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	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Terrace Health Care	7447 Sepulveda Blvd Van Nuys, CA 91405

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 38549 Based on interview and record review, the facility failed to keep a copy of a resident's Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions) in the medical record for one (Resident 4) out of 29 sampled residents. This deficient practice had the potential to create confusion, which could lead to conflict with the resident's wishes regarding his/her health care. Findings: During a review of Resident 4's Admission Record, the record indicated the facility originally admitted the resident on 4/4/2013 and readmitted the resident on 11/2/2022 with diagnoses including Parkinsonism (a general term for a group of conditions that cause similar motor symptoms, such as tremors, rigidity, and slow movement), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), and malignant neoplasm of the breast (breast cancer). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 10/29/2024, the MDS indicated the resident had intact cognition (thought processes) and required moderate assistance from staff for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 4's Advance Directive Acknowledgement Form, signed by the resident on 12/7/2022, the form indicated the resident had an Advance Directive. During a review of Resident 4's Advance Directive Acknowledgement Form, signed by the resident on 8/28/2024, the form indicated the resident had an Advance Directive. During a review of Resident 4's Social Services Assessment and Documentation form, dated 2/1/2024, the form indicated that the resident had an Advance Directive, but there was no copy in the medical record. (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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4's Social Services Assessment and Documentation form, dated 10/9/2024, the form indicated that the resident had an Advance Directive, but there was no copy in the medical record. On 11/21/2024 at 8:33 a.m., during a concurrent interview and record review, reviewed an email communication between the facility and Resident 4's son, dated 2/2/2024, with the Social Services Director (SSD). In the email, the resident's son indicated he had already sent the facility a copy of the Advance Directive three times. When asked to provide the copy of the resident's Advance Directive, the SSD stated she could not find it anywhere in the resident's medical record. The SSD stated it was important to have a copy of residents' Advance Directives so that in the event a resident was not able to make health care decisions, someone else would be designated to make the decisions. The SSD stated that an Advance Directive contained the resident's wishes for their health care, and if it was not available in the resident's medical record, then it could possibly result in confusion of what the resident's wishes were in the event of an emergency. On 11/21/2024 at 9:48 a.m., during an interview, the Director of Nursing (DON) stated it was important to keep a copy of the resident's Advance Directive in his/her medical record because it lays out how the resident want's his/her care to be provided in case of an emergency or change in condition. The DON stated that an Advance Directive indicated who would be the assigned decision maker when the resident was not able to make decisions for him/herself. The DON stated it was important to have a copy available of the Advance Directive in addition to the Physician Orders for Life-Sustaining Treatment (POLST - a medical order that allows patients to specify their preferences for end-of-life care) form because the information on both forms may be different, and the facility could end up providing different care from what is specified in the Advance Directive. The DON stated this could possibly violate the resident's right to make decisions about his/her own health care. During a review of the facility's policy and procedure titled, Advance Directives, last reviewed and revised on 9/3/2024, the policy indicated that the purpose of an Advance Directive was to provide residents with the opportunity to make decisions regarding their health care. A copy of the Advance Directive is maintained as part of the resident's medical record.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 47883 Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse (a type of abuse that uses language) for one of three sampled residents (Resident 89) when on 11/01/2024, Resident 88 screamed at Resident 89 I will kill you. This deficient practice resulted in Resident 89 being subjected to verbal abuse while under the care of the facility. Residents who are subjected to verbal abuse are at increased risk for low self-esteem (when someone lacks confidence in themselves and their abilities), anxiety (a feeling of fear, dread, and uneasiness), depression (mood disorder that causes a persistent feeling of sadness and loss of interest in activities for long periods of time) and social isolation (when someone has few or no social connections or support and lacks relationships with others). Findings: During a review of Resident 89's Admission Record, the Admission Record indicated the facility initially admitted Resident 89 on 7/28/2023 and readmitted the resident on 3/14/2024 with diagnoses including quadriplegia (a form of paralysis that affects all four limbs, plus the torso) and chronic pain syndrome (experiencing ongoing pain that last for a long time). During a review of Resident 89's Minimum Data Set (MDS - a resident assessment tool), dated 9/17/2024, the MDS indicated that the resident's cognitive skills (ability to understand and make decisions) were intact (not affected). The MDS indicated that Resident 89 required setup and clean-up assistance for dressing, transferring, oral hygiene, and showering. The MDS indicated that Resident 89 required maximal assistance with toileting hygiene. During a review of Resident 89's Change in Condition Evaluation form (CIC), dated 11/1/2024, the form indicated that Resident 89 and Resident 88 were loudly exchanging words on the patio and that Resident 89 was removed due to threatening Resident 88. During a review of Resident 89's Interdisciplinary (IDT) Care Conference form, dated 11/4/2024, the form indicated that Resident 89 was involved in a verbal altercation with Resident 88 on 11/01/2024. During an interview on 11/19/2023 at 4:05 PM, with Resident 89, Resident 89 stated that Resident 88 was screaming at him (resident does not remember the date) on the patio. During a review of Resident 88's Admission Record, the Admission Record indicated the facility initially admitted Resident 88 on 4/3/2023 and readmitted the resident on 7/29/2024 with diagnoses including acute osteomyelitis (an infection in the bone) of right and left foot and ankle, heart failure (heart muscle cannot pump enough blood to meet the body's needs), and acute respiratory failure (a condition in which your blood does not have enough oxygen causing shortness of breath and difficulty breathing, often caused by a disease or injury). