

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2024
NAME OF PROVIDER OR SUPPLIER Westlake Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 316 S Westlake Avenue Los Angeles, CA 90057	

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 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42342</p> <p>Based on observation, interview, and record review the facility failed to follow up on insurance authorization to have a modified barium swallow study (MBSS- an exam that looks at how you swallow different liquids and foods using real time x-ray called fluoroscopy) in a timely manner for one of three sampled residents (Resident 1).</p> <p>This deficient practice may have caused a delay in service subsequently causing Resident 1 to become angry and refuse meals.</p> <p>Findings:</p> <p>A review of the facility Admission Record indicated Resident 1 was admitted on [DATE] with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting the left side (weakness on the left side of the body after a stroke), Chronic Obstructive Pulmonary Disorder (COPD-condition involving constriction of the airways and or difficulty breathing), Dysphagia (difficulty swallowing), Encounter for Attention to Gastrostomy (g-tube: surgically inserted tube into the stomach through the abdominal wall for feeding), Unspecified severe protein-calorie malnutrition (the lack of sufficient energy or protein to meet the body ' s metabolic demands), Candidiasis Unspecified (fungal infection), Bilateral inguinal hernia with obstruction without gangrene (a condition in which soft tissue bulges through a weak point in the abdominal muscles), Congestive Heart Failure (a condition in which the heart does not pump blood efficiently),, Coronary heart Disease (damage or disease to the hearts major blood vessels), Atrial Fibrillation (irregular heart beat), Hyperlipidemia (high cholesterol), Hypertension (high blood pressure), Metabolic Encephalopathy (an acute condition of global cerebral dysfunction in the absence of primary structural brain disease), Gastro-Esophageal Reflux (GERD- indigestion) and Anemia (low red blood cells).</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/13/2024, indicated Resident 1 ' s cognition (the mental ability to make decisions of daily living)was moderately impaired. The assessment also indicated Resident 1 had a feeding tube, weighed 127 lbs. (pounds) and received 51% or more of calories through the feeding. Lastly, Resident 1 had no natural teeth and was dependent (helper does all the effort to complete the activity) for eating, toileting, showering and dressing.</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 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1 ' s physician order dated 2/4/2024 indicated enteral tube feeding bolus for g tube, 1 can Fiber source HH 7x a day to provide 1750 ml/2100calories per day to be given at 6am, 9am,12nn,3pm, 6pm,12am.</p> <p>A review of Resident 1 ' s physician order dated 2/4/2024 indicated psychiatric evaluation and treatment by consult as ordered.</p> <p>A review of Resident 1 ' s physician order dated 2/5/2024 indicated an appointment for a MBSS on 2/8/2024 arranged by the previous facility.</p> <p>A review of Resident 1 ' s physician order dated 2/6/2024 indicated a speech therapy (ST) evaluation.</p> <p>A review of Resident 1 ' s nursing progress noted dated 2/7/2024 timed at 12:23 p.m. indicated the director of social services (DSS) 1 was informed by LVN 1 about Resident 1 ' s appointment for MBSS. DSS 1 then called insurance to arrange transport; was told a specialty care transport had already been arranged with a pickup time of 9:15 a.m. The note does not indicate DSS 1 informed the transportation of Resident 1 ' s new location.</p> <p>A review of Resident 1 ' s nursing progress note dated 2/7/2024 timed at 3:00p.m. indicated the licensed vocational nurse (LVN) 1 called to confirm appointment for MBSS at 10:00 a.m. on 2/8/2024. LVN 1 informed Resident 1 of appointment time and Resident 1 became angry stating, this was already done why are we doing this again. Resident 1 became verbally abusive yet agreed to the appointment.</p> <p>A review of Resident 1 ' s nursing progress note dated 2/8/2024 timed at 9:15 a.m. indicated LVN 1 called to follow up transportation because they had not arrived. LVN 1 was told transportation went to the previous facility for pick up and the new arrival time was 10:30 a.m. Resident 1 ' s appointment was scheduled for 10:00 a.m.</p> <p>A review of Resident 1 ' s nursing progress note dated 2/8/2024 timed at 9:50 a.m. indicated LVN 1 called scheduling center to inform them Resident 1 would be late; the scheduling center informed LVN 1 they do not perform MBSS only regular swallow study. LVN 1 informed scheduling center the appointment was confirmed just the day prior, and the scheduling center apologized and cancelled the appointment. LVN 1 informed the medical doctor (MD) 1 who instructed LVN 1 to call the general acute care hospital (GACH) and re-schedule MBSS.