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	12/20/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview and record review, the facility failed to provide care in a manner that promote or enhanced resident ' s dignity and respect by failing to ensure staff was not standing over resident while feeding for two out of two sampled residents (Resident 5 and Resident 8). This deficient practice had the potential to cause psychosocial harm to the resident and could violate resident ' s right to be treated with dignity and respect. Findings: 1. A review of the Admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing) and dementia (a progressive state of decline in mental abilities). A review of the Minimum Data Set (MDS - resident assessment tool) dated 10/30/2024, indicated Resident 5 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 3 required maximal assistance to total dependent from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation with Resident 5 on 12/17/2024 at 12:33 p.m., Resident 5 was observed being fed by Certified Nursing Assistant 1 (CNA1). CNA1 was observed standing over Resident 5 while Resident 5 was raising her neck and looking up at CNA1. Observed a folding chair inside Resident 5 ' s room. During an interview with CNA1 on 12/17/2024 at 12:38 p.m., CNA1 stated, Resident 5 was a feeder and required assistance with feeding. CNA1 stated, she needed to sit down while feeding resident so that it would be comfortable for the residents. CNA1 was then observed grabbing the chair and sat down. 2. A review of the Admission Record indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain) and dysphagia. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the MDS dated [DATE], indicated Resident 8 ' s cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 3 required total dependent from staff for ADLs. During a concurrent observation with Resident 8 on 12/17/2024 at 12:36 p.m., Resident 8 was observed being fed by Certified Nursing Assistant 2 (CNA2). CNA2 was observed standing over Resident 8 while Resident 8 was raising his neck and looking up at CNA2. During an interview with CNA2 on 12/17/2024 at 12:40 p.m., CNA2 stated, he needed to ensure to keep the head of bed up while feeding resident and to sit down so that it will be comfortable for them. CNA2 stated, he did not sit down on a chair while feeding Resident 8 because there ' s was no available chair around. During an interview with Licensed Vocational Nurse 2 (LVN 2) on 12/17/2024 at 12:43 p.m., LVN 2 stated, staff should be sitting down while feeding residents as this is for their dignity and respect. LVN 2 stated, staff should be on eye-to-eye level with residents as it was more comfortable for residents as well. A review of facility ' s policy and procedure (P&P), titled, Restorative Dining Program, reviewed on 11/21/2024, the P&P indicated, Staff member should sit while assisting or feeding resident. A review of facility ' s P&P titled, Feeding the Resident, reviewed on 11/21/2024, the P&P indicated, Residents able to receive oral feedings are properly positioned to facilitate eating.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview and record review, the facility failed to ensure resident ' s call light (a device used to notify the nurse that the resident needs assistance) were answered promptly for one of three sampled residents (Resident 4). This deficient practice had the potential to result in the residents not being able to summon staff for assistance for care and services as needed, which could lead to accidents such as falls with injuries. Findings: A review of the Admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (afib- an irregular and very rapid heart rhythm that and can lead blood clots in the heart), muscle weakness and polyneuropathy (a condition in which a person's peripheral nerves are damaged). A review of the Minimum Data Set (MDS - resident assessment tool) dated 12/16/2024, indicated Resident 4 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 4 required moderate assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview with Resident 4 on 12/17/2024 at 11:54 a.m., Resident 4 was observed pressing the call light for help. Resident 4 stated, staff took a while to answer call lights and sometimes, staff would turn off the call light and never returned to assist the resident. Resident 4 ' s call light was observed on outside Resident 4 ' s door. At 12:05 p.m., Resident 4 ' s call light was still on, and staff were observed walking in the hallway, three staff were observed in the Nursing Station 1 and a sound alarm was heard in the Nursing Station 1. During an interview with Licensed Vocational Nurse 3 (LVN 3) on 12/17/2024 at 12:06 p.m. at the Nursing Station 1, LVN 3 stated, call lights had to be answered right away, and any staff could answer the call light. LVN 3 stated, nurses heard the alarm sound in the nursing station when a resident pressed their call light. LVN 3 stated, there was an alarm sound, and a call light was on for Resident 4. When asked why the call light had not been answered which had been on for more than 10 minutes, LVN 3 was not able to answer. A review of facility ' s policy and procedure (P&P), titled, Communication - Call System, reviewed on 11/21/2024, the P&P indicated that, The call alert device will be placed within the resident ' s reach. Facility staff will answer call alerts promptly and in a courteous manner.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview and record review, the facility failed to implement a comprehensive care plan that met the care/services based on the resident's individual assessed needs for one of three sampled residents (Resident 1) by failing to ensure that a comprehensive (CP) was developed after Resident 1 had a fall incident with injury on 12/5/24. This deficient practice had the potential to result negative impact on residents ' health and safety, as well as the quality of care and services received. Findings: A review of the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (loss of the ability to move in one side of the body) following nontraumatic subarachnoid hemorrhage (lack of blood flow resulting in severe damage to some of the brain tissue) affecting left dominant side, difficulty in walking and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). A review of the Minimum Data Set (MDS - resident assessment tool) dated 10/30/2024, indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were mildly impaired. The MDS indicated Resident 1 required moderate to maximal assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 1 ' s SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 12/5/2024 indicated, Falls, transferred to General Acute Care Hospital 1 (GACH 1). A review of Resident 1 ' s Progress Notes dated 12/5/2024 indicated, During 7 p.m. rounds, resident (1) resting in bed, at around 8:55 p.m., patient (Resident 1) was sitting on his bed, claimed that he fell off the bed. Per resident (1), I want to go down the stairs to the first floor. Skin/body check initiated and noted a 3 centimeter (cm - unit of measurement) by 5 cm by 0.5 cm bump on left forehead, no laceration/bleeding noted, complained of headache . A review of Resident 1 ' s electronic health record and paper health record indicated, there was no CP developed with a goal and interventions for the actual fall incident on 12/5/2024. During a record review and interview with Medical Record Director (MRD) on 12/17/2024 at 12:40 p.m., MRD stated, there are no care plan in the medical record for Resident 1 after Resident 1 had a fall incident with a bump on his forehead. