STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055060	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Post Acute Care	12121 Santa Monica Boulevard Los Angeles, CA 90025

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 0689 Level of Harm - 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** 48903 Based on interview and record review, the facility failed to ensure, the resident who was assessed as high risk for falls, did not fall four times and sustained injuries for one of three sampled residents (Resident 1). The facility failed to: 1. Provide Resident 1 with a full-time 1:1 sitter (one to one staff that is immediately at hand to help prevent a fall or redirect a patient from engaging in a harmful act) per a care plan titled, High Risk for Injury/Accidents and Falls, dated 11/24/23, to prevent the resident from falling on 1/25/2024, 4/11/24, 4/28/24, and 5/7/2024 and sustain injuries. Resident 1 was provided with the 1:1 sitter only after Resident fall on 5/7/2024. 2. Ensure after Resident 1's first fall on 1/25/2024, the resident's care plan titled High Risk for Injury/Accidents and Falls, interventions for the prevention of falls, were evaluated for effectiveness and other effective interventions were considered to prevent Resident 1 from future falls on 4/11/2024, 4/28/24, and 5/7/2024. 3. Ensure staff provided Resident 1 with 1:1 sitter to assist the resident with supervision in accordance with the facility policy and procedure (P&P) titled, Sitters. These deficient practices resulted in Resident 1 sustaining a fall on 1/25/2024 with dislocated (a separation of two bones where they meet at a joint) left hand 5th finger and left arm ulna (a bone in the forearm (the region of the upper limb between the elbow and the wrist) shaft (a long structure) fracture (brake in bone), and subsequent falls on 4/11/24, 4/28/24 without the injuries, and another fall on 5/7/2024 when the resident sustained a hematoma on the right eyebrow requiring transfer to the acute care hospital (GACH) for evaluation and treatment. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated Resident 1 was admitted to the facility, on 8/29/23, with diagnoses including an unspecified injury of the head, repeated falls, and an unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with external reality). (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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NAME OF PROVIDER OR SUPPLIER Westwood Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 12121 Santa Monica Boulevard Los Angeles, CA 90025	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Care Plan (CP) titled High Risk for Injury/Accidents and Falls, dated 9/18/23, indicated Resident 1 was a high risk for falls and injuries, with a history of falls and an actual fall on 9/18/23. The CP goals included resident 1 would have no injury/accidents or falls in the next three months. The CP interventions (specific care and services facility staff needed to provide a resident to promote healing and prevent a worsening of a condition) included the following interventions for Resident 1: 1. Maintain the resident's environment safe and hazard free. 2. Monitor residents' whereabouts often. 3. Keep the resident's bed in the lowest position. 4. Place a floor mat at the resident's bed. 5. Keep the resident's call light in reach. A review of Resident 1's Fall Risk Evaluation dated 9/28/23 at 6:36 AM, indicated Resident 1 had one to two falls (actual number falls not specified) in the past three months. Fall Risk Evaluation indicated Resident 1 was transferred to a general acute care hospital (GACH) on 9/28/23 for evaluation due to fall on 9/28/23 and suffered a laceration on the forehead. The Fall Risk Evaluation did not indicate if a physician was notified about the fall with injury. A review of Resident 1's CP titled, High Risk for Injury/Accidents and Falls, dated 11/24/23, indicated Resident 1 was a high risk for falls and injuries, with a history of falls. The CP goal indicated Resident 1 would not have injury/accidents or falls in the next three months. The CP interventions included the following interventions to prevent repeated falls for Resident 1: 1. Provide Resident 1 with 1:1 sitter as necessary for safety. 2. Frequent visual checks. 3. Keep the resident's bed in lowest position. 4. Keep floor mat at the resident's bed side. 5. Keep a call light in resident's reach. 6. Maintain environment safe and hazard free A review of Resident 1's Progress Notes for the months of 4/2023, 5/2023, and 6/2023, indicated there was no documentation Resident 1 was provided with a 1:1 sitter for safety and to prevent Resident 1 from falls. A review of Resident 1's Progress Notes dated 1/25/24 and timed at 10:10 AM indicated, Resident 1 was found by staff on the floor mat by her bed on 1/25/24 at around 9 AM. Resident 1 complained of mild (pain level not documented) left hand and right hip pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Progress Notes dated 1/25/24 at 2:13 PM indicated, Resident 1 had swelling of the left hand and right hip pain. A review of Resident 1's Progress Notes dated 1/25/24 at 9:42 PM, indicated, Resident 1 was noted to have left hand swelling. A review of Resident 1's untitled CP , initiated on 1/25/24, indicated Resident 1 was noted with swelling on the left hand and pain and right hip pain. Medical doctor (MD) was present and assessed with order. The CP indicated Resident 1 had a dislocated (a separation of two bones where they meet at a joint) left 5th digit as evidenced by x-ray of left hand (date not indicated). The CP goal for Resident 1 was to have no further decline and increase in pain level for the next three months. The CP interventions included: 1. Provide Resident 1 with sitter 1:1 around the clock (initiated on 1/28/24). 