

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  04/04/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>46843</p> <p>Based on observation, interview, and record review the facility failed to treat twelve of twelve sampled residents in need of feeding assistance, with respect and dignity by calling them feeders, and keeping a list of their room numbers labeling them Feeders for the purposes of making the assignments. Sampled residents included (21), (16), (247), (30), (6), (53), (8), (36), (248), (37), (54), and (19).</p> <p>This deficient practice caused or had the potential to cause depression (a prolonged feeling of sadness, hopelessness, or loss of interest in activities).</p> <p>Findings:</p> <p>A review of Resident 21's admission record, indicated Resident 21 was admitted to the facility (skilled nursing facility [SNF]) on 1/15/25, with the diagnosis of, but not limited to, diabetes Type 2 (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), muscle weakness (a lack of physical or muscle strength, throughout the body).</p> <p>A review of Resident 21's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/1/25, indicated Resident 21's cognition (the mental ability to make decisions of daily living) was severely impaired. Resident required substantial/maximal assistance with all activities of daily living (ADLs) bed mobility, transfer, eating, toilet use and personal hygiene.</p> <p>A review of Resident 16's admission record, indicated Resident 16 was admitted to the facility (skilled nursing facility [SNF]) on 10/23/24, with the diagnosis of, but not limited to, diabetes Type 2 (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), hypertension (Also known as high or raised blood pressure, a condition in which the blood pressure readings are consistently high).</p> <p>A review of Resident 16's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/30/25, indicated Resident 16's cognition (the mental ability to make decisions of daily living) was severely impaired. Resident required substantial/maximal assistance with all activities of daily living (ADLs) bed mobility, transfer, eating, toilet use and personal hygiene.</p> <p>(continued on next page)</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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 247's admission record, indicated Resident 247 was admitted to the facility (skilled nursing facility [SNF]) on 3/21/25, with the diagnosis of, but not limited to, diabetes Type 2 (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), schizophrenia (a serious mental illness that disrupts a person's ability to think, feel, and behave normally).</p> <p>A review of Resident 247's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/28/25, indicated Resident 247's cognition (the mental ability to make decisions of daily living) was severely impaired. Resident required substantial/maximal assistance with all activities of daily living (ADLs) bed mobility, transfer, eating, toilet use and personal hygiene.</p> <p>A review of Resident 30's admission record, indicated Resident 30 was admitted to the facility (skilled nursing facility [SNF]) on 5/7/24, with the diagnosis of, but not limited to, Parkinson's (a brain disorder that primarily affects movement, causing problems like, slow movements, and stiffness, muscle weakness (a lack of physical or muscle strength, throughout the body).</p> <p>A review of Resident 30's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/1/25, indicated Resident 30's cognition (the mental ability to make decisions of daily living) was intact. However, resident required substantial/maximal assistance with all activities of daily living (ADLs) bed mobility, transfer, eating, toilet use and personal hygiene.</p> <p>A review of Resident 6's admission record, indicated Resident 6 was admitted to the facility (skilled nursing facility [SNF]) on 9/28/24, with the diagnosis of, but not limited to, diabetes Type 2 (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), muscle weakness (a lack of physical or muscle strength, throughout the body).</p> <p>A review of Resident 6's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/5/25, indicated Resident 6's cognition (the mental ability to make decisions of daily living) was severely impaired. Resident required substantial/maximal assistance with all activities of daily living (ADLs) bed mobility, transfer, eating, toilet use and personal hygiene.</p> <p>A review of Resident 53's admission record, indicated Resident 53 was admitted to the facility (skilled nursing facility [SNF]) on 11/13/23, with the diagnosis of, but not limited to, diabetes Type 2 (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), muscle weakness (a lack of physical or muscle strength, throughout the body).</p> <p>A review of Resident 53's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/1/25, indicated Resident 53's cognition (the mental ability to make decisions of daily living) was severely impaired. Resident required substantial/maximal assistance with all activities of daily living (ADLs) bed mobility, transfer, eating, toilet use and personal hygiene.</p> <p>A review of Resident 8's admission record, indicated Resident 8 was admitted to the facility (skilled nursing facility [SNF]) on 2/7/25, with the diagnosis of, but not limited to, Parkinson's (a brain disorder that primarily affects movement, causing problems like, slow movements, and stiffness, muscle weakness (a lack of physical or muscle strength, throughout the body).</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 19's admission record, indicated Resident 19 was admitted to the facility (skilled nursing facility [SNF]) on 12/23/24, with the diagnosis of, but not limited to, hypertension (Also known as high or raised blood pressure, a condition in which the blood pressure readings are consistently high), muscle weakness (a lack of physical or muscle strength, throughout the body)</p> <p>A review of Resident 19's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/1/25, indicated Resident 19's cognition (the mental ability to make decisions of daily living) was severely impaired. Resident required substantial/maximal assistance with all activities of daily living (ADLs) bed mobility, transfer, eating, toilet use and personal hygiene.</p> <p>During an interview on 4/1/25 at 10:33 AM CNA 2 stated these people in this room are all feeders, they all need to be fed every meal and snacks. CNA 2 stated there are a lot of feeders, we all separate them between the CNA's and all the staff help with feeding them. CNA 2 stated there is a list of feeders, but the charge nurse keeps the list so she can assign the feeders evenly between staff. CNA 2 stated she can write out the feeders that she is aware of from memory. CNA 2 provided a handwritten list of the residents that need feeding assistance, that she addressed as feeders.</p> <p>During an interview on 04/01/25 at 10:34 AM CNA 2 stated this hole room is considered feeders. The ones that are feeders get nourishment also, they all get nourishment all feeders. Nourishment is given in between meals; it is snacks given three times a day.</p> <p>During an interview on 04/01/25 11:14 AM LVN 1 stated the feeders are divided among the CNA's and the RNA's. LVN 1 stated we have a list of all feeders, so that each charge nurse can distribute the workload evenly among the CNAs. During a concurrent record review and interview a list of residents that need feeding assistance was labelled as feeders in all capital letters ending in a semicolon. In each column the word FEEDERS: was at the top and just under the word was the room numbers of the residents that needed feeding assistance.</p> <p>During an interview on 04/01/25 at 11:23 AM Director of Nursing (DON) stated, all CNA staff must have feeders included in their assignment. The number of staff today is 10 CNAs and 11 or 12 feeders so one or two CNAs will have two feeders. The DON stated the word feeders is not a problem because we just use the word feeders between staff. We do not call residents feeders or say the word in front of the residents or their family members.</p> <p>During an interview on 04/01/25 at 11:37 AM MDS stated, we have a list of all feeders so that staff know who they are. The list includes all feeders in the facility. There is nothing wrong with calling residents' feeders because this is how we can identify the residents that need feeding assistance.</p> <p>During an interview on 04/03/25 at 12:38 PM Director of Staff Development (DSD) stated we make sure the staff care for the residents by dressing them in regular clothes making sure their hair is combed, and the residents are well groomed. Before entering in the resident's room staff should always knock and introduce themselves. The residents that need to be fed are called Feeders, however, they should be fed while staff is sitting down with them at eye level, staff are instructed to talk to all feeders and not just push food in their mouth.</p> <p>A record review of the facility's policies and procedures (P&amp;P) titled Resident Rights - Quality of Life reviewed 3/21/2025, indicated</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>45528</p> <p>Based on interview and record review, facility failed to accurately and completely document diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) education in the resident's chart for one of four sampled residents (Resident 76).</p> <p>This deficient practice had the potential to negatively affect the delivery of necessary care and services for Resident 76.</p> <p>Findings:</p> <p>During a record review, Resident 76's history and physical (H&amp;P -a thorough medical evaluation performed by the doctor) dated 9/17/2024 indicated Resident 76 had diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing)</p> <p>During a record review, Resident 76's Admission Record indicated the facility admitted Resident 39 on 5/4/2024 with diagnoses including DM, hyperlipidemia (HLD - high cholesterol, too much fats) and cerebral vascular accident (CVA- Stroke) without residuals, and hypertension (HTN - elevated blood pressure).