order Summary Report, dated 2/3/2025, the orders indicated Resident 10 was to be given Aripiprazole Lauroxil ER (to treat mental conditions such as schizophrenia), 882 milligrams ([mg] -a unit of mass or weight in the metric system) to be injected intramuscularly on the 15th of every month. During an interview on 3/2/2025 at 10:23 a.m. with Registered Nurse (RN) 1, RN 1 stated Resident 10 had received the medication Aripiprazole without consent. RN 1 stated the facility protocol was to get a consent for antipsychotic medications prior to administration. During a concurrent interview and record review on 3/2/2024 at 10:55 a.m. with Director of Nursing (DON), Resident 10's consent titled, Psychotropic Medication Administration Disclosure, dated 2/15/2025 was reviewed. The consent was incomplete there was no signature by the resident. The DON stated the consent was not signed nor completed. The DON stated antipsychotics required a consent from the resident. The DON stated the purpose of the consent was to ensure Resident 10 was aware of the medication's risks and. The DON stated if Resident 10 knew the risks and benefits, the resident would be able to tell facility staff about side effects if the resident were to have them. During a review of facility's policy and procedures (P&P) titled, Behavior Management, dated 2/2023, the P&P indicated resident exhibiting behavioral symptoms will be individually evaluated to determine the behavior. The P&P indicated to obtain the psychotropic medication administration disclosure form and consent.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 27) had the call light within reach. This deficient practice placed the resident at risk for not receiving needed care and placed the resident at risk for falls. Findings: During a review of Resident 27's Admission Record, the admission record indicated Resident 27 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 27's diagnoses included chronic kidney disease (a long-term condition where the kidneys gradually lose their ability filter waste products and excess fluid from the blood), dementia (a progressive state of decline in mental abilities), and contractures (tightening of muscles, tendons, skin and other tissues that limits mobility) to left hand. During a review of Resident 27's History and Physical (H&P), dated 8/30/2024, the H&P indicated, Resident 27 could not make medical decision but could make needs known. During a review of Resident 27's Minimum Data Set (MDS, a resident assessment tool), dated 2/10/2025, the MDS indicated Resident 27's ability to understand ranged from rarely to never understood. The MDS indicated Resident 27 was dependent on staff for showering, dressing, and personal hygiene. During an observation on 2/28/2025 at 8:39 p.m. in Resident 27's room, the call light was observed hanging down from the rail towards the floor and was not within of the resident to call for assistance. During a concurrent observation in Resident 27's room and interview on 3/1/2025 at 4:02 p.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated the call light was not within reach. CNA 3 stated it was important to have the call light within reach incase Resident 27 needed assistance. During an interview on 3/1/2025 at 4:08 p.m. with Director of Staff Development (DSD), the DSD stated the call light had to be within reach for Resident 27. The DSD stated the call light was a form of communication for the resident. The DSD stated if the call light was not within reach and the Resident 27 wanted to get up without assistance it could place the resident at risk for falls. During a review of the facility's policy and procedures (P&P) titled, Answering the Call Light, dated 10/2024, the P&P indicated the purpose of this procedure was to ensure timely response to the resident's requests and needs. The P&P indicated be sure that the call light is plugged in and functioning at all times. The P&P indicated ensure the call light is accessible to the resident when in bed.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based interview and record review, the facility failed to document for one of six sampled residents (Resident 10) when the nicotine smoking patch (used to help people to stop smoking cigarettes) was removed after usage. This deficient practice had the potential to ineffectively give the proper dosage of medication to Resident 10. Findings: During a review of Resident 10's Admission Record, the admission record indicated Resident 10 was admitted to the facility on [DATE]. Resident 10's diagnoses included encephalopathy (brain disorder disease or damage that affects your brain's function or structure), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and post-traumatic stress disorder ([PTSD]- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event). During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 1/7/2025, the MDS indicated Resident 10's cognition (ability to learn, reason, remember, understand, and make decisions) was intact. The MDS indicated Resident 10 required substantial assistance for showering, dressing, and toileting hygiene. During a review of Resident 10's care plan titled, Patient may smoke independently per smoking assessment, dated 12/18/2024, the care plan had no indication of the smoking patch. During a review of the Physician's Orders titled, Order Summary Report, dated 1/14/2025, the orders indicated Nicotine Patch (worn on the skin bay a person trying to give up smoking) 21 milligrams ([mg]- a measurement of mass in the metric system) one patch to skin every 24 hours as needed. During a review of Resident 10's medical record administration ([MAR] -used to document medications taken by each individual), dated 2/1/2025 to 2/28/2025, the MAR indicated Resident 10 was given Nicotine Patch 21 mg on dates 2/1, 2/6, 2/9, 2/18, and 2/22/2025. The MAR did not indicate when the Nicotine Patch 21 mg was removed from the resident. During a concurrent review and record review on 3/2/2025 at 9:15 a.m. with Registered Nurse (RN) 1, Resident 10's MAR dated 2/1/2025 to 2/28/2025, was reviewed. The MAR indicated Resident 10 was given Nicotine Patch 21 mg on dates 2/1, 2/6, 2/9, 2/18, and 2/22/2025. The MAR did not indicate when the Nicotine Patch 21 mg was removed from the resident. RN 1 stated after 24 hours the Nicotine Patch should be removed from the resident. RN 1 was not able to locate the documentation that the Nicotine Patch 21 mg was removed and disposed after 24 hours of usage on the dates 2/1, 2/6, 2/9, 2/18, and 2/22/2025. RN 1 stated the removal of the Nicotine Patch should have been documented on the MAR. RN 1 stated it was important to document the removal of the Nicotine Patch to communicate to the next nurse the patch was removed. RN 1 stated the staff had no way of knowing if the Nicotine Patch was effective or ineffective for the resident. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedures (P&P) titled, Nursing Documentation, dated 6/2022, the P&P indicated to communicate patient's status and provide complete, comprehensive, and accessible accounting of care and monitoring provided. The P&P indicated timely entry documentation must occur as soon as possible after the provision of care and conformance with time frames for completion.

