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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555218	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrews	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure staff implemented the fall prevention care plan for one of two sampled residents (Resident 2). This deficient practice increased the potential for avoidable physical harm to Resident 2 related to a repeat fall with possible injury. Findings: During a review of Resident 2 ' s Admission Record, the record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 ' s admitting diagnoses included hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), lack of coordination, and age-related osteoporosis (a condition in which bones become weak and brittle). During a review of Resident 2 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/4/2024, the MDS indicated Resident 2 did not have impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 2 was dependent on staff for activities of daily living (ALDs, self-care activities performed daily such as dressing, bathing, and personal hygiene) and mobility while in and out of his bed. During a review of Resident 2 ' s Change in Condition Evaluation, dated 7/11/2024, the evaluation indicated Resident 2 experienced an unwitnessed fall on 7/11/2024. The record indicated Resident 2 ' s physician was notified, and Resident 2 ' s physician ordered a landing pad (a piece of soft, thick rubber, placed on the ground to protect a part of the body) and an alarm to notify staff of Resident 2 ' s attempt to get out of bed. During a review of Resident 2 ' s care plan titled Actual Fall 7/11/2024, dated 7/11/2024, the care plan indicated Resident 2 had sustained a fall. The staff ' s interventions indicated to ensure a landing pad and alarm were in place to prevent repeat falls and injurious falls. During an observation on 8/27/2024 at 10:57 AM, at Resident 2 ' s bedside, Resident 2 was observed lying in bed. Resident 2 did not have a landing pad on either side of his bed. Resident 2 also did not have a readily visible bed alarm. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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 08/27/2024
NAME OF PROVIDER OR SUPPLIER St Andrews		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 W. Washington Blvd. Los Angeles, CA 90018	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 8/27/2024 at 11:13 AM, with Licensed Vocational Nurse (LVN) 1, Resident 2 ' s care plan titled Actual Fall 7/11/2024, dated 7/11/2024, was reviewed. LVN 1 stated Resident 2 was at risk for falls and stated the care plan indicated Resident 2 was supposed to have landing pads at the bedside and an alarm in place. During a concurrent observation and interview, on 8/27/2024 at 11:15 AM, with Licensed Vocational Nurse (LVN) 1, at Resident 2 ' s bedside, LVN 1 observed Resident 2 in bed and stated Resident 2 did not have landing pads at his bedside or a bed alarm in place. LVN 1 stated she could not state why the care plan interventions were not in place. LVN 1 stated Resident 2 was at risk for an unwitnessed fall without the alarm in place and stated Resident 2 was at risk for injury from the fall without the landing pad in place. During a concurrent interview and record review on 8/27/2024 at 2:27 PM, with the Director of Nursing (DON), Resident 2 ' s care plan titled, Actual Fall 7/11/2024, dated 7/11/2024 was reviewed. The DON stated Resident 2 ' s care plan indicated Resident 2 was supposed to have landing pads and an alarm at the bedside. The DON stated the landing pad was for injury prevention or minimization of injury after a fall. The DON stated absence of the landing pad could cause Resident 2 to sustain injury from a fall. The DON then stated the purpose of the alarm was to alert staff if the resident was attempting to get up unassisted and stated Resident 2 was at higher risk for falls if the alarm was not in place. During a review of the facility ' s undated policy and procedure (P&P) titled Safety and Supervision of Residents, the P&P indicated the facility was supposed to implement an individualized, resident-centered approach to safety, which included implementation of interventions reduce accident risks and hazards. During a review of the facility ' s undated P&P titled Falls and Fall Risk, Managing, the P&P indicated resident-centered approaches to managing falls and fall risk required staff to implement the resident-centered fall prevention plan to reduce the resident ' s specific risk factors contributing to falls.