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	05/29/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42342 Based on record review and interview for one of three sampled residents, Resident 1. The facility failed to: 1. Ensure regular re-evaluation of discharge plan. 2. Coordinate with resident representative (RR) in the discharge planning process. 3. Ensure Resident 1 was discharge with supply of hydroxyzine (medication given for itching). 4. Ensure the assisted living facility (ALF- a residential care facility the provides non-medical care and supervision for senior who need assistance with daily living activities but don ' t require 24-hour nursing care) was notified that Resident 1 had a gastrostomy tube (g-tube: a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) during discharge planning process. 5. Ensure Resident 1 was set up with home health. 6. Follow up with Resident 1 post discharge. These deficient practices lead to the discharge of Resident 1 to the ALF with a g-tube in place, no home health set up and no supply of hydroxyzine. Findings: A review of Resident 1 ' s Admission record indicated the facility admitted this [AGE] year-old male on 12/28/2024 with diagnoses including, Hemiplegia (paralysis) and hemiparesis (total weakness of the arm, leg, and trunk on the same side of the body) following cerebral infarction (CI-stroke, loss of blood flow to a part of the brain) affecting the right dominant side, primary thrombophilia (a condition that increases the likelihood of blood clots forming), depression (mental health condition characterized by persistent sadness), aphasia (a disorder that makes it difficult to speak), seborrheic dermatitis (dry patchy skin), dysphagia (difficulty swallowing), gastrostomy, hyperlipidemia (high fat in the blood), glaucoma (damage to the eye nerve) and occlusion (blockage) and stenosis (narrowing) of right coronary artery. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s care plan titled, Discharge Planning initiated 12/31/2024 indicated per family uncertain at this time. The goal indicated appropriate placement will be available, family choice. Interventions included the facility will assist in transitioning to place of choice, will discuss options with family, will follow up with rehabilitation services and nursing regarding update. A review of Resident 1 ' s Minimum Data Set (MDS-a resident assessment) dated 1/4/2025 indicated Resident 1 ' s cognition (mental ability to make decisions for daily living) was not intact. The MDS indicated Resident 1 was dependent (helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting, personal hygiene, and transfers (moving between surfaces) from bed to chair. The assessment indicated Resident ' s legal guardian participated in goal setting for discharge. Resident 1 ' s overall discharge goal was unknown. No referrals were made to local contact agency because the discharge date was 3 or fewer months away. A review of Resident 1 ' s physician order dated 2/7/2025 indicated to discharge Resident 1 to ALF; pick up time at 2:00pm via gurney (bed). During an interview on 5/28/2025 at 3:50 p.m. with the family member (FM), the FM stated, Resident 1 was placed with care coordination agency (CCA 2-responsible for assessing participants in the ALW program needs, developing individualized service plans and ensuring they receive the necessary services). The DSS told the FM the DSS would coordinate Resident 1 ' s discharge with CCA 2 but it never happened. Resident 1 had a managed health plan (MHCP-type of insurance plan that uses a limited network of contracted doctors, hospitals and other healthcare providers requiring the individual to choose a primary doctor within their network who makes referrals to specialist) and did not qualify for Medicare (federal insurance program for people [AGE] years and older). The DSS was supposed to assist with this, and it was never done. Resident 1 has not needed the g tube since 10/2024, Resident 1 has been eating since then. When we first arrived at the facility I tried to schedule a care meeting with the DSS, but the DSS kept rescheduling. When we finally had the meeting, that ' s when the DSS told me CCA 2 would be taking over the discharge planning and the DSS never got back to me and did not return any of my calls. I have a hearing with Medi-Cal now to get Resident 1 approved for straight Medi-Cal (state issued insurance for low-income individuals and families with disabilities and certain health conditions). This is a process I knew nothing about, and it was very frustrating having to learn how the system works, and I am fed up. I am trying to get Resident 1 straight Medi-Cal so Resident 1 can qualify for home health and continue with physical therapy because he was not getting any while at the facility. I would have never agreed to transfer Resident 1 out of the facility had I known I would have to do all of this to get home health, the DSS should have assisted, or returned any of my calls. