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	09/18/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 39550 Based on observation, interview, and record review, the facility failed to ensure call lights (a device used by a resident to signal his/her need for assistance from staff) were within residents' reach while in bed for two of three sampled residents (Resident 2 and Resident 3). This deficient practice had the potential to delay the provision of services and the residents' needs not being met. Findings: a. During a review of Resident 2's Admission Record, the document indicated the facility admitted the resident on 9/6/2024 with diagnoses that included dysphagia (difficulty swallowing), muscle weakness, and difficulty in walking. During an observation on 9/17/2024 at 7:55 a.m., observed Resident 2 in bed and yelling in Spanish. Observed Resident 2's call light not within reach and on the floor. During a concurrent observation and interview on 9/17/2024 at 7:57 a.m., with Certified Nursing Assistant 3 (CNA 3) in Resident 2's room, observed Resident 2 in bed. Observed Resident 2's call light not within reach and on the floor. Observed CNA 3 pickup Resident 2's call light from the floor and place the call light within Resident 2's reach. When asked what Resident 2 was yelling, CNA 3 stated that Resident 2 was yelling I need to use the restroom. During an interview on 9/17/2024 at 7:58 a.m., with the Infection Preventionist (IP), the IP stated that call lights should always be within residents' reach for safety. The IP continued to state that residents should not be yelling or calling out for help or assistance. b. During a review of Resident 3's Admission Record, the document indicated the facility readmitted the resident on 4/21/2024 with diagnoses that included hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]), abnormal posture, and difficulty walking. (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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Minimum Data Set (MDS- a standardized assessment and care planning tool) dated 9/5/2024, the document indicated Resident 3 had unclear speech, usually made self-understood, and usually had the ability to understand others. The MDS indicated Resident 3 required supervision or touching assistance with eating and oral hygiene and required partial/moderate assistance with toileting hygiene and personal hygiene. During an observation on 9/17/2024 at 8:07 a.m., observed Resident 3 in bed and calling out in Spanish. Observed Resident 3's call light not within Resident 3's reach. Observed Resident 3's call light coiled and hanging behind Resident 3's headboard. During a concurrent observation and interview on 9/17/2024 at 8:09 a.m., with CNA 4, in Resident 3's room, observed Resident 3 in bed. Observed Resident 3's call light not within reach and coiled and hanging behind Resident 3's headboard. Observed CNA 4 grabbing Resident 3's call light from behind Resident 3's headboard, uncoiled the call light and straitened it out and place Resident 3's call light within Resident 3's reach. CNA 4 stated that call lights should always be within reach incase residents need something they can call our attention and for safety. When asked what Resident 3 was saying in Spanish, CNA 4 stated Resident 3 was saying help. During an interview on 9/17/2024 at 12:07 p.m., with the Director of Nursing (DON), the DON stated that residents' call lights should always be within reach in case the resident needs something they can call for assistance and for safety. During a review of the facility-provided policy and procedure titled, Answering the Call Light, last reviewed 1/25/2024, the policy indicated the purpose of this procedure is to ensure timely responses to the resident's request and needs. Ensure that the call light is accessible to the resident when in bed.