</p> <p>During a record review, Resident 76's Minimum Data Set (MDS - a resident assessment tool) dated 2/1/2025, indicated Resident 76 was cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 76 required staff assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During an interview on 4/1/2025, at 10:03 A.M., with Resident 76, Resident 76 stated she did not know why she was taking insulin.</p> <p>During a concurrent interview and record review on 4/4/2025, at 12:27 P.M., with the Registered Nurse Supervisor (RNS) 1, Resident 76's electronic chart was reviewed. The RNS 1 stated the facility process for resident education on a new diagnosis is that the facility will have a care planning meeting held by the interdisciplinary team (IDT -a group of different types of healthcare professionals who work together to care for a resident, like a doctor, nurse, therapist, and social worker) and the resident/and or resident representative (RP) to discuss the new diagnosis, interventions and resident/and or RP will have an opportunity to ask questions about the diagnosis at the meeting and then documentation will be in the resident progress notes once completed. RNS1 stated Resident 76 had a diagnosis of DM however, there was no documented evidence in the resident's chart that education was provided to Resident 76 and/or RP. RNS 1 stated resident education should be provided so that the resident/RP is aware of what is going on with the resident, if the resident does not know about their diagnosis the resident may not adhere to the new lifestyle change based on their diagnosis which would lead the resident to feel denied of the information that was supposed to be given to them.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/4/2025, at 6:32 P.M., with the Director of Nursing (DON), the DON stated documentation is done to show that education was provided to the resident or RP. If the documentation is not done or education provided, then the resident or RP ma have not been given the chance to make a decision on the treatment that they are getting due to a diagnosis.</p> <p>During a record review, the facility's policy and procedures, titled, Progress notes revised 3/21/2025, indicated, Each discipline will be responsible for documenting the residents progress according to Federal and State regulations and facility policy.</p> <p>II. Progress notes will reflect the residents current status, progress or lack of progress, change in condition, adjustment to the facility and other relevant information.</p>

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>45528</p> <p>Based on observation, interview, and record review, facility failed to ensure that one of ten sampled residents (Resident 38) was assessed for medication self-administration.</p> <p>This deficient practice had the potential to cause over medication or harm to Resident 38.</p> <p>Findings:</p> <p>During a record review, Resident 38's Admission Record indicated the facility admitted Resident 38 on 2/3/2025, with diagnoses of hypertension (HTN-high blood pressure), generalized weakness (a feeling of weakness in most parts of the body), and diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a record review, Resident 38's Self Administration Assessment of medication dated 2/11/2025 indicated that resident required assistance with administering ointments, and topical medication. The Self Administration Assessment also indicated that Resident 38 was not approved for medication self-administration or to keep medication at the bedside.</p> <p>During a record review, Resident 38's Minimum Data Set (MDS - a resident assessment tool) dated 2/16/2025, indicated Resident 38 was cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 38 required supervisory to partial/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).</p> <p>During a concurrent observation and interview with Resident 38 on 4/1/2025 at 11:38 A.M., Resident 38 was observed to have white cream in two separate clear 30 milliliter (ML -unit of measure used for a liquid) medicine cups and a white powder also in a clear 30ml medicine cup. Resident 38 stated the white creams were prednisolone cream (steroid [hormone] -helps relieve swelling, redness itching and allergic reaction) and Vitamin A&amp;D ointment (used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritation). Resident 38 stated the white powder is athletes foot powder ( a medication in powder form used to treat fungal infections, specifically athletes foot).</p> <p>During a concurrent observation and interview with Licensed Vocation Nurse (LVN) 3 in Resident 38's room on 4/1/2025, at 1:39 P.M., LVN 3 stated that the white substance at Resident 38's bedside looked like a cream and that it should not be at the bedside. LVN 3 stated Resident 38's medications should be administered by the Licensed nurses and if there is any cream left over it should be properly discarded. LVN 3 stated medications should not be left the bedside of the resident because the resident may not know how much to administer, what time to administer the medication, if too much is given may cause harm and that medications should always be stored in the medication room or cart, locked at all times.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46843</b></p> <p>Based on interview and record review, the facility failed to ensure the residents' clinical records were complete and updated with advance directives (a written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) for three out of four sampled residents (Residents 18, 50 and 246) by failing to maintain an accurate and current copy of the resident's advance directives in the resident's clinical record.</p> <p>This failure resulted in or had the potential to cause conflict with te wishes regarding health care for Residents 18, 50 and 246.</p> <p>Findings:</p> <p>1. During a record review, Resident 18's Admission Record, indicated Resident 18 was admitted to the facility on [DATE], with diagnoses that included, muscle weakness (a lack of physical or muscle strength, throughout the body), Rheumatoid Arthritis, (a disease where the body's defense system mistakenly attacks the joint linings, causing pain, swelling and stiffness), hypertension (Also known as high or raised blood pressure, a condition in which the blood pressure readings are consistently high).</p> <p>During a record review, Resident 's Minimum Data Set (MDS - a resident assessment tool) dated 1/1/24, indicated Resident 18's cognition (a person's mental ability to think, learn, remember, use judgement, and make decisions) is intact. The MDS indicated Resident 18 requires staff assistance and standby supervision or touching assistance with bed mobility, transfer, putting on footwear; however, eating, toilet use and personal hygiene only partial assistance is needed from staff.</p> <p>During a concurrent record review of Resident 18's medical chart and an interview with licensed vocational nurse (LVN) 1 on 4/4/25 at 11:15 AM, LVN 1 stated the resident's advanced directive i(During a concurrent record review of Resident 50's medical chart and an interview on 04/04/25 at 11:20 AM LVN 1 stated the advanced directive is not in the chart. LVN 1 stated without an advanced directive in the chart; in the case of an emergency there could be confusion as to the last wishes of the Resident) was not in the medical chart. LVN 1 stated if there is no advanced directive in the chart; in the case of an emergency there could be confusion as to the resident's wishes regarding health care.</p> <p>2. During a record review, Resident 50's Admission Record indicated the resident was admitted to the facility on [DATE], with the diagnosis onot limited to, muscle weakness (a lack of physical or muscle strength, throughout the body), hypertension (Also known as high or raised blood pressure, a condition in which the blood pressure readings are consistently high), Atrial Fibrillation (AFib - a type of abnormal heartbeat, that causes the heart to beat extremely fast).</p> <p>During a record review, Resident 50's MDS dated [DATE], indicated Resident 50's cognition is moderately impaired. The MDS further indicated Resident 50 is independent with most activities of daily living (ADL's-they include bathing, showering, dressing, getting in and out of bed or chair, toileting, and eating).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Westwood Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE  12121 Santa Monica Boulevard Los Angeles, CA 90025	
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent record review of Resident 50's medical chart and an interview on 04/04/25 at 11:20 AM LVN 1 stated the advanced directive is not in the chart. LVN 1 stated without an advanced directive in the chart; in the case of an emergency there could be confusion as to the resident's regarding health care.</p> <p>3. During a record review, Resident 246's Admission Record indicated Resident 18 was admitted to the facility on [DATE], with the diagnoses not limited to, diabetes Type 2 or diabetes mellitus (DM - a disease characterized by elevated levels of blood sugar), and muscle weakness.</p> <p>During a record review of Resident 246's MDS dated [DATE], indicated Resident 246's cognition is moderately impaired. The MDS further indicated the resident requires supervision or touching assistance with activities of daily living (ADL's including bathing, showering, dressing, getting in and out of bed or chair, toileting, and eating).</p> <p>During a concurrent record review of Resident 246's medical chart and an interview with LVN 1 on 04/04/25 at 11:23 AM, LVN 1 stated the resident's advanced directive was not in the medical chart. LVN 1 stated without an advanced directive in the chart; in the case of an emergency there could be confusion as to the resident's regarding health care.</p> <p>During a review of the facilities policy titled Advance Directives dated 7/25/2024, indicated</p> <p>Policy:</p> <p>The facility will respect a resident's right to request, refuse, and/or discontinue treatment, to participate in, or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>An Advance Directive is defined as a resident's written preference regarding treatment options.