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/2025 at 4:00 p.m. with care coordinator (CC 2-individual responsible for performing assessment of participant in the ALW program needs, developing individualized service plans and ensuring they receive the necessary services). The CC2 stated, we were not informed about any home health arrangements for Resident 1, there was a lack of communication from the DSS, and we had trouble trying to get any documentation. We felt like the facility just threw Resident 1 out; Resident 1 was not established with a primary care doctor, so we had to do that. Resident 1 was not prepared to be discharged to the community. When we do the assessment, we ensure there are no ineligible conditions like g tubes because we do not provide skilled care (care provided by a licensed professional). Typically, a resident is established with a primary doctor prior to discharge in case there are issues with the medications. Upon discharge the facility did not provide all of Resident 1 ' s medication and usually it is the DSS that will assist to ensure this is done. I had to set up transportation for Resident 1 to get to the ALF which is something I do not normally do. I set up transportation because the DSS told me it depended on the type of insurance Resident 1 had on what would be covered and the facility would not cover any private pay transportation. I spoke with the DSS a few days before the discharge date and the DSS told me the family was going to arrange the transportation but when I called the next day to follow up (did not provide specific dates) because we did not want to lose the bed, there was still no transportation set up so that it why I tried to set it up. I told the DSS the ALF would be ready to take Resident 1 the next day and to please make sure home health or any needed durable medical equipment (DME-reusable medical devices and equipment prescribed by a health care provider) was arranged. We had to set him up with a new primary care doctor with the help of the FM; this is usually done by the DSS prior to discharge. I followed up with the DSS after Resident 1 was discharged but did not get a response. Resident 1 was sent to the ALF with the g tube, and they had to take Resident 1 to the general acute care hospital (GACH) to have it removed. During an interview on 5/29/2025 at 10:00 a.m. with CC2, CC2 stated, Resident 1 was placed on the ALW waiting list while at a different facility a long time ago and was about to fall off the list on 12/10/2024 so I reached out to the last known facility where Resident 1 was located and was told Resident had been discharged . The is when I reached out to FM and the FM informed me where Resident 1 was currently living. I conducted the assessment for Resident 1 with the FM over the phone, Resident 1 was not involved in the process. Typically, when I do these assessments I contact the facility, I asked the FM if the FM wanted me to contact the facility to complete the assessment and the FM stated no you can do the assessment for Resident 1 with me. We gave the FM a list of facilities to choose from and the FM chose the ALF. After this, Adm 1 from the ALF went to the facility on [DATE] to evaluate Resident 1 and {unnamed staff} told Adm 1 Resident 1 was eating regular food and never mentioned a g tube. Adm 1 then contacted CC2 and gave approval to admit Resident 1 to the ALF. The DSS became very difficult to reach after this, so the FM and myself found and arranged an appointment with a primary doctor for Resident 1 prior to discharge. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/2025 at 10:21 a.m. with the Director of Social Services (DSS), The DSS stated, If a resident is not going to return home, we can offer (ALW-a state funded program that allows eligible individuals to receive care in assisted living facilities instead of nursing home), to those residents who need minimal assistance. The Resident and or family will sign a consent and then we submit the referral to the ALW. The ALW will come and do an assessment on the resident, and I help to coordinate with the resident. We can do a video call and a registered nurse (RN) assessment from the facility. After the assessment we are in a waiting period again to hear from the state to let us know we can start looking for placement at an ALF in their preferred area. Then someone from the ALF can come to the facility to assess the resident. My role is to submit the signed consent by the resident, or we talk to the family to confirm they want the ALW. The next step is an interview with the ALW agency to determine the level of care the resident will need. My role in that process is to connect them when they call or facilitate their visit with the resident. After the ALF has