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	04/09/2026

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility staff failed to develop a base line individualized care plan addressing identified resident's behavior and refusal of wound care for one of four sampled residents, Resident 2. This deficient practice had the potential for delayed assessment and provision of necessary care and services for Resident 2. Findings: During a review of Resident 2's admission records, Resident 2 was admitted to the facility on [DATE] with a diagnoses including chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow), depression, (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living), unspecified dementia (loss of memory, thinking and reasoning). A review of Resident 2's Minimum Data Set (MDS- a comprehensive resident assessment and screening tool) dated 3/17/2026, indicated Resident 2's cognitive skills (mental ability or process of acquiring knowledge and understanding for daily decision-making) were intact. During a review of Resident 2's Social Services (SS) notes dated 4/3/2026, the SS note indicated, the resident refused wound care, informed SS he will skip the wound care for the day, and have it done next day. The note further indicated, physician notified and aware of episodes of refusal. During a review of Resident 2's Order Summary Report dated 4/10/2026, the Order Summary Report indicated, right shin venous stasis ulcer (a condition where blood flow slows down or pools in the veins, usually in the lower legs) cleanse with normal saline (a water and salt fluid used to clean wounds), pat dry, apply xeroform (medicated nonstick gauze dressing used to cover wounds) cover with dry dressings every day shift. During a review of Resident 2's baseline care plans (CP- a step-by-step roadmap created by licensed staff to manage specific health needs), the care plan did not address Resident 2's identified episodes of wound care refusals. During a review of Resident 2's February and March 2026 Treatment Administration Records (TAR), the TAR indicated, Resident 2 refused right shin wound care on February 17, 21, 28, March 3, and March 9, 20226. During an interview on 4/9/2026 at 9:30 AM with Resident 2, Resident 2 stated, he likes his wound be changed and treated at the General Acute Care Hospital (GACH) where he goes frequently for appointments. During an interview on 4/9/2026 at 10:37 AM with the licensed vocational nurse (LVN) 1, LVN 1 stated, Resident 2 is known to refuse care. LVN 1 also stated, resident care plans are important because it is a tool to know residents' baseline care needs. During a concurrent interview and record review on 4/9/2026 at 12:35 PM with the treatment nurse (TN), Resident 2's TAR and CP were reviewed. Resident 2's baseline CP does not indicate CP for refusal of wound care. TN stated Resident 2 refuses wound care treatments occasionally, this morning he refused wound care, I called and notified the charge nurse and nurse practitioner (NP). TN stated, wound treatment nurses are responsible for initiating and updating wound care. CP is important because it guides staff on how to care for residents. During an interview on 4/9/2026 at 12:49 PM with registered nurse supervisor (RN), RN stated care plans are needed for residents, care plans are the heart of nursing, it is where we do our plans for nursing care. RN further stated, CP shows residents are assessed appropriately and all their issues are addressed. RN acknowledged Resident 2's baseline care plan does not include Resident 2's refusal of wound care, (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services, and refusing to provide his clinic appointments to staff. During an interview on 4/8/2026 at 1:35 PM with the assistant director of nursing (ADON), DON stated, CP is resident specific, goal oriented, focused on specific interventions of residents' area of care needs. CP must be implemented for all areas of care. During a review of the facility's policy and procedures (P&P) titled Person-Centered Care Planning reviewed 4/24/225, the P&P indicated, Person-centered care plan means that the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what is important to teach resident with regard to daily routines and preferred activities and having an understanding of the resident's life before coming to reside in the nursing facility. The Baseline Care Plan will be developed and implemented, using the necessary combination of problem specific care plans to promote continuity of care and communication among facility staff, increase resident safety and safeguard against adverse events, within 48 hours of the resident's admission.