STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555738	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Terrace Health Care	7447 Sepulveda Blvd Van Nuys, CA 91405

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. 42275 Based on interview and record review, the facility failed to notify one of three sampled residents (Resident 1) physician, when on 5/19/2024, Resident 1's blood pressure (BP - pressure of circulating blood against the walls of blood vessels, normal range less than 120/80 millimeters of mercury [mmHg - unit of measure]) was low and Licensed Vocational Nurse 1 (LVN 1) failed to administer Atenolol (a medication used to treat hypertension [high blood pressure]) due to parameters (specific measurements or factors used such as to hold medications if out of range) being out of range. These deficient practices had the potential to cause a delay of obtaining appropriate medical treatment and interventions for which could have resulted in a negative impact to Resident 1's well-being. Findings: A review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 5/3/2024 with diagnoses that included hypertension and atrial fibrillation (an irregular, rapid heart rhythm). A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care-planning tool), dated 5/7/2024, indicated Resident 1's cognition (ability to think and make decisions) was intact. The MDS further indicated Resident 1 needed maximum assistance from staff with oral hygiene, upper body dressing, and bed mobility (movement) of rolling left and right. The MDS indicated Resident 1 was dependent on staff with toileting hygiene, bathing, and lower body dressing. A review of Resident 1's Physician's Order dated 5/5/2024, indicated to administer Atenolol 50 milligrams (mg- unit of measure) one (1) tablet orally one time a day for hypertension, with parameters to hold if systolic BP (SBP - indicates how much pressure your blood is exerting against your artery walls when the heart contracts) is less than (<) 100 mmHg or heart rate (HR - number of times your heart beats per minute [bpm], normal range for adult is 60 to 100 bpm) is < 60 bpm. A review of Resident 1's Medication Administration Record (MAR - a document of the medications administered to a resident on a day-to-day basis) for 5/2024, indicated that LVN 1 held (medication not given due to parameters being out of range) Atenolol on 5/19/2024 at 9:00 a.m. and documented 'not given' however the SBP and HR results obtained were not documented. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with Director of Nursing (DON) on 5/24/2024 at 1:14 p.m., the DON reviewed Resident 1's physician orders dated 5/5/2024 for Atenolol and the MAR for 5/2024. The DON stated that on 5/19/2024, LVN 1 should have document what the actual SBP reading, and pulse rate were in Resident 1's progress notes when LVN 1 held the administration of Atenolol at 9:00 a.m. The DON stated LVN 1 should have also notified Resident 1's physician the reason why Atenolol was not given. During a concurrent interview and record review with LVN 1 on 5/28/2024 at 4:20 p.m., LVN 1 reviewed Resident 1's physician orders dated 5/5/2024 for Atenolol and the MAR for 5/2024. LVN 1 stated that LVN 1 did not administer the Atenolol as ordered to Resident 1 on 5/19/2024 at 9:00 a.m. due to the low SBP reading obtained that was out of range. LVN 1 stated she did not document the actual SBP reading, or pulse rate obtained on 5/19/2024 and did not notify Resident 1's physician. LVN 1 was unable to recall Resident 1's specific SBP result and pulse rate result. LVN 1 stated that she should have notified the physician of Resident 1's low SBP so that the physician can decide how to manage and treat Resident 1's low SBP. During an interview with Resident 1's Physician (Physician 1) on 5/28/2024 at 4:29 p.m., Physician 1 stated that if a medication was held due to a low SBP, Physician 1 would determine treatment depending on the resident's condition. Physician 1 further stated treatment for low SBP may include administering intravenous (IV- within a vein) fluids to increase a low BP, or to monitor the BP for further changes. Physician 1 stated he did not receive a report from the facility staff and was not aware that Resident 1's Atenolol had been held on 5/19/2024 at 9:00 a.m. due to the low SBP. A review of the facility's policy and procedure titled, Change in Condition: Notification of, dated 8/25/2021 and last reviewed on 2/25/2024, indicated, To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition. A facility must immediately inform the resident, consult with the Resident's physician and/or NP (Nurse Practitioner - a nurse who has advanced clinical education and training, so share many of the same duties as doctors) and notify, consistent with his/her authority, Resident Representative where there is: 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.