

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055060	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Westwood Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524</p> <p>Based on observation, interview, and record review, the facility failed to ensure to change and update to a menu to meet the nutritional needs for one of the three sampled residents (Resident 1) who was identified as being at a risk for unplanned weight loss.</p> <p>This deficient practice resulted in Resident 1 experiencing significant weight loss (unplanned weight loss) and was transferred to General Acute Care Hospital (GACH) for further evaluation and treatment.</p> <p>Cross reference F755.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including prostate cancer, encephalopathy (a general term for a group of conditions that cause brain dysfunction. It can be caused by many different things, including disease, injury, drugs, or chemical), and obstruction of bile duct (a blockage in the tubes that carry bile from the liver to the gallbladder and small intestine. The biliary system is comprised of the organs and duct system that create, transport, store, and release bile into the duodenum for digestion).</p> <p>During a review of the physician ' s order dated 8/7/2024 indicated, RD (Registered Dietician) consult to evaluate and treat as needed.</p> <p>During a review of the weight log indicated the following weights:</p> <p>8/10/2024 3:42 pm 172 Lbs. (abbreviated measurements for pounds).</p> <p>8/19/2024 8:59 am 167 Lbs.</p> <p>During a review of the Minimum Data Set (MDS - a comprehensive assessment and screening tool), dated 8/14/2024, indicated Resident 1, moderate cognitive impairment (a condition in which people have more memory or thinking problems than other people their age) and required between supervision or touching assistance and substantial/maximal assistance for Activities of Daily Living (ADLs) such as toilet transfer and chair/beds-to-chair transfer; toilet hygiene, shower/bathe self, upper and lower body dressing, and putting on/taking off footwear.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the initial dietary profile dated 8/14/2024 at 11:54 am indicated, Resident 1 ' s weight was at 172 lbs. and that he like to eat ice cream and had requested it (ice cream). The note indicated ice cream to be provided at lunch and dinner and snacks at 2 pm and 8 pm.</p> <p>During a review of the nutrition/dietary note dated 8/21/2024 at 10:01 am indicated, Resident 1 had a weight loss of 5 lbs. which was 3% of his body weight in one week. The note indicated Resident 1 ' s weight was low for age. The note indicated the previous RD review was on 8/14/2024 with recommendations to receiving ice cream with lunch, dinner, 2pm and 8 pm snacks. The note indicate these recommendations were pending.</p> <p>During a review of a history and physical (a term used to describe a physician's examination of a patient. In an H&P, the physician obtains a thorough medical history from the patient, performs a physical examination, and then documents their findings) dated 8/21/20024 indicated Resident 1 was having memory loss and that he had fluctuating capacity to make decisions.</p> <p>During a review of the physician ' s order dated 8/22/2024 indicated, Transfer GACH ER (Emergency Department) due to failure to thrive (happens when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal)/ Poor oral intake for further evaluation and treatment via nonemergent ambulance transport.</p> <p>During an interview with the RD on 8/26/24 at 4:03 pm, RD stated that she had initially evaluated Resident 1 on 8/14/2024 and identified him to be at a risk for weight loss. RD stated that she had made some recommendations based on Resident 1 ' s likes to help improve his appetite. On 8/21/2024 during a weight variance meeting, it was noted that Resident 1 had significant weight loss of 5 bls in one week. As RD was reviewing Resident 1 ' s chart, she noted that her previous recommendations were not carried out. RD admitted that it was possible that the weight loss may have not been significant if the recommendations had been carried out. The potential effect if not eating or dehydrate then the resident will have malnutrition which is serious medical condition.</p> <p>During an interview with the Director of Nursing (DON) on 8/26/24 at 4:46 pm, the DON stated that she had been worried about Resident 1 not eating. DON stated that is was important to carry out the dietary recommendations as it may have prevented Resident 1 from having significant weight loss. DON stated that the potential of not eating may result in significant weight loss and worsen other medical health conditions.</p> <p>During a review of the facility's policy and procedures (P&P) titled, Evaluation of Weight & Nutritional Status revised 4/21/2022, the P & P indicated, to ensure the residents maintain acceptable parameters of nutritional status through evaluation of weight and diet. The P&P indicated the facility will work to maintain an acceptable nutritional status for residents by analyzing the assessment information to identify the medical conditions, causes and/or problems related to the residents condition. The P&P indicate defining and implementing interventions for maintaining or improving nutritional status that are consistent with residents needs, goals, and recognized standards of practice.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524</p> <p>Based on observation, interviews, and record reviews the facility failed to implement its own policies and procedure by failing to ensure the accurate administration of a medication Darolutamide 300 milligrams [mg] (Nubeqa- a prescription medicine used to treat adults with prostate cancer that has spread to other parts of the body and responds to medical or surgical treatment that lowers testosterone (metastatic hormone-sensitive prostate cancer [a disease that occurs when malignant cells grow in the prostate gland, which is located below the bladder in the male reproductive system] or mHSPC), for one out of three sampled residents (Resident 1) for .