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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** 40994 Based on interview and record review, the facility failed to accurately complete the minimum data set (MDS - a comprehensive resident assessment tool) assessment Section I (active diagnoses), dated 11/21/24, by failing to include a diagnosis of schizophrenia (a mental illness characterized by hearing or seeing things that are not there), depression (a mental illness characterized by depressed mood, difficulty sleeping, or lack of interest in usually enjoyable activities), and bipolar disorder (a mental health condition that causes extreme mood swings from emotional highs [mania] to deep lows [depression]) per information in the medical record for one of five residents sampled for unnecessary medications (Resident 26.) The deficient practice of failing to accurately assess active diagnoses and complete MDS Section I increased the risk that Resident 26 may not have received care planning and treatment according to his needs possibly leading to a decline in his overall health and well-being. Findings: A review of Resident 26's Admission Record dated 3/2/25, indicated he was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including schizophrenia and bipolar disorder A review of Resident 26's History and Physical (H&P - a record of a comprehensive physician's assessment) dated 1/22/25, did not indicate whether this resident had the capacity to understand and make decisions. A review of Resident 26's psychiatric note dated 9/25/24, indicated this resident had a history of schizophrenia manifested by visual and auditory hallucinations of a threatening nature. A review of Resident 26's psychiatric note dated 10/20/24, indicated Resident 26 had a history of bipolar disorder (manic type) manifested by paranoid delusions. A review of Resident 26's Order Summary Report (a summary of all current physician orders), dated 3/2/25 indicated Resident 26's attending physician prescribed: 1. Divalproex ER 250 milligram (mg - a unit of measure for mass) capsules to take three capsules by mouth two times a day for bipolar disorder manifested by rapid fluctuations of emotions ranging from calmness to anger on 12/27/24. 2. Xanomeline-Trospium (a medication used to treat schizophrenia) 100-20 mg by mouth two times a day for schizoaffective disorder manifested by paranoid delusions that gangsters are after him on 2/16/25. 3. Pimavanserin (a medication used to treat mental illness) 34 mg by mouth one time a day for Parkinson Disease Psychosis manifested by paranoid delusions that people are after him, visual hallucinations, auditory hallucinations, angry outbursts towards staff. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 26's MDS assessment Section I, dated 11/21/24, indicated he did not have depression, bipolar disorder, schizophrenia or any psychotic disorder (other than schizophrenia). During an interview on 3/2/25 at 11:42 AM, the Director of Nursing (DON) stated section I of the MDS dated [DATE] was inaccurate compared to his medical records. The DON stated the psychiatric section of Section I (active diagnosis) indicated this resident did not have depression, bipolar disorder, or schizophrenia, when his clinical record indicated that he has all of these. The DON stated this may interfere with accurate care planning and cause Resident 26 to experience a decline in his quality of life due to potential unmet needs. A review of the facility's policy titled, Resident Assessments, revised October 2023, indicated Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations / interviews.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review, the facility failed to ensure two of six sampled residents (Resident 16 and 10) care plans were revised for Resident 16 who refused to wear hearing aids and for Resident 10 regarding the interventions on when to remove and document the disposal of the smoking patch (skin patches are used to help people to stop smoking cigarettes). This deficient practice had the potential for Resident 16 and 10 to receive insufficient treatment and care. Findings: a. During a review of Resident 16's Admission Record, the admission record indicated Resident 16 was admitted to the facility on [DATE]. Resident 16's diagnoses included chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), dementia (a progressive state of decline in mental abilities), and heart failure (the heart is unable to pump sufficient blood to the tissues). During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool), dated 2/10/2025, the MDS indicated Resident 16's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 16 required moderate assistance from staff for showering, dressing, and personal hygiene. The MDS indicated Resident 16 required hearing aids and was highly impaired with hearing. During an observation on 2/28/2025 at 8:15 p.m., Resident 16 did not have hearing aids in her ears and had trouble hearing staff while communicating. During an observation on 3/1/2025 at 10 a.m., Resident 16 did not have hearing aids in her ears and had trouble hearing while communicating with staff. During a review of Resident 16's care plan titled, The resident has a communication problem related to hearing deficit, dated 1/20/2024, the care plan indicated the interventions to ensure hearing aids were in place daily and licensed nurses were to assist the resident in applying hearing aids. During a concurrent interview and record review on 3/1/2025 at 5:07 p.m. with Director of Nursing (DON), Resident 16's care plan titled, The resident has a communication problem related to hearing deficit, dated 1/20/2024 was reviewed. The DON stated Resident 16 was refusing to wear her hearing aids. The DON stated when Resident 16 refused to wear her hearing aids, and the issue was identified the care plan should have been revised. The DON stated it was important to set in place interventions that would include to adjust the hearing aids for comfort and to inform the resident of the risk and benefits when using hearing aids. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility policy and procedure (P&P) titled, Care Plan Comprehensive, dated 8/2021, the P&P indicated a comprehensive person-centered care plan fore each resident, that includes measurable objectives and timeframes to measurable objectives and timeframes to meet a resident's medical, physical, mental, and psychosocial needs that are identified. The P&P indicated assessments of residents are ongoing and care plans are reviewed and revised as information about the resident change. The P&P indicated when the residents refuse appropriate documentation will be entered into the resident's clinical records. b. During a review of Resident 10's Admission Record, the admission record indicated Resident 10 was admitted to the facility on [DATE]. Resident 10's diagnoses included encephalopathy (brain disorder disease or damage that affects your brain's function or structure), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and post-traumatic stress disorder ([PTSD]- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event). During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10's cognition was intact. The MDS indicated Resident 10 required substantial assistance from facility staff for showering, dressing, and toileting hygiene. During a review of Resident 10's care plan titled, Patient may smoke independently per smoking assessment, dated 12/18/2024, the care plan had no indication of the smoking patch. During a review of the Physician's Orders titled, Order Summary Report, dated 1/14/2025, the orders indicated Nicotine Patch (worn on the skin bay a person trying to give up smoking) 21 milligrams (mg - a measurement of mass in the metric system) one patch to skin every 24 hours as needed. During a concurrent interview and record review on 3/2/2024 at 10:23 a.m. with Registered Nurse (RN) 1, Resident 10's care plan titled, Patient may smoke independently per smoking assessment, dated 12/18/2024 was reviewed. The care plan had no indication of the smoking patch. RN 1 stated when the smoking patch was ordered the care plan for smoking should have been revised. RN 1 stated care plan interventions had to include to monitor the smoking patch and when to remove the smoking patch. RN 1 stated revising the care plan for monitoring would help to keep track the effectiveness of the smoking patch. During a review of facility P&P titled, Care Plan Comprehensive, dated 8/2021, the P&P indicated a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to measurable objectives and timeframes to meet a resident's medical, physical, mental, and psychosocial needs that are identified. The P&P indicated assessments of residents are ongoing and care plans are reviewed and revised as information about the resident change.