</p> <p>Purpose:</p> <p>To include provisions to inform and provide written information to all adult residents concerning their right to accept or refuse medical and surgical treatment, and, at the resident's option, formulate an advance directive.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46843</p> <p>Based on observation, and interview, the facility failed to ensure a safe, comfortable, and a homelike environment for one out of four residents sampled (Resident 64).</p> <p>This failure resulted:</p> <ol style="list-style-type: none"> <li>1. Resident 64 not having access to hot water for grooming and personal hygiene.</li> <li>2. Resident 64 got wet from the splashing water faucet to get wet.</li> </ol> <p>Also, this Failure paused the potential for accidents and falls with injuries</p> <p>Cross Reference F689.</p> <p>Findings:</p> <p>During a record review, Resident 64's Admission Record indicated Resident 64 was admitted to the facility on [DATE] with diagnoses that included, hypertension (Also known as high or raised blood pressure, a condition in which the blood pressure readings are consistently high), and muscle weakness (a lack of physical or muscle strength, throughout the body).</p> <p>During a record review, Resident 64's Minimum Data Set (MDS- a resident assessment tool), dated 2/2/2024, indicated Resident 64 is cognitively intact (able to make decisions concerning care, alert to situation and oriented to place and time). Resident 64 is primarily independent and able to perform all his daily needs for living.</p> <p>During an interview on 04/01/25 at 10:34 AM Resident 64 stated there is no hot water in the resident's room. The resident stated, the hot water is not coming out, it takes over ten minutes in the morning for it to even get warm, and it just dribbles out of the faucet after that. The cold water comes out of the faucet at an odd angle, and it splashes all over you when you turn it on. Resident 64 stated, the Television (TV) is loose and looks like it might fall to the floor, it is also tilting to the right and will not stay in front so that it can be seen. Also, the blinds are broken in various places, and it is bent in the middle because it is not attached to the hook that is in the middle of the frame. Because of this, it looks like it may fall to the floor at any time.</p> <p>During observation of Resident 64's room on 04/01/25 at 10:47 AM, the resident's room was clean, no unusual odor. The TV in the Resident 64's room was tilted to the side and appeared to be loosely affixed to the wall by the television bracket. The blinds on the room window were in disrepair and some of the slats were broken off, in addition to the top of the blinds being bent and not attached to the fixture on the wall. Additionally, in the restroom, the hot water when turned on did not get hot, and the cold water when turned on sprays, and splashed the person in front of the sink and onto the floor.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Maintenance Supervisor (MS) on 04/01/25 at 11:09 AM, MS stated the water does not get hot in this room (Resident 64's room). MS stated, perhaps because the pipe is probably clogged up somewhere. I would fix it right now. MS stated the cold-water splashes when it is turned on, so he will fix that also. MS stated the TV has a loose screw and it tilts to the side, so all it will need is a bracket screw to stabilize it. MS stated the blinds in the room have broken slats and bent at the top, and that MS will order a new one (blinds) right away and install it (blinds) when it arrives at the facility.</p> <p>During an interview on 04/03/25 at 12:33 PM, MS stated Resident 64's room has been repaired. The blinds are new and the TV has been stabilized. MS stated he faucet (Resident 64's bathroom) will be fixed tomorrow (4/4/2025) to restore the hot water and the cold water flow so that it does not splash outside the sink any longer.</p> <p>During an interview on 04/03/25 at 2:38 PM, the Administrator (ADM) stated he is aware of the repairs that have been done in Resident 64's room. The ADM stated the Plumber is scheduled to fix the hot water and the cold-water flow in Resident 64's room tomorrow (4/4/2025).</p> <p>During a record review, the facility policy and procedures (P&amp;P) titled Maintenance Service revised 1/1/2012, indicated, The maintenace department is respoinsible for maintaing the buildings, grounds, and equipment is safe and operable mannerat all times. C. Maintaining the building in good repair and free from hazards.</p> <p>During a record review, the facility P&amp;P titled Resident Rooms and Environment revised 1/1/2012, indicated The facility provides residents with a safe, clean, comfortable, and homelike environment.</p>		

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<p>F 0586</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Not prohibit or in any way discourage a resident from communicating with federal, state, or local officials.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45037</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure an unknown Liaison (a person who helps different groups communicate and work together) did not have access and retained the medical records for one of six residents (Resident 48).</p> <p>This failure resulted in a Health Insurance Portability and Accountability Act (HIPPA - is a federal law enacted in 1996 that aims to protect individuals' health information and ensure the continuity of their health insurance coverage) violation of medical records for Resident 48.</p> <p>Findings:</p> <p>During a record review, Resident 48's admission record indicated Resident 48 was readmitted to the facility on [DATE] with a diagnosis of paraplegia complete (a person has lost all feeling and movement in their legs and lower body, usually due to a complete spinal cord injury), essential hypertension (the most common type of high blood pressure where the cause is unknown).</p> <p>During a record review, Resident 48's Minimum Data Set (MDS - a resident assessment tool) dated [DATE], indicated Resident 48's cognition (The mental ability to make decision of daily living) was intact. The MDS indicated Resident 48 required setup for eating, required Partial/moderate assistance with oral hygiene, and completely dependent on staff for toileting, upper and lower dressing, putting on/taking off footwear, and for personal hygiene.</p> <p>During a record review, Resident 48's History and Physical (H&amp;P) dated [DATE], indicated Resident 48 has full code status (if a patient's heart or breathing stops, medical professionals will do everything possible to revive them, including CPR, defibrillation, and other life-saving measures). The H&amp;P further indicated Resident 48 has capacity to understand and make medical decisions.</p> <p>During a record review, Resident 48's care plan revised on [DATE], indicated: Focus: The resident has a terminal prognosis related to Dx (diagnosis) sepsis, unspecified organism. It further indicated Goal revision date of [DATE], indicated Resident 48 will have a safe transition if discharge plan is home and II needs will be met.</p> <p>During a record review, Resident 48's Discharge Summary dated [DATE], indicated a plan of care was discussed with the patient (Resident 48) and the nursing staff. The Discharge Summary did not indicate that a physician spoke to Resident 48's family and that Resident 48 has a terminal prognosis related to Dx (diagnosis) of sepsis, unspecified organism.</p> <p>During a record review, Resident 48's Discharge Planning Review Form dated [DATE], was incomplete.</p> <p>(continued on next page)</p>

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<p>F 0586</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a record review, the hospice contract for Resident 48 dated [DATE], II. Medical Records: Section 7.1, indicated the facility, and hospice will prepare and maintain an integrated medical record for each resident who has elected hospice care pursuant to this agreement. Such records will be prepared and maintained in conformity with the Federal and State law, rules, regulations, procedures, policies, guidelines, and generally accepted medical record practices. Section 7.4 indicated because hospice and facility will work together to care for the same patients and will share integrated systems of quality assessment these entities will function together as an organized health care arrangement (OHCA) for purposes of complying with the Health Insurance Portability and Accountability Act (HIPPA - is a federal law enacted in 1996 that aims to protect individuals' health information and ensure the continuity of their health insurance coverage) of 1996 standards for privacy of individually identifiable Health Information (HIPPA privacy standards). Both parties also agree to comply with all other applicable federal, state, and local laws and regulations that protect the privacy and confidentiality of medical records and patient health and financial information.</p> <p>During a telephone interview on [DATE] at 03:53 PM, Resident 48's Physician (MD) stated he was the primary care physician for Resident 48. MD stated that he did not give discharge orders to Liaison for Resident 48. MD stated he does not know who Liaison is and has never referred any of his residents in the facility to Liaison. MD Stated he could not remember Resident 48's medical diagnosis that he would call me back in the morning by 10:00 a.m. and email me his discharge order and discharge summary. MD stated Resident 48 was placed on hospice services due to the resident being paraplegic for over [AGE] years and having recurrent urinary tract infections (UTI's - infection of any part of the urinary system) with sepsis (a life-threatening condition where the body's immune system overreacts to an infection). Physician stated he will never send a resident home that do not have a care giver at home to care for him.</p> <p>During a telephone interview on [DATE] at 1:33 p.m., Liaison stated she is an independent liaison that help patients with placement. Liaison stated she is not an employee of the Hospice company or the facility. Liaison stated she did not meet with the Resident 48 or his sister prior to arranging the discharge for Resident 48 to go home on hospice services. Liaison stated she obtained Resident 48's medical records (did not specify which records) from the Hospice company. Liaison stated she reviewed and read in Resident 48's medical records that Resident 48 was unhappy with the facility and wanted to go home. Liaison stated she did not personally speak with the resident, did not get the resident's consent, or confirm with Resident 48 the the resident was unhappy with the facility prior to discharging Resident 48 from the facility and admitting Resident 48 to the Hospice company. Liaison stated hospice made the arrangements with the doctor (unidentified) and the Resident 48's family for the resident to go home. Liaison stated she do not have a medical background.</p> <p>During a record review, the facility policy and procedures titled Disclosure of PHI revised on [DATE], indicated: Purpose: To limit the access, use and disclosure of Protected Health Information (PHI) to the minimum necessary needed to accomplish the intended purpose of the use, disclosure or request for PHI.</p> <p>Policy:</p> <p>1. Minimum Necessary Standard:</p> <p>(continued on next page)</p>		