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 88's Minimum Data Set (MDS - a resident assessment tool), dated 10/2/2024, the MDS indicated that the resident's cognitive skills (ability to understand and make decisions) were intact (not affected). The MDS indicated Resident 88 required supervision or touching assistance for eating, oral and personal hygiene, and upper body dressing; as well as moderate assistance with showering, lower body dressing, and walking 50 feet. During a review of Resident 88's Care Plan (a document that outlines the actions and interventions needed to address a resident's health and care needs), dated 10/28/2024, the care plan indicated that Resident 88 had the potential to demonstrate verbally abusive behaviors. The care plan interventions indicated for a Certified Nursing Assistant to monitor, and document observed behavior and attempted interventions in a behavior log. During an interview on 11/20/2024 at 4:23 PM with Registered Nurse 3 (RN 3), RN 3 stated Resident 88 had a history of having anger outburst directed at another resident and was verbally abusive due to ineffective coping skills. RN 3 stated she created a care plan on 10/28/2024 addressing Resident 88's potential to demonstrate verbally abusive behavior with an intervention for the Certified Nursing Assistant (CNA) to monitor, document observed behavior and attempted interventions in the behavior log. During an interview on 11/20/2024 at 4:20 p.m., with Registered Nurse 2, (RN 2) stated that on 11/01/2024 after lunch she heard loud screaming coming from the patio. RN 2 stated that when she went to investigate, she witnessed Resident 88 yelling at Resident 89, I will kill you. RN 1 stated she separated the residents immediately and Resident 88 was sent to General Acute Care Hospital 1 (GACH 1) for further evaluation. During a concurrent interview and record review on 11/21/2024 at 1:35 PM with Certified Nursing Assistant 4 (CNA 4), Resident 88 could be very aggressive and would scream loudly. CNA 4 stated she was not aware Resident 88 was under behavioral monitoring. During an interview on 11/21/2024 at 1:40 p.m., with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated when she was doing her last rounds on 11/01/2024 at 1 PM, she heard loud screaming coming from the patio and when she went to investigate, she witnessed Resident 88 screaming at Resident 89, I will kill you. LVN 6 stated she was not aware Resident 88 was under behavioral monitoring. During an interview on 11/21/2024 at 1:50 PM, the Administrator (ADM), the ADM stated that on 11/1/2024, around 1 PM, she witnessed an anger outburst from Resident 88 against Resident 89 on the patio. The ADM stated that it was the first time a verbal altercation happened between Resident 88 and Resident 89, and that it should not have occurred according to the abuse policy and regulations. During a review of the facility's current policy and procedure titled Abuse Prohibition Policy and Procedure, last revised 9/3 2024, indicated: Healthcare Centers prohibit abuse residents have the right to be free from abuse . The Center will provide adequate supervision when the risk of resident-to-resident altercation is suspected.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 Based on interview and record review, the facility failed to develop and implement a person-centered care plan (a document that summarizes a resident's needs, goals, and care/treatment) for four of five sampled residents (Resident 51, 86, 96, and 88) by failing to: 1. Develop a care plan addressing Resident 51's use of lorazepam (medication used to treat anxiety disorder [a condition that causes excessive feelings of fear, worry, dread, or uneasiness that can interfere with daily life]) and venlafaxine (medication used to treat depression [a serious mental illness that can cause a persistent low mood, loss of interest, and other symptoms that affect how a person feels, thinks, and acts]). 2. Develop a care plan addressing Resident 86's use of quetiapine (antipsychotic- a medication used to treat psychosis [a mental condition in which thought, and emotions are so affected that contact is lost with external reality]). 3. Develop a care plan addressing Resident 96's language barrier. 4. Develop a care plan addressing Resident 88's decline in vision These deficient practices had the potential to delay the provision of necessary care and services to the residents. Findings: a. During a review of Resident 51's Admission Record, the Admission Record indicated the facility originally admitted the resident on 7/31/2024 and readmitted the resident on 8/12/2024 with diagnoses including anxiety disorder and depression. During a review of Resident 51's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 8/14/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 51's Minimum Data Set (MDS - a resident assessment tool), dated 11/15/2024, the MDS indicated the resident had moderately impaired cognition (thought processes) and required maximal assistance from staff for most activities of daily living (ADLs - activities related to personal care). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 11/20/2024 at 4:07 p.m., with Licensed Vocational Nurse 2 (LVN 2), reviewed Resident 51's physician's orders and care plans dated 7/31/2024 to 11/20/2024. LVN 2 stated Resident 51 had an order for lorazepam 0.5 milligrams (mg - metric unit of measurement) via gastrostomy tube (GT - a small tube that delivers nutrition, fluids, and medicine directly into the stomach through a small incision in the abdomen) twice a day (BID) for anxiety manifested by an inability to relax, ordered on 11/18/2024. LVN 2 stated Resident 51 also had an order for venlafaxine 75 mg GT BID for depression manifested by persistent diminished interest/pleasure in ADLs, ordered on 10/26/2024. When asked to see the care plans for Resident 51's use of lorazepam and venlafaxine, LVN 2 stated she could not find any care plans. During an interview on 11/21/2024 at 9:43 a.m., with the Director of Nursing (DON), the DON stated that when a resident is on a psychotropic medication (medications capable of affecting the mind, emotions, and behavior) there should be a care plan for it. When asked when a care plan should be developed, the DON stated it should be developed by the licensed nurse as soon as a new order is received. The DON stated it was important to have a care plan in place so that all disciplines who are caring for the resident will be on the same page on what to monitor and how to assist the resident. The DON stated if care plans were not in place, then the staff would not be able to address the resident's needs. During a review of the facility's policy and procedure titled, Care Plan Comprehensive, last reviewed and revised on 9/3/2024, the policy indicated that an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental, and psychosocial needs shall be developed for each resident. The comprehensive care plan includes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Assessments of residents are ongoing and care plans are reviewed and revised as information about the resident and the resident's condition change. b. During a review of Resident 86's Admission Record, the Admission Record indicated the facility admitted the resident on 7/17/2024 with diagnoses including hemiplegia (one-sided paralysis [complete or partial loss of muscle function]). During a review of Resident 86's H&P, dated 7/17/2024, the H&P indicated that the resident can make needs known but cannot make medical decisions. During a review of Resident 86's MDS, dated [DATE], the MDS indicated the resident had moderately impaired cognition and was dependent on staff for most ADLs. During a concurrent interview and record review on 11/20/2024 at 1:59 p.m., with LVN 2, reviewed Resident 86's physician's orders and care plans dated 7/17/2024 to 11/20/2024. LVN 2 stated Resident 86 had an order for quetiapine 25 mg by mouth (PO) BID for unspecified psychosis manifested by auditory hallucinations (hearing voices or noises that don't exist in reality), ordered on 11/15/2024. When asked to see the care plan for quetiapine, LVN 2 stated she could not find a care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/2024 at 9:43 a.m., with the Director of Nursing (DON), the DON stated that when a resident is on a psychotropic medication (medications capable of affecting the mind, emotions, and behavior) there should be a care plan for it. When asked when a care plan should be developed, the DON stated it should be developed by the licensed nurse as soon as a new order is received. The DON stated it was important to have a care plan in place so that all disciplines who are caring for the resident will be on the same page on what to monitor and how to assist the resident. The DON stated if care plans were not in place, then the staff would not be able to address the resident's needs. During a review of the facility's policy and procedure titled, Care Plan Comprehensive, last reviewed and revised on 9/3/2024, the policy indicated that an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental, and psychosocial needs shall be developed for each resident. The comprehensive care plan includes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Assessments of residents are ongoing and care plans are reviewed and revised as information about the resident and the resident's condition change. 