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	10/07/2024

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 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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45524

Based on observation, interview and record review, the facility failed to meet professional standards of quality by failing to:

1. Ensure Resident 1 had an abdominal binder to prevent her Gastrostomy Tube (often called a G tube, is a surgically placed device used to give direct access to the stomach for supplemental feeding, hydration, or medicine) from frequently being dislodged.

2. Ensure that Resident 1 was sent to General Acute Care Hospital (GACH) timely after her G tube was dislodged.

3. Ensure Resident 1 ' s abdominal assessment (a physical examination of the abdomen that includes inspection, auscultation, percussion, and palpation. It's a key part of a patient's physical exam and can help determine the cause of gastrointestinal or genitourinary issues) was performed 3 times a week.

4. ensure staff were trained or in-serviced on the signs and symptoms of bowel impaction.

These deficient practiced placed residents at a risk for unnecessary hospitalization s, malnutrition, dehydration, and bowel impactions (a large, hard mass of stool that is stuck in the colon or rectum and can't be passed during a normal bowel movement).

Findings:

A review of Resident 1 ' s Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included anoxic brain damage (a type of brain damage that occurs when the brain is completely deprived of oxygen), cirrhosis of the liver (a chronic disease that occurs when the liver is permanently damaged by scar tissue, making it difficult for the liver to function properly), and coagulation defect (disruptions in the body's ability to control blood clotting).

A review of the Minimum Data Set (MDS - a comprehensive assessment and screening tool), dated 8/8/2024, indicated Resident 1's cognitive skill (mental action or process of acquiring knowledge and understanding) for daily decision-making were severely impaired. The MDS indicated Resident 1 was dependent for all Activities of Daily Living (ADL-eating, oral hygiene, toilet hygiene, shower/bathe self, dressing, and personal hygiene).