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview, and record review, the facility failed to ensure two of five sampled Residents (Resident 22, and Resident 47) received professional standard of care and services to maintain clean fingernails with trim. This deficient practiced placed Resident 22, and Resident 47 at risk for a potential skin injury and bacteria growth of the fingernails. Findings: a. During a review of Resident 22's Admission Record, the Admission Record indicated Resident 22 was admitted to the facility on [DATE] with a diagnosis that included Dementia (a progressive state of decline in mental abilities), hypothyroidism (deficiency of thyroid hormones), and hypertension ((HTN-high blood pressure) During a review of Residents 22's Minimum Data Set (MDS - a resident assessment tool), dated 12/25/2024, the MDS indicated Resident 22 rarely/ never make self-understood and rarely/never understand others. The MDS indicated Resident 22 required dependent assistance with Activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) transfer and bed mobility. During a review of Resident 22's ADL care plan, the ADL care plan indicated Resident 22 has an ADL self-care performance deficit related to dementia, disease process and limited mobility. The ADL care plan interventions indicated while bathing Resident 22 check nails length and trim and clean on bath day and as necessary. During a concurrent observation and interview on 3/1/2025 at 12:31 p.m. with Certified Nurse Assistance (CNA) 2 in Resident 22's room. Resident 22 was observed with long and uncleaned bilateral hands fingernails. CNA 2 stated, I assess and trim fingernails every two weeks. CNA 2 stated, I clean the nails every day when dirty. CNA 2 stated yes Resident 22 fingernails were long with some dirt. CNA 2 stated it was important to check fingernails length because Resident 22 can scratch herself and develop a skin breakdown. CNA 2 stated when fingernails were uncleaned it was a potential for microbes to get inside then fingernails and can cause skin infection. b. During a review of Resident 47's Admission Record, the Admission Record indicated Resident 47 was admitted to the facility on [DATE] with a diagnosis that included hypertension ((HTN-high blood pressure), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and other seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness.) During a review of Residents 47's MDS, dated [DATE], the MDS indicated Resident 47 could usually makes self-understood and the ability to usually understand others. The MDS indicated Resident 47 required dependent assistance with ADLs. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 47's ADL care plan, the ADL care plan indicated Resident 47 had an ADL self-care performance deficit related to disease process and impaired balance. The ADL care plan interventions indicated while bathing Resident 22 check nails length and trim and clean on bath day and as necessary. During a concurrent observation and interview on 3/1/2025 at 12:38 p.m. with CNA 2 in Resident 47's room, Resident 47 was laying on bed. Observed Resident 47's bilateral hand fingernails long and uncleaned. CNA 2 stated Yes, I need to trim Resident 47 fingernails. CNA 2 stated, I will do it after lunch. CNA 2 informed Resident 47 and Residents was agreed. During an interview on 3/1/2025 at 5:42 p.m. with Infection Preventionist (IP), IP stated ADL care was done every day by the CNAs. The IP stated CNAs should assess the fingernails every day. The IP stated if fingernails were long and uncleaned the CNAs must trim Residents fingernails. The IP stated it was important to do the assessment to keep the nails clean and free of any skin infection. During an interview on 3/2/2025 at 12:05 p.m. with the Director of Nursing (DON), the DON stated nurses oversee Residents fingernails everyday while providing ADL care. The CNAs were responsible to trim the fingernails. The DON stated the risk of living the fingernails dirty can be a source of contaminations. The DON stated if Residents scratch it can be at risk of skin breakdown. During a review of the facility's policies and procedures (P&P) titled, Fingernails/Toenails, care of, dated 2/6/2025, the P&P indicated nail care includes daily cleaning and regular trimming. Proper nail care can aid in the prevention of skin problems around the nail bed. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review, the facility failed to ensure facility staff assisted one of six sampled residents (Resident 16) with hearing aids (a device worn in or behind the ear designed to amplify sound for individuals who have difficulty hearing) place the hearing aid in the resident's ears daily. This deficient practice of not providing hearing aids to Resident 16 had the potential for the resident to not hear clearly and communicate needs to staff. Findings: During a review of Resident 16's Admission Record, the admission record indicated Resident 16 was admitted to the facility on [DATE]. Resident 16's diagnoses included chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), dementia (a progressive state of decline in mental abilities), and heart failure (the heart is unable to pump sufficient blood to the tissues). During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool), dated 2/10/2025, the MDS indicated Resident 16's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 16 required moderate assistance from staff with showering, dressing, and personal hygiene. The MDS indicated Resident 16 required hearing aids and was highly impaired. During an observation on 2/28/2025 at 8:15 p.m. Resident 16 did not have hearing aids in her ears and had trouble hearing staff while communicating. During an observation on 3/1/2025 at 10 a.m. Resident 16 did not have hearing aids in her ears and had trouble hearing while communicating with staff. During a review of Resident 16's care plan titled, The resident has a communication problem related to hearing deficit, dated 1/20/2024, the care plan indicated the interventions to ensure hearing aids were in place daily and licensed nurses will assist resident to apply hearing aids. During a concurrent observation and interview on 3/1/2025 at 4:28 p.m. with Social Service Director (SSD), the SSD stated Resident 16 was not wearing her hearing aids. The SSD stated the hearing aids were in the medication cart. The SSD stated Resident 16 did not like wearing her hearing aids. The SSD stated the hearing aids had to be offered to Resident 16 daily. The SSD stated the use of the hearing aids would help Resident 16 to communicate needs with the staff. During an interview on 3/1/2025 at 5:07 p.m., the Director of Nursing (DON) stated the hearing aids had to be offered to Resident 16 daily and removed at night. The DON stated it was important to offer the hearing aids to Resident 16 so she could communicate effectively and ensure the resident's needs were met. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedures (P&P) titled, Hearing Impaired Resident, Care of, dated 2/2018, the P&P indicated staff would assist hearing impaired residents to maintain effective communication with clinicians, caregivers, other residents and visitors. The P&P indicated staff would assist residents with care and maintenance of hearing devices. The P&P indicated to evaluate resident's adaptive needs and progress at regular intervals.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 341), who was on a low air loss mattress ([LAL]- a medical device that helps prevent and treat pressure ulcers by distributing body weight and improving air circulation) had the correct setting to prevent skin breakdown (damage to the skin caused by prolonged pressure on bony areas of the body). This deficient practice had the potential to worsen skin breakdown. Findings: During a review of Resident 341's Admission Record, the admission record indicated Resident 341 was admitted to the facility on [DATE]. Resident 341's diagnoses included malignant neoplasm (a cancerous tumor that can spread to other parts of the body), diabetes mellitus([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing), and parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 341's Minimum Data Set (MDS, a resident assessment tool), dated 2/23/2025, the MDS indicated Resident 341's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 341 was dependent on staff for showering, dressing, and personal hygiene. During an observation on 2/28/2025 at 8:02 p.m., in Resident 341's room, the LAL mattress setting was set at 325 pounds (lbs). During a review of the Physician's Orders titled, Order Summary Report, dated 2/25/2025, the Order Summary Report indicated air loss mattress, control knob to be set at 113 (lbs.- a unit of measurement for weight). During a review of Resident 341's care plan titled, The resident has a pressure ulcer unstageable pressure ulcer (a full-thickness skin loss where the depth of the wound is covered by dead tissue), dated 2/24/2025, the care plan intervention indicated to provided treatment as ordered. During a concurrent observation and interview on 3/1/2025 at 4:10 p.m., with Director of Staff Development (DSD) was reviewed. The DSD stated Resident 341's LAL mattress settings was set at 325 lbs. The DSD stated the LAL mattress setting was not aligned with Resident weight of 113 lbs. The DSD stated Resident 341 was at risk for skin breakdown. The DSD stated not having the correct LAL mattress setting result in worsening skin breakdown. During a review of facility policy and procedure (P&P) titled. Skin Integrity Management, dated 5/2021, the P&P indicated to provide safe and effective care to prevent the occurrence of pressure ulcers, mange treatment, and promote healing of all wounds. The P&P indicated to identify patient's kin integrity status and need for prevention intervention or treatment modalities through review of all appropriate assessment information. The P&P indicated determine the need for support surface for bed and chair. The P&P indicated determine the need for offloading devices.