

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056451	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/08/2024
NAME OF PROVIDER OR SUPPLIER  Windsor Care Center of Cheviot Hills		STREET ADDRESS, CITY, STATE, ZIP CODE  3533 Motor Avenue Los Angeles, CA 90034	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903</b></p> <p>Based on observations, interviews and record reviews, the facility failed to protect the resident's right to be free from abuse for one of three Residents (Resident 1).</p> <p>As a result, on 4/5/24 Resident 2 punched Resident 1 (Resident 2's roommate) in the face, resulting in a cut to Resident 1's lip.</p> <p>Findings:</p> <p>A review of Resident 1's Face Sheet indicated the resident was admitted to the facility on [DATE], with diagnoses that included unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life).</p> <p>A review of Resident 1's History and Physical (H&amp;P) dated 1/30/24, indicated, Resident 1 did not have the capacity to understand and make decisions. H&amp;P indicated Resident 1 was yelling, unable to calm down, and lashing out at individuals both staff and family.</p> <p>During a review of Resident 1's Minimum Data Set (MDS; a standardized assessment and care screening tool) dated 2/2/24, indicated Resident 1 did not have intact cognition (mental ability to remember, learn new things, concentrate, or make decisions that affect everyday life). MDS indicated Resident 1 required assistance from staff for eating, hygiene (oral and physical), and toileting.</p> <p>A review of Resident 2's Face Sheet indicated the resident was admitted to the facility on [DATE], with diagnoses that included: major depressive disorder (decreased interest in pleasurable activities, feelings of guilt or worthlessness, lack of energy, poor concentration, appetite changes, psychomotor retardation or agitation, sleep disturbances, or suicidal thoughts) and anxiety disorder (persistent and excessive worry that interferes with daily activities).</p> <p>A review of Resident 2's H&amp;P dated 8/2/23 indicated, Resident 2 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 2's MDS, dated [DATE], indicated Resident 2 had intact cognition and required assistance from staff for eating, hygiene (oral and physical), and toileting.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Change in Condition Evaluation (COC) dated 4/5/24, indicated, [Resident 1] had redness on the right side of the face and minor skin tear on upper lip. [Resident 1] stated [Resident 2] hit him in the face.</p> <p>A review of Resident 1's Care Plan titled, Resident has behavioral problem related to agitated/disruptive behavior indicated, Goal: Resident episodes of behavioral problem will be less than 7 to 10 times a day for 90 days. The care plan did not have timeframes, initiation date, or revision date documented on care plan.</p> <p>A review of Resident 1's Social Services Assessment and Documentation dated 1/31/24, indicated, Resident is awake, alert with confusion and cognitive decline due to diagnosis of dementia.</p> <p>A review of Resident 2's Order Summary Report, indicated a physician's order to, Monitor for episodes of agitation, screaming and aggressive behaviors toward staff and others every shift.</p> <p>A review of Resident 2's Change in COC dated 4/5/24, indicated, [Resident 1] was found on [Resident 2's] bed with redness on the right side of the face and lips. [Resident 2] states [Resident 1] was going through his personal belongings and when he tried to stop him, he scratched his left middle finger, so he returned to defend himself.</p> <p>During an interview with Director of Nursing (DON) on 4/8/24 at 9:33 AM, DON stated, [Resident 1] has dementia, is forgetful, he said he was in the bed area near [Resident 2] trying to pick up something, then Resident 2 came in and yelled at him. Resident 1 got startled and scuffle ensued.</p> <p>During an interview with Licensed Vocational Nurse (LVN) on 4/8/24 at 10:58 AM, LVN stated, I saw redness on rt eye area of [Resident 1]. [Resident 1] is ambulatory and walks around, is confused, sometimes is aware and sometimes he's not. If a resident has dementia there should be behavioral monitoring orders. There should be an order. LVN stated there were no orders to monitor Resident 1's behavior and no documentation of Resident 1's behavior in resident's medical chart and electronic medical record (eMAR). LVN stated, There is a safety consequence if there is no monitoring for behavior and a resident has dementia.