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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: 055060	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2024
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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of a physician ' s order dated 5/21/2024 at 10:57 am., indicated, transfer Resident 1 to GACH via non-emergency transport for further evaluation (G Tube replacement). During a review of a physician ' s order dated 5/25/2024 at 3:51 pm., indicated, transfer Resident 1 to GACH via non-emergency transport for further evaluation (G Tube replacement). During a review of Situation, Background, Assessment, and Recommendation (SBAR - a communication tool used in nursing to help healthcare professionals share information about a patient's condition or other issues) dated 5/25/2024 at 2:57 pm, indicated, Gastrostomy tube blockage or displacement. During a review of the GACH encounter summary dated 5/27/2024 at 12:10 am to 5/28/2024 at 2:34 pm indicated Resident 1 ' s diagnoses description included: Abdominal pain. During a review of the GACH discharge summaries dated 5/28/2024 at 9:59 am, indicated under hospital course including complications, indicated Resident 1 was sent to the Emergency Department (ED) for evaluation of rectosigmoid dilation as seen on Kidney Ureter Bladder (KUB x-ray [a type of radiation called electromagnetic waves. X-ray imaging creates pictures of the inside of your body]. The same summaries indicated Resident 1 had gaseous distention of the colon and rectum and a large amount of stool in the rectum and was to be discharged back to the facility on an aggressive bowel regimen. The same documented indicated Resident 1 had a fecal impaction before probably from colonic inertia (a condition where the colon is unable to move stool efficiently to the rectum, resulting in severe constipation) and being bedbound. During a review of a physician ' s order dated 5/28/2024 at 3:08 pm., indicated, transfer Resident 1 to GACH via non-emergency transport for further evaluation (G Tube replacement). During a review of a physician ' s order dated 5/28/2024, indicated, Enteral Feed (also known as enteral nutrition, are a way to deliver nutrition and calories to the body through the G Tube) Order every shift Jevity (a high-protein, fiber-fortified liquid nutritional supplement that is used as a tube feeding formula) 1.5 at 60 milliliters (ml) per (/) hr x 20 hours to provide 1200ml/1800 calories(kcal)/day and Flush (the process of using a syringe to add water to the tube to keep it clean and prevent clogging) with 50 ml/hr X20 hours to provide 1000 ml/day. Until volumetric dose is complete. During a review of an SBAR dated 9/3/2024 at 1:30 pm, indicated, G tube malfunctioning, unable to flush. The SBAR indicated physician had recommended for Resident 1 to be transferred to GACH via non-emergency transportation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the GACH ED discharge summary dated 9/4/2024 indicated the reason for Resident 1 ' s visit included abdominal pain, feeding tube problem, and fecal impaction. The same summary indicated Resident 1 was seen because of an x-ray which indicated abnormal dilation of large bowel (an abnormal dilation of the colon [large intestines] that is not caused by mechanical obstruction. It is usually accompanied by symptoms such as abdominal discomfort, but may result in serious complications (colonic perforation [medical emergency where the digestive tract has a hole in it], peritonitis [a life-threatening inflammation of the peritoneum, the tissue that lines the abdominal cavity and covers most of the abdominal organs], and/or sepsis [a life-threatening medical emergency that occurs when the body's immune system has an extreme response to an infection or injury]) if left untreated) and colonic ileus (a condition in which the bowel does not work correctly, but there is no structural problem). Pt c/o right upper abd (abdomen) pain10/10 (scales used to rate pain from 0 to 10, 10 being the worst). Pt (patient) is anxious (feeling or showing uncomfortable feelings of uncertainty). The same document indicated the primary diagnosis as fecal impaction (a serious condition that occurs when a large, hardened mass of stool blocks the colon or rectum, making it difficult or impossible to pass stool). During a review of Resident 1 ' s abdominal-pelvis (The bones between the lower abdomen and upper thighs that connect the spine to the legs) Computed Tomography (CT) scan, is a noninvasive medical imaging procedure that uses X-rays and a computer to create detailed images of the inside of the body dated 9/4/2024 at 1:34 pm indicated, Fecal impaction in the rectum with severe distention of the sigmoid colon measuring up to 14 centimeters [cm] (non-distended colon is generally considered to be less than 6 cm in diameter). During a review of the ED notes dated 9/4/2024 at 4:20 pm under Emergency Department Course, indicated Resident 1 had a large bowel movement. The same note indicated to perform an additional soap suds enema given extensive fecal impaction. During a review of a physician ' s order dated 9/19/2024 at 11:21 am., indicated, transfer Resident 1 to GACH via non-emergency transport for further evaluation (G Tube replacement). During a concurrent observation of Resident 1 and interview with Licensed Vocational Nurse (LVN) 1 on 9/23/24 at 1:15 pm, LVN 1 admitted that Resident 1 had a history of G Tube multiple dislodgments. LVN 1 stated that an abdominal binder (a wide, elastic, or non-elastic belt that is wrapped around the lower torso to provide support and compression to the abdomen) should have been used to prevent frequent G Tube dislodgements. During a concurrent record review and interview of Resident 1 ' medical records with Treatment Nurse (TxN) 1 on 9/23/24 at 2:01 pm, TxN admitted that Resident 1 had a history of G Tube dislodgments which was why a care plan was initiated to place an abdominal binder to prevent Resident 1 from pulling it out. TxN stated that potential of not placing the abdominal binder could result in the continued frequent dislodgements of Resident 1 ' s G Tube. (continued on next page)

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview with the Assistant Director of Nursing Director (ADON) on 9/23/24 at 2:33 pm admitted that having an abdominal binder placed on Resident 1 may have helped prevent Resident 1 from pulling it out do many times and avoid the frequent GACH transfers. The ADON confirmed that there was a delay in the transfer of Resident 1 when the G Tube malfunctioned on 9/3/2024 at 1:30 pm to the time that she was transferred to GACH on 9/4/2024 at 10:55 pm and that the physician should have been notified when Resident 1 was still in the facility 3 hours later. The ADON admitted that Resident 1 received her nutrition and hydration via the G-Tube and the potential of not sending her timely to GACH could result in Resident 1 being malnourished and dehydrated.