47883 c. During a review of Resident 96's Admission Record, the Admission Record indicated the facility originally admitted the resident on 3/31/2024 and readmitted the resident on 7/12/2024 with diagnoses including acute pyelonephritis (occurs as a complication of an ascending urinary tract infection that spreads from the bladder to the kidneys), type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate). The Admission Record indicated Resident 96's primary language is Hungarian. During a review of Resident 96's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 10/24/2024, the MDS indicated the resident had moderately impaired cognition (thought processes) and required maximal assistance from staff for most activities of daily living (ADLs - basic tasks that people do every day to survive and be well). On 11/18/2024 at 11:15 p.m., during a concurrent observation and interview, in Resident 96 's room with Licensed Vocational Nurse (LVN), Resident 96 was observed in the bed and was not able to communicate in English. LVN stated that she uses translation services by telephone to communicate with the resident. When asked by surveyor what language Resident 96 speaks, LVN 6 was not able to answer. On 11/19/2024 at 11:00 a.m., during concurrent interview and record review , Resident 96's electronic record was reviewed by Licensed Vocational Nurse (LVN 2) . When asked to see the care plans (a document that outlines a patient's health information, conditions, treatments, care services, and goals) addressingr the resident's language barrier, LVN 2 stated she could not find any. On 11/20/2024 at 11:10 a.m., during concurrent interview and record review, Resident 96's social service assessment form dated 10/24/2024 was reviewed by Social Service Director (SSD). The SSD stated that document indicated that Resident 96 speaks limited English and prefers for a family member to translate. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/2024 at 11:20 a.m., during an interview with the Director of Nursing (DON), the DON stated that when a resident has a language barrier, then there should be a care plan for it. The DON stated it was important to have a care plan for language barrier in place so that all disciplines who are caring for the resident will know what language he speaks and how to assist the resident. The DON stated if care plans were not in place, then the staff would not be able to address the resident's needs. During a review of the facility's policy and procedure titled, Care Plan Comprehensive, last reviewed and revised on 9/3/2024, the policy indicated that an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental, and psychosocial needs shall be developed for each resident. The comprehensive care plan includes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Assessments of residents are ongoing and care plans are reviewed and revised as information about the resident and the resident's condition change. d. During a review of Resident 88's Admission Record, the Admission Record indicated that the facility initially admitted Resident 88 on 4/3/2023 and readmitted the resident on 7/29/2024 with diagnoses including acute osteomyelitis (an infection in the bone) of the right and left foot and ankle, heart failure (when heart muscle cannot pump enough blood to meet the body's needs), and acute respiratory failure (a condition in which your blood doesn't have enough oxygen causing shortness of breath and difficulty breathing, often caused by a disease or injury). During a review of Resident 88's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/2/2024, the MDS indicated that the resident's cognitive skills (ability to understand and make decisions) were intact (not affected). The MDS indicated that Resident 88 required supervision or touching assistance for eating, oral and personal hygiene, and upper body dressing; as well as moderate assistance with showering, lower body dressing, and walking 50 feet. The MDS indicated that Resident 88 was using corrective glasses. During concurrent interview and record review on 11/20/2024 at 11:00 a.m., with Licensed Vocational Nurse (LVN 2), Resident 88's care plans were reviewed. LVN 2 was asked if Resident 88 had a care plan addressing the resident's vision. LVN 2 stated she could not find any. During an interview on 11/20/2024 at 11:20 a.m., with the Director of Nursing (DON), the DON stated Resident 88 should have a care plan for impaired vision because the resident was diagnosed with cataracts (the clouding of the eye's lens that can cause blurry, hazy, or double vision, and difficulty seeing at night). The DON stated if care plans were not in place, then the staff would not be able to address the resident's vision needs. During a review of the facility's policy and procedure titled, Care Plan Comprehensive, last reviewed and revised on 9/3/2024, the policy indicated that an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental, and psychosocial needs shall be developed for each resident. The comprehensive care plan includes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Assessments of residents are ongoing and care plans are reviewed and revised as information about the resident and the resident's condition change.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review, the facility failed to ensure two of two sampled residents (Resident 69 and 12) were invited and participated in Interdisciplinary Team (IDT - a group of professionals with different areas of expertise who work together to achieve a common goal for the resident) care plan meetings (a written document that summarizes a resident's needs, goals, and care/treatment) investigated under the care area of care planning. These deficient practices violated the residents' right to be included in developing a resident-centered care plan and a missed opportunity in obtaining the cooperation of the resident which had the potential to result in failure in the delivery of necessary care and services. Findings: a. During a review of Resident 69's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/23/2023 and readmitted the resident on 7/7/2023, with diagnoses that included but not limited to, gastroesophageal reflux disease (stomach contents flow backward, up into the esophagus, the tube that carries food from your throat into stomach) and osteoporosis (a disease that causes bones to become weak and more likely to break). During a review of Resident 69's Minimum Data Set (MDS - a resident assessment tool), dated 11/1/2024, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact and required moderate assistance from staff for toileting hygiene, dressing and personal hygiene. During a concurrent interview and record review on 11/20/2024 at 11:57 a.m., with Licensed Vocational 3 (LVN 3), reviewed Resident 69's Interdisciplinary Care Conference dated 10/8/2024. The review indicated that Resident 69's IDT Care Conference (IDT-CC) was attended by the Director of Nursing, Director of Rehabilitation, and the Registered Dietitian. LVN 3 stated that the IDT-CC was to discuss Resident 69's weights. LVN 3 stated that the IDT should have included Resident 69 in the meeting and find out from Resident 69 if she has any food preferences that is compatible with her dietary order and restrictions. LVN 3 stated that IDT-CC objective is to develop a resident-centered care plan that would accommodate Resident 69's suggestions to achieve the goal of addressing Resident 69's weight loss problem. b. During a review of Resident 12's Admission Record, the Admission Record indicated the facility originally admitted the resident on 7/4/2018 and readmitted the resident on 3/1/2024, with diagnoses that included but not limited to, muscle weakness and type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 12's MDS dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was intact and dependent on staff for toileting hygiene, shower, putting on/taking off footwear and personal hygiene. (continued on next page)