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s policy and procedure (P&P) titled, Fall Management Program, reviewed on 11/21/2024 indicated, Interventions will be documented on the resident ' s plan of care in the resident ' s clinical record.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview and record review, the facility failed to ensure resident received treatment and care in accordance with professional standards of practice for one of three sampled residents, Resident 1 by failing to implement facility ' s policy and procedure (P&P) titled, Death of a Resident when Resident 1 expired on [DATE]. This deficient practice resulted in incomplete assessment and documentation required per facility ' s policy and procedure upon death. Findings: A review of the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (loss of the ability to move in one side of the body) following nontraumatic subarachnoid hemorrhage (lack of blood flow resulting in severe damage to some of the brain tissue) affecting left dominant side, difficulty in walking and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). A review of the Minimum Data Set (MDS - resident assessment tool) dated [DATE], indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 1 required moderate to maximal assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 1 ' s Progress Notes dated [DATE] indicated, At 6:50 a.m., Certified Nursing Assistant noticed resident not responsive . Resident (1) not responsive to verbal commands, no pulse, no rise and fall of the chest . Paramedics (a healthcare professional trained in the medical model, whose main role has historically been to respond to emergency calls for medical help outside of a hospital) pronounce time of death. A review of Resident 1 ' s electronic medical record and paper medical record as of [DATE], indicated there was no physician ' s progress notes that was completed, and no record of death was filed. During an interview with Medical Record Director (MRD) on [DATE] at 2:05 p.m., MRD stated, there are no physician ' s progress notes on Resident 1 ' s death and no death certificate on file. A review of facility ' s policy and procedure (P&P) titled, Death of a Resident, revised on [DATE], the P&P indicated, Only a Licensed Physician may declare a resident dead. i. The Licensed Nurse will report the resident's symptoms to the Attending Physician so the Attending Physician can make an official determination of death . All documentation pertaining to the resident ' s death, including the official pronouncement of death, communication with the resident ' s family/surrogate, communication with state agencies, and communication with the funeral home will be maintained in the medical record. Document on the licensed progress notes when the Coroner's office was notified, the name of the officer, the deceased assigned case number and the disposition of the case.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for two of two sampled residents (Resident 2 and Resident 4) by failing to ensure a physician ' s order was in place for oxygen (O2) therapy for Resident 4 and the nasal cannula (NC -a connector attached to oxygen) tubing and humidifier (a device used to make supplemental oxygen moist) was changed for Resident 2 and Resident 4 per facility ' s policy. These deficient practices had the potential to cause complications associated with oxygen therapy. Findings: 1. A review of the Admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (afib- an irregular and very rapid heart rhythm that and can lead blood clots in the heart), muscle weakness and polyneuropathy (a condition in which a person's peripheral nerves are damaged). A review of the Minimum Data Set (MDS - resident assessment tool) dated 12/16/2024, indicated Resident 4 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 3 required moderate assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 4 ' s Order Summary Report as of 12/17/2024, the Order summary indicated, there were no physician ' s orders for supplemental oxygen therapy. During a concurrent interview and observation with Resident 4 on 12/17/2024 at 11:54 a.m., Resident 4 stated, he was on oxygen therapy since admission to the facility (12/9/24). Resident 4 was observed with an oxygen concentrator machine with NC and humidifier at the bedside. Resident 4 ' s NC tubing and humidifier were observed to have no label date. The humidifier was also observed empty, and no bubbling was observed. During a concurrent observation and interview with Licensed Vocational Nurse 3 (LVN 3) on 12/17/2024 at 12:08 p.m., LVN 3 observed Resident 4 ' s NC and humidifier and confirmed by stating, Resident 4 ' s NC tubing and humidifier had no label date. LVN 3 stated, the NC had to be dated and had to be changed weekly and as needed to prevent risk of infection. LVN 3 further stated, the humidifier bottle was empty and needed to be changed as well. 2. A review of the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), afib, and heart failure (a condition in which the heart does not pump blood as well as it should). A review of the MDS dated [DATE], indicated Resident 2 ' s cognitive skills for daily decisions were intact. The MDS indicated Resident 2 required supervision from staff for ADLs. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2 ' s Order Summary Report dated 12/9/2024 indicated, O2 via nasal cannula at 2 liters per minute (lpm - unit of measurement), may administer with humidifier every shift. During a concurrent interview and observation with Resident 2 on 12/17/2024 at 11:33 a.m., Resident 2 stated, the NC tubing has not been changed since he got admitted from the hospital. Resident 2 was observed with an oxygen concentrator machine with NC and humidifier at the bedside. Observed Resident 2 ' s NC tubing and humidifier did not have a label date. The humidifier bottle was also observed at more than halfway empty and no bubbling was observed. During a concurrent observation and interview with Licensed Vocational Nurse 2 (LVN 2) on 12/17/2024 at 11:41 a.m., LVN 2 observed Resident 2 ' s NC and humidifier confirmed by stating, Resident 2 ' s NC tubing and humidifier have no label date. LVN 2 stated, the NC and humidifier should have been dated and should have been changed weekly. When asked why it needed to be changed weekly and as needed, LVN 2 answered, she did not know. A review of the facility ' s policy and procedure (P&P) titled, Oxygen Therapy, reviewed on 11/21/2024, the P&P indicated, Administer oxygen per physician ' s orders . The humidifier and tubing should be changed no more than every 7 days and labeled with the date of change.