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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. 39550 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) who is at risk of developing a pressure ulcer/injury (injury to skin and underlying tissue resulting from prolonged pressure on the skin) was repositioned. This deficient practice had the potential to place Resident 1 at risk of developing a pressure ulcer/injury. Findings: During a review of Resident 1's Admission Record, the document indicated the facility originally admitted the resident on 2/26/2021 with diagnoses that included quadriplegia (paralysis [complete or partial loss of muscle function] of all four limbs), polyneuropathy (when multiple peripheral nerves [a network of nerves that run throughout the head, neck, and body] become damaged), and pain in left knee. During a review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 6/1/2024, the document indicated Resident 1's cognitive skills (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) for daily decision making was intact. The MDS indicated Resident 1 was dependent with eating, oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 1's Braden Scale for Predicting Pressure Sore Risk (a tool to help health professionals, especially nurses, assess a resident's risk of developing a pressure ulcer) dated 6/30/2024, the document indicated a score of 15, indicating mild risk. During a review of Resident 1's Care Plan (a written document that summarizes a resident's needs, goals, and care/treatment titled, Preventative: Resident has high risk/or at risk for pressure ulcer development or skin impairment related to bladder & bowel impairment, limited mobility . revised on 4/13/2024, the document indicated an order to reposition every two (2) hours or as determined turning/repositioning plan when in bed/chair. During a review of Resident 1's Order Summary Report, the document indicated an order for LAL (Low Air Loss - designed to distribute the resident's body weight over a broad surface area and help prevent skin breakdown) mattress for skin integrity management, every shift, ordered on 9/5/2023. During an interview on 9/16/2024 at 8:30 a.m., with Resident 1, Resident 1 stated that no one likes to reposition Resident 1. Resident 1 continued to state that he is a two-person assist and no one is available to help his assigned certified nursing assistant (CNA) to reposition him during the 11 p.m. -7 a.m. shift. Resident 1 stated that his assigned CNA for the 11 p.m. -7 a.m. shift on 8/26/2024 did not reposition him. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/17/2024 at 6:43 a.m., with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated that she was the assigned CNA for Resident 1 during the 11 p.m. -7 a.m. shift on 9/16/2024. CNA 2 stated she did not reposition Resident 1 during her shift because Resident 1 didn't tell her to. CNA 2 stated that she only moved Resident 1's legs the way he tells CNA 2 to. CNA 2 stated that CNA 2 only does what Resident 1 asks her to do. CNA 2 stated that CNA 2 should be turning and repositioning Resident 1 every two (2) hours to help prevent any ulcers from forming, but CNA 2 did not have anyone to assist her because Resident 1 is a two-person assist. CNA 2 further stated that CNA 2 just does what Resident 1 tells her to do. During an interview on 9/17/2024 at 9:56 a.m., with CNA 5, CNA 5 stated that she was the assigned CNA for Resident 1 during the 11 p.m. -7 a.m. shift on 8/26/2024. CNA 5 stated she did not reposition Resident 1 during her shift. When asked why CNA 5 did not reposition Resident 1 during her shift, CNA 5 stated Resident 1 requires a two-person assist and she does not turn Resident 1 unless Resident 1 asks. CNA 5 stated that Resident 1 does not usually ask to be turned and repositioned. CNA 5 continued to state that CNA 5 only does what Resident 1 tells her to do. When asked if CNA 5 offered Resident 1 to be turned or repositioned, CNA 5 stated that she did not. During an interview on 9/17/2024 at 12:16 p.m., with the Director of Staff Development (DSD), the DSD stated that residents should be turned and repositions every two (2) hours and as needed to help prevent the formation of pressure injuries. The DSD stated staff should be offering and explaining to residents the importance of turning and repositioning. The DSD continued to state that staff should not be waiting on residents to tell them to be repositioned and should be offering. During an interview on 9/17/2024 at 12:46 p.m., with the Director of Nursing (DON), the DON stated that turning and repositioning is to help prevent pressure injuries and to maintain skin integrity. The DON stated staff should not have to wait for residents to tell them to turn and reposition residents. The DON stated facility staff should be offering to turn and reposition residents and educate residents on the importance of turning and repositioning. During a review of the facility's policy and procedure titled, Turning a Resident on His/Her Side Away From You, last reviewed 1/25/2024, the policy indicated the purposes of this procedure are to provide comfort to the resident, to prevent skin irritation and breakdown, and to promote good body alignment. The following information should be recorded in the resident's medical record: 1. The date and time that care was given. 2. The name and title of the individual(s) who assisted with the care. 3. The position in which resident was placed. 4. The reason for changing the resident's position. 5. If and how the resident participated in the procedure or any changes in the resident ability to participated in the procedure. 