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interviews, and record reviews, the facility staff failed to ensure resident received appropriate treatment and services to prevent urinary tract infections urinary tract infection (UTI- an infection in the bladder/urinary tract) for one of three sampled residents (Resident 46) by failing to ensure report to the resident's physician (MD) the presence of sediment (particles in liquid) in the indwelling urinary (foley) catheter (a hollow tube inserted into the bladder to drain or collect urine). This deficient practice had the potential to delay the healing of Resident 46's urinary tract infection (UTI; an infection in the bladder/urinary tract) or cause the infection to worsen. Findings: During a review of Resident 46's Admission Record, the admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included benign prostatic hyperplasia (BPH; a condition in which the prostate gland [A gland in the male reproductive system] grows larger than normal). During a review of Resident 46's History and Physical (H&P) dated 4/25/2024, the H&P indicated Resident 46 did not have the capacity to make medical decisions. During a review of Resident 46's Minimum Data Set (MDS, a resident assessment tool) dated 1/31/2025, the MDS indicated the resident was assessed to have intact cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and was dependent (helper does all the effort) of facility staff for toileting, hygiene, showering, and dressing the lower have of the body. During a review of Resident 46's Care Plan (CP) titled Resident requires an Indwelling Catheter dated 9/10/2021, the CP indicated to monitor and report to MD if urine is cloudy. During a review of Resident 46's CP titled [Resident 46] has the potential for recurrence of UTI dated 2/13/2023, the CP indicated to monitor and report to MD cloudy urine. During a review of Resident 46's Order Summary Report (OSR) dated 4/22/2024, the OSR indicated Resident 46 had an order for monitoring for signs and symptoms of possible UTI (change in character of urine, foul smell, change in sediment) and to notify the resident's MD if signs were present. During a review of Resident 46's Order Summary Report (OSR) dated 1/21/2025, the OSR indicated Resident 46 had an order for Indwelling catheter. During a review of Resident 46's Progress Notes from 12/1/2024 to 3/1/2025, the Progress Notes indicated there was no documentation indicating Resident 46's MD was notified of sediment in urine. During an observation in Resident 46's room on 2/28/2025 at 8:01 PM, Resident 46's indwelling catheter was observed to have urine with cloudy sediment in the tubing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation in Resident 46's room and interview on 2/28/2025 at 8:04 PM with Licensed Vocational Nurse (LVN) 2, Resident 46's indwelling catheter tubing was observed. LVN 2 stated, there's sediment in the tubing of the indwelling catheter, the MD should be notified. A resident can get a UTI if it's not addressed to the MD. During a concurrent record review and interview on 2/28/2025 at 8:12 PM with LVN 2, Resident 46's Progress Notes dated 12/1/2024 to 2/28/2025 were reviewed. LVN 2 stated, there's no documentation of notifying MD of sediment in urine. During a concurrent interview and record review on 3/2/2025 at 9:17 AM with the Director of Nursing (DON), the facility's P&P titled Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing revised 9/2017 and Resident 46's Progress Notes dated 12/1/2024 to 3/1/2025 were reviewed. The P&P indicated: 1. The purpose of this procedure is to provide guidelines for the prevention of catheter associated UTIs. 2. Document any signs and symptoms of UTI. 3. Report signs or symptoms of UTI to the MD. The DON stated, The documentation does not show that the MD was notified of sediment in the urine, there's no documentation of specific symptoms of UTI. The MD must be notified of the specific symptoms of UTI such as blood in urine, bad smelling urine and sediment in urine so the appropriate treatment for can be ordered. He may get the incorrect treatment if the specific symptoms of UTI are not reported, and his condition can get worse.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 Based on observation, interview, and record review, the facility failed to ensure one of eight sampled residents (Residents 52) received the appropriate treatment and services needed to maintain and prevent gastrostomy tube (GT - a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration) complications. Resident 52's GT was not securely connected to prevent leakage. This deficient practice caused feeding to leak from the GT soaking the resident's skin and bed linen, placing the resident at risk for malnutrition and skin break down. Findings: During a review of Resident 52's Admission Record, the Admission Record indicated Resident 52 was originally admitted to the facility on [DATE], with diagnoses including major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), single episode, unspecified (first time episode of depression), unspecified protein- calorie malnutrition and dysphagia (difficulty swallowing). During a review of Resident 52's History and Physical (H&P), dated 10/15/2023, the H&P indicated, Resident 52 did not have the capacity to make decisions. During a review of Resident 52's Minimum Data Set (MDS, a comprehensive assessment tool) dated 6/28/2025, the MDS indicated, Resident 52 was dependent (helper does all the effort) on facility staff for rolling left and right, and chair/bed to chair transfers. During a record review of Resident 52's Order Summary Report (OSR) for 6/29/2024 the OSR indicated there was an order for Glucerna 1.5 (a nutritional product designed for people with diabetes) at 70 cc (the flow rate of fluid) /hour x 20 hours to provide 1400 cc / 2100 cc calorie by enteral feed to start at 12 p.m. and turn off at 8 a.m. or until dose limit was completed. During a record review of Resident 52's care plan initiated on 11/10/2022, the care plan indicated the resident required tube feeding related to dysphagia and to meet the resident's nutritional needs. The care plan indicated the resident was at risk for complications related to use of feeding tube such as aspiration (when something enters your airway or lungs by accident) and fluid imbalance. The interventions indicated to monitor / document / report to doctor and when necessary: aspiration, fever, shortness of breath, tube dislodged, infection at the tube site. During an observation in Resident 52's room on 3/1/2025 at 9:20 a.m., Resident 52 was observed lying in bed receiving tube feeding through the gastrostomy tube feeding with the head of the bed elevated. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation in Resident 52's room and interview on 3/1/2025 at 9:45 a.m., with the Certified Nurse Assistant 1 (CNA 1), CNA 1 observed the feeding was leaking into a towel and on Resident 52's skin. CNA 1 stated she did not know there was feeding spilling in the towel and on the resident's skin. CNA 1 stated the feeding had been infusing since 7 a.m. CNA 1 stated, I do not assess the resident's body. I assess the face to see if they are alive. CNA 1 stated it was night shifts responsibility to make sure the feeding tube was attached and infusing well. During an observation in Resident 52's room and interview on 3/1 2025 at 10 a.m., with Licensed Vocational Nurse (LVN 2), LVN 2 observed the resident's tube feeding formula leaking onto the resident's skin and soaking a towel. LVN 2 stated the process for assessing a resident when starting shift was to look at the feeding tube site to make sure it was in place and not leaking. LVN 2 stated because the feeding tube had been leaking and not going into the resident, there could be a potential the resident could lose weight or become dehydrated. LVN 2 stated because the formula feeding was wet the leaking feeding could cause the resident's skin break to down. LVN 2 stated when she started her shift, she relied on night shift to have everything in place the whole resident was not checked. During an interview on 3/2/3035 at 2:33 p.m., the Director of Nursing (DON) stated CNA's and LVN's need to make rounds at the beginning of the shift to see if the residents' needs were being met. The DON stated you must do your assessment to address the problem, if a resident's gastrostomy tube was not working they must report to the LVN. The outcome can be resident not getting the proper nutrition and skin breakdown because feeding was not going to the patient and running in the bed. During a review of the facility's Policy and Procedures (P&P) titled, Enteral tube Feeding via Gravity Bag, dated 2009, the P&P indicated, the purpose of this procedure is to provide nourishment to the resident who is unable to obtain nourishment orally. Verify placement of feedings tube. Report complications to the supervisor and the attending physician.