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	555738	A. Building B. Wing	11/21/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/21/2024 at 10:37 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 12's Interdisciplinary Care Conference dated 9/13/2024 and 9/27/2024 regarding Skin Alterations and other concerns. RN 1 stated that the department heads from nursing, dietary, activities, and rehabilitation services participated in the IDT meeting on these two dates. RN 1 stated that they should have invited or included Resident 12 in the meetings of 9/13/2024 and 9/27/2024 and consider Resident 12's goals for his treatment and consider Resident 12's input. RN 1 stated the care plan developed for the resident must be resident-centered to ensure the resident's participation in achieving the goals of the care plan. RN 1 stated that Resident 12's treatment goals for his stage four (4) pressure ulcer (full-thickness skin and tissue loss that exposes bone, tendon, muscle, or other tissue) of right buttock may not heal and can lead to infection without the resident's cooperation such as his preference for sitting on his wheelchair for prolong period. During a review of the facility's policy and procedure titled, Care Planning-Interdisciplinary Team, last reviewed on 9/3/2024, the policy indicated, Interdisciplinary team is responsible for the development of resident care plans .The IDT includes but is not limited to: to the extent practicable, the resident and/or the resident's representative .

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	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Terrace Health Care	7447 Sepulveda Blvd Van Nuys, CA 91405

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 47883 Based on observation, interview and record review, the facility failed to meet the professional standards of care for one (Resident 72) out of 29 sampled residents by failing to check the resident's respiration rate (a number of breaths a person takes per minute) before administering Gabapentin (medication used to control seizures and for neuropathic pain [a pain caused by damage to the nervous system]) as ordered by the physician. This deficient practice had the potential to result in Resident 72 having unintended complications related to the administration of Gabapentin, such as respiratory depression (condition when breathing is too slow or too shallow). Findings: During a review of Resident 72's Admission Record, the Admission Record indicated the facility initially admitted Resident 72 on 9/5/2021 and readmitted the resident on 3/24/2023 with diagnoses including cerebrovascular disease (a condition that affect blood flow to your brain), epileptic seizures (a sudden electrical storm in the brain that causes temporary disruptions in a person's body functions, like movements, awareness, or sensation), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During a review of Resident 72's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/1/2024, the MDS indicated the resident had severely impaired cognition (severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 72 was dependent on the assistance of two or more helpers for eating, showering, toileting and personal hygiene, dressing, chair-to-bed transfer, and was not able to walk. During a review of Resident 72's Order Summary Report, dated 11/1/2024, the Order Summary Report indicated a physician order for Gabapentin oral tablet: give 900 milligrams (mg-unit of measurement) by mouth two times a day, hold if perspiration is less than 12, dated 2/22/24. During a medication administration observation on 11/20/2024 at 8:50 AM in Resident 72's room, observed Licensed Vocational Nurse 9 (LVN 9) administering Gabapentin to Resident 72 without checking Resident 72's respiration rate. During an interview on 11/20/2024 at 9:43 AM with LVN 9, LVN 9 stated that she missed checking Resident 72's respiration rate before administering Gabapentin to Resident 72. During an interview on 11/20/2024 at 11:20 AM with the Director of Nursing (DON), the DON stated that failure to follow a physician's order may lead to complications related to Gabapentin administration such as respiratory depression. The DON stated that according to the facility's policy, LVNs should always follow the physician's orders and check residents' vital signs (body temperature, blood pressure, pulse, and respiration [breathing] rate) as ordered. (continued on next page)

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	555738	A. Building B. Wing	11/21/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility policy titled Administering Medications, last reviewed on 9/23/2024, the policy indicated Medications are administered in accordance with prescribed orders .The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications

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	555738	A. Building B. Wing	11/21/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on interview and record review, the facility failed to clarify (contacting the physician to obtain additional details about an existing order) fingerstick (a way to check the blood sugar by inserting a small needle into a finger) orders with the physician which indicated the resident was to receive a fingerstick seven times a day instead of the usually prescribed four times a day. This deficient practice had the potential to result in pain from excessive finger sticks. Findings: During a review of Resident 78's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (high blood sugar). During a review of Resident 78' s Minimum Data Set (MDS, a resident assessment tool), dated 9/24/2024, the MDS indicated Resident 78 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 78 required supervision (helper provides verbal cues) with oral hygiene and eating. During a review of Resident 78's Physician's Orders, the Physician Orders indicated the following orders: -Insulin Aspart Injection Solution (a medication to lower blood sugar) 100 unit/milliliters (unit/ml, a unit of measure for insulin), inject as per sliding scale subcutaneously (into the fat under the skin) before meals (QAC, before every meal; from Latin quaque ante cibum) and hour of sleep (HS, bedtime); for diabetes mellitus; rotate injection sites: -If blood sugar is less than (<) 70, give orange juice eight ounces (a unit of measurement for liquids) and notify the physician. - if 150 - 199 mg/dL, give 3 units. - if 200 - 249 mg/dL, give 5 units. - if 250 - 299 mg/dL, give 8 units. - if 300 - 349 mg/dL, give 10 units. - if blood sugar is greater than (>) 400 mg/dL, notify the physician, dated 6/25/2024. -Finger stick blood glucose QAC and HS; call the physician if blood sugar is less than 60 milligrams mg/dL or blood sugar > 400 mg/dL every six hours for diabetes Accu-Checks (a brand of glucose monitoring system), dated 6/25/2024. (continued on next page)

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	555738	A. Building B. Wing	11/21/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Finger stick blood glucose QAC and HS; call the physician if blood sugar is less than 60 mg/dL or blood sugar greater than 400 mg/dL before meals and at bedtime, dated 6/25/2024 and discontinued same day. -Order for Resident 78 transfer to GACH 1 for G-Tube (a plastic tube inserted into the stomach for residents to receive medications and nourishment for those having swallowing problems) removal, dated 6/21/2024. During a review of Resident 78's Medication Administration Record (MAR, a report detailing the drugs administered to a patient by the licensed nurses), dated 06/2024 to 11/2024, the MAR indicated that the resident had finger sticks conducted Q6H for the following times: 12 a.m., 6 a.m., 12 p.m., and 6 p.m. and for QAC and HS for the following times: 7:30 a.m., 11:30 a.m., 4:30 p.m., and 9 p.m. The 11:30 a.m. and the 12 p.m. times had the same value on all days which indicated the blood sugar was taken once for 11:30 a.m and 12:00 p.m. time periods. This practice indicated the following times that Resident 78's blood sugar was taken more than the usual four times a day for a total of 158 days as indicated in the following: June 2024 5 days July 2024 31 days August 2024 31 days September 2024 30 days October 2024 31 days November 2024 20 days During a concurrent interview and record review with Licensed Vocational Nurse 3 (LVN 3) on 11/21/2024 at 11:42 a.m., reviewed Resident 78's 11/2024 MAR. When asked why Resident 78 was receiving finger sticks for QAC, HS, and every six hours, LVN 3 stated they did not know. (continued on next page)

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	555738	A. Building B. Wing	11/21/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the Director of Nurses (DON) on 11/21/2024 at 1:23 p. m., reviewed Resident 78's Physician's Orders and the facility's policy and procedure titled, Medication Utilization and Prescribing - Clinical Protocol, last reviewed 9/03/2024. The DON confirmed Resident 78 received finger sticks QAC, HS, and every six hours which was more than the usual QAC and HS time frames. The DON stated Resident 78 had a G-Tube had self-removed the G-Tube approximately 6/21/2024 and physician and family decided not to re-insert the G-tube. The DON stated the Q6H finger stick order was when Resident 78 was on a G-tube but should be discontinued because Resident 78 eats by mouth now. The DON stated this was a duplicate order and should have been caught after the decision not to re-insert the G-tube. The DON stated Resident 78's nurse practitioner (a registered nurse with advanced training and education and writes orders under the physician's guidance) was notified earlier on 11/21/2024 who prescribed an order to conduct finger sticks only for QAC and HS. The DON stated the excess finger sticks could put Resident 78 at risk for increased pain in the finger sticks and it is important to make sure orders are reviewed to make sure duplicate orders are caught. The DON stated finger sticks would be included in the staff monthly review for duplicate orders although not specifically mentioned in the policy and procedure titled, Medication Utilization and Prescribing - Clinical Protocol. During an interview with LVN 7 on 11/21/2024 at 1:35 p.m., LVN 7 stated they take Resident 78's blood sugar at 7:30 a.m. and 11:30 a.m. for the 7 a.m. to 3 p.m. shift, and if they work the 3 p.m. to 11 p.m. shift, then they take the blood sugar at 4 p.m., 6 p.m., and 8 p.m. LVN 7 stated Resident 78 had complained about getting a finger stick so many times. LVN 7 stated it is the physician's order, and they are required to follow the order. During a phone interview with Resident 78's Nurse Practitioner 1 (NP 1) on 11/21/2024 at 2:38 p.m., the NP stated the fingerstick Q6H order was when Resident 78 had a G-Tube. NP 1 stated, since Resident 78 is currently eating and does not have the G-Tube, the order should be for QAC and HS. NP 1 stated they were not aware Resident had been receiving finger sticks for Q6H and QAC and HS. During a review of the facility's policy and procedures entitled, Medication Utilization and Prescribing - Clinical Protocol, last reviewed 9/03/2024, the document indicated the physician and staff will evaluate the effectiveness and effects of the medications in a resident's regimen. The policy and procedure indicated based on input from the staff and resident, the physician will adjust medications based on their efficacy (the ability to produce a desired or intended result), indications and the continued presence of clinically significant risks.

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	555738	A. Building B. Wing	11/21/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on observation, interview, and record review, the facility failed to: 1. Ensure a resident's bed was in low position per physician's orders for one of five sampled residents (Resident 32) investigated under the care area of accidents. 2. Provide a resident who was at high risk for falls with a tab alarm (a safety device used primarily in healthcare settings to alert caregivers when a patient attempts to get out of bed or chair without assistance) and floor mats (a cushioned floor pad designed to help prevent injury should a person fall) as ordered by the physician for one of five sampled residents (Resident 51) investigated under the care area of accidents. These deficient practices had the potential to place the residents at increased risk of sustaining a fall with injuries. Findings: a. During a review of Resident 32's Admission Record, the Admission Record indicated that the facility admitted the resident on 9/16/2024 with diagnoses that included type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]), history of falling, and dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities). During a review of Resident 32's Minimum Data Set (MDS - a resident assessment tool), dated 9/8/2024, indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was impaired and required assistance from staff for toileting, shower, dressing, and for personal hygiene. During a review of Resident 32's physician's orders, the physician's orders indicated an order for low height bed every shift, dated 6/18/2024. During a concurrent observation and interview on 11/18/2024 at 11:16 a.m., with Licensed Vocational Nurse 4 (LVN 4), observed Resident 32 sleeping in bed with their bed raised up. LVN 4 confirmed by stating that the Resident 32's bed was placed in high position and stated that it should be lower to prevent serious injury in the event of a fall. LVN 4 stated that Resident 32 could get hurt if she fell . During a concurrent interview and record review on 11/20/2024 at 11:09 a.m., with Licensed Vocational Nurse 2 (LVN 2), reviewed Resident 32's Fall Risk assessment dated [DATE]. Resident 32's Fall Risk assessment dated [DATE], indicated that Resident 32 is a high fall risk and according to LVN 2 the bed should be in low position to prevent serious injury in the event of a fall. (continued on next page)

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	555738	A. Building B. Wing	11/21/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Fall Management, last reviewed on 9/3/2024, the policy indicated, Patients will be assessed for falls risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury . 38549 b. During a review of Resident 51's Admission Record, the Admission Record indicated the facility originally admitted the resident on 7/31/2024 and readmitted the resident on 8/12/2024 with diagnoses including displaced intertrochanteric fracture of the left femur (broken hip bone), displaced fracture of the surgical neck of the left humerus (a severe injury where the upper arm bone is broken near the shoulder joint), and subsequent encounter after a specified fall. During a review of Resident 51's History and Physical (H&P - a comprehensive assessment of a resident that includes taking a detailed medical history from the resident and performing a physical examination to gather information about their current health condition), dated 8/14/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 51's MDS dated [DATE], the MDS indicated the resident had moderately impaired cognition (thought processes) and required moderate assistance from staff for most activities of daily living (ADLs - activities related to personal care). During a review of Resident 51's physician's orders, dated 11/18/2024, the physician's orders indicated an order to place the resident on fall precautions by providing a low bed position, tab alarm in bed or in wheelchair, and a floor mattress. Check for placement every shift. During a review of Resident 51's care plan (a document that summarizes a resident's needs, goals, and care/treatment) for high risk for falls, initiated on 11/18/2024, the care plan indicated a goal that the risk for fall to occur will be minimized by the review date. During a concurrent observation and interview on 11/19/2024 at 3:47 p.m., with Certified Nursing Assistant 1 (CNA 1), observed Resident 51 inside her room and awake in her wheelchair. When asked if Resident 51 had a tab alarm on her wheelchair, CNA 1 stated she did not see a tab alarm on Resident 51's wheelchair. During a concurrent observation and interview on 11/20/2024 at 8:35 a.m., with Certified Nursing Assistant 2 (CNA 2), observed Resident 51 in bed eating breakfast. When asked if Resident 51 had a tab alarm on her bed and floor mats, CNA 2 stated she (CNA 2) did not see a tab alarm on Resident 51's bed or floor mats. During an interview on 11/21/2024 at 9:40 a.m., with the Director of Nursing (DON), the DON stated that if the physician placed an order for Resident 51 to be placed on fall precautions and to be provided with a tab alarm while in bed or in the wheelchair and a floor mat, then the facility should have provided Resident 51 with these items. The DON stated the nurses should also be monitoring for the placement of these devices. The DON stated the physician placed the order to decrease the chance of Resident 51 suffering another fall or another injury from a fall. The DON stated that if these devices were not in place, as ordered by the physician, then it increased Resident 51's potential for another injury from a fall. (continued on next page)

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	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Terrace Health Care	7447 Sepulveda Blvd Van Nuys, CA 91405

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Fall Management, last reviewed and revised on 9/3/2024, the policy indicated that patients will be assessed for falls risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury.