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<p>F 0586</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A . When using, disclosing, or requesting PHI the facility will make reasonable efforts to use, disclose and request only the information that is minimally necessary to accomplish the intended purpose of the use, disclosure, or request. Procedure: 1. Minimum Necessary Disclosure of PHI Within the Facility.</p> <p>E. Facility staff who believes that a staff person, contractor, business associate or other person or entity is not complying with this policy will report those concerns to the HIPPA Privacy Officer. VI. Entire Medical record:</p> <p>A. As a general rule, the facility should not use, disclose, or request the entire medical record of a resident unless the entire medical record is specifically and reasonably necessary to accomplish the purpose of the use disclosure or request, such as for treatment purposes.</p> <p>B. Any request made for the entire medical record, other than for treatment purposes, must be justified in writing, and placed in the medical record.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>45528</p> <p>Based on interview and record review, the facility failed to develop a baseline care plan in accordance with the facility's policy and procedures (P&amp;P) titled Comprehensive Person-Centered Care Planning revised 3/21/2025 for one of four sampled residents (Resident 55).</p> <p>These deficient practices had the potential to negatively affect the delivery of necessary care and services for Resident 55.</p> <p>Findings:</p> <p>During a record review, Resident 55's Admission Record indicated the facility admitted Resident 55 on 6/14/2023, and readmitted Resident 55 on 10/14/2024 with diagnoses including Cerebral vascular (CVA-stroke, loss of blood flow to a part of the brain), generalized weakness (a feeling of weakness in most parts of the body), and diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a record review, Resident 55's Minimum Data Set (MDS - a resident assessment tool) dated 3/19/2025, indicated Resident 55 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 55 was dependent on staff for activities of daily living.</p> <p>During a concurrent interview and record review, on 4/4/2025, at 12:41 P.M., with Assistant Director of Nursing (ADON), Resident 39's electronic chart was reviewed. The ADON stated a care plan is meant to help with the patients plan of care, if they have issues it helps with managing and preventing by having goals and interventions to ensure that the situation does not get worse or prevent things from happening. ADON states if there is no 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) dislodgment, the resident may be at risk for weight loss as a result of the g-tube being out of place including frequent hospitalizations which may lead to further complications such as infection.</p> <p>During an interview, on 4/4/2025, at 6:36 P.M., with the Director of Nursing (DON), the DON stated a care plan directs facility staff on what to do individually, per resident making interventions appropriate for the patient to see is more can be done. The care plan needs to be done within the time of the change of condition but no more than 14 days after the change of condition. The DON stated if a resident does not have a care plan, the facility staff may not be in unison with care, we (facility staff) may be thinking differently. The DON stated if there is no care plan for g-tube dislodgement, it may lead to affect the quality of care and possible infection.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review, the facility's P&amp;P, titled, (P&amp;P) titled Comprehensive Person-Centered Care Planning revised 3/21/2025, indicated, Purpose: To ensure that a comprehensive person-centered care plan is developed for each resident . It is the policy of this facility to provide person centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial wellbeing.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>45528</p> <p>Based on interview and record review, the facility failed to conduct an interdisciplinary team meeting (IDT - a group of experts from several different fields) for one of three sampled residents (Resident 55), per the facility's policy.</p> <p>This deficient practice had the potential to result in Resident 55's care needs not being met comprehensively when resident/resident's representative were not involved in developing a care plan and making decisions for Resident 55.</p> <p>Findings:</p> <p>During a record review, Resident 55's Admission Record indicated the facility admitted Resident 55 on 6/14/2023, and readmitted Resident 55 on 10/14/2024 with diagnoses including Cerebral vascular (CVA-stroke, loss of blood flow to a part of the brain)), generalized weakness (a feeling of weakness in most parts of the body), and diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a record review, Resident 55's Minimum Data Set (MDS - a resident assessment tool) dated 3/19/2025, indicated Resident 55 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 55 was dependent on staff for activities of daily living.</p> <p>During a concurrent interview and record review on 4/4/2025 at 12:41 P.M., with the Assistant Director of Nursing (ADON), Resident 55's medical chart was reviewed. The ADON stated from 1/2025 to date, Resident 55 was sent to the General Acute Care Hospital (GACH) for 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) dislodgement however, there was no documented evidence that an IDT was done on the g-tube dislodgements. The ADON stated the facility should have conducted an IDT meeting and described the facility's process for the IDT meeting, ADON stated IDT meeting is done as needed per family/resident request, quarterly, annually. The ADON stated there was no documented evidence that IDT meeting was done for the multiple g-tube dislodgements. The ADON stated should have been done so that the facility and the resident's representative can be on the same page to be able to create a plan for the resident with the resident representative on board and prevent the issue from reoccurring. The ADON further stated the IDT meeting should have been done at the change of condition to avoid frequent hospitalization s.</p> <p>During an interview, on 4/4/2025, at 6:36 P.M., with the Director of Nursing (DON), the DON stated IDT should be done upon admission, quarterly, and as needed to discuss measure that can be put in place to help with issue at hand. The DON stated that IDT meetings are done to see if there is anything that can be done with the input from the family to prevent multiple hospitalization s.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review, the facility's P&amp;P, titled, (P&amp;P) titled Comprehensive Person-Centered Care Planning revised 3/21/2025, indicated, Purpose: To ensure that a comprehensive person-centered care plan is developed for each resident . It is the policy of this facility to provide person centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial wellbeing . The baseline care plan will be initiated upon admission . the baseline care plan must be completed within 48 hours from the resident's admission. The IDT team will include the following members .</p> <p>v.the resident and the resident's representative(s).</p>		

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NAME OF PROVIDER OR SUPPLIER  Westwood Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE  12121 Santa Monica Boulevard Los Angeles, CA 90025	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48026</b></p> <p>Based on interview, and record review, for one of three sampled resident (Resident 56), the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Ensure that on 3/19/2025 at 4:30 PM, Resident 56 received Humalog KwikPen insulin (a rapid-acting hormone for regulating blood sugar levels) 10 units (a unit of measurement) subcutaneous (SQ- injecting into the fatty tissue layer just beneath the skin) for a blood sugar (BS) of 541 milligrams per deciliter (mg/dL- unit of measurement. Normal BS is 70mg/dL-120 mg/dL) and notify a physician of the high BS according to physician order.</li> <li>2. Licensed Vocational Nurse (LVN) 6 did not administer Humalog KwikPen before checking Resident 56's BS before meals on 3/20/2025 at 11:30 AM and on 3/20/2025 at 4:30 PM.</li> <li>2. LVN 6 checked Resident 56's BS before administering Humalog KwikPen insulin 5 units SQ on 3/20/2025 at 10:30 PM.</li> <li>3. LVN 6 rechecked Resident 56's BS after administering Humalog KwikPen insulin 5 units SQ on 3/20/2025 at 10:30 PM.</li> </ol> <p>These deficient practices had the potential to cause confusion among staff regarding the accuracy of the BS and the appropriate interventions necessary for Resident 56 to suffer a repeat hypoglycemia event, complications related to hypoglycemia including death.