STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056451	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Care Center of Cheviot Hills	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on observation, interview, and record review, the facility failed to implement its' policy and procedure (P&P) by failing to ensure prompt physician notification of one of the three sample residents (Resident 2) when Resident 2 had chills on 10/18/2024 at 3:47 pm and 10/18/2024 at 11:49 pm. As a result of this deficient practice, Resident 2 was found to have Altered Mental Status (AMS -a change in mental function that stems from illnesses, disorders and injuries affecting your brain)and was transferred to General Acute Care Hospital (GACH) where she was diagnosed with sepsis (a life-threatening blood infection), Urinary Tract Infection (UTI- an infection in the bladder/urinary tract). Findings: During a review of the admission record indicated Resident 2 was i admitted to the facility on [DATE] with diagnoses that included sepsis, and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 2 ' s History and physical (a term used to describe a physician's examination of a patient. In an H&P, the physician obtains a thorough medical history from the patient, performs a physical examination, and then documents their findings) dated 10/4/2024 indicated Resident 2 had capacity for decision making). During a review of Resident 2 ' s care plan initiated 10/4/2024 for Resident 2 ' s indwelling catheter (a thin, flexible tube that is inserted into the bladder to drain urine), indicated a goal of The resident (Resident 2) will show no s/sx (signs and symptoms of urinary infection, included the following interventions: Monitor/record/report to MD for s/sx UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp (body temperature), urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s Minimum Data Set (MDS - a esident assessment tool) dated 10/8/2024, the MDS indicated Resident 2 was cognitively intact (had sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The same MDS indicated Resident 1 was required substantial/maximal assistance for most of her Activities of Daily Living such as: (ADLs - ADLs- routine tasks/activities such as bathing, lower body dressing, toileting hygiene) and partial/moderate assistance for oral hygiene, upper body dressing, personal hygiene. During a review of Resident 2 ' s progress note dated 10/18/2024 at 3:47 pm indicated, Resident 2 Resident was noted shaking and were given blankets & hot packs. During a review of Resident 2 ' s progress note dated 10/18/2024 at 11:49 pm indicated, Resident 2 Resident was noted shaking and were given blankets & hot packs. During a review of a Change of Condition (COC) dated 10/28/2024 at 8:01 am, indicated Resident appeared to have altered mental status and seems more lethargy (a state of feeling drowsy, tired, or lacking mental alertness) during breakfast rounds, upon assessment resident was noted hypotensive (low blood pressure lower than 90/60), o2 sat (Oxygen saturation, or O2 sat, is a measure of how much oxygen is in your blood normal between 95 to 100 percent [%]) of 89% on RA (room air), responds to pain by opening eyes but unable to answer questions. Oxygen was provided via NC (nasal cannula- via a tube that goes in your nose) at 5L (liters) initially, o2 sat rechecked at 97%, gradually decreased o2 to 3L_and o2 sat stabilized at 96-97% on 2L of oxygen. Rechecked _bp noted 84/40. MD notified. The same COC indicated Resident 2 was transferred to the hospital. During a review of a transfer form for Resident 2 dated 10/28/2024 at 8:28 am, the form indicated Resident 2 was transferred to GACH on 10/28/2024 at 8:30 am for the following reasons: AMS appears to be lethargic, hypotensive. During an inter with the Assitant Director of Nursing (ADON), on 11/6/24 at 2:15 pm, the ADON stated that Resident 2 ' s physician should have been notified promptly when Resident 2 was noted to be shaking both times on 10/18/2024 given that she had a foley catheter and a history of UTIs/sepsis. The ADON confirmed that chills was one of the symptoms the facility should have been monitoring per Resident 2 ' s care plan. During a review of the facility's P&P titled Change in a Resident's Condition or Status, revised 10/21/2024 the P&P indicated the policy statement Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The same P&P indicated under policy interpretation and implementation: - significant change in the resident's physical/emotional/mental condition.