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on interview and record review, the facility failed to ensure signs and symptoms of bleeding and bruising related to the use of aspirin (a medication used to prevent blood clots and Eliquis (a medication used to prevent blood clots) in one of five residents sampled for unnecessary medications (Resident 78). The deficient practice of failing to monitor for signs and symptoms of bleeding during aspirin and Eliquis therapy increased the risk that Resident 78 could have experienced adverse effects (unwanted and dangerous side effects of medication) such as bleeding and bruising leading to medical complications requiring hospitalization . Findings: A review of Resident 78 ' s Admission Record dated 3/2/25, indicated he was admitted to the facility on [DATE] with diagnoses including unspecified sequelae of cerebral infarction (medical complications following a blood clot in the brain) and personal history of other venous thrombosis and embolism (a history of blood clots causing medical complications). A review of Resident 78 ' s History and Physical (H&P - a record of a comprehensive physician ' s assessment) dated 2/6/25, also indicated that Resident 78 was in end stage renal failure (advanced kidney disease) and received hemodialysis (a medical procedure that removes waste, toxins, and excess fluids from the blood when the kidneys can no longer do so effectively). A review of Resident 78 ' s Order Summary Report (a summary of all current physician orders), dated 3/2/25 indicated Resident 26 ' s attending physician prescribed: 1. Aspirin 81 milligram (mg - a unit of measure for mass) by mouth one time a day for blood clot prevention on 2/3/25. 2. Eliquis 5 mg by mouth two times a day for blood clot prevention on 2/3/25. A review of Resident 78 ' s available Care Plans dated 2/12/25, indicated Resident 78 was at high risk of bleeding, bruising, and skin discoloration due to his use of aspirin and Eliquis and facility staff should monitor for any signs of bleeding (unexplained bruising, nosebleeds, bleeding gums, signs of gastrointestinal bleeding, etc. A review of Resident 78 ' s Medication Administration Record (MAR - a monthly record of medications administered and monitoring documented for a resident) February 2025 indicated facility staff failed to monitor for signs and symptoms or bleeding and bruising as potential adverse effects of his therapy with aspirin and Eliquis between 2/3/25 and 2/28/25. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/02/25 at 11:19 AM with the Director of Nursing (DON), the DON stated the facility failed to monitor Resident 78 for bleeding and bruising in the MAR between 2/3/25 and 2/28/25. The DON stated Resident 78 was a dialysis resident and monitoring for bleeding and bruising was very important because his frequent dialysis port access further increases his risk for bleeding. The DON stated failing to monitor for bleeding and bruising increased Resident 78 ' s risk of bleeding-related adverse effects of aspirin and Eliquis which could lead to medical complications possibly resulting in hospitalization or death. A review of the facility ' s undated policy titled, Anticoagulation - Clinical Protocol, indicated The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems. In an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Two medication errors out of 26 total opportunities contributed to an overall medication error rate of 7.69 % affecting two of three residents observed for medication administration (Residents 19 and 48.) The medication errors noted were as follows: -Attempted to administer carbamazepine (a medication used to treat nerve pain) suspension (a liquid medication dosage form in which a solid is suspended, but not dissolved, in a liquid vehicle) without first shaking the bottle to Resident 48. -Administered the wrong formulation of multivitamins (a vitamin supplement) to Resident 19. The deficient practice of failing to administer medications in accordance with professional standards and the physician ' s orders increased the risk that Residents 19 and 48 may have experienced medical complications possibly resulting in hospitalization . Cross Reference F760 Findings: A review of Resident 48 ' s Admission Record dated 3/1/25, indicated he was admitted to the facility on [DATE] with diagnoses including other chronic pain (pain lasting longer than three months.) A review of Resident 48 ' s History and Physical (H&P - a record of a comprehensive physician ' s assessment), dated 6/20/24, did not indicate whether he had the capacity to understand and make decisions. A review of Resident 48 ' s Order Summary Report (a monthly summary of all active physician orders), dated 3/1/25, indicated he was prescribed carbamazepine 100 milligrams (mg - a unit of measure for mass) per 5 milliliters (ml - a unit of measure for volume) suspension to take 2.5 ml by mouth two times a day for nerve pain, give with food, shake suspension well prior to use, use gloves to handle. During an observation on 3/1/25 at 8:08 AM with the Licensed Vocational Nurse (LVN) 2, LVN 2 was observed pouring out 2.5 ml of carbamazepine 100 mg/5 ml suspension from a pharmacy bottle for Resident 48 labeled shake well into a small plastic dosage cup without first shaking the bottle. During an observation on 3/1/25 at 8:25 AM, LVN 2 was observed attempting to administer the carbamazepine suspension to Resident 48 and was stopped by the surveyor and advised to discuss the medication preparation with the surveyor in the hallway. (continued on next page)

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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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(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 - Few	During a concurrent interview, LVN 2 stated she failed to shake the carbamazepine suspension prior to preparing the dose. LVN 2 stated all liquid medications in suspension form need to be shaken prior to preparing the dose because the medication separates from the vehicle and there is a risk that, if not shaken, the resident may get too much or too little of the medication when administered. LVN 2 stated Resident 48 used carbamazepine for nerve pain and failing to shake the bottle before administration may cause him to receive more or less medication than intended possibly leading to medical complications or a decreased quality of life from additional nerve pain. A review of Resident 19 ' s Admission Record, dated 3/1/25, indicated she was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including muscle weakness. A review of Resident 19 ' s History and Physical, dated 2/15/25, did not indicate whether she had the capacity to understand and make decisions. A review of Resident 19 ' s Order Summary Report, dated 3/1/25, indicated she was prescribed multivitamins with minerals to take one tablets by mouth one time a day for supplement on 11/23/21. During an observation on 3/11/25 at 8:31 AM, LVN 3 was observed preparing one tablet of multivitamins (formulation without minerals) for Resident 19. During an observation on 3/1/25 at 8:38 AM, Resident 19 was observed taking the multivitamin tablet by mouth along with her other medications and water. During an interview on 3/1/25 at 9:19 AM with LVN 3, LVN 3 stated she administered the regular multivitamins (without minerals) to Resident 19 instead of the formulation with minerals. LVN 3 stated Resident 19 ' s order is specifically for the multivitamin with minerals formulation. LVN 3 stated usually she checks the product label against the order in the computer system prior to administering medications, but accidentally overlooked the vitamin formulation and administered the wrong product to Resident 19. LVN 3 stated the minerals component of the multivitamin formulation is used to prevent mineral deficiencies which could cause the resident to have medical complications if not given. A review of the facility ' s policy titled, Administering Medications, revised April 2019, indicated Medication are administered in a safe and timely manner, and as prescribed . Medications are administered in accordance with prescriber orders, including any time frame . The individual administering the medication checks to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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	056194	A. Building B. Wing	03/02/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40994

Based on observation, interview, and record review, the facility failed to ensure its residents were free from significant medication errors by attempting to administer carbamazepine (a medication used to treat nerve pain) suspension (a liquid medication dosage form in which a solid is suspended, but not dissolved, in a liquid vehicle) without first shaking the bottle to one of three sampled residents observed for medication administration (Resident 48).