2. Inform MD and responsible party that Resident 1's left 5th finger was dislocated. 3. Resident 1 was sent to emergency room (ER) for further evaluation. The same CP indicated that on 1/27/2024, Resident 1 returned to the facility from ER with a splint (a medical device to support and immobilize a joint/body part). The CP did not indicate if Resident 1 was provided with a sitter. A review of Resident 1's Progress Notes dated 1/27/24 at 4:30 PM, indicated, Resident 1 was readmitted from a GACH and that at the GACH it was confirmed Resident 1 had a dislocated left 5th finger. Resident 1's Progress Notes indicated the GACH's physician (MD) was unable to put Resident 1's finger back in place and a splint (a medical device that stabilizes a part of your body and holds it in place) was applied. A review of Resident 1's Progress Notes dated 1/29/24 at 5:41 PM, indicated, the facility's social worker discussed with Resident 1's conservator (a court appointed person or organization to be legally responsible for someone who cannot manage alone) regarding the conservator providing a 1:1 siter for Resident 1. The progress notes indicated the conservator could only provide a 1:1 sitter for Resident 1 from 10 AM to 1 PM. The progress notes did not indicate Resident 1 was provided a 1:1 sitter for safety to prevent repeated falls. A review of Resident 1's Progress Notes dated 1/30/24 at 1:13 PM, indicated, Resident 1 was arguing with staff, trying to kick and bite them. A review of Resident 1's Progress Notes dated 1/30/24 at 3:52 PM, indicated, Resident 1 was trying to throw herself on to the floor and was scratching and trying to hit staff. Resident 1 was also twisting her (Resident 1's) body and arms while in bed. A review of Resident 1's Progress Notes dated 1/30/24 at 4:10 PM, indicated Resident 1 was getting out of bed to her wheelchair all night and staff had to prevent Resident 1 from falling. The progress notes indicated staff tried to redirect Resident 1 to stay in bed, but Resident 1 was kicking, biting, and moving upside down in bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's untitled CP dated 1/30/24, indicated Resident 1 was physically aggressive toward staff and was trying to throw self on the floor. The CP goals indicated Resident 1 would not harm self or others through review date of 4/30/24. The CP included the following interventions: 1. Continue 1:1 sitter at the bedside. 2. Give the resident choices about care. 3. Assess the resident sensory (relating to sensation or to the senses) deficits. 4. Redirect resident. The same CP did not indicate if a sitter was provided to Resident 1. A review of Resident 1's History and Physical (H&P) from a general acute care hospital (GACH) dated 1/31/24 at 11:17 AM, indicated, Resident 1 was in the emergency department to be evaluated for aggressive behavior at the facility. The H&P indicated Resident 1 was observed to be combative, agitated, and aggressive both physically and verbally with lashing out at staff. A review of Resident 1's Physician's Progress Notes from the GACH dated 2/11/24 at 1:48 PM, indicated Resident 1 was noted to be confused and was trying to get out of bed. The Physician's Progress Note's indicated Resident 1 was on fall precaution and that Resident 1 was noted to have significant swelling of a left-hand 5th digit. The physician progress notes indicated GACH admitted Resident 1 for dehydration (excessive loss of body water), metabolic encephalopathy (a group of conditions that cause brain dysfunction), urinary tract infection ([UTI] - infection of any part of the urinary system), and impaired balance (unsteadiness), strength, and mobility. Resident remained at GACH from 2/11/24 and was discharged back to the facility on [DATE]. A review of Resident 1's Physician's Progress Notes from the GACH dated 2/12/24 at 4 PM, indicated Resident 1's assessment included left ulna shaft fracture and dislocated left 5th finger with an open wound. A review of Resident 1's H&P from the facility dated 2/14/24, indicated Resident 1 did not have the capacity to understand and make decisions. A review of Resident 1's CP titled, Resident is high risk for fall related to (r/t) repeated falls, revised 3/15/24, indicated the goal for Resident 1 was to be free of falls and injuries through the review date of 8/28/24. The CP interventions included the following: 1. Evaluate the resident for the risk for falls on admission and as necessary (PRN). 2. Provide 1:1 sitter as deemed necessary for safety. 3. Initiate fall risk precautions. 4. Review information on past falls and attempt to determine the cause of falls and record possible root causes. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's CP titled The Resident had an actual fall. Fall Risk score:13, dated 1/25/24, indicated the resident had an assisted fall on 4/11/24 with no injury or pain. The CP did not indicate where the resident fell from or the circumstances of the fall. The same CP indicated Resident 1 had a witnessed fall on 5/7/24 and was transferred to a GACH via 911 for further evaluation. The CP interventions indicated Resident 1 to have 1:1 sitter at all times and to conduct frequent room visit. A review of Resident 1's Progress Notes dated 4/11/24 at 5:46 AM, indicated Resident 1 slid to the floor from her wheelchair in the hallway. A review of Resident 1's CP (untitled) dated 4/15/24, indicated Resident 1 was at risk for falls with the following interventions to achieve a goal for Resident 1 to be free of falls: 1. 