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	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Terrace Health Care	7447 Sepulveda Blvd Van Nuys, CA 91405

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on interview and record review, the facility failed to ensure that residents who needed respiratory treatment (the health care discipline that specializes in the promotion of optimum cardiopulmonary function and health and wellness) were provided such care consistent with professional standards of practice to one out of three sampled residents (Residents 84) when Resident 84's nebulizer (a small machine that turns liquid medicine into mist that can be easily inhaled) tubing was not labeled with the date it was last changed. This deficient practice had the potential to cause respiratory infection to Resident 84 Findings: During a review of Resident 84's Admission Record, the Admission Record indicated that the facility initially admitted Resident 84 on 11/25/2022 and readmitted the resident on 7/30/2024 with diagnoses including acute respiratory failure (a condition in which your blood doesn't have enough oxygen causing shortness of breath and difficulty breathing, often caused by a disease or injury), and chronic obstructive pulmonary disease (a common lung disease that makes it difficult to breathe), and encephalopathy (a brain disorder that caused recurring seizures). During a review of Resident 84's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/5/2024, the MDS indicated that the resident had mildly impaired cognition (a slight decline in mental abilities, memory and completing complex tasks). The MDS further indicated that Resident 84 needed supervision or touch up assistance for dressing, oral hygiene, and moderate assistance for showering. During a review of Resident 84's Physician Order, the Physician Order indicated an order dated 10/11/2024, for Ipratropium- Albuterol Solution (medication used as oral inhalation to prevent wheezing [a high-pitched [NAME] sound that occurs when the airways in the lungs are narrowed or blocked]) 0.5-2.5 ml/mg (unit of measurement), three (3) ml (unit of volume) inhale orally (through the mouth) two times a day for shortness of breath. During a concurrent observation and interview on 11/20/2024 at 10:00 AM in Resident 84's room with Licensed Vocational Nurse 6 (LVN 6), observed the nebulizer machine on Resident 84's bedside table with the tubing not labeled with the date it was last changed. LVN 6 stated that the nebulizer tubing should be changed and labeled every seven (7) days to prevent the resident from developing respiratory infections. During an interview on 11/20/2024 at 10:45 AM with the Infection Preventionist (IP), the IP stated that the nebulizer tubing should be changed every seven (7) days on Wednesday by the Licensed Vocational Nurses and labeled with the date it was last changed to prevent Resident 84 from developing respiratory infections. (continued on next page)

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	555738	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Terrace Health Care	7447 Sepulveda Blvd Van Nuys, CA 91405

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/2024 at 11:20 PM with the Director of Nursing (DON), the DON stated that nebulizer tubing should be changed every seven (7) days and labeled with the date it was last changed. The DON further stated that the failure to change the nebulizer tubing according to the facility policy could have caused a respiratory infection to Resident 84. During a review of the facility policy and procedure (P&P) titled Changing of Nasal Cannula/Oxygen Tubing, last reviewed on 9/3/2024, the P&P indicated, It is the policy of this facility to change nasal canula and tubing weekly and as needed.

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	555738	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Terrace Health Care	7447 Sepulveda Blvd Van Nuys, CA 91405

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 38549 Based on interview and record review, the facility failed to monitor a resident for side effects and behavioral episodes for the use of quetiapine (antipsychotic- a medication used to treat psychosis [a mental condition in which thought, and emotions are so affected that contact is lost with external reality]) for one of five sampled residents (Resident 86) investigated under the care area of unnecessary medications. This deficient practice had the potential to place the resident at increased risk of taking an unnecessary medication and experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention). Findings: During a review of Resident 86's Admission Record, the record indicated the facility admitted the resident on 7/17/2024 with diagnoses including hemiplegia (one-sided paralysis [complete or partial loss of muscle function]). During a review of Resident 86's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 7/17/2024, the record indicated that the resident can make needs known but cannot make medical decisions. During a review of Resident 86's Minimum Data Set (MDS - a resident assessment tool), dated 10/18/2024, the MDS indicated that the resident had moderately impaired cognition (thought processes) and was dependent on staff for most activities of daily living (ADLs - activities related to personal care). During a review of Resident 86's physician's orders, the physician's orders indicated the following orders: - Administer quetiapine 25 milligrams (mg - metric unit of measurement) by mouth (PO) two times a day (BID) for unspecified psychosis manifested by auditory hallucinations (the perception of sounds or voices that aren't actually there), ordered on 11/15/2024. - Monitor episodes of unspecified psychosis manifested by auditory hallucination every shift, ordered on 11/15/2024. - Monitor side effects related to unspecified psychosis: dry mouth, constipation, blurry vision, disorientation/confusion, difficulty urinating, hypotension (low blood pressure), dark urine, yellow skin, nausea and vomiting, lethargy (a state of feeling exhausted, lacking energy, and having little mental alertness), drooling, extrapyramidal symptoms (EPS - a group of side effects that can occur when taking certain medications, especially antipsychotic drugs), weight gain, and loss of appetite every shift, ordered on 11/15/2024. (continued on next page)

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	555738	A. Building B. Wing	11/21/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 11/20/2024 at 4:11 p.m., with Licensed Vocational Nurse 2 (LVN 2), reviewed Resident 86's Medication Administration Record (MAR - a report detailing the drugs administered to a resident by a healthcare professional) dated 11/2024. LVN 2 stated Resident 86 received quetiapine 25 mg on the following dates and times: - 11/17/2024 at 5 p.m. - 11/18/2024 at 9 a.m. - 11/18/2024 at 5 p.m. - 11/19/2024 at 9 a.m. - 11/19/2024 at 5 p.m. - 11/20/2024 at 9 a.m. When asked to provide documentation that the licensed nurses were monitoring for side effects and behavioral episodes for Resident 86, LVN 2 stated she could not find any documentation indicating that the nurses were monitoring for side effects and behavioral episodes. During an interview on 11/21/2024 at 9:52 a.m., with the Director of Nursing (DON), the DON stated it was important to monitor behavioral episodes if a resident was taking an antipsychotic medication in order to determine if the dosage needed to be adjusted. The DON stated that, in addition, nurses needed to monitor for adverse side effects so it could be reported to the physician and necessary changes could be made to the dosage. The DON stated if the nurses did not monitor for either of these, then the resident may possibly be receiving an unnecessary medication. During a review of the facility's policy and procedure titled, Antipsychotic Medication Use, last reviewed and revised on 9/3/2024, the policy indicated the staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician .

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	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Terrace Health Care	7447 Sepulveda Blvd Van Nuys, CA 91405

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on interview, and record review, the facility failed to ensure residents were free from any significant medication errors for one (Resident 78) of five residents investigated for unnecessary medications by failing to follow the hold parameters (indications when to hold a blood pressure medication because the blood pressure is too low) for lisinopril (medication to treat high blood pressure) as ordered by the physician. This deficient practice had the potential to cause complications such as low blood pressure and syncope (fainting) and, possible requirement of hospitalization . Findings: During a review of Resident 78's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hypertension (HTN, high blood pressure). During a review of Resident 78' s Minimum Data Set (MDS, a resident assessment tool), dated 9/24/2024, the MDS indicated Resident 78 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 78 required supervision (helper provides verbal cues) with oral hygiene and eating. During a review of Resident 78's Physician's Orders, the Physician Orders indicated an order, dated 621/2024 for lisinopril tablet, give one tablet one time a day for HTN; hold for systolic blood pressure (SBP, how much pressure the blood is exerting against the artery walls when the heart beats) less than 110 millimeters of mercury (mm Hg, a unit of measure, normal reference range is less than 120 mm Hg). During a review of Resident 78's Care Plan (CP) for Decreased Cardiac Output (how much blood is pumped by the heart in one minute, indicator of heart function), initiated on 10/27/2023, the CP indicated a goal that the resident will have effective cardiac function. The care plan indicated interventions to administer medications as prescribed, and to evaluate blood pressure. During a review of Resident 78's Medication Administration Record (MAR, a report detailing the drugs administered to a patient by the licensed nurses) dated 11/01/2024 to 11/20/2024, the MAR indicated that on 11/04/2024 at 9 a.m., lisinopril was given to Resident 78, and the blood pressure taken before the medication administration was 98/65. During a concurrent interview and record review with Licensed Vocational Nurse 6 (LVN 6) on 11/20/2024 at 2:45 p.m., reviewed Resident 78's 11/2024 MAR. LVN 6 stated she marked the MAR as having given the lisinopril but would not have given for that blood pressure. However, LVN 6 stated she (LVN 6) could not remember the events on that date and time and could not confirm that the medication was held on 11/04/2024. LVN 6 stated the importance of following physician's parameters for blood pressure administration is to make sure the blood pressure medication does not drop the blood pressure more than it already is. (continued on next page)

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	555738	A. Building B. Wing	11/21/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the Director of Nurses (DON) on 11/21/2024 at 8:26 a. m., reviewed Resident 78's 11/2024 MAR. The DON confirmed that the lisinopril was administered and should not have been given. The DON stated it is important to hold the lisinopril to prevent decreasing the blood pressure further. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, last reviewed on 9/03/2024, the P&P indicated all medications are administered in accordance with the physician's orders.

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	555738	A. Building B. Wing	11/21/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38549 Based on observation, interview, and record review, the facility failed to ensure proper food handling and storage practices by failing to: 1. Ensure a bin full of zucchini and a bin full of cantaloup found inside the walk-in refrigerator were labeled with the date they were received. 2. Ensure an open bag of dry pasta and an open bag of tostadas found inside the dry storage room were labeled with the date they were opened. These deficient practices had the potential to place 114 out of 116 residents who receive food from the facility kitchen at risk for foodborne illness (illness caused by the ingestion of contaminated food or beverages). Findings: During a concurrent observation and interview on 11/18/2024 at 7:51 a.m., with [NAME] 1, observed the facility's walk-in refrigerator. Observed a plastic bin full of zucchini with no label of when it was received. Observed a plastic bin full of cantaloup with no label of when it was received. [NAME] 1 verified by stating that neither bin had a label on it and stated they should have been labeled with the date they were received. Observed the facility's dry storage room with the Maintenance Supervisor (MS). Observed an open bag of dry pasta with no label for when it was opened. Observed an open bag of tostadas with no label for when it was opened. The MS verified by stating the MS could not find a label for when both the bag of dry pasta and bag of tostadas were opened. During an interview on 11/21/2024 at 9:25 a.m., with the Dietary Supervisor (DS), the DS stated that all the food should be labeled with the date they were received and the date they were opened. The DS stated the purpose of labeling the food was to ensure that staff knew how long a particular item had been in the refrigerator or opened. The DS stated that food can expire or spoil if not used within a certain time frame, which could cause foodborne illness to residents. During a review of the facility's policy and procedure titled, Food Receiving and Storage, last reviewed and revised on 9/3/2024, the policy indicated that food shall be received and stored in a manner that complies with safe food handling practices. Dry food that are stored in bins are removed from original packaging, labeled, and dated (use by date). Such foods are rotated using a first in - first out system. All foods stored in the refrigerator or freezer are covered, labeled, and dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on observation, interview, and record review, the facility failed to: 1. Ensure Licensed Vocational Nurse 9 (LVN 9) removed gloves and performed hand hygiene in between cleaning a resident's eyes and after cleaning a resident's eye and opening a new package of supplies and ensure LVN 9 removed gloves and performed hand hygiene in between administering eye drops to both eyes for one of five sampled residents (Resident 72) investigated under the care area of infection control. These deficient practices had the potential to cause cross contamination (unintentional transfer of bacteria/germs or other contaminants from one surface to another) between Resident 72's eyes and from Resident 72 to other residents. 2. Ensure a trash bin used for Personal Protective Equipment (equipment designed to protect the wearer from injury or the spread of illness or infection such as gloves and gowns) was provided to two of 23 residents who were on Enhance Barrier Precaution (EBP- a method of using PPE to reduce the spread of pathogens between residents in skilled nursing facilities). This deficient practice had the potential to increase the risk of spreading infection among residents. 3. Ensure a resident's nasal cannula oxygen tubing (a medical device used to deliver supplemental oxygen to a resident through two small prongs that are inserted into the nostrils) was changed weekly as indicated in the facility's policy and procedure for one of four sampled residents (Resident 87) investigated under the care area of infection control. This deficient practice had the potential to place the resident at increased risk of contracting an infection. Findings: During a review of Resident 72's Admission Record, the Admission Record indicated that the facility initially admitted Resident 72 on 9/5/2021 and readmitted the resident on 3/24/2023 with diagnoses including cerebrovascular disease (a condition that affect blood flow to your brain), epileptic seizures (disorder that causes recurring seizures [sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain]), and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 72's Minimum Data Set (MDS - a resident assessment tool), dated 11/1/2024, the MDS indicated that the resident had severely impaired cognition (thought processes). The MDS further indicated that Resident 72 was dependent on the assistance of two or more helpers for eating, showering, toileting and personal hygiene, dressing, chair-to-bed transfer, and was not able to walk. (continued on next page)