6. Any problems or complaints made by the resident related to the procedure. 7. If the resident refused the treatment, the reason(s) why and the intervention taken. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy further indicated to notify the supervisor if the resident refuses the care and report other information in accordance with facility policy and professional standards. During a review of the facility's policy and procedure titled, Positioning/Transfer and Changing Resident with Airloss Mattress, undated, the policy indicated positioning, repositioning, transferring, and changing a resident is a primary responsibility of nursing assistant. However, all nursing staff are expected to assist. Under procedure for positioning/transferring a resident in bed indicated, two staff CNAs or nurses or combination of the two must perform procedure. Explain procedure to resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39550 Based on interview and record review, the facility failed to ensure the Medication Administration Record (MAR, a report detailing the medications administered to a resident by the licensed nurses) coincided with the Controlled Drug Record (CDR- accountability record of medications that are considered to have a strong potential for abuse) and entries were accurately documented per facility policy for one of three sampled residents (Resident 1). This deficient practice had the potential to result in medication error and/or drug diversion (illegal distribution or abuse of prescription drug). Findings: During a review of Resident 1's Admission Record, the document indicated the facility originally admitted the resident on 2/26/2021 with diagnoses that included quadriplegia (paralysis [complete or partial loss of muscle function] of all four limbs), polyneuropathy (when multiple peripheral nerves [a network of nerves that run throughout the head, neck, and body] become damaged), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and pain in left knee. During a review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 6/1/2024, indicated Resident 1's cognitive skills (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) for daily decision making was intact. The MDS indicated Resident 1 was dependent with eating, oral hygiene, toileting hygiene, and personal hygiene. a. During a review of Resident 1's Order Summary Report, the document indicated an order for tramadol hydrochloride oral tablet (medication used to treat moderate to severe pain), give 50 milligrams (mg- unit of measurement) by mouth every eight (8) hours as needed for left knee pain mid-severe pain. If after one hour still mid-severe pain, may have another 50 mg of tramadol, ordered on 9/6/2024. During an interview on 9/17/2024 at 11:36 a.m., with the Director of Staff Development (DSD), the DSD stated that after administering a narcotic (a drug or other substance that affects mood or behavior) medication, licensed nurses are to document on the MAR that the medication was administered and document on the CDR the time the medication was administered. The DSD stated that the MAR and the CDR should mirror each other. During a concurrent interview and record review on 9/17/2024 at 12:22 p.m., with the Director of Nursing (DON), reviewed Resident 1's CDR form for tramadol 50 mg and MAR dated 9/2024. The DON stated tramadol 50 mg was documented on the CDR on 9/9/2024 at 10:18 a.m. and was not documented on the MAR. The DON stated that when administering narcotic pain medication, the licensed nurse should first assess for pain, document on the CDR, administer the medication, then document on the MAR. The DON stated that that the CDR is not the MAR and documenting on the CDR is the process to ensure that that actual narcotic medication count is accurate. The DON further stated that licensed nurses must document on the MAR to indicate that the medication was actually given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 1's Order Summary Report, the document indicated an order for Ativan tablet (medication used for anxiety), give one (1) mg by mouth every eight (8) hours as needed for anxiety for 90 days manifested by inability to relax, ordered on 6/28/2024. During a concurrent interview and record review on 9/17/2024 at 12:34 p.m., with the DON, reviewed Resident 1's CDR form for Ativan 1 mg and MAR dated 9/2024. The DON stated Ativan tablet 1 mg was documented on the CDR on 9/9/2024 at 7:41 a.m. and 9/11/2024 at 10:53 p.m., and was not documented on the MAR. The DON continued to state that on 9/10/2024 at 7:38 p.m., Ativan tablet 1 mg was administered, however not documented on the CDR. The DON stated that that the CDR is not the MAR. The DON stated licensed nurses should be following the facility's policy and procedure on medication administration. During a review of the facility's policy and procedure titled, Administering Medication, last reviewed 1/25/2024, the policy indicated medications are administered in a safe and timely manner, and as prescribed. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. During a review of the facility's policy and procedure titled, Controlled Substances, last reviewed 1/25/2024, the policy indicated the facility complies with all laws, regulation, and other requirements related to handling, storage, disposal, and documentation of controlled medications. Controlled substances inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow up. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personal access and usage; b. Medication administration records; c declining inventory records; and d. destruction, waste and return to pharmacy records.