assessed the resident and accepted them, we do a discharge care plan meeting and nursing will inform the assigned doctor to obtain a discharge order. I will then reach out to the accepting facility to inquire if they will arrange home health or are we going to arrange home health. If we arrange, we will get the order from the physician prior to discharge and send it to the home health agency. During a concurrent Interview and record review on 5/29/2025 at 11:05 a.m. with the DSS, Resident 1 ' s Multidisciplinary Care Conference form dated 12/30/2024 was reviewed. The Multidisciplinary Care Conference form indicated Resident 1 was non-verbal and admitted to the facility with (g-tube for medication administration, on no added salt (NAS) diet, mechanical soft chopped texture diet with nectar thick consistency liquids. Resident 1 was currently admitted under long term care until further notice. The DSS stated, The meeting was very brief, and the FM wanted Resident 1 to be sent somewhere close to where the FM lives. No other details regarding discharge planning were discussed other than that. During a concurrent Interview and record review on 5/29/2025 at 11:05 a.m. with the DSS, Resident 1 ' s case manager note dated 2/4/2025 was reviewed. Resident 1 ' s case manager note indicated Resident 1 ' s FM stated Resident 1 was in the ALW program consented to sending referral and referral was accepted. The FM and ALW found an ALF that accepted Resident 1 and wanted Resident 1 transferred to the ALF ASAP. Will assist and work on FM request. The DSS stated, I did not give the FM any referrals or consents for the ALW program, The FM is the one who informed us it had been done. The DSS stated, CC1 then called and informed the DSS of receiving a call from the Administrator (Adm 1) informing CC1 that Resident 1 was scheduled for a discharge date of [DATE] and transportation was going to be arranged by the FM. The DSS could not remember if the DSS followed up with the FM after receiving this phone call to confirm the arrangement and offer any assistance. The DSS stated, Adm 1 called the DSS and informed the DSS that home health had been arranged for Resident 1 with HH 1. The DSS stated, there was no order for home health included in Resident 1 ' s orders, I do not know what doctor wrote the order for home health; that was arranged between the FM and the Adm 1. I did not work with the FM, CC1 nor Adm 1 to make any of these arrangements. Lastly, The DSS stated, no one from ALW or any ALF came to evaluate Resident 1, Resident 1 must have been evaluated at a previous facility because the ALW program will not accept Resident ' s without an evaluation. During an interview on 5/29/2025 at 11:43 a.m. The DSS initially stated, I did not do a follow up call post discharge, and I don ' t normally do discharge follow up calls on Residents in the ALW program because they go to ALF ' s where they have staff, and they are not alone so there is no need to do follow up. We do follow up post discharge on residents who went home to ensure they get there safely. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent Interview and record review on 5/29/2025 at 11:45 a.m. with the DSS, Resident 1 ' s post discharge follow-up evaluation dated 2/12/2025 was reviewed. Resident 1 ' s post discharge follow-up evaluation indicated Resident 1 was discharged to the ALF on 2/7/2025. The first attempted call to follow up was made on 2/11/2025 to CCA 1 and CC1 informed the DSS that Resident 1 was happy being closer to the FM. Additionally, no appointment with Resident 1 ' s primary doctor was scheduled because Resident 1 went to an ALF where they had a contracted physician and home health available for Resident 1 so Resident 1 would not have to leave the facility. The DSS stated, I called CCA 1to follow up because they are the ones that arranged Resident 1 ' s transfer to the ALF. I did not call the ALF directly and speak with any staff where Resident 1 was physically located. The DSS stated, I did not follow up and ask about home health because it was my understanding CC 1 had it arranged, and it was covered through the ALW program so there was nothing for me to arrange or follow up on. During an interview on 5/29/2025 at 12:01 p.m. with the director of nursing (DON), The DON stated, the discharge planning process starts at admission, we meet with residents and or family within the first 72 hours of admission to identify any potential barriers to discharge and continue to assess the resident ' s needs for discharge during their stay. If a resident is on the ALW program our social worker should be sending that referral and coordinating a visit by a representative from the ALW to come to the facility and evaluate the resident to ensure there are no barriers to placement. Some barriers include if the resident is on hospice (compassionate care for people who are near