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who had a history of falls, and identified to have fall risk indicators was not left unattended sitting on bed by the Certified Nursing Assistant (CNA) 1 on 11/5/2024. This failure resulted in Resident 1 had a fall on 11/5/2024 at 12:12 am and was sent to General Acute Care Hospital (GACH) on 11/5/2024. Resident 1sustained a mildly displaced right 10th through 12th rib fracture and right 10th rib fracture is segmental (happen when one of your bones is broken in at least two places, leaving a segment of your bone totally separated by the breaks). Findings: During a review of Resident 1 ' s admission record, the record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including history of falling, unsteadiness on feet, and need for assistance with personal care. During a review of Resident 1 ' s History and physical (H&P, a term used to describe a physician's examination of a patient. In an H&P, the physician obtains a thorough medical history from the patient, performs a physical examination, and then documents their findings) dated 10/4/2024 it indicated Resident 1 did not have the capacity for medical decision making due to cognitive decline (the mental processes that allow people to think, understand, and complete tasks). During a review of Resident 1 ' s Nursing documentation evaluation dated 10/2/2024 at 4:55 pm, the nursing documentation evaluation indicated under the fall risk factor Fall Risk Indicators Identified. During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 10/7/2024, indicated Resident 1 had moderate cognitive impairments (a stage of cognitive decline where a person has significant difficulty with complex tasks and may become confused about their surroundings). The same MDS indicated Resident 1 was required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs) for most of her Activities of Daily Living such as: (ADLs - ADLs- routine tasks/activities such as bathing, dressing, toileting hygiene) and partial/moderate assistance for oral hygiene, personal hygiene. During a review of a Change of Condition (COC) dated 11/5/2024 at 12:12 am, it indicated Resident 1 had a fall on 11/5/2024. Resident 1 was seen sitting on the floor next to the foot of the bed in her room and had pain 10/10 (10 being the worst) to the back after the fall. The same COC indicated Resident 1 was transferred to the hospital per her request and MD (Medical Doctor) was made aware. During a review of a physician ' s order dated 11/5/2024 indicated Transfer to Acute hospital via 911 (a three-digit number that people in the United States can call to request emergency assistance) for further eval (evaluation) s/p (status post-after) fall. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s care plan initiated 10/4/2024 indicated Resident 1 was at risk for falls: impaired mobility. The interventions included to monitor for and assist with toileting needs. During a review of the computed tomography scan (CT scan - a noninvasive medical imaging procedure that uses X-rays (a type of electromagnetic radiation that can pass through most objects, including the human body, to create images of internal structures) and a computer to create detailed pictures of the inside of the body) dated 11/5/2024 at 4:57 am indicated Recent appearing mildly displaced right 10th through 12th rib fractures. Right 10th rib fracture is segmental. During an interview with Family Member (FM) 1 on 11/6/24 at 10:54 am, FM 1 stated she spoke with the Licensed Vocational Nurse (LVN) 1 who informed her that Resident 1 had a fall earlier that morning and had requested to be sent to GACH because was experiencing severe pain which had not resolved after taking some pain medication. FM 1 stated that she (FM 1) called GACH where Resident 1 was admitted and was informed that Resident 1 had a right hip and several rib fractures which she did not have before. During an interview with LVN 1 on 11/6/2024 at 1:45 pm, LVN 1 stated that Resident 1 was incontinent (the inability to control the flow of urine or stool) of bowel and bladder but did not get up overnight (on 11/5/2024). LVN 1 stated she changed the Resident 1 incontinence briefs in bed. LVN 1 stated that she heard a scream coming from Resident 1 ' s room around midnight and when she got there, she found Resident 1 on the floor. LVN 1 stated CNA 1 who was assigned to her (Resident 1) reported that Resident 1 asked to go be taken to the bathroom. CNA 1 sat Resident 1 on the side of her bed with her feet on the floor and went to the bathroom to get it prepared. While in the bathroom, she (CNA) heard Resident 1 scream, ran back to the room, and found her (Resident 1) on the floor. She stated that Resident 1 was a fall risk should not have been taken out of bed and left unsupervised. During an interview with the Assistant Director of Nursing (ADON), on 11/6/24 at 2:15 pm, the ADON stated that Resident 1 was a fall risk because she had a history of falls, had some cognitive impairments, and had a (history of) humerus (shoulder bone) fracture. ADON stated that Resident 1 should not have been left sitting at the bedside unsupervised to prevent falls. During a review of the facility ' s policy and procedure (P&P) titled Fall Management, with an effective date 5/26/2021, the P&P indicated, To reduce risk for falls and minimize the actual occurrence of falls. The same P&P indicated; Patients will be assessed for falls risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury.