STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056194	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Gardens Convalescent Hospital	915 S. Crenshaw Blvd. Los Angeles, CA 90019

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to meet the needs of the residents in a timely manner for three of six sampled residents (Resident 1, Resident 2 and Resident 3). For Resident 1, Resident 2 and Resident 3, the facility failed to respond to the call lights and requests for assistance timely.These deficient practices resulted in Resident 1 stating she felt irritated, Resident 2 stated he .was so upset and angry and Resident 3 stated she felt staff do not treat me with respect. 1. During a review of the admission Record indicated the facility admitted Resident 1 on 7/24/25 with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and generalized muscle weakness. During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 7/29/25 indicated Resident 1 was cognitively intact. Resident 1 was dependent on putting on/taking off footwear, substantial assistance with lower body dressing, supervision with oral hygiene, shower/bathe self, upper body dressing and set-up with eating and toileting hygiene. The MDS indicated Resident 1 was occasionally incontinent or urine. 2. During a review of the admission Record indicated the facility admitted Resident 2 on 7/17/25 with diagnoses including diabetes mellitus and age-related physical debility.During a review of the MDS dated [DATE] indicated Resident 2 was cognitively intact. Resident 2 was dependent on toileting hygiene, shower, putting on/taking off footwear, substantial assistance with lower body dressing, partial assistance with upper body dressing, supervision with personal hygiene and set up with eating and oral hygiene. The MDS indicated Resident 2 was always incontinent of urine and bowel. 3. During a review of the admission Record indicated the facility admitted Resident 3 on 3/21/24 with diagnoses including cerebral infarction (disrupted blood flow to the brain) affecting the left side of the body and difficulty in walking.During a review of the MDS dated [DATE] indicated Resident 3 was cognitively intact. Resident 3 was independent with activities of daily living (ADLs). During an interview on 8/13/25 at 9:34 a.m., Resident 2 stated he requested to be changed on 8/4/25 at about 8 p.m. and the .nurse did not change me. Resident 2 stated he asked again during the night shift and the .nurse did not change me until 5 a.m. Resident 2 stated he saw the CNA who was supposed to change him sleeping in the nursing station. Resident 2 stated he felt very angry and upset when he saw the nurse sleeping instead of helping him. During an interview on 8/14/25 at 9 a.m., Resident 1 stated she called for assistance during the night shift (stated she does not remember the date) and no one came to help her. Resident 1 stated she had seen night shift staff sleeping in the nursing station. Resident 1 stated .it irritates me really bad when they are sleeping and no one gives her assistance when she needs it. During an interview on 8/14/25 at 10:09 a.m., Resident 3 stated during the night shift, last week, (Resident 3 unable to remember the exact date), Resident 3 called for assistance at around 3 a.m., and the nurse did not attend to her until 5 a.m., in the morning. Resident 3 stated .I feel the staff do not treat me with respect. During an interview on 8/14/25 at 7:14 a.m., Certified Nursing Assistant (CNA 1) stated during the night shift there are (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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	six CNAs. CNA 1 stated the CNAs take turns in taking their breaks for 30 minutes. CNA 1 stated the CNA who was not on their break would cover the floor while the other CNAs are on their breaks. CNA 1 stated no one should be sleeping in the nursing station. During an interview on 8/14/25 at 8:42 a.m., the director of nursing (DON) stated the nurses can do anything on their 30 minutes break. However, the DON stated the staff are not allowed to sleep in the nurses' station because this is a place of work. During an interview on 8/14/25 at 11:57 a.m., the director of staff development (DSD) stated staff can do what they want during their 30 minutes break. DSD further added for the staff who want to sleep during their 30-minute break should sleep in the break room and not in the nurses station. During a review of the facility Policy titled Accommodation of Needs revised on 3/13/25 the facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe, independent functioning, dignity and well-being. The same Policy indicated the resident's individual needs and preferences will be accommodated to the extent possible except when the health and safety of the individual or other residents would be endangered. During a review of the facility's policy and procedures (P&P) titled Answering the Call Light revised on 3/13/25, indicated answer the resident call system immediately. When answering an auditory request for assistance, identify yourself and politely respond to the resident by his/her name. If the resident needs assistance, indicate the approximate time it will take to respond. If the resident's request is something you can fulfill, complete the task within five minutes if possible.

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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. Based on interview and record review, the facility failed to obtain a physician order for fingerstick to obtain the blood sugar level (BSL, measure of sugar in the blood by using a glucometer [medical device that measures the blood glucose level in the body] for one of six sampled residents (Resident 1) according to the professional standards of quality. For Resident 1, the facility failed to:1.Obtain a physician order to obtain BSL by fingerstick from Resident 1's physician. The fingerstick were done on 7/24/25, 8/2/25, 8/8/25/ 8/9/25, 8/10/25 and 8/11/25.2.Notify the physician when Resident 1's BSL results were above 189 milligrams per deciliter (mg/dL, a unit of measurement for the concentration of glucose in the blood, normal range is between 60 mg./dL to 100 mg./dL).These deficient practices had the potential for Resident 1 to suffer from hyperglycemia (high blood sugar level) and not given appropriate treatment.During a review of the admission Record indicated the facility admitted Resident 1 on 7/24/25 with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and generalized muscle weakness. During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 7/29/25 indicated Resident 1 was cognitively intact. Resident 1 was dependent on putting on/taking off footwear, substantial assistance with lower body dressing, supervision with oral hygiene, shower/bathe self, upper body dressing and set-up with eating and toileting hygiene. During a review of Resident 1's Care Plan initiated on 7/24/25, indicated Resident 1 was newly admitted to the facility. The care plan goal indicated Resident 1's needs will be met to address the primary reason for admission for rehabilitation and nursing care. The care plan interventions included administer medications, treatments and other services in accordance with physician orders. During a review of the Blood Sugar Summary Resident 1's had the following BSL results:7/24/25 at 3:38 p.m., 189 mg./dL8/2/25 at 10:32 am 395 mg./dL8/2/25 at 5:19 p.m. 395 mg./dL8/8/25 at 10:06 pm 400 mg./dL8/9/25 at 4:49 p.m. 238 mg./dL8/10/25 at 5:15 p.m. 236 mg./dL8/11/25 at 4:48 p.m. 372 mg./dL During an interview on 8/14/25 at 9 a.m., Resident 1 stated she is a diabetic and the nurse had been checking her blood sugar levels. Resident 1 stated her BSL was high, around 300 mg./dL to 400 mg./dL sometimes and the facility was not doing anything about the BSL. Resident 1 stated .they are not giving me anything, I don't know why. for the high blood sugar levels. During a concurrent interview and record review on 8/14/25 at 10:36 a.m., Resident 1's Blood Sugar Summary was reviewed with the licensed vocational nurse (LVN 1). LVN 1 stated Resident 1's blood sugar was obtained because Resident 1 was requesting to have her blood sugar checked. LVN 1 stated a physician's order is needed to check the blood sugar levels of Resident 1. During a telephone interview, on 8/14/25 at 4:30 p.m., LVN 2 stated there is no physician order to obtain Resident 1's blood sugar level. LVN 2 stated he obtains Resident 1's BSL because Resident 1 was requesting to have her BSL checked. LVN 2 stated the normal blood sugar was between 60 mg./dL to 100 mg./dL. LVN 2 further added Resident 1's BSL were elevated at times because the BSL were obtained right after Resident 1 had eaten. LVN 2 stated he notified Resident 1's physician about the BSL results, but LVN 2 stated he did not document that he notified the physician. During a review of the facility's policy and procedures titled Guidelines for Charting and Documentation reviewed on 3/13/25, the P&P indicated the purpose of charting and documentation is to provide a complete account of the resident's care, treatment, response to care, signs and symptoms, etc. and the progress of the resident's care. The Policy indicated the documentation should include any time the physician or family is called about the resident and their response. The same Policy indicated physician orders must be written and maintained in chronological order. Physician orders are needed for including diet, activity, laboratory work, transfers and discharges. Treatment orders should specify what is to be done, location and frequency (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and duration of the treatment.