</p> <p>Findings:</p> <p>During record review, Resident 56's face sheet (admission record - a document containing demographic and diagnostic information) indicated the facility admitted Resident 56 on 3/17/2025 with the following diagnoses: type 1 diabetes mellitus (an ongoing disease characterized by abnormally high blood glucose [sugar] levels), and essential hypertension (HTN - a condition where the force of blood against the artery walls is consistently too high).</p> <p>During record review, Resident 56's History and Physical (H&amp;P - a physician's complete patient examination), dated 3/18/2025, indicated, Resident 56 had the capacity to make medical decisions. The H&amp;P indicated Resident 56 has Type 1 diabetes mellitus ., is on insulin Glargine (long-acting insulin used to treat Type1 diabetes and Type 2 diabetes) 18 u (units) SQ QD (daily) AM, and Insulin Lispro sliding scale (SS - increasing administration of the pre-meal insulin dose based on the blood sugar level before the meal) before meals.</p> <p>During a record review, Resident 56's Medication Administration Record (MAR) for 3/2025, indicated the Resident 56 was administered Lantus Solostar 18 units SQ as follows:</p> <p>On 3/19/2025 at 6:30 AM, BS was 181 mg/dL</p> <p>On 3/20/2025 at 6:30 AM, BS was 180 mg/dL.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The MAR indicated to hold if BS is &lt; (less than) 100 mg/dL.</p> <p>During a record review, Resident 56's Medication Administration Record (MAR) for 3/2025, indicated the Resident 56 was administered Lantus Solostar 18 units</p> <p>During a record review, Resident 56's Care Plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient), (undated) under Special Instructions, indicated Resident 56 is receiving skilled nursing services (svcs) for observation and medical management related to (r/t) . 2. DM1 management (mgt): On Insulin Lispro 7 Glargine, monitoring for hypoglycemia and hyperglycemia .</p> <p>During a record review, Resident's CP Report titled Patient (Pt - Resident 56) with decline in ADLs . initiated 3/18/2025, indicated Pt will demonstrate (demo) supervised (sup) with ADLs and functional mobility.</p> <p>During a record review, Resident 56's Physician's Phone Order dated 3/18/2025 at 4:58 PM, indicated Resident 56 to receive Lantus Solostar (Insulin Glargine) 6 units SQ in the afternoon for diabetes give if patient (Resident 56) eats 50% or less of meal.</p> <p>During a record review, Resident 56's Physician's Phone Order dated 3/18/2025 at 5 PM, indicated Resident 56 to receive Lantus Solostar (Insulin Glargine) 18 units SQ in the morning for diabetes hold if BS&lt;100 mg/dL. Rotate site.</p> <p>During a record review, Resident 56's Physician's Phone Order dated 3/18/2025 at 5:55 PM, indicated Resident 56 to receive Humalog KwikPen Insulin 4 units with meals for diabetes, rotate site, hold if BS&lt;100 mg/dL.</p> <p>During a record review, Resident 56's Physician's Phone Order dated 3/18/2025 at 6:15 PM, indicated Resident 56 to receive Humalog KwikPen Insulin SQ as per sliding scale for diabetes give before meals for BS levels as follows:</p> <p>70-200 = 0 (zero) insulin</p> <p>201-250 = 2 unit</p> <p>251-300 = 4 units</p> <p>301-350 = 6 units</p> <p>351-400 = 8 units</p> <p>BS &gt; 400 = 10 units and notify the medical doctor (MD).</p> <p>During record review, Resident 56's Physician's Phone Order dated 3/18/2025 at 8:18 PM, indicated to inject Resident 56 with Humalog KwikPen Insulin SQ as per SS two times a day for diabetes give at 2 AM and 10 PM for BS levels as follows:</p> <p>70-200 = 0 (zero) insulin</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>201-250 = 1 unit</p> <p>251-300 = 2 units</p> <p>301-350 = 3 units</p> <p>351-400 = 4 units</p> <p>BS &gt; 400 = 5 units</p> <p>During a record review, Resident's CP Report dated 3/19/2025, indicated, Resident 56 had a hypoglycemia problem related to blood sugar of 25 mg/dL. The CP's goal indicated that Resident 56 will have BS in normal range and will not have complication by target date of 6/16/2025. The CP's interventions indicated, Resident 56's doctor and responsible party (family) will be notified, and to monitor Resident 56's vital signs.</p> <p>During a record review of Resident 56's Situation Background Assessment Recommendation (SBAR) date unspecified, indicated that this (change in condition [CIC - a deviation from a patient's baseline health or functionality, requiring evaluation and intervention]) dated 3/19/2025 (time unspecified). The SBAR indicated the CIC was hypoglycemia. The SBAR indicated that per out going nurse the endorsement was that the resident refused blood draw in the morning. The SBAR indicated . that at 9 PM (no date) CN (Charge Nurse - licensed vocational nurse [LVN] 6) checked on Resident 56 and the resident was awake with eyes open. At 10:30 PM (no date) CN (LVN 6) went to offer the bedtime medications (unspecified), CN trying to wake up the resident but the resident was asleep and was cold and calmy to touch. Resident 56's BS was 25 mg/dL, BP 94/55 mmHg, HR 52 (normal 60-100) beats per minute (bpm), O2 saturations (O2 sat) 85 percent (%-normal 90%-100%). However, the same SBAR indicated the primary care clinician [a healthcare professional who provides direct patient care] notified on 3/20/2025 at 10 PM.</p> <p>During a record review, Resident 56's Health Status Notes dated 3/19/2025 at 11:50 PM, Registered Nurse Supervisor (RNS) 1 documented Resident 56 was found unresponsive. Resident 56's BS was 25 mg/dL, BP was 91/55 milliliters of mercury (mmHg - normal 120/80 mmHg), SpO2 (Saturation Periphery Oxygen [O2] - a measurement of the percentage in the blood) was 85% room air (the normal air we breathe in everyday environments; normal 90%-100%), RR was 27 breaths per minute (bpm - normal 16-20 bpm), Temp was 96.8 F (normal 97 F to 99 F). Resident 56 was administered O2 (oxygen) at 15 Liters per minute (L/min - the rate of oxygen flow rate per minute) via nonrebreather mask (a device used to deliver high concentrations of oxygen), Glucagon 1 mg x1 (once) IM for hypoglycemia (low blood sugar). The Health Status Note indicated Resident 56's blood glucose was 60 mg/dL upon rechecking, but the resident remained unresponsive. 911 (designated as a universal emergency number) call was initiated . and D50% administered while waiting for 911 to arrive . Resident 56 was transferred to GACH emergency room via 911 for further evaluation and treatment .</p> <p>During a record review of Resident 56's Minimum Data Set (MDS - a federally resident assessment tool) dated 3/20/2025, indicated, Resident 56's cognition (the ability to think, learn, and remember clearly) was intact. The MDS indicated Resident 56 needed setup or clean-up assistance with eating and oral hygiene. The MDs indicated Resident 56 needed substantial/maximal assistance with toileting hygiene and showering/bathing. The MDS indicated Resident 56 was dependent for lower body dressing and putting on/taking off footwear.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review, Resident 56's Blood Sugar Summary report for 3/2025, indicated the following BS levels for Resident 56:</p> <p>On 3/19/2025 at 6:29 AM, BS was 181 mg/dL</p> <p>On 3/19/2025 at 12:55 PM, BS was 288 mg/dL</p> <p>On 3/19/2025 at 5:05 PM, BS was 380 mg/dL</p> <p>On 3/19/2025 at 10:35 PM, BS was 25 mg/dL</p> <p>On 3/19/2025 at 10:45 PM, BS was 60 mg/dL</p> <p>On 3/20/2025 at 6 AM, BS was 183 mg/dL.</p> <p>On 3/20/2025 at 6:01 AM, BS was 180 mg/dL</p> <p>On 3/20/2025 at 10:30 PM, BS was 541 mg/dL.</p> <p>On 3/21/2025 at 6:22 AM, BS was 348 m/dL.</p> <p>On 3/21/2025 at 12:46 PM, BS was 350 mg/dL</p> <p>However, there was documented BS check for 3/20/2025 at 4:40 PM.</p> <p>During a record review of Resident 56's document titled Amount eaten for 3/2025, indicated the resident's nutritional intake as follows:</p> <p>On 3/18/2025 recorded at 11:02 AM, 0 percent (% - unit of measurement0</p> <p>On 3/18/2025 recorded at 1:35 PM, 51%-71%</p> <p>On 3/18/2025 recorded at 9:27 PM, 26%-50%</p> <p>On 3/19/2025 recorded at 1:56 PM, 51%-71%</p> <p>On 3/19/2025 recorded at 1:56 PM, 51%-71%</p> <p>On 3/19/2025 recorded at 9:50 PM, 51%-71%</p> <p>On 3/20/2025 recorded at 8:23 AM, 0%</p> <p>On 3/20/2025 recorded at 12:24 PM, 0%</p> <p>On 3/20/2025 recorded at 10:15 PM, 99%</p> <p>On 3/20/2025 recorded at 10:17 PM, 99%</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During record review of Resident 56's MAR for 3/2025, indicated the following:</p> <p>On 3/20/2025 at 6:30 AM, BS was 183 mg/dL. Humalog KwikPen (Insulin Lispro) SQ 4 units administered.</p> <p>On 3/20/2025 at 11:30 AM. BS not checked, however, Resident 56 received Humalog KwikPen (Insulin Lispro) 5 units SQ</p> <p>On 3/20/2025 at 4:30 PM, BS not checked, however Resident 56 received Humalog KwikPen (Insulin Lispro) 8 units.</p> <p>During record review of Resident 56's MAR for 3/2025, indicated the following:</p> <p>On 3/20/2025 at 6:30 AM, BS was 180 mg/dL and Resident 56 received Lantus Solostar 18 units SQ.</p> <p>During a record review, Resident 56's Progress Notes dated 3/20/2025 at 8:30 PM indicated MD (unidentified) was informed that Resident 56 didn't eat, drink, no medication.</p> <p>During a record review, Resident 56's Physician's Phone Order dated 3/20/2025 at 9:57 PM, indicated Resident 56 to receive Humalog KwikPen (Insulin Lispro) SQ 5 units one time only for BS &gt; (greater) 400 mg/dL.</p> <p>During a record review, Resident 56's Progress Notes dated 3/20/2025 at 9:59 PM, indicated Resident 56 to receive Humalog KwikPen (Insulin Lispro) SQ 5 units one time only for BS &gt; 400 mg/dL. The Progress Note further indicated Has triggered the following drug protocol alerts/warning(s). Drug to drug interaction. The system has identified a possible drug interaction with the following orders:</p> <p>Humalog KwikPen Insulin SQ as per sliding scale for diabetes give before meals for BS levels as follows:</p> <p>70-200 = 0 (zero) insulin</p> <p>201-250 = 2 unit</p> <p>251-300 = 4 units</p> <p>301-350 = 6 units</p> <p>351-400 = 8 units</p> <p>BS &gt; 400 = 10 units and notify the medical doctor (MD).</p> <p>Severity moderate.</p> <p>During a record review, Resident 56's MAR for 3/2025, indicated that on 3/20/2025 at 10:30 PM, Resident 56's BS was 541 mg/dL, and that Resident 56 received Humalog KwikPen 5 units SQ.