</p> <p>During an interview with Resident 2 on 4/8/24 at 7:30 AM, Resident 2 stated, [Resident 1] was going through my things, my blanket, he was dribbling and wiping it on my stuff, I did yell at him, he surprised me. He attacked me: he was punching me, trying to hit me in the face. I wanted him to get away from my stuff and he went off on me. I put my hands up and I got my left middle finger cut. He cut me with his nail, I was just blocking. He would act eccentric; he would spit on the floor. As long as I could see him doing I could avoid it. It happened very fast. I was next to my bed using my wheelchair when I saw him going through my things and dribbling on them. Afterwards somebody came in, I was yelling because he usually responds to that.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review with DON, on 4/8/24 at 1:04 PM, Resident 1's Order Summary was reviewed. DON stated, there is no order for monitoring his behavior or order for care plan found in the eMAR. Dementia needs a lot of redirection, they can forget their room, be wandering, monitoring is important, safety, eating, mostly they are only alert to name and place. DON stated the residents can be doing things they are not supposed to and can be going to another patient. DPN stated monitoring resident's behavior is important, residents can be very confused, and the roommate might not understand residents with dementia and get upset. DON stated the charge nurse can initiate the care plan without a doctor's order and should monitor residents for safety. DON stated abuse can be prevented with further monitoring. DON stated care plans are made to have a better outcome, evaluation of effectiveness of interventions.</p> <p>A review of the facility's policy and procedures (P&amp;P) titled, Behavior Management dated 2/1/23, indicated, The interdisciplinary team identifies underlying medical, psychosocial, and psychiatric causes that contribute to resident's behavior. Staff ensures a resident diagnosed with mental disorder receives appropriate treatment and services.</p> <p>A review of the facility's P&amp;P titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 4/21, indicated, Residents have the right to be free from abuse. The resident abuse, neglect and exploitation prevention program consists of a facility wide commitment and resource allocation to support the following objectives: Develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents.</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48903</p> <p>Based on observations, interviews and record reviews, the facility failed to obtain a physician ' s order for behavior monitoring and implement behavior monitoring for signs and symptoms of dementia ((loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) for one of three Residents (Resident 1).</p> <p>As a result, on 4/5/24 Resident 2 punched his roommate (Resident 1) in the face, resulting in a cut to Resident 1 ' s lip.</p> <p>Cross Reference F600</p> <p>Findings:</p> <p>A review of Resident 1 ' s Face Sheet indicated the resident was admitted to the facility on [DATE], with diagnoses that included unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life).</p> <p>A review of Resident 1 ' s History and Physical (H&amp;P) dated 1/30/24, indicated, Resident 1 did not have the capacity to understand and make decisions. H&amp;P indicated Resident 1 was yelling, unable to calm down, and lashing out at individuals both staff and family.</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS; a standardized assessment and care screening tool) dated 2/2/24, indicated Resident 1 did not have intact cognition (mental ability to remember, learn new things, concentrate, or make decisions that affect everyday life). MDS indicated Resident 1 required assistance from staff for eating, hygiene (oral and physical), and toileting.</p> <p>A review of Resident 1 ' s Change in Condition Evaluation (COC) dated 4/5/24, indicated, [Resident 1] had redness on the right side of the face and minor skin tear on upper lip. [Resident 1] stated [Resident 2] hit him in the face.</p> <p>A review of Resident 1 ' s Care Plan titled, Resident has behavioral problem related to agitated/disruptive behavior indicated, Goal: Resident episodes of behavioral problem will be less than 7 to 10 times a day for 90 days. There are no timeframes, initiation date, or revision date documented on care plan.</p> <p>A review of Resident 1 ' s Social Services Assessment and Documentation dated 1/31/24 indicated, Resident is awake, alert with confusion and cognitive decline due to diagnosis of dementia.</p> <p>During a review of Resident 1 ' s Order Summary Report, indicated, there was no physician ' s order placed for behavior monitoring due to dementia.</p> <p>(continued on next page)</p>

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