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	05/06/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview and record review the facility to: 1. Ensure timely communication and management of a resident's pain for one of three sampled residents (Resident 3) when on 5/5/2025 at around 10:00 a.m. Certified Nurse Assistant 1 (CNA 1) failed to report Resident 3's complaint of headache to a licensed nurse. 2. Ensure a pain risk assessment was completed quarterly (12/2024 and 3/2025) for one of three sampled residents (Resident 3) as per facility policy. These deficient practices resulted in a delay in assessment and pain relief for Resident 3 and had the potential to result in Resident 3 experiencing unnecessary pain and discomfort. Findings: 1. During a review of Resident 3's Admission Record, the Admission Record indicated the facility originally admitted Resident 3 on 6/3/2014 and readmitted on [DATE] with diagnoses that included chronic pain syndrome (persistent pain that lasts for months or longer and can significantly impact a person's daily life). During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated 3/18/2025, the MDS indicated that Resident 3 had unclear speech and had severely impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) skills for daily decision making. The MDS further indicated Resident 3 required supervision or touching assistance with eating and oral hygiene and partial or moderate assistance from staff with toileting hygiene, dressing and personal hygiene. During a review of Resident 3's Pain Evaluation Form dated 9/5/2024, timed at 8:52 a.m., the Pain Evaluation indicated that Resident 3 had chronic (persisting for a long time or constantly recurring) pain onset. During an observation on 5/5/2025 at 8:40 a.m., in Resident 3's room, observed Resident 3 in bed with her call light within reach. During an observation on 5/5/2025 at 11:35 a.m., in Resident 3's room, observed Resident 3 in bed with her call light within reach. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/5/2025 at 2:01 p.m., in Resident 3's room, observed Resident 3 in bed with her call light within reach. During an interview on 5/5/2025 at 2:25 p.m., with CNA 1, when asked if Resident 3 was taken out of bed for the day, CNA 1 stated Resident 3 did not get out of bed for the day because Resident 3 reported to CNA 1 that Resident 3 had a headache, and that Resident 3 felt cold. CNA 1 stated that because Resident 3 reported she (Resident 3) had a headache, CNA 1 did not assist Resident 3 out of bed. CNA 1 continued to state that CNA 1 reported Resident 3's headache to Licensed Vocational Nurse 1 (LVN 1). During an interview on 5/5/2025 at 2:45 p.m., with LVN 1, LVN 1 stated that he (LVN 1) was not aware that Resident 3 complained of a headache. LVN 1 continued to state that LVN 1 was only made aware of Resident 3's headache after CNA 1 was interviewed. LVN 1 stated that CNA 1 should have communicated to him (LVN 1) Resident 3's complaint of headache timely. LVN 1 stated if he (LVN 1) had knowledge of Resident 3's complaint of headache earlier, LVN 1 would have assessed Resident 3 and offered Resident 3 pain medication to relieve Resident 3's headache. During an interview on 5/5/2025 at 2:51 p.m., with CNA 1, CNA 1 stated that she (CNA 1) did not inform LVN 1 of Resident 3's headache. CNA 1 stated that while CNA 1 was providing morning care to Resident 3 at around 10:00 a.m., Resident 3 complained of a headache. CNA 1 stated that she (CNA 1) was going to inform LVN 1 of Resident 3's headache however, it slipped her (CNA 1) mind when she was called by another resident for assistance. CNA 1 continued to state that she (CNA 1) should have informed the licensed nurse (LVN 1) when Resident 3 complained of headache. CNA 1 stated that she (CNA 1) is supposed to notify licensed nurses when residents complain of pain immediately so that residents can be evaluated by the licensed nurses and residents can be given pain medication for their comfort. During an interview on 5/5/2025 at 3:45 p.m., with the Director of Nursing (DON), the DON stated that CNA 1 should have informed LVN 1 of Resident 3's complaint of headache for proper assessment, to provide pain medication as needed, and for pain monitoring. The DON stated by reporting the resident's complaint of pain to a licensed nurse, the staff can ensure timely pain assessment and pain intervention, thereby avoiding prolonged or unnecessary pain or discomfort for the resident. The DON stated all residents should be pain free. A review of the facility provided policy and procedure titled Pain Management, reviewed date 1/16/2025, indicated under purpose: to maintain the highest possible level of comfort for Residents by providing a system, to identify, assess, treat, and evaluate pain. Facility staff will report any observation or communication of pain to the nurse responsible for that resident. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent interview and record review on 5/6/2025 at 2:57 p.m., with the DON, the DON stated that pain risk assessments are done upon admission, quarterly (every three months), and as needed if a resident complains of any new onset of pain. The DON reviewed Resident 3's pain risk assessments, the DON stated that the last documented pain risk assessment was done on 9/5/2024. The DON stated that Resident 3's pain risk assessment should have been reviewed and completed in 12/2024 and in 3/2025. The DON continued to state that the MDS Nurse (MDSN) is responsible for reviewing the pain risk assessment which is included in the MDS quarterly assessment. When asked about the importance of a pain risk assessment, the DON stated that it is a tool the facility uses to thoroughly assess a resident's pain and helps the facility implement a better plan of care to address and effectively manage residents' pain so residents can be pain free. A review of the facility provided policy and procedure titled Pain Management, reviewed date 1/16/2025, indicated residents will be evaluate as part of the nursing assessment process for the presence of pain upon admission/re-admission, quarterly, with any change in pain status, and as required by the state thereafter.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview and record review, the facility failed to implement its policy and procedure for Administering Medications for one of three sampled residents (Resident 1) by failing to document Resident 1's medication refusals (total of seven refusals on 4/22/2025) of Golytely (an oral solution indicated for bowel cleansing prior to colonoscopy [a diagnostic procedure used to examine the inner lining of the large intestine using a flexible, lighted tube]) and failing to ensure Resident 1's physician was made aware of Resident 1's refusals of the Golytely Oral Solution on 4/22/2025. This deficient practice may result in inadequate bowel cleansing making it hard to see the colon lining clearly during the colonoscopy which may lead to missed diagnosis such as inflammation and increased risk of procedure complications due to poor visibility. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility originally admitted Resident 1 on 3/7/2025 and readmitted on [DATE] with diagnoses that included chronic ulcerative recto sigmoiditis (prolonged inflammation involving the lower end of the colon [longest part of the intestine) with fistula (abnormal passage or connection between two parts of the body that don't normally connect), malignant neoplasm of sigmoid colon (a cancerous tumor that has formed in the sigmoid colon [a part of the large intestine]) and vascular dementia (refers to changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/23/2025, the MDS indicated that Resident 1 had clear speech, able makes self understood, and had the ability to understand others. The MDS indicated Resident 1 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) skills for daily decision making. The MDS further indicated Resident 1 required setup or clean-up assistance with eating, partial or moderate assistance with oral hygiene, and was dependent on staff with toileting hygiene, shower or bathing and lower body dressing. During a review of Resident 1's Physician's Order dated 4/15/2025, timed at 10:40 a.m., the Physician's Order indicated an appointment for colonoscopy procedure on 4/23/2025. During a review of Resident 1's Physician's Order dated 4/15/2025, timed at 10:47 a.m., the Physician's Order indicated to administer Golytely Oral Solution Reconstituted (refers to a powdered medication that has been mixed with water to create a drinkable solution before it can be ingested or administered) 236 grams (gm- unit of mass). Give eight (8) ounces (oz - unit of weight) by mouth one time only for colonoscopy preparation for one (1) day. Drink one (eight oz glass) of Golytely Oral Solution every 15 minutes until it is gone. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Medication Administration Record (MAR - a legal record of all medications and treatments administered to a resident) for 4/2025, the MAR indicated Resident 1 received (on 4/22/2025 at 2:12 p.m.) Golytely Oral Solution Reconstituted 236 grams. Give eight oz by mouth one time only for colonoscopy preparation for one day. Drink one (eight oz glass) of Golytely Oral Solution every 15 minutes until it is gone. During a review of Resident 1's Nurses Progress Note dated 4/22/2025, timed at 11:15 p.m., the Nurses Progress Note indicated the resident (Resident 1) refuses to finish the Golytely Oral solution and had only finished two-thirds (2/3 - two out of three equal parts of a whole) of the jug. During an interview on 5/2/2025 at 4:55 p.m., with Resident 1's Family Member (FM), the FM stated that Resident 1 was not given her (Resident 1's) medication (referring to Golytely Oral Solution) correctly as ordered by Resident 1's physician. FM 1 further stated because Resident 1's medication was not given correctly, Resident 1's colonoscopy procedure had to be rescheduled. During a concurrent interview and record review on 5/5/2025 at 12:20 p.m., with MDS Nurse 1 (MDSN 1), MDSN 1 reviewed Resident 1's Physician's Order dated 4/15/2025 and Resident 1's MAR dated 4/22/2025. MDSN 1 stated that Resident 1 had an order on 4/15/2025 for Golytely Oral Solution to be started on 4/22/2025 for colonoscopy preparation. MDSN 1 continued to state that Resident 1 had a colonoscopy appointment scheduled for 4/23/2025. MDSN 1 stated that Resident 1 was administered the Golytely Oral Solution on 4/22/2025 at 2:12 p.m. During a concurrent interview and record review on 5/5/2025 at 12:54 p.m., with MDSN 1, MDSN 1 reviewed Resident 1's Nurses Progress Note dated 4/22/2025 timed at 11:15 p.m. MDSN 1 stated that when residents refuse medication, licensed nurses are to document the refusal and inform the resident's physician of the refusal. MDSN 1 reviewed Resident 1's Nursing Progress Notes and Change of Condition (COC- when there is a sudden change in a resident's condition) notes for 4/22/2025 and stated that there is no documentation found indicating that Resident 1's physician was made aware of Resident 1's refusals of Golytely Oral Solution. During a concurrent interview and record review on 5/5/2025 at 1:02 p.m., with the Director of Nursing (DON), the DON reviewed Resident 1's Nurses Progress Note dated 4/22/2025. The DON stated that there is no documented evidence found that Resident 1's physician was made aware of Resident 1's refusals of Golytely Oral Solution. The DON stated Resident 1's physician should have been made aware of the Golytely Oral Solution because Resident 1 needed to finish the whole jug in preparation of Resident 1's colonoscopy. The DON stated Resident 1 was sent to her (Resident 1's) colonoscopy appointment on 4/23/2025. However, the colonoscopy procedure was not done because Resident 1 did not finish the Golytely Oral solution and had to reschedule for 4/25/2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/5/2025 at 3:22 p.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated that she (LVN 2) worked on 4/22/2025, 3:00 p.m. to 11:00 p.m. shift. LVN 2 stated that on 4/22/2025, LVN 2 received report from the 7:00 a.m. to 3:00 p.m. shift nurse that Resident 1 was administered the Golytely Oral Solution. LVN 2 stated that LVN 2 was to continue administering the Golytely Oral Solution, eight oz, every 15 minutes until the whole jug is done. Resident 1 drank the first two cups that were offered. LVN 2 stated that when LVN 2 offered more, Resident 1 refused to drink the Golytely Oral Solution. LVN 2 continued to state that LVN 2 did not inform Resident 1's physician of the refusals. LVN 2 stated she (LVN 2) informed the Registered Nurse Supervisor (RNS) on shift. When asked how many times Resident 1 refused the Golytely Oral Solution, LVN 2 stated that Resident 1 refused seven times. LVN 2 stated that she did not inform Resident 1's physician because she had informed the RNS. LVN 2 further stated that LVN 2 did not document Resident 1's refusals of medication. When asked why LVN 2 did not document refusals, LVN 2 stated she (LVN 2) thought the RNS would do it. During an interview on 5/5/2025 at 3:35 p.m., with the DON, the DON stated that LVN 2 should have documented each time Resident 1 refused her Golytely Oral Solution and either the licensed nurse (LVN 2) or RNS should have informed Resident 1's physician. The DON continued to state that the Golytely Oral Solution was supposed to prepare Resident 1 for her colonoscopy and because it was not completed, the procedure was affected, and Resident 1 was not able to go through with the procedure. The DON stated Resident 1's physician should have been made aware so that licensed nurses (LVN 2 or RNS) would have received further instructions regarding Resident 1's refusal and medication management. During a review of the facility policy and procedure titled Administering Medications, review date 1/16/2025, indicated medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document accordingly.