

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 09/24/2025
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 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor each resident's preferences, choices, values and beliefs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure one of three sample residents, Resident 3, had call lights (a call system a resident uses to call for help from staff) within reach while in bed as required to maintain immediate access to staff assistance. This deficient practice had the potential to place Resident 3 at risk for unmet care needs and delayed response by staff to emergencies. Findings: A review of Resident 3's admission records indicated Resident 3 was admitted to the facility on [DATE] with a diagnosis including blindness in the right and left eye, hypertension (when the pressure in your blood vessels is too high), generalized muscle weakness (a lack of strength in the muscles). A review of Resident 3's progress notes dated 9/23/2025 at 6:45 PM indicated, resident 3 was admitted to the facility from a General Acute Care Hospital (GACH) with muscle weakness (a lack of strength in the muscles), dysphagia (difficulty swallowing), Alzheimer's disease (a progressive disease that destroys memory and other important metal functions), and Resident 3 is bed bound (when someone is unable to leave their bed due to physical issue, injury, or illness and spend the majority of their bed in bed). During a concurrent observation and interview on 9/24/2025 at 11 AM Resident 3 was lying in bed, the resident call light was not visible for the surveyor. Resident 3 stated, I don't know what a call light is no one told me about it. Resident 3 is unaware and did not have access to call staff for help. During an observation on 9/24/2025 at 11:14 AM, the call light was not near Resident 3. It took several seconds for CNA 1 to locate the call light which was found on a nightstand under a pillow. The call light was out of Resident 3's reach at least by more than an arm's length. During an interview on 9/24/2025 at 11:14 AM, Certified Nursing Assistant (CAN) 1 stated, I was in Resident 3's room few minutes ago. I must have forgotten to check if the call light was within the resident's reach before I left the room. CNA 1 stated, call lights are important to residents because it is their means of communication for routine care and during an emergency. Not having a call light withing reach can lead to delayed response and it can make them feel neglected. During an interview on 9/24/2025 at 11:39 AM, Licensed Vocational Nurse (LVN) 1 stated, Resident 3 is newly admitted , primarily Spanish speaking, bed bound, and with impaired vision. Call lights must be accessible and within reach of each resident. LVN 1 stated, call lights use education should be provided during admission and frequent reminder for residents who are forgetful. When a resident can't access a call light, they can be at risk for accidents and delayed response during emergencies. During an interview on 9/24/2025 at 1:11 PM, the Director of Staffing Development (DSD) stated, the admitting nurse is responsible to educate newly admitted residents about use of call lights and accessibility. DSD stated, psychosocial and physical decline, accidents, delay of response for emergency care are the outcomes of not having a call light within reach of a resident. A review of the facility's Policy and Procedures (P&P) titled Communication - Call System revised on 3/21/2025 indicated, The facility will provide a call system to enable residents to alert the nursing staff from their room and toileting/bathing facilities. Upon admission, each resident will be instructed on how to use the call bell system.</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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