the end of life provided at the person ' s home or within a health care facility), has wounds that require treatments or has a g tube. After they have evaluated the resident, then we can do discharge planning to find out when they can accept the resident and discharge them with their remaining supply of medications. If at the time of discharge, the resident does not have an appointment with their primary doctor to obtain medication refills and depending upon the type of assistance they will have to get to their primary doctor, we can discharge them with up to 30-day supply of medication. If a resident is going to an ALF, we discharge them with the medications they have on hand because the ALF will have their own supply or let us know what medications they don ' t have on hand. Our DSS should assist with the ALW referrals, it doesn ' t matter if the family picks the place; the DSS should be calling the ALF and giving them a summary of the resident and providing rehabilitation notes, face sheets, orders and other information for the resident. We do a post discharge follow up call within 30 days of discharge whether they went home or to an ALF. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/29/2025 at 3:15 p.m. with The Adm 1, Resident 1 ' s physician order summary report dated 2/7/2025 was reviewed. Resident 1 ' s physician order summary report indicated a zero handwritten next to hydroxyzine 25 mg (milligrams, unit of measurement) give 1 tablet via g-tube every 6 hours as needed for itching. Adm 1 stated, I went to the facility to see Resident 1 back in February 2025, I don ' t remember who I spoke to, but they did not inform me he had a g tube. We were surprised to see the g tube when Resident 1 arrived on 2/7/2025. When we reviewed the medication list and the medication that were sent with Resident 1, we noticed there was no hydroxyzine and Resident 1 did not have any primary doctor to call for a refill. I saw that Resident 1 was eating regular food when I visited Resident 1. When the facility sent the face sheet I saw gastrostomy, but I thought it was just a history of g-tube because Resident 1 was eating regular food. The FM found a doctor for Resident 1 and I made the appointment and took Resident 1 there to have the g tube removed. We are still trying to arrange home health, we called several companies, and none will accept Resident 1 because Resident 1 is so young the current insurance does not cover. The FM has been trying to get the Resident 1 ' s qualified for disability insurance so we can arrange home health. We do not have any doctors or licensed staff here at this facility, we have care givers that assist with bathing, toileting, medication administration and activities. We did not receive any follow calls from anyone at the facility Resident 1 was transferred from. A review of the facility's policy and procedures (P&P) titled, Discharge and Transfer of Residents reviewed 3/21/2025, the P&P indicated Disposition of Resident's Drugs Upon Discharge A. Drugs which have been dispensed for individual resident use and are labeled in conformance with State and Federal law for outpatient use will be furnished to a resident by the Licensed Nurse upon discharge according to the orders of the resident's Attending Physician. B. If the Attending Physician's discharge orders do not include provisions for drug dispositions, drugs will be furnished to residents unless: The Attending Physician specifies otherwise; The resident leaves or is discharged without an Attending Physician's order or approval; The resident is discharged to a general acute care hospital, acute psychiatric hospital, or acute care rehabilitation hospital; The drug was discontinued prior to discharge; or The labeled directions for use are not substantially the same as most current orders for the drug in the resident's health record. A review of the facility's P&P titled, Transfer and Discharge, reviewed 3/21/2025, the P&P indicated I. Discharge Planning A. Discharge planning will begin on the residents' admission to the Facility. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. The resident's overall expectation related to discharge will be documented in Section Qof the MDS. C. An initial discharge assessment will be completed by Social Services Staff or designee within seven (7) days of admission. D. Referrals made to local contact agencies will be documented in the medical record. Preparations for and assistance with discharge planning will be documented in the medical record as well. E. The MDS will be updated to reflect resident's improvement in status quarterly, annually and with significant changes in the resident's condition. F. If the IDT team and the Attending Physician determine that the resident may be appropriate for discharge, Social Services Staff will coordinate the discussion of discharge with IDT, the resident, and the responsible party. G. Social Services Staff will communicate with Facility Staff, the resident and responsible party as the time for discharge approaches. H. Social Services Staff will document the discharge planning, preparation, and the resident's post discharge needs. I. Social Services Staff will orient the resident to the impending discharge. J. Social Service Staff may coordinate a care conference to discuss discharge needs, plans, and teaching, and will involve other IDT members as appropriate.

