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	04/18/2025

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 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** 44252 Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 5) had a call light the resident was able to use within reach. This failure resulted in Resident 5's inability to call staff for assistance due to inability to push the call light button. Findings: During a review of Resident 5's Admission Record , dated 4/18/25, indicated Resident 5 was admitted to the facility on [DATE], with a diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), abnormal posture, muscle wasting and atrophy (thinning of muscle mass), generalized osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and muscle weakness. During a review of Resident 5's Minimum Data Set (MDS-resident assessment tool) dated 2/13/25 indicated Resident 5 had intact cognitive (thinking, reasoning, judgement and learning) function and required maximal assistance for eating and was completely dependent on staff for bathing toileting, oral and personal hygiene, dressing, transferring and bed mobility. During an observation with concurrent interview on 4/18/25 at 10:23 am with Resident 5, the resident was observed attempting to find and use the call light but was unsuccessful. The resident stated she was calling for help because she could not find the call light, and the movement in her hands is not strong enough to push the button to call down. During an observation with concurrent interview on 4/18/25 at 10:28 am with Certified Nurse Assistant (CNA) 6, the CNA agreed the resident was unable to press the call light button and suggested they could change it to a tap call light for ease of use.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on interview, and record review, the facility failed to ensure one of five sampled residents (Resident 1) their care plan intervention of Low Air Loss (LAL-mattress designed to prevent and treat pressure injuries by reducing moisture and heat buildup using a system of inflated air cells that continuously circulate air) mattress was implemented. This failure resulted in a decline in Resident 1's pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). Findings: During a review of Resident 1's Admission Record , dated 4/18/25, indicated Resident 1 was admitted to the facility on [DATE], with a diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), abnormal posture, muscle weakness, generalized osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), heart failure (a condition where the heart cannot pump enough blood to meet the body's needs), hypertension (high blood pressure) and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool) dated 2/2/25 indicated Resident 1 had severe cognitive (thinking, reasoning, judgement and learning) problems and required setup or clean-up assistance for eating and was completely dependent on staff for bathing toileting, oral and personal hygiene, dressing, oral and personal hygiene, and transferring and required substantial/maximal assistance with bed mobility. The same MDS further indicated the resident rejected care (e.g., bloodwork, Activities of Daily Living [ADLs-- a set of basic self-care tasks that individuals perform to maintain their independence and well-being], medications) one to three times in a week. During a concurrent interview and record review with Director of Nursing (DON) on 4/18/25 at 3:00 pm Resident 1's care plan for pressure ulcer decline dated 2/6/25 was reviewed. The record indicated intervention of Low Air Loss mattress. Ensure LAL mattress is on correct setting . The DON verified the record. Further review of Resident 1's records indicated an order for Low Air Loss mattress entered on 2/10/25, 2/12/25 and 2/14/25, with a note indicating the LAL mattress was installed on 2/14/25. The DON verified the records and stated the mattress was not put on the resident until later because the family were concerned for the resident would fall from the bed with the mattress (it makes the bed higher). The DON further stated they put the LAL mattress on the date indicated in the charting a few days after the decline on 2/6/24. During a review of the facility's policy and procedures (P&P) titled Mattresses, reviewed 3/21/25, the P&P indicated provide a mattress appropriate to the residents' needs . provide pressure reduction to residents at risk for skin breakdown . relief to residents at risk for skin breakdown . under the direction of an Attending Physician's order or when the resident's clinical condition warrants pressure reducing devices.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on interview, and record review, the facility failed to ensure the medical record documentation of ADLs was accurate and complete for one of five sampled residents (Resident 1). This failure resulted in an inaccurate and incomplete medical record for the resident. Findings: During a review of Resident 1's Admission Record , dated 4/18/25, indicated Resident 1 was admitted to the facility on [DATE], with a diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), abnormal posture, muscle weakness, generalized osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), heart failure (a condition where the heart cannot pump enough blood to meet the body's needs), hypertension (high blood pressure) and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool) dated 2/2/25 indicated Resident 1 had severe cognitive (thinking, reasoning, judgement and learning) problems and required setup or clean-up assistance for eating and was completely dependent on staff for bathing toileting, oral and personal hygiene, dressing, oral and personal hygiene, and transferring and required substantial/maximal assistance with bed mobility. The same MDS further indicated the resident rejected care (e.g., bloodwork, Activities of Daily Living [ADLs-- a set of basic self-care tasks that individuals perform to maintain their independence and well-being], medications) one to three times in a week. A review of Resident 1's ADL record from 1/27/25-2/6/25 indicated the following missing documentation: Eating: 1/27/25 night shift, 1/28/25 evening and nigh shift, 1/29/25 all shifts, 1/30/25 day and night shifts, 1/31/25 day and night shifts, 2/1/25 evening and night shifts, 2/2/25 night shift, 2/4/25 night shift, 2/5/25 night shift, 2/6/25 day and night shifts. Roll left to right: 1/28/25 evening and night shift, 1/29/25 evening and night shift, 1/30/25 evening and night shift, 1/31/25 night shift, 2/1/25 night shift, 2/2/25 night shift, 2/4/25 night shift, 2/5/25 night shift, 2/6/25 night shift. Personal hygiene: 1/27/25 night shift, 1/28/25 evening and night shift, 1/29/25 day, evening and night shift, 1/30/25 evening and night shift, 1/31/25 night shift, 2/1/25 night shift, 2/2/25 night shift, 2/4/25 night shift, 2/5/25 night shift, 2/6/25 night shift. Toilet hygiene: 1/28/25 evening and night shift, 1/29/25 evening and night shift, 1/30/25 evening and night shift, 1/31/25 night shift, 2/1/25 night shift, 2/2/25 night shift, 2/4/25 night shift, 2/5/25 night shift, 2/6/25 night shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oral hygiene: 1/28/25 evening, 1/29/25 evening shift, 1/30/25 day and evening shift, 1/31/25 evening shift, 2/1/25 evening shift. During a concurrent interview and record review on 4/18/25 and 3:00 pm with the DON, Resident 1's ADL documents were reviewed as indicated above. The DON verified the missing documentation and stated there was an issue with the documentation before, because the facility had the Ipads used for documentation by the CNAs stolen and they had not replaced them so the CNAs had only the computers to share with the nurses and they would leave without documenting, because there would be a line to use the computers. During a review of the facility's policy and procedures (P&P) titled Completion & Correction Medical Records Manual - General , reviewed 3/21/25, the P&P indicated The facility will work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation . Entries will be recorded promptly as events or observations occur . Entries will be complete . descriptive and accurate.