</p> <p>A review of Resident 1 ' nursing progress note dated 2/8/2024 timed at 10:30 a.m. indicated LVN 1 called the GACH to schedule appointment for MBSS and faxed over necessary paperwork. The GACH informed LVN 1 paperwork would be reviewed, and they would give them a call back the next day. LVN 1 called the resident representative (RR)1 to inform and left a message. The note does not say Resident 1 was informed.</p> <p>A review of Resident 1 ' s nursing progress note dated 2/9/2024 timed at 11:30 a.m. indicated LVN 1 was informed by the GACH they would need prior authorization from Resident 1 ' s insurance before the appointment for MBSS could be scheduled. LVN 1 then notified the business office assistant (BOA) , Resident 1 and the MD .</p> <p>(continued on next page)</p>		

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1 ' s physician order dated 2/26/2024 indicated a diet puree texture (soft pudding-like texture) with thin liquids at lunch only, small portion.</p> <p>A review of Resident 1 ' s nursing progress note dated 2/27/2024 timed at 12:00 p.m. indicated Resident 1 was served a puree diet for lunch and resident became extremely upset using profanity instructing staff to take it away and attempted to throw tray on the floor. Resident 1 stated the previous facility should have removed the g tube and threatened to file a complaint with the California Department of Public health (CDPH). Resident 1 stated he wanted to eat regular food and would not be eating the puree food and to tell that expletive doctor. MD 1 was made aware.</p> <p>On 2/28/2024 at 4:59 p.m. CDPH received a complaint indicated Resident 1 wanted the g tube removed and the facility refused to remove it due to no coverage from the insurance.</p> <p>A review of Resident 1 ' s nursing progress note dated 3/13/2024 timed at 12:05 p.m. indicated Resident 1 refused puree diet and began yelling at the nurse as the risks and benefits of refusing meal were being explained stating, take that tray and stop explaining I know what ' s good for me, if you want it you can eat it.</p> <p>During a concurrent interview and record review on 3/13/2024 at 12:36 p.m. with the BOA (employed at the facility for three months), Resident 1 ' s authorization fax request form dated 2/12/2024 was reviewed. The authorization indicated the request for approval of MBSS at the GACH was sent to Resident 1 ' s insurance company. The BOA stated LVN 1 notified her of the need for authorization and this was the initial request. A concurrent record review of Resident 1 ' s authorization fax request form dated 2/13/2024 was reviewed. The authorization fax request form indicated please re-direct this request to Resident 1 ' s medical group for authorization. The BOA stated, I made a follow up call to Resident 1 ' s insurance and they told me the medical group would be responsible for the authorization for the MBSS at the GACH and to re-fax request directly to Resident 1 ' s medical group so I did that on 2/14/2024. A concurrent record review of Resident 1 ' s authorization fax request form dated 2/14/2024 was reviewed. Resident 1 ' s authorization fax request form indicated the medical group was not responsible for authorization and instructed the BOA to resubmit request for authorization of MBSS at the GACH back to insurance company. The BOA stated, at this point I am getting the runaround from the insurance company, so I followed their instruction and re-submitted the original request back to the insurance company as I did initially so at this point, we are back to square one.</p> <p>(continued on next page)</p>		

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent record review of the BOA ' s note dated 2/20/2024 was reviewed. The BOA ' s note indicated the BOA called the insurance company and verified they were indeed responsible for authorization for MBSS at the GACH; left a message with a known connection to get assistance with expediting the authorization. The BOA stated she had not heard from the insurance company, so she called one of her known contacts within the company to get assistance and left a message. A concurrent record review of Resident 1 ' s fax cover sheet dated 2/28/2024 was reviewed. Resident 1 ' s fax cover sheet indicated the authorization request form was marked urgent and re-faxed to the insurance company. The BOA stated, I did a follow up call and spoke with my known contact within the insurance company who instructed me to re-fax the request and mark it as urgent to expedite the process, So I refaxed the request that day. The BOA was asked the process for follow up on authorizations and stated, I usually do authorizations for room and board and for those I follow up weekly, we do not get a lot of these types of authorizations for procedures. I am not aware of any policies stating the time frame in which to follow up on procedural authorizations; it really depends on my workload on how often I follow up. A concurrent record review of Resident 1 ' s nursing progress note dated 2/26/2024 3/1/2024, 3/4/2024, 3/8/2024 and 3/11/2024 was reviewed. Resident 1 ' s nursing progress notes indicated LVN 1 followed up with the BOA regarding status of authorization for MBSS at the GACH and was told it was still pending. The BOA stated, I don ' t ' recall nursing following up with me on these dates let me see if I have any additional notes. The BOA returned and stated, I do not have any further notes on this honestly I don ' t know what happened, usually when the nurses call, I follow up right away, I should have followed up, I will be sure to follow up today if the authorization is not received by 5:00p. m.