

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555218	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER St Andrews		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 W. Washington Blvd. Los Angeles, CA 90018	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505</p> <p>Based on interviews and record review, the facility failed to notify resident representative for one of four sampled resident 's (Resident 1, after Resident 1 was found on the floor.</p> <p>This deficient practice resulted in Resident 1's representative not aware of the fall incident.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record, dated 5/2/2024, indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included chronic obstructive pulmonary disease [(COPD), a group of lung diseases that block airflow and make it difficult to breathe], dementia (a group of conditions characterized by impairment of at least two brain functions such as memory loss and judgement), and muscle weakness.</p> <p>A review of Resident 1 ' s History and Physical (H&P), dated 11/2/2023, indicated Resident 1 was able to make decisions for activities of daily living and Resident 1 ' s son was the surrogate decisionmaker.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/16/2024, indicated Resident 1 was sometimes understood by others and can sometimes understand others. The MDS indicated Resident 1 was dependent on staff for activities of daily living such as oral hygiene, toileting hygiene, shower/bath self, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. The MDS indicated Resident 1 was dependent on staff for rolling left and right in bed, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed to chair transfer, and walking 10 feet. The MDS indicated Resident 1 used a wheelchair and was dependent on staff for wheeling in the corridor.</p> <p>A review of Resident 1 ' s progress note, dated 7/13/2023, indicated Resident 1 ' s son wanted to be notified when Resident 1 had low oxygen level and needed oxygen, medication changes, falls, and other life-threatening conditions or emergencies.</p> <p>A review of Resident 1 ' s fall risk evaluation, dated 3/25/2024, indicated Resident 1 was at risk for falls and the fall prevention plan was to have a landing pad, a low bed, and educate the resident about fall risks and consequences.</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 0580</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 change of condition evaluation, dated 4/29/2024, indicated Resident 1 was found sitting on the floor on 4/29/2024.</p> <p>During an interview with the Director of Nursing (DON) on 5/2/2024 at 2:49 p.m., the DON stated Resident 1 was found sitting on the floor on 4/29/2024 and the Licensed Vocational Nurse (LVN 1) did not inform the son about the incident. The DON stated LVN 1 should have informed the son.</p> <p>During a phone interview with LVN 1 on 5/9/2024 at 12:16 p.m., LVN 1 stated Resident 1 was found sitting on the floor leaning on the bed. LVN 1 stated he did not notify Resident 1 ' s son or the doctor because Resident 1 did not have any signs or symptoms of injury.</p> <p>During an interview with the DON on 5/9/2024 at 3:25 p.m., the DON stated when a resident is found on the floor, it was considered a fall. The DON stated when Resident 1 was found on the floor, even if there were no injuries, the resident ' s doctor and family should have been notified.</p> <p>A review of the facility ' s undated policy and procedure (P&P) titled Change in a Resident ' s Condition or Status, indicated the facility would promptly notify the resident, the resident ' s physician, and the resident representative of changes in the resident ' s medical/mental condition and/or status. The P&P indicated the nurse would notify the resident ' s attending physician when there had been an accident or incident involving the resident.</p> <p>A review of the facility ' s undated P&P titled Falls and Fall Risk, Managing, indicated a fall without injury was still a fall and unless there was evidence suggesting otherwise, when a resident was found on a floor, a fall was considered to have occurred.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505</p> <p>Based on interviews and record review, the facility failed to ensure staff supervision was provided to one of four sampled residents (Resident 1), who was left on the floor alone, after a fall, while the other staff called for assistance.</p> <p>This deficient practice had the potential to cause further injury to Resident 1 and Resident 2, who put Resident 1 back to bed.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record, dated 5/2/2024, indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease [(COPD), a group of lung diseases that block airflow and make it difficult to breathe], dementia (a group of conditions characterized by impairment of at least two brain functions such as memory loss and judgement), and muscle weakness.</p> <p>A review of Resident 1 ' s History and Physical (H&P), dated 11/2/2023, indicated Resident 1 was able to make decisions for activities of daily living and Resident 1 ' s son was the surrogate decisionmaker.