

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555738	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/19/2025
NAME OF PROVIDER OR SUPPLIER  Windsor Terrace Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>39739</p> <p>Based on interview and record review, the facility failed to ensure accurate documentation of the administration of medications for one of three sampled residents (Resident 1), by failing to document the administration and refusal of Resident 1's medications on the Medication Administration Record (MAR - a report detailing the medications administered to a resident by the licensed nurse in the facility).</p> <p>This deficient practice had the potential to result in medication errors and/or drug diversion (illegal distribution or abuse of prescription drug).</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 2/26/2021 with diagnoses that included quadriplegia (paralysis [complete or partial loss of muscle function] of all four limbs), muscle wasting and atrophy (partial or complete wasting away of a body part), and anxiety disorder (mental health condition characterized by persistent and excessive worry, fear, and nervousness that can interfere with daily life).</p> <p>During a review of Resident 1's History and Physical (H&amp;P - a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) dated 10/1/2024, the H&amp;P indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 3/2/2025, the MDS indicated Resident 1 had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS further indicated Resident 1 was dependent on staff for eating, oral hygiene, personal hygiene, upper body dressing toileting hygiene and showering and bathing.</p> <p>During a review of Resident 1's MAR for 5/1/2025 - 5/31/2025, the MAR indicated Resident 1 had scheduled medications that were due during the evening shift (3 p.m. - 11 p.m.) of 5/18/2025, which included:</p> <ol style="list-style-type: none"> <li>1. Baclofen (muscle relaxant) tablet 10 milligrams (mg- unit of measurement) two (2) tablets.</li> <li>2. Diclofenac sodium external gel (a medication used to treat pain of the joints).</li> </ol> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Docusate sodium (a medication used for stool softener) capsule 250 mg.</p> <p>4. Fluorometholone suspension (a medication used for swelling, redness or itching of the eyes) 0.1% eye drops for both eyes.</p> <p>5. Hiprex (a medication to prevent urinary tract infections [an infection in any part of the urinary system]) tablet one (1) gram (gm- unit of measurement).</p> <p>6. Methocarbamol (a medication used for muscle relaxation) tablet 500 mg two (2) tablets.</p> <p>7. Pepcid (a medication used to decrease stomach acid production) tablet 20 mg.</p> <p>8. Simethicone (a medication used to relieve the symptoms of gas, including uncomfortable or painful pressure, fullness, and bloating) tablet 80 mg two (2) tablets.</p> <p>9. Sodium Chloride tablet (commonly known as salt tablets, are used in medicine to treat or prevent sodium loss) 1 gm.</p> <p>Resident 1's MAR dated 5/18/2025 indicated the evening shift, 3 p.m. to 11 p.m., was left blank with no indication if Resident 1 received the scheduled medication or if Resident 1 refused the medication.</p> <p>During an interview on 5/19/2025 at 12:10 p.m., with Resident 1, Resident 1 stated there is always confusion on who will be giving his medications during the evening shift, 3 p.m. to 11 p.m. Resident 1 stated he does not like that he has to remind the nurses to give him his evening medications, so he ends up refusing most of his medications for the evening shift.</p> <p>During an interview on 5/19/2025 at 3:20 p.m., with the Director of Nursing (DON), the DON stated Registered Nurse 1 (RN 1) was assigned to administer Resident 1's medication on 5/18/2025 for the evening shift, 3 p.m. to 11 p.m., but RN 1 had forgot to sign off on Resident 1's MAR. The DON stated that per facility protocol, the nurse administering the medication should document on the MAR immediately after administering the medication so there is no confusion about whether the medication was administered or not. The DON further stated even refusals need to be documented on the MAR.</p> <p>During an interview on 5/19/2025 at 3:33 p.m., with RN 1, RN 1 stated that she was the licensed nurse assigned to administer medications for Resident 1 during the evening shift, 3 p.m. to 11 p.m., on 5/18/2025. RN 1 stated that she offered Resident 1 his evening medication, but he only took his simethicone and refused the rest of the evening medications. RN 1 stated that after she administered medication to Resident 1 there was an emergency in the facility that she had to deal with which caused her to forget to document on Resident 1's MAR. RN 1 stated the proper procedure would be to administer the medication and document on the MAR right after administering the medication.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure titled, Administering Medications, last revised 4/2019, the policy indicated it is the policy of the facility to ensure medications are administered in a safe and timely manner and as prescribed. The policy and procedure further indicated the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and administering the next ones. If the drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document accordingly.</p>