The facility failed to ensure to follow the parameteres (fixed high and low limits in which the blood pressure must be to safely administer the medication) when administering antihypertensive (used to treat high blood pressure) medication for Resident 18.

These deficient practices increased the risk that Resident 48 and Resident 18 may have experienced medical complications such as increased nerve pain or hypotension (low blood pressure) due to the improper administration possibly leading to a decline in quality of life.

Cross Reference F759

Findings:

a. A review of Resident 48's Admission Record, dated 3/1/25, indicated he was admitted to the facility on [DATE] with diagnoses including other chronic pain (pain lasting longer than three months).

A review of Resident 48's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 6/20/24, did not indicate whether he had the capacity to understand and make decisions.

A review of Resident 48's Order Summary Report (a monthly summary of all active physician orders), dated 3/1/25, indicated he was prescribed carbamazepine 100 milligrams (mg - a unit of measure for mass) per 5 milliliters (ml - a unit of measure for volume) suspension to take 2.5 ml by mouth two times a day for nerve pain, give with food, shake suspension well prior to use, use gloves to handle.

During an observation on 3/1/25 at 8:08 AM with the Licensed Vocational Nurse (LVN) 2, LVN 2 was observed pouring out 2.5 ml of carbamazepine 100 mg/5 ml suspension from a pharmacy bottle for Resident 48 labeled shake well into a small plastic dosage cup without first shaking the bottle.

During an observation on 3/1/25 at 8:25 AM, LVN 2 was observed attempting to administer the carbamazepine suspension to Resident 48 and was stopped by the surveyor and advised to discuss the medication preparation with the surveyor in the hallway.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview, LVN 2 stated she failed to shake the carbamazepine suspension prior to preparing the dose. LVN 2 stated all liquid medications in suspension form need to be shaken prior to preparing the dose because the medication separates from the vehicle and there is a risk that, if not shaken, the resident may get too much or too little of the medication when administered. LVN 2 stated Resident 48 uses carbamazepine for nerve pain and failing to shake the bottle before administration may cause him to receive more or less medication than intended possibly leading to medical complications or a decreased quality of life from additional nerve pain. A review of the facility's policy titled, Administering Medications, revised April 2019, indicated Medications are administered in a safe and timely manner, and as prescribed . Medications are administered in accordance with prescriber orders, including any time frame . The individual administering the medication checks to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication . 45777 b. A review of Admission Record indicated Resident 18 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnoses including hypotension (low blood pressure) unspecified, muscle weakness and Type II diabetes mellitus (the body h controlling blood sugar and using it for energy). A review of the MDS dated [DATE] indicated Resident 18 had the capacity to make decisions. The MDS indicated Resident 18 required supervision or touching assistant (helper provides verbal cues and or touching/steadying and or contact guard assistant as resident completes activity) when rolling left and right, sitting to lying, siting to standing, and walking 10 feet. During a record review of Resident 18's Order Summary Report (OSR), the OSR indicated a start date of 2/3/2025 to give Entresto oral tablet 24-26 mg (unit of measure) give 1 tablet by mouth two times a day for hypertension (high blood pressure and congestive heart failure (when the heart cannot pump enough blood to meet the body's needs, leading to fluid buildup in the lungs and other tissues), related to unspecified systolic (when the heart contracts to pump blood out of the heart chambers) congestive heart failure. The OSR indicated parameters in place indicated to hold if systolic blood pressure (SBP) was below 110 and heart rate below 60. The OSR indicated a start date 2/3/2025 to give carvedilol (blood pressure medication) oral tablet 3.125 mg 1 tablet by mouth two times a day hold for SBP below 110 or heart rate below 60 administer with food to slow the rate of absorption and reduce the orthostatic effects. During a record review on 3/2/2025 at 9 p.m., with Licensed Vocational Nurse 5 (LVN), LVN 5 reviewed Resident 18's Medication Administration Record (MAR) and noted Entresto oral tablet 24-26 mg 1 tablet was administered as follows: 2/16/2025 at 9 a.m., blood pressure of 103/74. 2/24/2025 at 9 a.m., blood pressure 106/46. 2/24/2025 at 9 a.m., blood pressure 106/46. LVN 5 reviewed carvedilol 125 mg 1 tablet was administered as follows: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/14/2025 at 9 a.m., blood pressure 109/70 2/16/2025 at 9 a.m., blood pressure 103/74 2/23/2025 at 5 p.m., blood pressure 106/46 2/24/2025 at 9 a.m., blood pressure 106/46 2/20/2024 at 5 p.m., blood pressure 106/47. LVN 5 stated if a blood pressure was below the parameters (<110 SBP) the nurses were to hold the medication and chart the reason why the medication was held. LVN 5 stated the nurses were to then call the doctor and notify family. LVN 5 stated this was unsafe to give medication that was not within the parameters. LVN 5 stated administering medication outside of the parameters could cause a resident to become hypotensive, syncope (fainting), or vertigo (spinning in the head) which could lead to a fall. LVN 5 stated it was important to follow the parameters and guidelines. During a record review and interview on 3/2/2025 at 2:40 p.m., with LVN 6, LVN 6 stated she gave Resident 18 the Carvedilol oral tablet on 2/16/2025, 2/24/2025, Entresto oral tablet 2/16/2025 and 2/24/2025. LVN 6 stated the process was to administer blood pressure medications as written by the doctor if blood pressure was too low the resident did not need the medication, it must be held because the resident's blood pressure could drop making the resident worse. LVN 6 stated we must chart the reason why the blood pressure medication was given or why it was held and notify the doctor. During a record review interview on 3/2/2025 at 3:30 p.m. with the Director of Nursing (DON), the DON stated there were options on what to document on MAR to indicate the reason blood pressure medication was held. The DON stated if blood pressure medication was given outside of parameters the outcome could be the residents blood pressure would decrease drastically. The DON stated it was important to be accurate when charting. During a review of the facility's policy and procedures (P&P) titled, Administering Medication, undated the P&P indicated, medications were administered in a safe and timely manner, and as prescribed. The P&P indicated medications were to be administered in accordance with the prescribed orders, including any required time frame.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38740 Based on observation, interview and record review, the facility failed to follow the menu and provide residents a variety of food options when: 1. Resident 25, who did not want fish, received boiled diced chicken instead of baked chicken per menu. 2. Resident 28, who was on vegan plant-based diet, did not receive vegan options and vegan menu was not prepared. 