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review of Resident 56's Situation Background Assessment Recommendation (SBAR) form dated 3/19/2025 (time unspecified), indicated, that on 3/19/2025 at 10:30 PM, CN (charge nurse - LVN 6) was trying to wake up Resident 6 but Resident 56 was asleep, felt cold and calmy to touch. Resident 56's BS was 25 mg/dL, BP 94/55 mmHg, HR 52 (normal 60-100) beats per minute (bpm), O2 saturations (O2 sat) 85 percent (%- normal 90%-100%), and the primary care clinician [a healthcare professional who provides direct patient care] notified on 3/20/2025 at 10 PM.</p> <p>During record review, Resident 56's MAR for 3/2025, indicated that on 3/19/2025 at 10:35 PM, Resident 56 received Glucagon (an emergency medicine used to treat severe hypoglycemia [low blood sugar; less than 70 mg/dL] in diabetic patients treated with insulin who have passed out or cannot take some form of sugar by mouth) injection of 1 mg (milligram - a unit of measurement) intramuscularly (IM - to inject into a muscle), a one-time dose, for BS level of 25 mg/dL.</p> <p>During a record review of Resident 56's Skilled Nursing Facility; NF-Nursing Facility (SNF/NF) to Hospital Transfer Form dated 3/19/2025 at 10 PM, indicated, Resident 56 was not on scheduled insulin.</p> <p>During a record review of Resident 56's GACH After Visit Summary report, dated, 3/19/2025, indicated the reason for visit was altered mental status (AMS- refers to any change from a person's normal mental state, including alterations in alertness, attention, cognition, and/or consciousness), diagnoses included hypoglycemia.</p> <p>During a record review of Resident 56's Health Status Notes on 3/20/2025 at 1:09 AM, indicated, the facility readmitted Resident 56 from the GACH.</p> <p>During a record review, Resident 1's Initial Encounter (physician notes) dated 3/20/2025, indicated Resident 1 with brief emergency room (ER) visit due to hypoglycemia to 25 mg/dL and that Resident 56 was very fatigued.</p> <p>During an interview on 4/03/2025 at 10:21 AM with Resident 56's family member (FMR1), FMR1 stated, we were (did not specify who) in the facility on 3/20/2025, I got a call from MD 1 who asked FMR1 if Resident 56 was on the way to the hospital now because MD 1 was informed that Resident 56 was unresponsive. FMR1 stated my (Resident 56) went to the hospital on 3/19/2025 and came back to the facility like an hour later. Why they just called [Resident 56's] doctor today [3/20/2025]? FMR1 also stated, why is a diabetic patient, with their (facility) own protocol to check BS 3 times a day, not check the blood sugar for more than 11 hours? Why being patient (Resident 56) administered insulin after a high reading of over 300 and is just left there for 6 hours? Why a nurse like (LVN 6) check on (Resident 56) at bedtime but not check the BS at bedtime? . FMR1 stated FMR1 is absolutely traumatized, shocked and heartbroken. FMRI stated Resident 56 has struggled with type 1 diabetes since the resident was [AGE] years old. FMR1 stated it felt like Resident 56 was laying there (in the facility), the BS was dropping, Resident 56 was alone, and that no one was checking on Resident 56. FMR1 stated Resident 56 ended up in a coma, and that FMR1 was angry.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with MD 1 on 4/04/2025 at 3:14 PM, MD 1 stated MD 1 was not aware that Resident 56 did not receive insulin 03/20/2025 at 4:30 PM. MD 1 stated that type I diabetic patient whose BS levels is not managed appropriately and consistently, would result in the resident experiencing higher or lower blood sugars, hypoglycemic which will lead in sweating, fainting, passing out, and seizures, it could be life threatening and ultimately the demise of the resident. MD 1 stated MD! Was not aware that Resident 56 was administered Lantus Insulin 18 units SQ when the resident ate between 0% 25% for breakfast on 3/20/2025 at 8:23 AM.</p> <p>During a concurrent interview and record review on 4/04/2025 at 3:38 PM with LVN 6, Resident 56's MAR for 3/2025 was reviewed. LVN 6 stated at around 7 PM, Resident 56 was just asleep in bed and called Resident 56 by name to wake up the resident but the resident didn't say anything back to me. LVN 6 stated that LVN 6 did not attempt to arouse Resident 56. LVN 6 stated Resident 56's BS on was 541 mg/dL on 3/20/2025 at 4:30 PM but did not administer insulin to the resident. LVN 6 stated LVN 6 and notified RNS 1 about the BS, and that RNS 1 notified the doctor (unspecified). LVN 6 stated that on 3/20/2025 at 10:20 PM, MD 1 gave a telephone order to administer Humalog 5 units SQ one time only to Resident 56. LVN 6 stated LVN 6 administered the Humalog insulin to Resident 56 on 3/20/2025 at 10:30 PM, and did not recheck the resident's BS before administering Humalog insulin, and after administering Humalog insulin. LVN 6 stated LVN 6 did not administer Humalog KwikPen to Resident 56 on 3/20/2025 at 4:30 PM, because I was afraid what happened to (Resident 56 - BS was 25 mg/dL) on 3/19/2025 may happen again to the resident. So, to be safe, I told my RN Supervisor (RNS 1) about it. LVN 6 then corrected self and stated, LVN 6 checked Resident 56's blood sugar was 541 mg/dL on 3/20/2025 at 4:30 PM. LVN 6 stated LVN 6 did not check Resident 56's BS prior to administering Humalog Kwikpen 5 units insulin SQ on 3/20/2024 at 10:30 PM or after administering Humalog insulin. LVN 6 stated, I gave [Resident 56] the Humalog insulin based on the 541 mg/dL checked on 3/20/2025 at 4:30 PM. LVN 6 stated the resident's BS may be really low or really high if the BS level check is missed, the resident may become unresponsive, non-verbal, cannot be aroused, and will need to be sent to the hospital for further evaluation and interventions.</p> <p>During an interview with the Director of Nursing (DON) on 4/04/2025 at 4:18 PM, the DON stated the facility's protocol is to inform the doctor when a resident has a COC and monitor the patient. The DON sated the nurse should have checked the BS again prior to administering the Humalog 5 units at 4:30 PM on 3/20/2025 because 6 hours has passed you (nurse) don't know what the real BS level. The DON stated the nurse should request a MD to re-check Resident 56's BS after administering the Humalog 5 units SQ. The DON stated that using Resident 56's BS that was on 3/20/2025 at 4:30 PM and not documented as the basis to administer Humalog 5 units of insulin to Resident 56, may lead to hyperglycemic episodes, diabetic coma, and possibly complications (did not elaborate). The DON stated delaying or missing to check a resident's BS can result in the resident experiencing hypoglycemia or hyperglycemia, unresponsiveness, coma, and death.</p> <p>During a record review of the facility Policy and Procedures (P&amp;P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks), titled Diabetic Care revised on 1/01/2012, indicated, Licensed nurses must notify the physician, in any case, when resident's BS level is less than 70 or greater than 350 mg/dL. Licensed nurses will document clearly and consistently all diabetic monitoring and administration of medications. Licensed nurses will assess the resident continuously for any risk factors for dehydration and/or malnutrition. The nursing staff will monitor the resident for signs and symptoms of hypoglycemia or hyperglycemia, initiate interventions .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46843</p> <p>Based on observation, and interview, the facility failed to ensure a safe, comfortable, and a homelike environment for one out of four residents sampled (Resident 64).</p> <p>This failure paused the potential for accidents and falls with injuries for Resident 64</p> <p>Cross Reference F584.</p> <p>Findings:</p> <p>During a record review, Resident 64's Admission Record indicated Resident 64 was admitted to the facility on [DATE] with diagnoses that included, hypertension (Also known as high or raised blood pressure, a condition in which the blood pressure readings are consistently high), and muscle weakness (a lack of physical or muscle strength, throughout the body).</p> <p>During a record review, Resident 64's Minimum Data Set (MDS- a resident assessment tool), dated 2/2/2024, indicated Resident 64 is cognitively intact (able to make decisions concerning care, alert to situation and oriented to place and time). Resident 64 is primarily independent and able to perform all his daily needs for living.</p> <p>During an interview on 04/01/25 at 10:34 AM, Resident 64 stated, the Television (TV) is loose and looks like it might fall to the floor, it is also tilting to the right and will not stay in front so that it can be seen. Also, the blinds are broken in various places, and it is bent in the middle because it is not attached to the hook that is in the middle of the frame. Because of this, it looks like it may fall to the floor at any time.</p> <p>During observation of Resident 64's room on 04/01/25 at 10:47 AM, the resident's room was clean, no unusual odor. The TV in the Resident 64's room was tilted to the side and appeared to be loosely affixed to the wall by the television bracket. The blinds on the room window were in disrepair and some of the slats were broken off, in addition to the top of the blinds being bent and not attached to the fixture on the wall.</p> <p>During an interview with the Maintenance Supervisor (MS) on 04/01/25 at 11:09 AM, MS stated the TV has a loose screw and it tilts to the side, so all it will need is a bracket screw to stabilize it. MS stated the blinds in the room have broken slats and bent at the top, and that MS will order a new one (blinds) right away and install it (blinds) when it arrives at the facility.</p> <p>During an interview on 04/03/25 at 12:33 PM, MS stated Resident 64's room has been repaired. The blinds are new and the TV has been stabilized. MS stated he faucet (Resident 64's bathroom) will be fixed tomorrow (4/4/2025) to restore the hot water and the cold water flow so that it does not splash outside the sink any longer.</p> <p>During an interview on 04/03/25 at 2:38 PM, the Administrator (ADM) stated he is aware of the repairs that have been done in Resident 64's room.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Westwood Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE  12121 Santa Monica Boulevard Los Angeles, CA 90025	