1:1 Sitter (initiated on 5/7/24). 2. Assist with ambulation and transfers. 3. Evaluate fall risk as needed. A review of Resident 1's CP dated 4/28/24, indicated Resident 1 had a witnessed/assisted fall on 4/28/24. The CP interventions included to determine and address causative factors of fall. A review of Resident 1's Progress Notes dated 4/28/24 at 6:22 AM, indicated Resident 1 was trying to get out of bed and a Certified Nursing Assistant (CNA) helped her to slide to the floor in an assisted fall. A review of Resident 1's Progress Notes dated 4/30/24 at 10:58 AM, indicated Resident 1 stood up and tried to walk. Resident 1 bit CNA that tried to assist Resident 1 back to bed. A review of Resident 1's Progress Notes dated 5/7/24 at 9:50 AM, indicated that during an interview with Resident 1, the resident stated she rolled out of bed and fell on her face. The Progress Notes indicated Resident 1's roommate stated the resident's roommate heard a loud thump and saw Resident 1 on the floor face down. The Progress Notes indicated Resident 1 developed a bump on her forehead and complained of pain, 911 was called, and Resident 1 was transferred to a hospital for further evaluations. A review of Resident 1's Progress Notes dated 5/7/24 at 10:23 AM indicated, Resident 1 was observed with hematoma (when an injury causes blood to collect and pool under the skin) on her right eyebrow and was transferred to the GACH 1 for evaluation. A review of Resident 1's Progress Notes dated 5/7/24 at 3:44 PM indicated, Resident 1 was treated at a GACH 1's Emergency Department (ED) after falling from bed and sustaining an injury to the head. The Progress Notes indicated Resident 1's ED's evaluation included a physical exam, laboratory tests and diagnostic imaging of head and face. The Progress Notes indicated Resident 1 had a Computed Tomography ([CT] a computerized x-ray imaging procedure) exam on 5/7/24 of the spine, face, and brain. The CT of the resident's brain results dated 5/7/24 indicated a small anterior (front) midline (middle) scalp (the skin on top of the head) hematoma. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 6/1/24 indicated Resident 1 had sever impairment of cognitive (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) skills for daily decision making and required maximal assistance form staff with oral hygiene, toileting, showering, dressing and personal hygiene. During an interview on 6/21/24 at 10:50 AM a Certified Nursing Assistant (CNA 3) stated Resident 1 gets violent when staff try to get her back in bed. CNA 3 stated Resident 1 tries to kick and slap her (CNA 3). During a concurrent interview and record review on 6/21/24 at 11:01 AM with the Licensed Vocational Nurse (LVN 2) Resident 1's CPs history was reviewed. The CP history indicated the resident had to be provided with 1:1 sitter at all times in accordance with the CP dated 11/24/23, 1/25/24, 1/30/24, 3/15/24, and 4/15/24. LVN 2 stated, Resident 1 did not have a full-time sitter before Resident 1's most recent fall on 5/7/24. LVN 2 stated, the CP interventions after Resident 1's first fall on 1/25/24 were not effective because Resident 1 was continuing falling. During a concurrent interview and record review on 6/21/24 at 11:57 AM the Director of Nursing (DON), Resident 1's Fall Incidents were reviewed on the Facility Fall Incidents List. Resident 1's Fall Incidents indicated Resident 1 experienced four falls on the following dates 1/25/24, 4/11/24, 4/28/24, and 5/07/24. The DON stated Resident 1 was transferred to the hospital after sustaining an injury to the hand from the first fall on 1/25/24. The DON stated Resident 1 was transferred back to this facility. The DON stated Resident 1 was sent on a 5150 (danger to others) hold after biting a staff member. The DON stated this facility is not appropriate for Resident 1 but we had to readmit the resident back from the hospital because no other facility will accept her. The DON stated Resident 1 did not have a full-time sitter before the resident's most recent fall (on 5/7/24). The DON stated the facility could have prevented further falls if Resident 1 had a full-time sitter. A review of the facility's policy and procedures (P&P) titled, Sitters dated 1/1/12, indicated, Purpose: to assist residents who need additional supervision. Sitter responsibilities: 1. Notifying facility staff if and/or when resident attempts to get out of bed unassisted. 2. Notifying facility staff of any resident needs. A review of the facility's P&P titled, Fall Prevention and Management Program dated 8/1/14, indicated, residents will be provided with a safe environment that minimizes complications associated with falls. The facility will provide an environment free from the hazards that the facility has control over. The interdisciplinary team ([IDT] - a group of health care professionals with various areas of expertise who work together toward the goals of their clients) will initiate, review and update resident fall risks and plan of care upon significant change of condition and post fall.