3. Six residents who were on the renal diet (a diet intended for residents with impaired kidney function. The purpose is to provide adequate nutrition, prevent protein loss and manage fluid and electrolyte balance) received peas instead of oven French fries per menu. These deficient practices had the potential to result in inadequate nutrition status and meal dissatisfaction when the menu was not followed and updated to reflect the needs of the residents. Findings: 1. During a review of the facility lunch menu for the regular diet on 3/1/2025, the menu indicated the following items would be served: Regular diet: Breaded fish fillet 1 each; oven French fries 1/2 cup; buttered carrots 1/2 cup; chocolate cake/icing 1square; Milk; water. Renal Diet: Baked fish fillet 1 each; oven French fries 1/4 cup; buttered carrots 1/2 cup; chocolate cake/icing 1/2 square; beverages. Vegan Diet Pureed: pureed carrot cutlets; vegan mashed potatoes, buttered carrots; pureed fresh fruits, dairy free milk and water. Fish alternative: Baked chicken; oven French Fries; buttered carrots, chocolate cake and beverages. During a concurrent observation and interview with cook 1 on 3/1/2025, at 11:52 AM, there was a medium pan on the stove with chopped/diced chicken boiling in broth. [NAME] 1 stated she made the chicken for residents who do not want fish. She stated she boiled the chicken with water and seasonings. However, according to the lunch menu on 3/1/2025, for residents who do not want fish the alternative is baked chicken. During an observation of the tray line service for lunch on 3/1/2025 at 11:56 AM, Resident 25 who was on regular texture diet and according to diet order, dislikes fish, received chopped/diced chicken boiled in water, mashed potatoes and chopped buttered carrots instead of baked chicken and over French fries. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with [NAME] 1 and the DS on 3/1/2025 at 12:45 PM, Cook1 stated she made chopped chicken for residents who did not like fish. [NAME] 1 stated the menu is to use baked chicken, but she only had the diced chicken in the freezer and not the chicken breast or thigh. The DS stated lately the facility was having delays in their delivery, and they just received the regular chicken order to be ready for lunch. During a dining observation on 3/1/2025 at 1:00 PM, Resident 25 received his tray in his room, the tray included boiled diced chicken with the liquid running on the plate, mashed potato and diced carrots while the resident's meal ticket indicated baked chicken and oven French fries. During a review of the facility baked chicken recipe, the recipe indicted to arrange chicken thighs or breast fillet on a sheet, add seasoning, pour melted margarine over and bake. For mechanical soft, chop or grind the baked chicken and serve with gravy. 2. During observation of tray line service for lunch (a system of food preparation, in which trays move along an assembly line) on 1/3/2025, at 11:56 AM, for Resident 28 who was vegan plant based, [NAME] 2 served pureed carrots and mashed potato. During an interview with [NAME] 1 and [NAME] 2 on 3/1/2025, at 12:45PM, [NAME] 2 stated they did not have veggie patty, or anything prepared for the vegan menu. [NAME] 1 stated when making the mashed potato she added chicken bouillon powder (a flavoring made from concentrated chicken broth), [NAME] 1 stated chicken is not on vegetarian diet. During the same interview with the DS on 3/1/2025 at 12:45 AM, the DS stated she didn't know there is a resident who is vegan. During a review of Resident 28's meal ticket, the ticket indicated the resident is vegan plant based and will receive vegan carrot cutlet, vegan mashed potato, carrots, fresh fruits and nondairy beverage. During a dining observation on 3/1/2025 at 1:10 PM, Resident 28 was in the dining room while certified nursing assistant (CNA 1) assisting Resident 28 with food. CNA 1 stated the resident received pureed carrots and mashed potato for lunch. CNA 1 stated Resident 28 also received almond milk, thickened water and desert. CNA 1 stated the resident ate 100% of the meal. CNA 1 stated Resident 28 is vegetarian, and she (Resident 28) did not eat the fish or chicken that was served today. During the same observation and interview with Resident 28, Resident 28 stated she has been vegan since 1953. Resident 28 stated she doesn't eat chicken, fish, beef, eggs or dairy. During a review of Resident 28's meal ticket indicated Residents 28 will receive vegie cutlets, vegan mashed potato, buttered carrots, desert and non-dairy almond milk. 3. During observation of tray line service for lunch on 3/1/2025, at 11:56 AM, residents who were on renal diet received peas instead of oven French fries. During a concurrent observation and interview with [NAME] 1 and [NAME] 2 at 11:56 AM, [NAME] 2 stated residents on renal diet received peas instead of the potato. [NAME] 2 stated potatoes are not allowed on the renal diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and review of the menu with Cook1 and [NAME] 2 at 11:56 AM, both cooks stated they didn't check the menu, and they should have served French fries not the peas. During an interview with the DS on 3/1/2025 at 12:45PM, the DS stated the cooks should follow the menu. During a review of facility policy and procedure (P&P) titled Menus (revised 2017), the (P&P) indicated, If a food group is missing from a resident's daily diet (e.g. dairy products), the resident is provided an alternate means of meeting his or her nutritional needs (e.g., calcium supplementation or fortified non-dairy alternatives). During a review of facility P&P, titled Liberal Renal Diet (Revised 2025), the P&P indicated Renal diet restrictions are based on current recommendations. The nutritional needs of kidney patients are often specific to the individual, this diet may not fit the needs of every kidney patient .a Registered dietitian should be consulted foe an individualized assessment and recommendations. During a review of cook's job description (revised 2020), the job description indicated, Duties and responsibilities include: Inspect special diet trays to assure that the correct diet is served to the resident; review menus prior to preparation of food, prepare food in accordance with standardized recipe, planned menus and special diet orders, prepare and serve meals that are palatable and appetizing in appearance.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 38740 Based on observation, interview and record review, the facility failed to ensure: 12 residents on pureed diet received the correct pureed diet texture (foods that do not require chewing and are easily swallowed. Food should be smooth .consistency of pudding) as ordered when the cook served thin and soupy carrots instead of pureed carrots that was homogenous (of the same kind; alike), cohesive and had a pudding like consistency. This deficiency had the potential to result in meal dissatisfaction and increased choking and aspiration risk for residents on pureed diet. Findings: During an observation of the tray line service for lunch on 3/1/2025 at 11:56AM, residents who were on pureed diet received carrots that was soupy and thing liquid consistency. During a concurrent observation and interview with [NAME] (Cook 1), [NAME] 1 said she added liquid to the carrots and blended until smooth. During an interview with [NAME] 1 and Dietary Supervisor (DS) on 3/1/2025 at 12:45PM, [NAME] 1 stated she agreed that the carrots had liquid consistency. [NAME] 1 stated she should have used less water. The DS explained to [NAME] 1 to start with less water and slowly add water to the pureed mix. The DS stated pureed food consistency should be like pudding. The DS stated thin consistency pureed food is a risk for choking, especially for residents who are pureed and on thickened liquids. During a review of the recipe for buttered carrots, the recipe indicated for pureed, to take drained portions needed from the regular prepared recipe and process until fine .add thickener and liquid and process until smooth .final product should pass the spoon tilt test (where the pureed product fall from a spoon when tilted and on the plate, intact) During a review of facility policy and procedure (P&P) titled Dysphagia (difficulty swallowing) Diets Puree IDDSI Level 4 (revised 2025), the P&P indicated, Definition: food texture prepared lump-free, not firm or sticky and holds it shape on a plate .Any liquids must not separate from the food and the food can fall of a spoon intact .food is easily swallowed and prevents aspiration .Should have a pudding like smooth consistency without lumps.