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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** 42342 Based on interview and record review for two of three sampled residents (Resident 1 and Resident 3). The facility failed to: 1. Develop a care plan for the gastrostomy tube (g-tube: a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) for Resident 1. 2. Develop a discharge care plan for Resident 3. This deficient practice placed Resident 1 at risk of infection and placed Resident 3 at risk of inaccurate discharge plan. Findings: A review of Resident 1 ' s Admission record indicated the facility admitted this [AGE] year-old male on 12/28/2024 with diagnoses including, Hemiplegia (paralysis) and hemiparesis (total weakness of the arm, leg, and trunk on the same side of the body) following cerebral infarction (CI-stroke, loss of blood flow to a part of the brain) affecting the right dominant side, primary thrombophilia (a condition that increases the likelihood of blood clots forming), depression (mental health condition characterized by persistent sadness), aphasia (a disorder that makes it difficult to speak), seborrheic dermatitis (dry patchy skin), dysphagia (difficulty swallowing), gastrostomy, hyperlipidemia (high fat in the blood), glaucoma (damage to the eye nerve) and occlusion (blockage) and stenosis (narrowing) of right coronary artery. A review of Resident 1 ' s Minimum Data Set (MDS-a resident assessment) dated 1/4/2025 indicated Resident 1 ' s cognition (mental ability to make decisions for daily living) was not intact. The MDS indicated Resident 1 was dependent (helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting, personal hygiene, and transfers (moving between surfaces) from bed to chair. The assessment indicated Resident 1 had a g tube. A review of Resident 1 ' s physician order dated 12/28/2024 indicated no added salt (NAS) diet: mechanical soft chopped texture, nectar thick consistency liquids. A review of Resident 1 ' s physician order dated 1/1/2025 indicated enteral (specifies how nutrients will be delivered by g-tube) order: 250 cc (cubic centimeter: unit of measurement) free water every shift. A review of Resident 1 ' s speech therapy discharge summary dated 1/2/2025 indicated Mechanical soft/chopped texture diet with nectar thick liquids. Resident should alternate between liquids and solids when eating, upright posture during and 30 minutes after meals. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/29/2025 at 1:47 p.m. with the director of nursing (DON), Resident 1 ' s care plan titled, the resident has a nutritional problem or potential nutritional problem related to diet restrictions. The care plan indicated mechanical soft, NAS diet; dysphagia. The care plan does not indicate resident 1 had a g tube. The DON stated, I do not see a care plan for the g tube; it was coded on the MDS we should have a care plan. The Resident ate by mouth and did not receive any feeding through the tube, only water; there should be a care plan. A review of Resident 3 ' s admission record indicated the facility admitted this [AGE] year old female on 4/21/2025 with diagnoses including monoplegia (paralysis of one limb) of the right upper limb, dysphagia (difficulty swallowing), essential hypertension (high blood pressure), hyperlipidemia (high fat in the blood), depression (mental condition with persistent low mood), cognitive communication deficit, emphysema (long term lung disease). A review of Resident 3 ' s MDS dated [DATE] indicated Resident 3 ' s cognition (mental ability to make decisions for daily living) was not intact. Resident 3 required moderate assistance (helper does less than half the effort to complete the task) with toileting, bathing and dressing. During an interview on 5/29/2025 at 1:47 p.m. with the DON, The DON stated, discharge starts at admission, the discharge care plan should be initiated at admission and updated as needed. A review of the facility's policy and procedure (P&P) titled, Comprehensive person-centered care planning revised 11/2018, the P&P indicated a comprehensive care plan should be developed within 7 days from the completion of the comprehensive MDS assessment, the comprehensive care plan will be developed. All goals, objectives, interventions, etc. from the current baseline care plan will be included in the resident's comprehensive care plan.