</p> <p>During a concurrent observation and telephone interview on 3/13/2024 at 1:00 p.m. with the resident representative (RR), at Resident 1 ' s bedside, Resident 1 was very upset with flushed face yelling at top of his lungs, grabbed g- tube stating, I will tie a knot in this damn thing and rip it out. Surveyor and RR discouraged Resident 1 from pulling at g tube and Resident 1 stopped but was still upset and yelling. Surveyor stepped outside of room to finish conversation with RR and allow Resident 1 to calm down. The RR stated, I did sign for the insertion of the g tube at the previous facility when he was on the breathing machine, and he was there for about nine months. I was under the impression the g tube was supposed to be removed three months ago however no one from the previous facility discussed that with me but I know he has been asking to have it removed before they sent him there. The previous facility did not speak to me about removing the g-tube but when Resident 1 brought it up, all of a sudden he was transferred to this facility and he is very upset and feels like he is being bounced around an no one is listening to him.</p> <p>During a concurrent observation and interview on 3/13/2024 at 2:12 p.m. with Resident 1, g tube noted in left upper abdomen and clamped currently eating small spoons full of ice cream tolerating well with no choking and able to speak clearly. Appears visibly upset with flushed face and yelling while talking. Resident 1 stated, they told me I had that appointment when I first got here and then the next thing, I know it ' s cancelled because the (f word) ambulance went to the other facility. They tell lies about the insurance company; The doctor comes here and listens to my heart and lungs then leaves and does not say anything else. I ' m sorry about yelling but I am so (f word) pissed off and I ' m tired of fighting to get this tube out. Resident 1 stated, at the previous facility they removed my tracheostomy (tube surgically inserted into the windpipe to assist with breathing) three months ago and they were supposed to remove the g tube at the same time. They had me on a feeding machine and I told them then I wanted the tube out and I want to eat solid foods. That facility never discussed removing the tube with me and instead they passed me off to this place and nothing is getting done, I WANT THE TUBE OUT.</p> <p>(continued on next page)</p>		

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 3/14/2024 at 11:23 a.m. with LVN 1, Resident 1 ' s nursing progress note dated 2/8/2024 timed at 9:15 a.m. was reviewed. The progress note indicated LVN 1 called to follow up transportation because they had not arrived and found out they went to the previous facility. LVN 1 stated, I told the DSS about the appointment after I confirmed it on 2/7/2024 and she asked me if he could go by gurney and if he needed a respiratory therapist (RT) and I told her RT was not required. I called the insurance transportation to find out how they ended up at the previous facility and I gave them the address to this facility and told them the Resident was here now, I am not sure if they had the address here before I gave it to them. I was not aware the DSS ordered a specialty transport for him, he did not need that.</p> <p>During an interview on 3/14/2024 at 11:47 a.m. LVN 2 stated, he does allow me to give the bolus feedings but he refuses the puree lunch tray and gets upset saying, I am supposed to be able to eat regular food you need to call the doctor and the speech therapist and tell them I want to eat regular food and then yells at us for giving him puree diet. I informed the MD, and he would say to follow the recommendation of the speech therapist so that is what we do. I have seen him refuse his lunch twice.</p> <p>During an observation on 3/14/2024 at 12:11p.m. in Resident 1 ' s room, the certified nursing assistant (CNA) 1, donned personal protective equipment (PPE), entered room, and served a disposable tray of 4 puree textured items and 2 scoops of ice cream. The diet card did not indicate the name of the food items, Resident 1 refused the entire tray including the ice cream and CNA 1 threw entire lunch tray into the trash can.