</p> <p>This deficient practice had the potential to result in Resident 1 ' s prostate cancer worsening.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including prostate cancer, encephalopathy (a general term for a group of conditions that cause brain dysfunction. It can be caused by many different things, including disease, injury, drugs, or chemical), and obstruction of bile duct (a blockage in the tubes that carry bile from the liver to the gallbladder and small intestine. The biliary system is comprised of the organs and duct system that create, transport, store and release bile into the duodenum for digestion).</p> <p>During a review of a physician ' s order dated 8/7/2024 indicated, Darolutamide Oral Tablet 300 MG (Darolutamide) Give 2 tablet by mouth two times a day for Prostate Cancer.</p> <p>During a review of the nursing progress notes dated: 8/9/2024 5:27 pm; 8/10/2024 8:05 am; 8/10/2024 5:41 pm; 8/11/2024 10:47 am; 8/11/2024 5 pm; 8/12/2024 2:51 pm; 8/13/2024 7:32 pm; 8/15/2024 10:17 am; 8/15/2024 6:12 pm; 8/16/2024 5:33 pm; 8/17/2024 9:55 am; 8/17/2024 8:16 pm; 8/18/2024 9:57 am; 8/18/2024 5:21 pm; 8/19/2024 8:57 am; 8/19/2024 5:05 pm; 8/20/2024 9:31 am; 8/20/2024 5:22 pm; 8/21/2024 9:36 am; and 8/22/2024 9:11 am.</p> <p>Indicated that medication Darolutamide Oral Tablets 300 mg was not administered and was pending delivery. There was no documented evidence that the physician was notified.</p> <p>During a review of the Minimum Data Set (MDS - a comprehensive assessment and screening tool), dated 8/14/2024, indicated Resident 1, moderate cognitive impairment (a condition in which people have more memory or thinking problems than other people their age) and required between supervision or touching assistance and substantial/maximal assistance for Activities of Daily Living (ADLs) such as toilet transfer and chair/beds-to-chair transfer; toilet hygiene, shower/bathe self, upper and lower body dressing, and putting on/taking off footwear.</p> <p>During a review of a history and physical (a term used to describe a physician's examination of a patient. In an H&P, the physician obtains a thorough medical history from the patient, performs a physical examination, and then documents their findings) dated 8/21/20024 indicated Resident 1 was having memory loss and that he had fluctuating capacity to make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review of Resident 1 with Licensed Vocational Nurse (LVN) 2 on 8/26/24 at 12:53 pm, LVN confirmed that the pharmacy had not delivered medication Darolutamide since his admission on 8/7/2024 because it was so expensive, and insurance would not be able to cover it. LVN 2 stated when a resident does not have ordered medications on hand, the physician must be informed so that they can order an alternative or reevaluate. She stated that she had informed Resident 1 ' s attending physician Medical Doctor (MD)1 but was unable to provide documented evidence. LVN 2 admitted that Resident 1 ' s oncologist was not notified that Resident one had not received his medication. LVN 2 stated that it was important for the resident to take it because he had prostate cancer medication. The potential effect of not taking it would be that the cancer would be worse.</p> <p>During an interview with LVN 1 on 8/27/24 at 11:54 am, LVN 1 confirmed that she (LVN 1) had not called the MD regarding Resident 1 ' s missing medication because she (LVN 1) believed that LVN 1 had called. LVN 1 stated that she had did not speak with LVN 2 directly but had overheard another nurse say LVN 2 may have spoken with MD 1.</p> <p>During an interview with the Pharmacy Consultant (PharmD) on 8/27/24 at 2:58 pm, PharmD stated the medication Darolutamide was classified as an antineoplastic drug (medications used to treat cancer by preventing or disrupting cell division) and was important to take daily as ordered to slow the progression of the disease. If not taken as ordered, the situation could get worse. The Facility must do whatever is reasonable to make sure that medications are available to residents.</p> <p>During an interview with the Director of Nursing (DON) on 8/27/24 at 1:47 pm, the DON acknowledged that Resident 1 had not received any of his prostate cancer medication Darolutamide since he had moved in to the facility on [DATE]. The DON admitted that the facility should have made sure that they would be able to provide the appropriate medications the Resident 1 needed. The DON acknowledged that the missed medication is a medication error, and that the facility should have called and informed not only the attending physician, but also Resident 1 ' s Oncologist for orders for alternatives or medication adjustments as needed. The DON stated that the potential effect of not taking the Darolutamide could be worsening of his (Resident 1) cancer.</p> <p>During an interview with the Administrator (AD) on 8/27/24 at 2:40 pm, the AD admitted that when Resident 1 was admitted to the facility, the facility should have ensured that all his medications including the Darolutamide should have been purchased by the facility.</p> <p>During an interview with the MD 2 on 8/27/24 at 3:07 pm, MD 1 stated that he was not aware that the Resident 1 was not taking his medication Darolutamide, and that the facility should have informed him.</p> <p>During a review of the facility's policy and procedure (P&P) titled Medication - Administration, reviewed 7/25/2024, indicated To ensure the accurate administration of medications for residents in the Facility.</p>		