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38740 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food preparation practices in the kitchen when one can opener blade was dented and stained with dried brown residue. This deficient practice had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness in out of residents who received food from the facility. Findings: During an observation in the kitchen food preparation area on 2/28/2025 at 6:30PM, one can opener blade was observed worn and dented. The blade was not smooth to touch, was stained, covered with brown residue and metal shavings. During a concurrent observation and interview with Dietary Supervisor (DS) on 2/28/2025 at 6:35PM, the DS verified that there were metal shavings around the blade and the blade had dents. DS stated can opener needs to be washed. The DS stated she was new and did not know when the last time the blade was changed. The DS stated she will immediately replace the blade to prevent cross contamination. During a review of facility policy and procedure (P&P) Sanitization (Revised 2022), the P&P indicated, All utensils .equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped area that may affect their use or proper cleaning. During a review of the 2022 U.S. Food and Drug Administration Food Code titled Good Repair and proper Adjustment Code # 4-501.11(C), the Food Code indicated, Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate food when the container is opened. During a review of 2022 Food Code titled, Can Openers Code# 4-202.15, the Food Code indicated, Once can openers become pitted or the surface in any way becomes uncleanable, they must be replaced because they can no longer be adequately cleaned and sanitized.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation and interview, the facility failed to ensure the treatment nurse (TN) 1 changed gloves after removing a soiled dressing from Resident 13 and applying a clean dressing. This deficient practice had the potential to result in spread of infection and can lead to a delay in wound healing process. Finding: During a concurrent observation and interview on 3/1/2025 at 9:48 a.m., TN 1 was observed applying gloves and removing a soiled dressing from the right foot of Resident 13. TN 1 proceeded to clean the wound with normal saline (NS- sterile, clear solution containing 0.9% sodium chloride (NaCl) without changing gloves. TN 1 pat dry the wound. TN 1 did not change her gloves and applied Betadine Solutions (topical antiseptic), and cover wound with dry gauze. TN 1 removed gloves, sanitized hands, and applied clean gloves. TN 1 then proceeded to change the dressing from the left heel wound. TN 1 removed soiled dressing, did not change gloves and cleaned the wound with NS. TN 1 applied Calcium Alginate External Miscellaneous (high absorption dressing for highly exuding wounds; creates moist wound environment conducive to healing) and applied clean dressing using the same gloves. TN 1 removed gloves, sanitized hands, applied clean gloves, and proceeded to change the right buttocks dressing of the resident. TN 1 cleaned the wound with NS did not change gloves and applied Medi honey gel (supports the removal of necrotic tissue and aids in wound healing), and cover with board dressing. The TN stated when providing wound care, We need to change gloves every time the wound was touched. TN 1 stated, When I removed the soiled dressing, I should change the gloves before cleaning the wound. TN 1 stated, I should sanitize hands, apply clean gloves and proceed to apply clean dressing. TN 1 stated it was important to do it to prevent cross contamination and the wound to get infected. TN 1 stated not following proper wound care can delay wound healing process. TN 1 stated the policy of the facility was to change gloves and follow infection control practices. During a review of Resident 13's Admission Record, the Admission Record indicated Resident 13 was admitted to the facility on [DATE] and re admitted on [DATE] with diagnoses including Alzheimer's disease, (a disease characterized by a progressive decline in mental abilities), muscle waste and atrophy (loss of muscle mass and strength), and lack of coordination (difficulty in controlling and coordinating muscle movements). During a review of Residents 13's Minimum Data Set (MDS - a resident assessment tool), dated 8/20/2024, the MDS indicated Resident 13 rarely/ never make self-understood and rarely/never understand others. The MDS indicated Resident 13 required dependent assistance with Activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) transfer and bed mobility. During a review of the Physician's Orders (PO) indicated Resident 13 had an order for Betadine external solution 10% (povidone - iodine), apply to right 1st, right 4th toes topically everyday shift for arterial ulcer cleanse with NS, pat dry, paint with betadine. (continued on next page)

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 03/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Gardens Convalescent Hospital	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 13's PO indicated Resident 13 has an order for Calcium Alginate External Miscellaneous, apply to left heel topically everyday for arterial ulcer. Cleanse with NS, pat dry, apply AG Alginate cover with gauze the dry dressing. During a review of Resident 13's PO indicated Resident 13 has an order for Medi honey external gel, apply to right buttocks topically every day shift for pressure ulcer. Cleanse with NS, pat dry, apply Medi honey cover with dry dressing. During an interview on 3/1/2025 at 5:49 p.m. with Infection Preventionist (IP) nurse, the IP stated TN 1 will remove soiled dressing sanitized hands and applied clean gloves. The IP stated after cleaning the wound, the gloves are changed and with clean gloves applied clean dressing. The IP stated nurses changed gloves for infection control. The IP stated nurses need to prevent any bacteria to growth in the wound. The IP stated it was important to keep the wound clean. The IP stated not changing gloves while providing wound care can contaminated the wound. The IP stated Resident 13 could be at risk for infection and delay in wound healing. During an interview on 3/2/2025 at 11:59 a.m. with the Director of Nursing (DON), the DON stated the TN 1 should check doctors' orders get all supplies and make sure the wound care was done correctly. The DON stated the TN 1 needed to wash hands and changed gloves. The DON stated with any dirty field, nurses must change gloves. The DON stated aseptic technical needs to be maintain, every time we removed soiled dressing the hands need to be sanitized and apply clean gloves. The DON stated we do it to prevent infection. The DON stated nurses responsibility is to avoid the wound to be expose for further infection. During a review of the facility's policies and procedures (P&P) titled, Hand washing/hand Hygiene dated 9/18/2023, the P&P indicated single -use disposable gloves should be used: before aseptic procedures; when anticipating contact with blood or body fluids; and when in contact with resident, or equipment or environment of a resident. The P&P Infection Prevention and control dated 2/6/2025, the P&P indicated to help maintain a safe, sanitary, and to help prevent and manage transmission of disease and infections. Provide evidence-based guidelines for infection prevention and control based on current best practice.