</p> <p>During an interview on 3/14/2024 at 2:50 p.m. the MD stated, I requested a psychiatric evaluation for Resident 1 because it was reported to me that he was aggressive with staff and harmed a staff member. I was trying to protect the staff members. I know he had the evaluation, but I was not made aware of the results. it was reported to me that he was unpolite but I have not received any further calls from the facility about escalating behavior. My observation is he seems extremely anxious and demanding, that is not a diagnosis just my observation that he is unhappy because of the food.</p> <p>During a concurrent interview and record review on 3/14/2024 at 3:07 p.m. with the psychiatrist (PSY), Resident 1 ' s psychiatric progress note dated 2/12/2024 was reviewed. The psychiatric progress note indicated Resident 1 was a new admission referred for an initial psychiatric evaluation and follow up. Resident 1 had a history of major depressive disorder (MDD- a mental health disorder characterized by persistently depressed mood, or loss of interest in activities causing significant impairment in daily life), sad facial expressions and mood instability (abrupt changes in mood or emotional state). Resident 1 was not currently on any psychotropic medications for any psychotropic diagnoses. Recommendations included cognitive behavioral therapy to improve behaviors and or prevent regression. The Psy stated, he did not display any behaviors during the evaluation but that is common, I will continue to see him as my assessment is ongoing. He does not have a history of MDD or any psychiatric disorders, that is my diagnosis and what I will be evaluating him for.</p> <p>A review of Resident 1 ' s notice of authorization of services dated 3/14/2024 indicated Resident 1 was approved for MBSS at the GACH.</p> <p>A review of Resident 1 ' s fax cover sheet dated 3/14/2024 indicated authorization for MBSS was faxed to the GACH.</p> <p>(continued on next page)</p>		

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1 ' s nursing progress note dated 3/18/2024 timed at 9:30 a.m. indicated LVN 1 called the GACH to follow up on appointment Resident 1 was scheduled for MBSS on 3/25/2024, Resident 1 was informed.</p> <p>During an interview on 3/18/2024 at 10:30 a.m. the business office manager (BOM) stated, we follow up weekly for authorizations for room and board because the MDS assessment takes 14 days to complete, and we need the first week of the assessment to determine the needs of the resident. We don ' t process authorizations for procedures very often but when we do nursing will inform of the order for the procedure and we will fax the request to the insurance and initially follow up in 3-5 days to give them time to receive and clear their faxes. After that we should be following up daily because the resident needs the procedure, and we don ' t want to delay any care. It is not ok to follow up weekly for these types of requests especially if they are marked as urgent.</p> <p>During an interview on 3/18/2024 at 12:14 p.m. the director of nursing (DON) stated, when we send requests for insurance authorizations to the business office, we usually follow up regularly or three times a week. If the request is urgent, we will follow up with the business office daily. We follow up frequently to ensure the resident gets the procedure they need timely. If we do not follow up, we can cause a delay in access to the care for the resident. We know he wants the g tube out and a delay in access to this procedure could possibly make the resident more upset.</p> <p>A review of the facility's policy and procedures titled, The Prior Authorization Process Flow indicated:</p> <ol style="list-style-type: none"> 1. A healthcare provider must determine if a patient needs a medical procedure. The attending physician shall give the order to the facility nursing staff who then provided a copy to the business office personnel for processing. 2. Immediately upon receipt of the physician ' s order, the business of office personnel much check insurance and health plan ' s policy to see if Prior Authorization is needed for the prescribed treatment. 3. If Prior Authorization is not required, business office will notify the Nursing and or social services department to proceed in setting the appointment. 4. If Prior Authorization is required, the facility business office personnel must immediately complete a Prior Authorization request form with copies of the physician order and face sheet to be submitted to the insurance. 5. A log for Authorizations for Procedures shall be kept in the business office and updated daily for timely follow up to be able to provide patient care promptly. This log shall be available to the designated facility staff for monitoring. Business office assigned personnel shall inform the designated facility staff in writing of any development or problems incurred during the authorization process. 6. Business office manager shall review log for Authorizations for Procedures on a weekly basis to ensure timely approval. 		