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	12/17/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43636 Based on interview and record review the facility failed to maintain medical records in accordance with accepted professional standards for one of three sampled residents (Resident 1) by failing to complete the admission assessment form titled, Nursing Documentation Evaluation (a form that is used by nursing staff to document the initial assessment of a resident) upon Resident 1's admission to the facility. This deficient practice had the potential to negatively affect the overall care provided to Resident 1. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that including sepsis (a life-threatening blood infection), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), and morbid obesity (excessive overweight). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 9/20/2024, the MDS indicated, Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the sense) was moderately impaired. Resident 1 required set up assist with eating, and dependent on staff for toileting, showering, and lower body dressing. During a review of Resident 1's History and Physical (H&P) dated 9/15/2024, the H&P indicated Resident 1 can make needs known but cannot make medical decisions. During a review of Resident 1's initial assessment form titled Nursing Documentation Evaluation dated 9/15/2024, the form was left blank. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/2024 at 12:25 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated that she was the admitting nurse for Resident 1 when the resident was admitted to the facility. RNS 1 stated that when a resident is admitted to the facility the RNS is responsible in completing the admission assessment. RNS 1 stated that the Nursing Documentation Evaluation form should have been completed for Resident 1 at the time of admission. RNS 1 stated that she forgot to complete the Nursing Documentation Evaluation for Resident 1 at the time of admission. During an interview on 12/17/2024 at 12:35 p.m. with the Director of Nursing (DON), the DON stated that when a resident is admitted to the facility the correct process is for the RNS to complete the initial assessment of the resident and to complete all the required admission forms including the Nursing Documentation Evaluation. DON stated that RNS 1 should have completed the Nursing Documentation Evaluation form for Resident 1 upon admission. The DON stated that the Nursing Documentation Evaluation will assist with providing a detailed plan of care for the resident upon admission. During a review of the facility policy and procedure (P&P) titled Nursing Documentation with a review date of 1/25/2024, the P&P 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. Documentation for subsequent and/or routine care and procedures may be completed by exception or the use of a checklist, flow charts, or other documentation tools. Clinical judgment is used to determine the need for additional data collection and/or more frequent documentation.