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	555738	A. Building B. Wing	11/21/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 72's Order Summary Report , dated 11/1/2024, the Order Summary Report indicated the following physician orders: - OcuSoft eyelid cleansing external pad (eyelid cleanser to clean, comfort, and soothe irritated eyelids) to apply to both eyes topically two times a day in both eyes, dated 3/24/2023. - Cyclosporine (medication used for dry eye syndrome [condition that occurs when your eyes don't produce enough tears or the tears they produce don't work properly]), ophthalmic emulsion 0.05% (unit of concentration measurement) one (1) drop in both eyes two times a day, dated 7/13/2023. During a medication administration observation on 11/20/2024 at 8:50 a.m., in Resident 72's room, observed LVN 9 administering OcuSoft eyelid cleansing external pad and Cyclosporine 0.05% eye emulsion one (1) drop to both of Resident 72's eyes. LVN 9 performed hand hygiene, put gloves on, prepared two cleansing pads and an Ocusoft foam container at Resident 72's bedside table. LVN 9 then performed hand hygiene, put gloves on, pumped a small amount of Ocusoft foam onto two cleansing pads. LVN 9 cleaned Resident 72's right eye lid with the first pad, did not remove their gloves, and cleaned Resident 72's left eye lid with a second pad. Observed LVN 9 not removing her gloves after cleaning Resident 72's eyelids and then opened a clean bag of cleansing pads. LVN 9 pumped more OcuSoft foam and cleaned Resident 72's left eyelid again. LVN 9 then removed the gloves, performed hand hygiene, put new gloves on, and administered Cyclosporine 0.05% eye emulsion one (1) drop in Resident 72's right eye. LVN 9 did not remove the gloves or perform hand hygiene and proceeded to administer Cyclosporine 0.05% eye emulsion one (1) drop in Resident 72's left eye. During an interview on 11/20/2024 at 9:43 a.m., with LVN 9, LVN 9 stated that she was not aware that she had to clean her hands after touching a resident and before opening a clean bag of cleansing pads. LVN 9 stated she did not know that she had to remove gloves and clean her hands in between eyes when administering eye drops to both eyes of a resident. During an interview on 11/20/2024 at 10:45 a.m., with the Infection Preventionist (IP), the IP stated that according to the facility's policies, during the administration of eye drops in both eyes, LVN 9 should have washed and dried her hands thoroughly to prevent cross contamination of infection between left and right eye. The IP stated that LVNs should perform hand hygiene after touching residents to prevent the spread of infection among residents. During an interview on 11/20/2024 at 11:20 a.m., with the Director of Nursing (DON), the DON stated that failure to properly perform hand hygiene during administration of eye drops for Resident 72 may lead to cross contamination of infection between the resident's left and right eyes. The DON stated not cleaning the hands after the touching a resident may lead to the spread of infection among the other residents. During a review of the facility's policy and procedure titled, Installation of Eye Drops, last reviewed on 9/23/2024, the policy indicated, Should both eyes require instillation, wash and dry your hands thoroughly before treating each eye. During a review of the facility's policy and procedure titled, Hand washing/Hand hygiene, last reviewed on 9/23/2024, the policy indicated, This facility considers hand hygiene the primary means to prevent the spread of infection .Use an alcohol-based hand rub containing at least 62% alcohol. a. before and after contact with resident. (continued on next page)

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	555738	A. Building B. Wing	11/21/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	38469 2. During a review of Resident 3's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/5/2018 and readmitted the resident on 2/1/2024 with diagnoses that included hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]) and heart failure (a serious condition that occurs when the heart can't pump enough blood and oxygen to the body's organs). During a review of Resident 3's MDS dated [DATE], the MDS indicated the resident had the ability to understand others and the ability to make self-understood. The MDS indicated Resident 3 required partial/moderate assistance from staff for lower body dressing putting on/taking off footwear and personal hygiene. During a review of Resident 33's Admission Record, the Admission Record indicated the facility originally admitted the resident on 5/9/2024 and readmitted the resident on 8/22/2024 with diagnoses that included muscle wasting and type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 33's MDS dated [DATE], the MDS indicated the resident had the ability to understand others and the ability to make self-understood. The MDS indicated Resident 33 required partial/moderate assistance from staff for lower body dressing putting on/taking off footwear and personal hygiene. During a concurrent observation and interview on 11/18/2024 at 10:50 a.m., with the IP, the IP stated that residents are placed on EBP if they have wounds, have a urinary catheter (a flexible tube inserted into the bladder and left in place to continuously drain urine into a collection bag), and on enteral feeding via gastrostomy tube (a method of providing nutrition to the body through a feeding tube that delivers liquid food directly to the stomach or small intestine). The IP stated that staff who will provide bedside care, such as wound treatments, diaper change, or any tasks that requires direct contact between the residents and staff must wear full PPE. The IP stated that used PPE are discarded when exiting a room that is on EBP to prevent the spread of infection. The IP stated all rooms on EBP will have a trash bin placed inside the room directly before the door for used PPE. The IP stated that they do not allow staff to bring used PPE outside of the resident's room to prevent infection. The IP stated that other residents will be at risk for infection if the PPE is brought and discarded outside of the room. The IP verified by stating that Resident 3 and 33's shared room had no trash bin provided when there was a clear signage by Resident 3 and 33's door that the occupants of the room are on EBP. During a review of the facility's policy and procedure titled, Enhanced Barrier Precautions (EBP`s), last reviewed and revised on 9/3/2024, the policy indicated, It is the policy of this facility to implement enhanced standard/barrier precautions for the prevention of transmission of multi-drug resistant organism (MDROs) . position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing for another resident in the same room . 38549 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 87's Admission Record, the Admission Record indicated the facility admitted the resident on 10/8/2024 with diagnoses including morbid (severe) obesity (is when you weigh more than 80 to100 pounds above your ideal body weight) due to excess calories. During a review of Resident 87's Minimum Data Set (MDS - a resident assessment tool), dated 10/14/2024, the MDS indicated the resident had intact cognition (thought processes) and required maximal assistance for staff for most activities of daily living (ADLs - activities related to personal care). During a review of Resident 87's physician's orders, dated 10/9/2024, the physician's orders indicated an order indicated to provide the resident with oxygen at two (2) liters per minute (LPM - unit of measurement) via nasal cannula as needed for sleep apnea (a sleep disorder that causes people to repeatedly stop or shallowly breathe while sleeping). During an observation on 11/18/2024 at 10:23 a.m., observed Resident 87 awake in bed. Observed Resident 87 receiving oxygen at 2 LPM via nasal cannula with the tubing dated 11/6/2024. During a concurrent observation and interview on 11/18/2024 at 10:34 a.m., with Registered Nurse 4 (RN 4), RN 4 verified by stating that Resident 87's nasal cannula oxygen tubing was dated 11/6/2024. RN 4 stated that the night shift nurses were supposed to change residents' oxygen tubing every week on Wednesdays. During an interview on 11/21/2024 at 9:34 a.m., with the Infection Preventionist (IP), the IP stated that residents' oxygen tubing were supposed to be changed every Wednesday. The IP stated it was important to change residents' oxygen tubing weekly and as needed for infection control purposes. The IP stated they want to ensure that residents' oxygen tubing were clean and not soiled because an unclean tubing could harbor bacteria and increase the risk for residents developing a respiratory infection. During a review of the facility's policy and procedure titled, Changing of Nasal Cannula/Oxygen tubing, last reviewed and revised on 9/3/2024, the policy indicated it is the policy of the facility to change the nasal cannula and oxygen tubing weekly and as needed, if the nasal cannula is visibly soiled or damaged.