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	08/19/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on observation, interview, and record review, facility failed to ensure the licensed nurse notified the physician about the change of condition (COC- a sudden or acute deviation from a patient's baseline that may lead to complications or death if left untreated) for one out of three sampled residents (Resident 1) by: - Failing to report to the physician about resident 1 ' s abdominal distention (when the abdomen is abnormally swollen outward and can be caused by a buildup of fluid, tissue, or digestive contents, or by gas and may be related to constipation) on [DATE]. - Failing report the inconsistent bowel movement (BM). This deficient practice had the potential to result in Resident 1 being constipated and lead to bowel obstruction (occurs when the lumen of the bowel becomes either partially or completely blocked. Obstruction frequently causes abdominal pain, nausea, vomiting, constipation-to-obstipation [severe or complete constipation], and distention). Findings: During a review of a care plane with a focus that indicated The resident has bowel and bladder incontinence, initiated on [DATE] and revised on ,d+[DATE].2024 had interventions which indicated to report Resident 1 ' s changes In bowel and bladder status to MD (Medical Doctor). During a review of Resident 1 ' s Admission Record (FS) indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including complete paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), essential hypertension (high blood pressure not caused by another disease), and [NAME] ' s encephalopathy (an unusual type of memory disorder due to a lack of thiamin [vitamin B1]). During a review of Resident 1 ' s Minimum Data Set (MDS- a standardized assessment and care screening tool), dated [DATE], indicated Resident 1 had some severe cognitive impairment (people with severe cognitive impairment have a very hard time remembering things, making decisions, concentrating, or learning) and was depended on staff for all activities of daily living such as eating, personal hygiene, toilet transfers, shower/bathing, and dressing. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the nurse progress notes for Resident 1 dated [DATE] at 8:18 pm indicated, Certified Nursing Assistant (CNA) was service dinner at 4:43 pm and noted Resident was unresponsive. Other staff responded to the CNAs cry for help and Cardiopulmonary Resuscitation (CPR- a medical procedure involving repeated compression of a patient's chest, performed to restore the blood circulation and breathing of a person who has suffered cardiac arrest) was initiated, 911 called and the paramedics arrived on scene and took over CPR. Resident 1 was pronounced dead at 5:15 pm. During an interview on [DATE] at 11:07 am., CNA 1 stated that Resident 1 was observed to be pale (light in color or having little color), had abdominal distention and was refusing to eat on [DATE] in the morning. CNA 1 stated she reported the observation to LVN 2. During an interview with Licensed Vocational Nurse (LVN) 2, on [DATE] at 11:16 am, LVN 2 stated that CNA 1 notified her around 11:30 to 12 pm that Resident 1 ' s abdomen was distended (swollen) and that she (Resident 1) had not had a bowel movement. LVN 2 stated that she brought the medication MiraLAX (a medication that is used in the management and treatment of constipation). LVN 2 observed that Resident 1 ' s abdomen was more distended than usual. LVN 2 then administered the MiraLAX at that time because she (Resident 1) had refused to take it as prescribed in the morning. LVN admitted that the abdominal distention was a COC and should have immediately notified the physician and initiated a COC form. LVN 1 stated that the physician must know about the COC and prescribe some necessary medications if needed. During an interview with CNA 2, on [DATE] at 3 pm, CNA 2 stated that Resident 1 did not have a BM on [DATE] and did not know if Resident 1 had had a BM that morning because she had not received report from the CNA that worked with Resident 1 during the day. CNA 2 stated that at 5:30 pm, She (CNA 2) went to feed Resident 1 and found her (Resident 1) in supine position. There were no movement and was paralyzed. She called Resident 1 ' s name and got no response. She walked out of the room to call for help and two charge nurses came in to the room. They began CPR and immediately after they started CPR, the resident began to throw up a very large amount of black liquid. The Charge nurses asked if I fed her, and I replied that I did not. They turned her to the side, let liquid come out then began CPR again. During an interview with the Director of Nursing (DON), on [DATE] at 3:56 pm, the DON stated Resident 1 had a history of abdominal distention due to her diagnosis of alcohol-induced chronic pancreatitis (inflammation of the pancreas often associated with long-term alcohol consumption). DON admitted that assessments for Resident 1 should have included abdominal girth measurements daily to determine even the smallest changes. The DON stated that when there is a COC, the physician must be made aware as soon as possible to ensure timely assessments and orders. During a review of the facility's policy and procedures titled Change of Condition Notification, reviewed on [DATE], indicated the following: I. The Facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal representative or an interested family member, if known, when the resident endures a significant change in their condition caused by, but not limited to: A. An accident. B. A significant change in the resident ' s physical, mental or psychosocial status; and/or (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. A significant change in treatment. II. Change of Condition related to Attending Physician notification is defined as when the Attending Physician must be notified when any sudden and marked adverse change in the resident ' s condition which is manifested by signs and symptoms different than usual denote a new problem, complication or permanent change in status and require a medical assessment, coordination and consultation with the Attending Physician and a change in the treatment plan.