During an interview with the Medical Doctor (MD) 1 on 10/1/2024 at 11:44 am, MD 1 stated that Resident needed to wear the abdominal binder to prevent the G Tube from getting dislodged and did not understand why facility staff stopped using it. MD 1 stated that Resident 1 is at a risk for getting dehydrated and malnourished if G Tube access is lost and must therefore be transferred to GACH within three to four hours of the dislodgement.

During an interview with Licensed Vocational Nurse (LVN) 1, at 10/4/2024 at 9:58 am, LVN 1 stated that the facility had no policy and procedure on constipation. LVN 1 stated that she had never performed a manual disimpaction on any Residents and stated, I am not a professional, so I ask the treatment nurse to perform it or watch me perform the procedure. LVN 1 stated that the procedure was within her scope of practice and admitted that having a policy and procedure may enhance her confidence in performing the procedure.

During an interview with the DON, on 10/4/24 at 10 am, the DON stated that abdominal assessments are done quarterly (every 3 months) of which she admitted was too long and must be done at least three to four times a week to track if a resident is constipated or not. The DON stated that it was possible for someone to have a small bowel movement when they were impacted. she admitted that the facility had no policy and procedure on constipation and that the people responsible for ensuring the facility had sufficient and necessary policies were herself and the administrator. The DON was unable to provide documented evidence of staff training or in services on constipation.

During a review of the facility's policy and procedure (P&P) titled Change of Condition Notification, reviewed 7/25/2024, the P&P indicated, To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. The same P&P indicated under procedure which included:

- The Licensed Nurse will assess the change of condition and determine what nursing interventions are appropriate.

A. Before notifying the Attending Physician, the Licensed Nurse must observe and assess the

overall condition utilizing a physical assessment and chart review.

i. Notification to the Attending Physician will include a summary of the condition change and an assessment of the resident ' s vital signs and system review focusing on the condition and/or signs and symptoms for which the notification is required.

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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's P&P titled Hydration Program, reviewed 7/25/2024, the P&P indicated, The Facility will provide residents with fluids to minimize episodes of dehydration or over hydration. The same P&P indicated, the Licensed Nurse will notify the DON or designee, Dietary Department, Attending Physician, and resident ' s responsible party if the resident refuses fluids for 24 hours, and/or if the resident shows any signs and symptoms of fluid deficit or fluid overload. During a review of the facility's P&P titled Evaluation of Weight Nutritional Status Copyright, reviewed 7/25/2024, the P&P indicated the following: - The Facility will work to maintain an acceptable nutritional status for residents by: a. Assessing the resident ' s nutritional status and the factors that put the resident at risk of not maintaining acceptable parameters of nutritional status. b. Analyzing the assessment information to identify the medical conditions, causes and/or problems related to the resident ' s condition and needs. c. Defining and implementing interventions for maintaining, or improving nutritional status that are consistent with resident needs, goals, and recognized standards of practice. d. Monitoring and evaluating the resident ' s response, or the lack of response to the interventions. e. Revising or discontinuing the approaches as appropriate, or justifying the continuation of current approaches. During a review of an article at https://www.ncbi.nlm.nih.gov/books/NBK448094/, titled Fecal Impaction, dated 7/4/2023, the article indicated Fecal impaction occurs because of hardened fecal matter retained in the large bowel which cannot be evacuated by regular peristaltic activity. If this is not recognized and treated early, it can give rise to the formation of fecoliths, or stone-like feces. Fecal impaction is a cause for increased morbidity and a significant cause of a decrease in quality of life among the elderly. The article indicated an associated history of progressive abdominal distention with increasing abdominal discomfort are present in most instances.