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review, the facility policy and procedures (P&amp;P) titled Maintenance Service revised 1/1/2012, indicated, The maintenace department is respoinsible for maintaing the buildings, grounds, and equipment is safe and operable mannerat all times. C. Maintaining the building in good repair and free from hazards.</p> <p>During a record review, the facility P&amp;P titled Resident Rooms and Environment revised 1/1/2012, indicated The facility provides residents with a safe, clean, comfortable, and homelike environment.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>45528</p> <p>Based on observation, interview, and record review, the facility failed to ensure that one of four sampled residents (Resident 55) received appropriate treatment and services.</p> <p>This deficient had the potential to cause inadequate nutrition and possible infection.</p> <p>Findings:</p> <p>During a record review, Resident 55's Admission Record indicated the facility admitted Resident 55 on 6/14/2023, and readmitted Resident 55 on 10/14/2024 with diagnoses including Cerebral vascular (CVA-stroke, loss of blood flow to a part of the brain), generalized weakness (a feeling of weakness in most parts of the body), and diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a record review, Resident 55's physician order dated 3/29/2025, indicated enteral feed order, two times a day provide glucerna1.5 at 75 milliliters (ml- metric unit of measurement, used for liquids) per hour .</p> <p>During a record review, Resident 55's Minimum Data Set (MDS - a resident assessment tool) dated 3/19/2025, indicated Resident 55 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 55 was dependent on staff for activities of daily living.</p> <p>During an observation on 4/1/2025, at 1:30 P.M., in Resident 55's room, feeding tube connection device was observed on the floor by the feeding pump running to the floor and not connected to Resident 55 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).</p> <p>During a concurrent observation and interview on 4/1/2025, at 1:39 P.M., with Licensed Vocation Nurse (LVN) 3 in Resident 55's room, LVN 3 stated the feeding tube connection device was loose, the connection device was not connected to Resident 55's g-tube but was running and going to the floor instead of into to Resident 55 g-tube. LVN 3 stated not having the tube properly connected may lead to infection, and the resident's stomach being empty which may lead to weight loss, also possibly causing medications that need to be taken on a full stomach to not work properly.</p> <p>During an interview, on 4/4/2025, at 6:47 P.M., with the Director of Nursing (DON), the DON stated tube feeding set need to be a closed unit to prevent infection. The DON stated if the resident is not connected to the tube feeding it may lead to possible weight loss, a deficit in nutrition as the tube feeding is their source of food.</p> <p>During a record review, the facility's policy and procedure titled, Nursing Manual -Dietary &amp; Dining reviewed 8/24/2023, indicated,</p> <p>2. Administer enteral feeding formula per physician order.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12. Connect feeding to the resident.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45037</p> <p>Based on interview and record review, the facility failed to ensure that Liaison did not have access and retain the medical records and identifiable documents for one of six residents (Resident 48).</p> <p>This failure resulted in the facility violating the Health Insurance Portability and Accountability Act of 1996 standards for privacy of individually identifiable Health Information (HIPPA privacy standards) for Resident 48.</p> <p>Cross Reference F624</p> <p>Findings:</p> <p>During a record review, Resident 48's admission record indicated Resident 48 was readmitted to the facility on [DATE] with a diagnoses of paraplegia complete (a person has lost all feeling and movement in their legs and lower body, usually due to a complete spinal cord injury), and essential hypertension (the most common type of high blood pressure where the cause is unknown).</p> <p>During a record review, the hospice (a type of care focused on comfort, quality of life, and symptom management for individuals with a terminal illness) contract for Resident 48 dated 2/14/2025, indicated:</p> <p>Article II. Hospice Admission:</p> <p>Section 7.4 indicated because hospice and facility will work together to care for the same patients and will share integrated systems of quality assessment these entities will function together as an organized health care arrangement (OHCA) for purposes of complying with the Health Insurance Portability and Accountability Act of 1996 standards for privacy of individually identifiable Health Information (HIPPA privacy standards). Both parties also agree to comply with all other applicable federal, state, and local laws and regulations that protect the privacy and confidentiality of medical records and patient health and financial information.</p> <p>During a record review, Resident 48's Minimum Data Set (MDS - a resident assessment tool) dated 3/3/2025, indicated the resident 48's cognition (The mental ability to make decision of daily living) was intact. The MDS indicated Resident 48 required setup for eating, required Partial/moderate assistance with oral hygiene, and completely dependent on staff for toileting, upper and lower dressing, putting on/taking off footwear, and for personal hygiene.</p> <p>During a record review, Resident 48's History and Physical (H&amp;P) dated 3/15/2025, indicated Resident 48 had the capacity to understand and make medical decisions.</p> <p>During a record review, Resident 48's Discharge Summary dated 3/10/2025, indicated the plan of care was discussed with the patient and the nursing staff.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 4/2/2025 at 11:13 AM, with FM 1 stated Resident 48 owes the facility a significant amount of money. FM 1 stated she believes that is why the facility wanted Resident 48 out of the facility. FM 1 stated a FM paid the facility over \$4,000 dollars and a couple of days after paying the facility, Liaison telephoned FM 1 and told FM 1 that the family needs to take Resident 48 home the next day or place Resident 48 somewhere else. FM 1 stated the Liaison was very demanding and pushy. FM 1 stated Liaison told her that [NAME] Post Acute was not a place for a resident like Resident 48. FM 1 stated the facility and Liaison did not give them (did not specify) and a heads up that Resident 48 was to be discharged the next day.</p> <p>During a telephone interview on 04/03/25 at 09:05 AM, Family Member (FM) 1 stated Liaison told FM 1 that Liaison was a Case Manager for the facility's corporate office and that the facility called (unable to recall the date) and Liaison told FM 1 to take Resident 48 home the next day. FM 1 stated that Liaison told FM 1 that if FM 1 did not take Resident 48 home, the facility was going to send Resident 48 to a facility in Glendora (city).</p> <p>During a telephone interview on 04/03/25 at 1:33 p.m., Liaison stated she is an independent liaison that help patients with placement. Liaison stated she is not an employee of the Hospice company and did not meet with Resident 48 or FM 1 prior to arranging the discharge for Resident 48 to go home on hospice services. Liaison stated she obtained Resident 48's medical records from the Hospice company and read Resident 48's medical records which indicated the resident was unhappy with the facility and wanted to go home. Liaison stated she did not personally speak with the resident, did not get his consent, or confirm that Resident 48 was unhappy with the facility prior . Liaison stated she does not have a medical background.</p> <p>During an interview on 4/3/25 at 1:46 p.m., Hospice Case Manager stated she received the doctors order from Liaison to place Resident 48 on Hospice services. Hospice Case Manager stated she did not speak to Resident 48's family prior to admitting Resident 48 to hospice services.</p> <p>During an interview on 4/4/25 at 8:17 a.m., the facility [NAME] President of Operations (VPO) stated he does not know who Liaison is, has not heard of (Liaison) name, and that Liaison was not an employee of the facility or the corporation, and has no relationship with the company. the VPO stated Liaison is an independent liaison who help patients with placement into nursing facilities. The VPO stated Liaison placed resident 48 on Hospice. The VPO stated the facility Administrator and the DON notified the VPO about Liaison when the writer was conducting investigation about Resident 48 discharge home. The VPO stated he never told Liaison to liaison regarding Resident 48. The VPO stated he will further investigate the situation with Liaison.</p> <p>During a record review titled Summary HIPAA Privacy Rule, <a href="https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html#what">https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html#what</a>, reviewed 3/14/2025, indicated:</p> <p>Protected Health Information:</p> <p>The Privacy Rule protects all individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information protected health information (PHI).</p> <p>Individually identifiable health information is information, including demographic data, that relates to:</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>the individual's past, present or future physical or mental health or condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.13 Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).</p> <p>Permitted Uses and Disclosures</p> <p>Permitted Uses and Disclosures. A covered entity is permitted, but not required, to use and disclose protected health information, without an individual's authorization, for the following purposes or situations: (1) To the Individual (unless required for access or accounting of disclosures); (2) Treatment, Payment, and Health Care Operations; (3) Opportunity to Agree or Object; (4) Incident to an otherwise permitted use and disclosure; (5) Public Interest and Benefit Activities; and (6) Limited Data Set for the purposes of research, public health or health care operations.18 Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make.