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	04/03/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42342 Based on interview and record review for one of three sampled residents (Resident 2), the facility failed to develop a care plan for the left foot treatments. This deficient practice had the potential to led to the development of redness to the left heel. Findings: A review of Resident 2's admission record indicated the facility admitted this [AGE] year-old male on 2/3/2025 with diagnoses including peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), Type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), atherosclerosis (chronic disease where sticky substances build up in the inner lining of the arteries) of right leg with gangrene (dead tissue caused by infection or lack of blood flow), atherosclerosis of aorta (largest blood vessel in the body), atherosclerotic heart disease, hypertensive heart disease (heart issues related to high blood pressure), presence of coronary angioplasty implant and graft (procedure where balloon is inserted into heart arteries to widen and improve blood flow), specified disorder, chronic obstructive pulmonary disorder (COPD-a chronic lung disease causing difficulty in breathing), hyperlipidemia (high fat in the blood), scoliosis (curvature in the spine), unilateral (on one side) osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) left hip. A review of Resident 2's Minimum Data Set (MDS-a resident assessment) dated 2/7/2025 indicated Resident 2's cognition (mental ability to make decisions for daily living) was intact. The MDS indicated Resident 2 was dependent (helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting, personal hygiene, and transfers (moving between surfaces) from bed to chair. Lastly, Resident 2 was identified at risk for developing a pressure injury and did not currently have any pressure injuries. (continued on next page)

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/3/2025 at 2:51 p.m. with the DON. Resident 2's physician order dated 2/4/2025 was reviewed. Resident 2's physician order indicated to apply A&D ointment (skin moisturizer) to left foot/toes excessive dryness, leave open to air and monitor for skin breakdown every dayshift. The DON stated, This is considered a treatment order so we should have care planned some interventions for the left foot. The DON stated Resident 2 was at risk for developing a pressure injury due to his medical condition. The DON stated some interventions to prevent pressure ulcers included providing heel protector boots (boots used to reduce the risk of bed sores by keeping the heel floated, reliving pressure), low air loss (LAL- mattress designed to distribute body weight over a broad surface area to help prevent skin breakdown) mattress if appropriate and monitoring the skin daily. Lastly, the DON confirmed no care plan was developed for the care of Resident 2 ' s left foot. During a review of the facility's policy and procedure (P&P) titled,Skin Integrity Management, reviewed 10/2024, the P&P indicated, .Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments as indicated. Implement pressure ulcer prevention for identified risk factors. 4.2 Determine the need for support surface for bed and chair. 4.3 Determine the need for offloading devices. 4.4 Turning and repositioning based on resident care needs 4.5 For surgical wounds (e.g., flaps, grafts, donors, incisions, etc.), follow specific orders from the surgeon. 4.6 Implement Special Wound Care treatments/techniques, as indicated and ordered. A review of the facility policy and procedure titled, Care plans, comprehensive, person-centered reviewed 10/2024 indicated, [.] Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment.

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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 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** 42342 Based on observation, interview and record review for one of three sampled residents (Resident 2), the facility failed to monitor skin and report redness on Resident 2's left heel to the attending physician (AP). This deficient practice placed Resident 2 at risk of developing a pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) to the left heel. Findings: A review of Resident 2's admission record indicated the facility admitted this [AGE] year-old male on 2/3/2025 with diagnoses including peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), Type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), atherosclerosis (chronic disease where sticky substances build up in the inner lining of the arteries) of right leg with gangrene (dead tissue caused by infection or lack of blood flow), atherosclerosis of aorta (largest blood vessel in the body), atherosclerotic heart disease, hypertensive heart disease (heart issues related to high blood pressure), presence of coronary angioplasty implant and graft (procedure where balloon is inserted into heart arteries to widen and improve blood flow), specified disorder, chronic obstructive pulmonary disorder (COPD-a chronic lung disease causing difficulty in breathing), hyperlipidemia (high fat in the blood), scoliosis (curvature in the spine), unilateral (on one side) osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) left hip. A review of Resident 2's Minimum Data Set (MDS-a resident assessment tool) dated 2/7/2025 indicated Resident 2's cognition (mental ability to make decisions for daily living) was intact. The MDS indicated Resident 2 was dependent (helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting, personal hygiene, and transfers (moving between surfaces) from bed to chair. Lastly, Resident 2 was identified at risk for developing a pressure injury and did not currently have any pressure injuries. On 4/1/2025 The California Department of Public Health (CDPH) received a complaint alleging a resident developed pressure ulcer while in the facility. During an interview on 4/3/2025 at 12:03 p.m. with the Ombudsman (OMBUDS-an advocate for residents of nursing homes, board and care centers, and assisted living facilities). The OMBUDS visited Resident 2 a week prior because Resident 2 informed the facility there was a possible pressure ulcer developing on Resident 2's heels and Resident 2 did not feel as if the facility addressed this concern. