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	09/05/2024

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 0689 Level of Harm - Minimal harm or potential for 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** 43636 Based on interview and record review, the facility failed to accurately assess one of three sampled residents (Resident 1) for elopement (leaving the facility without notice or permission) risk, when on 8/31/2024, Resident 1 left the facility's premises without staff supervision. This deficient practice had the potential for Resident 1 not to be monitored for elopement and may result in harm, injury and or death. Findings: During a review of Resident 1's Admission Record indicated the facility originally admitted Resident 1 on 8/31/2012 and readmitted on [DATE] with diagnoses that included Parkinsonism disease (disorder of the central nervous system [made up of the brain and spinal cord] that affects movement, often including tremors), dysphagia (difficulty in swallowing), difficulty in walking, bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels and concentration), and hypertension (elevated blood pressure). During a review of Resident 1's Minimum Data Set (MDS - a comprehensive assessment and screening tool) dated 7/3/2024, indicated that Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 1 required set up assistance with eating, supervision with oral hygiene, moderate assistance with toileting hygiene and dependent on staff for showering and dressing. The MDS further indicated that Resident 1 required supervision when using his motorized wheelchair. During a review of Resident 1's Change of Condition (COC- a sudden deviation from a resident's health status) Form dated 8/31/2024 indicated, Resident 1 left (the facility) without a pass (an order from the physician to leave the facility) on 8/31/2024 at 5:20 p.m. During a review or Resident 1's Elopement Evaluation Form, completed by Registered Nurse Supervisor (RNS) 1, dated 9/1/2024 (upon re-admission) indicated that Resident 1 did not have a history of actual elopement or attempted elopement in the past. (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:	(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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/5/2024 at 12:55 p.m., with RNS 1, RNS 1 stated that she completed the Elopement Evaluation Form for Resident 1 on 9/1/2024. RNS 1 confirmed the finding and stated that she marked no when asked if the resident (Resident 1) had a history of actual elopement or attempted elopement. RNS 1 stated that she should have indicated that Resident 1 had a history of actual elopement or attempted elopement. During an interview on 9/5/2024 at 1:10 p.m., with the Director of Nursing (DON), the DON stated that when completing resident assessments, the assessment must be accurate. The DON confirmed that the Elopement Evaluation Form completed on 9/1/2024 by RNS 1 for Resident 1 was not accurate. The DON stated that the Elopement Evaluation Form should have noted that Resident 1 did have a history of elopement or attempted elopement on 8/31/2024. A review of the facility policy and procedure titled Elopement of Resident last revised on 7/12/2023 indicated residents will be evaluated for elopement risk upon admission, re-admission, quarterly and with a change in condition as part of the clinical assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. A review of the facility policy and procedure titled Nursing Documentation dated 6/27/2022 indicated, the purpose of the policy is to communicate patient's status and provide complete, comprehensive, and accessible accounting of care and monitoring provided .Nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the resident's condition, situation, and complexity.