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	10/04/2024

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 39550 Based on interview and record review, the facility failed to ensure laboratory results were communicated with the physician timely for one of three sampled residents (Resident 4). This deficient practice had the potential to delay necessary care and services for the resident. Findings: During a review of Resident 4's Admission record, the document indicated the facility readmitted the resident on 9/16/2024 with diagnoses that included paroxysmal atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), cardiomyopathy (condition makes it hard for the heart to deliver blood to the body), and sepsis (a life-threatening complication of an infection) due to Escherichia coli (E. coli - a type of bacteria that normally lives in your intestines). During a review of Resident 4's Minimum Data Set (MDS-a standardized assessment and screening tool) dated 9/23/2024, the document indicated the resident's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 4 required substantial/maximal assistance with toileting hygiene and required supervision/ touching assistance with personal hygiene. During a review of Resident 4's physician's order, the document indicated an order for STAT (immediately) urinalysis (UA- a test of your urine) and Culture and Sensitively (C+S- a lab procedure that determines which antibiotic or other medicine is best to treat an infection), ordered 9/18/2024. During a review of Resident 4's Lab Results dated 9/19/2024, the document indicated urinalysis result: Leukoesterase (an enzyme found in white blood cells [type of cell that is a part of the body's immune system] that can be detected in a urine sample to indicate a possible urinary tract infection [UTI, an infection in any part of the urinary system] or other infection). Result: Large. During a review of Resident 4's Lab Results dated 9/21/2024, the document indicated urine culture result: E. coli. (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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/3/2024 at 11:45 a.m., with the Director of Nursing (DON), reviewed Resident 4's UA lab result report dated 9/19/2024 and 9/21/2024 and Resident 4's nursing progress notes dated 9/19/2024-9/21/2024. The DON stated that the facility received Resident 4's UA lab result report on 9/19/2024 which indicated abnormal lab results. The DON reviewed Resident 4's nursing progress notes dated 9/19/2024-9/20/2024 and stated that there is no documented evidence that the physician was made aware of the lab results. The DON continued to state that after receiving a lab result, licensed nurses are to inform the physician of lab results and licensed nurses document that it was done. The DON stated it is important to document that the physician was made aware so that the proper interventions can be done for the residents. The DON further stated if it was not documented it was not done. The DON further stated that since the order was for a UA and C+S, licensed nurses should have made the physician aware after the results of the UA were received so that the physician will make the determination if the physician would like to wait for the results of the C+S. The DON further reviewed Resident 4's lab result report dated 9/21/2024. The DON stated that the facility received Resident 4's C+S results on 9/21/2024. The DON reviewed Resident 4's nursing progress notes dated 9/21/2024 and stated that there is no documented evidence that the physician was made aware of the lab results received on 9/21/2024. The DON stated that the physician was not made aware of the lab results until 9/22/2024. The DON continued to state that staff should have made the physician aware on 9/21/2024 when labs were received. The DON stated staff should have made the physician aware sooner so that interventions could have been initiated promptly. During a review of the facility-provided policy and procedure titled, Lab and Diagnostic Test Results, reviewed 1/25/2024, the policy indicated when test results are reported to the facility, a nurse will first review the results. If staff who first receive or review lab and diagnostic tests results cannot follow the remainder of this procedure for the reporting and documenting the results and their implementations, another nurse in the facility (supervisor, charge nurse, etc.) should follow or coordinate the procedure. A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individual's current condition. Under options for physician notification: Facility staff should document information about when, how, and to whom the information was provided and the response.