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/3/2025 at 12:12 p.m. with Resident 2. in Resident 2's room, Resident 2 was lying in a regular mattress, two heel protector boots (boots used to reduce the risk of bed sores by keeping the heel floated, reliving pressure) were observed in the chair next to the bed, Resident 2 ' s right foot was wrapped in a clean gauze dressing and Resident 2's left foot was covered with a non-skid sock. Resident 2 stated, I feel like I was getting a bed sore or my right butt and, on my heels, I asked them to check while they are giving me a bath and they just say no you don ' t have one. I told them this about two weeks ago and I told the doctor during a video call. The doctor just said I needed to get out of bed and sit in a chair. I had a partial amputation on my right foot, and they change the dressing every day. They did not put any lotion or cream on my left foot today but that is normal; sometimes they do sometimes they don ' t. They did not put those boots on today nor last night, its hurts when I wear them on the right foot, but I haven ' t tried wearing them on just the left foot because they don ' t put them on. I overheard one of the unnamed staff nurses telling them to put the boots on me for two hours and then take them off for one hour, but no one has done that. During an interview on 4/3/2025 at 12:33 p.m. with the certified nursing assistant (CNA). The CNA stated the skin on Resident 2's left foot was very dry and needed A&D ointment. The CNA stated, I can't do it so I told the treatment nurse, I did not put anything on the left foot today after the bed bath. Lastly, the CNA stated, I did not notice any redness of Resident 2's skin today. During an interview on 4/3/2025 at 12:50p.m. the licensed Vocational Nurse (LVN) treatment nurse stated, Resident 2 has gangrene on the right foot, and I see him everyday and change the dressing. Resident 2 does not have any wounds on the left foot just dry skin. I believe we are doing A&D ointment for the dry skin. I usually apply it because it is considered a medication. No, it was not done this morning when I did the treatment on the right foot. During a concurrent observation and interview on 4/3/2025 at 1:27 p.m. with the LVN in Resident 2's room, Resident 2's sock was removed from left foot and the left foot was observed. A large amount of skin flakes feel from sock as sock was removed and the heel appeared reddened with a an approximate quarter sized area black area at the base of the heel. The LVN pushed on the reddened area and Resident 2 jumped in response. The LVN stated, I see some redness and a scab, usually the CNA is good about reporting any redness, but no one told me about any redness on the left heel today, I will have to call the doctor and do a COC. During a concurrent interview and record review on 4/3/2025 at 2:38 p.m. with the director of nursing (DON). Resident 2's change of condition (COC-document used to report a change in resident ' s health status that requires action) form dated 3/18/2025 was reviewed. Resident 2's COC form indicated Resident 2 developed a deep tissue injury (DTI- a serious form of pressure injury where damage occurs to the underlying tissue and appears as a purple or maroon discoloration on the intact skin). On the right heel. The DON stated Resident 2 was at risk for pressure ulcer due to Resident 2 ' s medical diagnoses. The DON stated the prevention measure in place were the heel protector boots. The DON stated a low air loss (LAL- mattress designed to distribute body weight over a broad surface area to help prevent skin breakdown) mattress would not have been appropriate because Resident 2 did not have and wounds on the back. Lastly, the DON stated the CNA ' s are also a second set of eyes to monitor the skin and report and changes. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/3/2025 at 2:51 p.m. with the DON. Resident 2's physician order dated 2/4/2025 was reviewed. Resident 2's physician order indicated to apply A&D ointment (skin moisturizer) to left foot/toes excessive dryness, leave open to air and monitor for skin breakdown every dayshift. The DON stated, This should be done every shift by the treatment nurse. If the treatment nurse noticed and redness or skin changes to the left foot the doctor should be notified because the treatment orders may need to be changed. During an interview on 4/4/2025 at 11:56 a.m. The AP stated Resident 2 refused to wear the boots and that may have contributed to the development of the DTI on the right heel along with Resident 2's history of PVD. The AP stated the facility informed the AP of the redness to Resident 2's left foot on 4/3/2025 and instructed them to follow their protocol which would include encouragement to wear the protective heel boots. During a review of the facility's policy and procedure (P&P) titled, Change in Condition, reviewed 10/2024, the P&P indicated: I.PURPOSE To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition. II.POLICY A Facility must immediately inform the resident, consult with the Resident's physician and/or NP, and notify, consistent with his/her authority, Resident Representative where there is: An accident involving the Resident. A significant change in the Resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications). A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or A decision to transfer or discharge the Resident from the Center. A review of the facility policy and procedure titled, Skin integrity management reviewed 10/2024 indicated the implementation of an individual patient's skin integrity management occurs within the care delivery process. Staff continually observes and monitors patients for changes and implements revisions to the plan of care as needed. Notify Medical Director, Director of Nursing (DON), Administrator, and or Designee if deviation from protocol is requested by physician/advanced practice provider (APP), managed care companies, or others. [.] Nursing staff will observe for any sign of potential or active pressure injury daily while providing nursing care.