</p> <p>(1) To the Individual. A covered entity may disclose protected health information to the individual who is the subject of the information.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528</b></p> <p>Based on interview and record review, the facility failed to ensure Pneumonia (PNA-infection that inflames air sacs in one or both lungs which may fill with fluid) vaccines were offered and/or administered to two of five sampled residents (Resident 58, and Resident 71) per facility policy.</p> <p>This deficient practice had the potential for Resident 58 and Resident 71 to acquire and/or transmit PNA infection to other residents in the facility and possible hospitalization .</p> <p>Findings:</p> <p>1. During a record review, Resident 58's Admission Record indicated the facility admitted Resident 58 on 1/12/2023, and readmitted Resident 58 on 11/30/2023 with diagnoses including spinal stenosis (a condition where the spinal canal, the space that surrounds the spinal cord becomes narrowed), muscle spasm (an involuntary and sudden, often painful contraction of the muscle, that can last from a few seconds to several minutes), and Gastroesophageal reflux disease (GERD-a condition where the stomach acid flow back up into the esophageal [tube that carries food from the mouth to the stomach], causing a burning sensation, often called heartburn).</p> <p>During a record review of Resident 58's Minimum Data Set (MDS - a resident assessment tool) dated 3/9/2025, indicated Resident 58 was cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 58 required set up or clean up assistance from staff for activities of daily living.</p> <p>During a concurrent interview and record review, on 4/4/2025, at 4:10 P.M., with Infection Prevention (IP) Nurse, Resident 58's electronic chart was reviewed. The IP nurse stated the facility's process for vaccinations is that residents are screened upon admission if they are up to date with their vaccinations by asking the residents if they are cognitively intact or their resident representative (RP) if they are not cognitively intact what their vaccination status is and also by utilizing California Immunization Registry (CAIR 2 -a digital record of a person's vaccination history) and Care Connect the facility's inhouse vaccination history network. The IP nurse stated depending on their current vaccination status, a consent or declination form is obtained from the resident/the RP. The IP nurse stated Resident 58 was admitted on [DATE], there was no documented evidence that resident 58 had a consent or declination form for the PNA vaccination and the consent was obtained on 4/3/2025. The IP nurse stated Resident 58 should have been offered/consented and/or declination form for the PNA vaccine at the times of admission to prevent an infection such as PNA which may lead to hospitalization .</p> <p>2. During a record review, Resident 71's Admission Record indicated the facility admitted Resident 71 on 10/22/2024 with diagnoses including anemia (a condition where the blood does not carry enough oxygen to the body tissues), generalized weakness (a feeling of weakness in most parts of the body), and diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review, Resident 71's MDS dated [DATE], indicated Resident 71 was cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 71 was moderately dependent on staff for activities of daily living.</p> <p>During a concurrent interview and record review, on 4/4/2025, at 4:10 P.M., with IP Nurse, Resident 71's electronic chart was reviewed. The IP nurse stated the facility's process for vaccinations is that residents are screened upon admission if they are up to date with their vaccinations by asking the residents if they are cognitively intact or their resident representative (RP) if they are not cognitively intact what their vaccination status is and also by utilizing California Immunization Registry (CAIR 2 -a digital record of a person's vaccination history) and Care Connect the facility's inhouse vaccination history network. The IP nurse stated depending on their current vaccination status, a consent or declination form is obtained from the resident/the RP. The IP nurse stated Resident 71 was admitted on [DATE], there was no documented evidence that resident 71 had a consent or declination form for the PNA vaccination and the consent was obtained on 4/3/2025. The IP nurse stated Resident 71 should have been offered/consented and/or declination form for the PNA vaccine at the times of admission to prevent an infection such as PNA which may lead to hospitalization .</p> <p>During a record review, the facility policy and procedure (P&amp;P), titled, Pneumococcal Disease Prevention, reviewed on 2/18/2021, indicated, facility will offer pneumococcal immunization according to Centers for Disease Control and prevention (CDC) recommendations.</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528</b></p> <p>Based on interview and record review, the facility failed to ensure that COVID-19 (a viral infection, highly contagious, that easily transmits from person to person, causing respiratory problems and may cause death) vaccination was offered and/or administered for two of five sampled residents (Resident 58, and Resident 71) per facility policy and procedures.</p> <p>This deficient practice placed Resident 58, and Resident 71 at risk for COVID-19 infection and/or hospitalization .</p> <p>Findings:</p> <p>1. During a record review, Resident 58's Admission Record indicated the facility admitted Resident 58 on 1/12/2023, and readmitted Resident 58 on 11/30/2023 with diagnoses including spinal stenosis (a condition where the spinal canal, the space that surrounds the spinal cord becomes narrowed), muscle spasm (an involuntary and sudden, often painful contraction of the muscle, that can last from a few seconds to several minutes), and Gastroesophageal reflux disease (GERD-a condition where the stomach acid flow back up into the esophageal [tube that carries food from the mouth to the stomach], causing a burning sensation, often called heartburn).</p> <p>During a record review, Resident 58's Minimum Data Set (MDS - a resident assessment tool) dated 3/9/2025, indicated Resident 58 was cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 58 required set up or clean up assistance from staff for activities of daily living.</p> <p>During a concurrent interview and record review, on 4/4/2025, at 4:10 P.M., with Infection Prevention (IP) Nurse, Resident 58's electronic chart was reviewed. The IP Nurse stated the facility's process for vaccinations is that residents are screened upon admission if they are up to date with their vaccinations by asking the residents if they are cognitively intact or their resident representative (RP) if they are not cognitively intact what their vaccination status is and also by utilizing California Immunization Registry (CAIR 2 -a digital record of a person's vaccination history) and Care Connect the facility's inhouse vaccination history network. The IP Nurse stated depending on their current vaccination status, a consent or declination form is obtained from the resident/the RP. IP Nurse stated Resident 58 was admitted on [DATE], there was no documented evidence that resident 58 had a consent or declination form for the COVID-19 vaccination. IP Nurse stated Resident 58 should have been offered, provided a consented and/or declination form for the COVID-19 vaccine at the time of admission to prevent an infection such as COVID-19 which may lead to hospitalization .</p> <p>2. During a record review of Resident 71's Admission Record indicated the facility admitted Resident 71 on 10/22/2024 with diagnoses including anemia (a condition where the blood does not carry enough oxygen to the body tissues), generalized weakness (a feeling of weakness in most parts of the body), and diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>(continued on next page)</p>		

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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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review, Resident 71's MDS dated [DATE], indicated Resident 71 was cognitively intact. The MDS indicated Resident 71 was moderately dependent on staff for activities of daily living.</p> <p>During a concurrent interview and record review, on 4/4/2025, at 4:10 P.M., with Infection Prevention (IP) Nurse, Resident 58's electronic chart was reviewed. The IP Nurse stated the facility's process for vaccinations is that residents are screened upon admission if they are up to date with their vaccinations by asking the residents if they are cognitively intact or their resident representative (RP) if they are not cognitively intact what their vaccination status is and also by utilizing California Immunization Registry (CAIR 2 -a digital record of a person's vaccination history) and Care Connect the facility's inhouse vaccination history network. The IP Nurse stated depending on their current vaccination status, a consent or declination form is obtained from the resident/the RP. The IP Nurse stated Resident 58 was admitted on [DATE], there was no documented evidence that resident 58 had a consent or declination form for the COVID-19 vaccination. The IP Nurse stated Resident 58 should have been offered, provided a consented and/or declination form for the COVID-19 vaccine at the time of admission to prevent an infection such as COVID-19 which may lead to hospitalization .</p> <p>During a record review, the facility policy and procedures (P&amp;P), titled, COVID-19 Vaccination Program, reviewed on 12/18/2020, P&amp;P indicated that facility will support the safe and efficient distribution of COVID-19 vaccines. The facility will support the local health department (LHD) and vaccine providers immunize staff and Residents against COVID-19 infection.</p>