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/16/2024, indicated Resident 1 was sometimes understood by others and can sometimes understand others. The MDS indicated Resident 1 was dependent on staff for activities of daily living such as oral hygiene, toileting hygiene, shower/bath self, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. The MDS indicated Resident 1 was dependent on staff for rolling left and right in bed, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed to chair transfer, and walking 10 feet. The MDS indicated Resident 1 used a wheelchair and was dependent on staff for wheeling in the corridor.</p> <p>A review of Resident 1 ' s progress note, dated 4/29/2024, indicated Resident 1 was trying to get up from bed and the assigned Certified Nursing Assistant (CNA 1) was advised by Licensed Vocational Nurse (LVN 1) to watch Resident 1 to avoid a fall incident. The progress note indicated Resident 1 ' s roommate notified CNA 2 at 1:30 a.m. about Resident 1 sitting on the floor. The progress notes indicated LVN 1 went to assess Resident 1. The progress notes indicated after LVN1 assessed Resident 1, LVN 1 left Resident 1 on the floor and went to CNA 1 (who was in another room) so they can put Resident 1 back to bed. The progress note indicated when LVN 1 and CNA 1 went back to the room, Resident 1 was already back in bed. The progress note indicated Resident 1 ' s roommate stated he put Resident 1 back to bed.</p> <p>During an interview with LVN 1 on 5/9/2024 at 12:16 p.m., LVN 1 stated he should have told CNA 2 to stay with Resident 1, who was on the floor, while he (LVN1) called CNA 1 to assist in putting Resident 1 back to bed.</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>During an interview with LVN 2 on 5/9/2024 at 1:38 p.m., LVN 2 stated if a resident was on the floor after a fall, staff should not leave the resident alone on the floor. LVN 2 stated someone should have stayed with Resident 1 while another staff went to get help. LVN 2 stated if the resident was left alone, the resident could hurt themselves.</p> <p>During an interview with the Director of Nursing (DON) on 5/9/2024 at 3:25 p.m., the DON stated when a resident falls, the staff were not supposed to leave the resident by themselves on the floor.</p> <p>A review of the facility's undated policy and procedure (P&P), titled Safety and Supervision of Residents, indicated the resident safety and supervision and assistance to prevent accidents were facility-wide priorities. The P&P indicated resident supervision was a core component of the systems approach to safety.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505</p> <p>Based on interviews and record review, the facility failed to maintain accurate documentation for one of four sampled residents (Resident 1).</p> <p>This failure resulted to an inaccurate documentation for Resident 1 ' s incident.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record, dated 5/2/2024, indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease [(COPD), a group of lung diseases that block airflow and make it difficult to breathe], dementia (a group of conditions characterized by impairment of at least two brain functions such as memory loss and judgement), and muscle weakness.</p> <p>A review of Resident 1 ' s History and Physical (H&P), dated 11/2/2023, indicated Resident 1 was able to make decisions for activities of daily living and Resident 1 ' s son was the surrogate decisionmaker.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/16/2024, indicated Resident 1 was sometimes understood by others and can sometimes understand others. The MDS indicated Resident 1 was dependent on staff for activities of daily living such as oral hygiene, toileting hygiene, shower/bath self, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. The MDS indicated Resident 1 was dependent on staff for rolling left and right in bed, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed to chair transfer, and walking 10 feet. The MDS indicated Resident 1 used a wheelchair and was dependent on staff for wheeling in the corridor.</p> <p>A review of Resident 1 ' s fall risk evaluation, dated 3/25/2024, indicated Resident 1 was at risk for falls and the fall prevention plan was to have a landing pad, a low bed, and educate the resident about fall risks and consequences.</p> <p>A review of Resident 1 ' s change of condition evaluation, dated 4/29/2024, indicated Resident 1 was found sitting on the floor on 4/29/2024. The change of condition evaluation indicated the charge nurse attempted and was unable to reach the Resident 1 ' s family on 4/29/2024 at 1:35 a.m.</p> <p>During a phone interview with Licensed Vocational Nurse (LVN 1) on 5/9/2024 at 12:16 p.m., LVN 1 stated he did not notify Resident 1 ' s son or the doctor because Resident 1 did not have any signs or symptoms of injury.</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 concurrent interview and record review of the change of condition evaluation with the Director of Nursing (DON), the DON stated the documentation was not accurate because LVN 1 did not call Resident 1 ' s family. The DON stated the staff were not supposed to document something they did not do. The DON stated when LVN 1 called Resident 1 ' s family later that day, Resident 1 ' s family already knew about the accident and was upset at LVN 1 for not notifying him about Resident 1 ' s fall.</p> <p>A review of the facility ' s undated policy and procedure (P&P) titled, Purpose/General Documentation Guidelines, indicated every entry should be recorded promptly and all entries should be complete, concise, descriptive, and accurate.</p>		