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure fall prevention interventions were implemented, as indicated in the care plan, for one of two sampled residents (Resident 2). This deficient practice increased the potential for avoidable physical harm to Resident 2 related to a repeat fall with possible injury. Findings: During a review of Resident 2 ' s Admission Record, the record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 ' s admitting diagnoses included hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), lack of coordination, and age-related osteoporosis (a condition in which bones become weak and brittle). During a review of Resident 2 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/4/2024, the MDS indicated Resident 2 did not have impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 2 was dependent on staff for activities of daily living and mobility while in and out of his bed. During a review of Resident 2 ' s Change in Condition Evaluation, dated 7/11/2024, the evaluation indicated Resident 2 experienced an unwitnessed fall on 7/11/2024. The record indicated Resident 2 ' s physician was notified, and Resident 2 ' s physician ordered a landing pad (a piece of soft, thick rubber, placed on the ground to protect a part of the body) and an alarm to notify staff of Resident 2 ' s attempt to get out of bed. During a review of Resident 2 ' s physician orders, dated 7/11/2024, the orders indicated Resident 2 was supposed to have a landing pad and alarm. During a review of Resident 2 ' s care plan titled Actual Fall 7/11/2024, dated 7/11/2024, the care plan indicated Resident 2 had sustained a fall. The staff ' s interventions indicated to ensure a landing pad and alarm were in place to prevent repeat falls and injurious falls. During an observation on 8/27/2024 at 10:57 AM, at Resident 2 ' s bedside, Resident 2 was observed lying in bed. Resident 2 did not have a landing pad on either side of his bed. Resident 2 also did not have a readily visible bed alarm. During a concurrent interview and record review, on 8/27/2024 at 11:13 AM, with Licensed Vocational Nurse (LVN) 1, Resident 2 ' s care plan titled, Actual Fall 7/11/2024 dated 7/11/2024, was reviewed. LVN 1 stated Resident 2 was at risk for falls and stated the care plan indicated Resident 2 was supposed to have landing pads at the bedside and an alarm in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 8/27/2024 at 11:15 AM, with LVN 1, at Resident 2 ' s bedside, LVN 1 observed Resident 2 in bed and stated Resident 2 did not have landing pads at his bedside or a bed alarm in place. LVN 1 stated she could not state why the care plan interventions were not in place. LVN 1 stated Resident 2 was at risk for an unwitnessed fall without the alarm in place and stated Resident 2 was at risk for injury from the fall without the landing pad in place. During a concurrent interview and record review on 8/27/2024 at 2:27 PM, with the Director of Nursing (DON), Resident 2 ' s physician orders dated 7/11/2024 and care plan titled Actual Fall 7/11/2024, dated 7/11/2024 were reviewed. The DON stated Resident 2 ' s physician orders and care plan indicated Resident 2 was supposed to have landing pads and an alarm at the bedside. The DON stated the landing pad was for injury prevention or minimization of injury after a fall and stated absence of the landing pad placed Resident 2 at risk for sustaining injury from a fall. The DON then stated the purpose of the alarm was to alert staff if the resident is attempting to get up unassisted and stated Resident 2 was at higher risk for falls if the alarm was not in place. During a review of the facility ' s undated policy and procedure (P&P) titled Falls and Fall Risk, Managing, the P&P indicated resident-centered approaches to managing falls and fall risk required staff to implement the resident-centered fall prevention plan to reduce the resident ' s specific risk factors contributing to falls.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, Licensed Vocational Nurse (LVN) 1 failed to administer medications according to the facility ' s policy and procedure (P&P) for one of two sampled residents (Resident 2). This deficient practice created the potential for Resident 2 to take medications affecting his blood pressure and heart rate, without his blood pressure or heart rate being within the required range for safe administration. The failure also created the potential for Resident 2 ' s medications to be taken by a facility resident the medications were not ordered or intended for. Findings: During a review of Resident 2 ' s Admission Record, the record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 ' s admitting diagnoses included hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), aphasia (loss of ability to understand or express speech, caused by brain damage), lack of coordination, paroxysmal atrial fibrillation (irregular heartbeat), and high blood pressure. During a review of Resident 2 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/4/2024, the MDS indicated Resident 2 did not have impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 2 had impairments of his upper extremities on one side of his body and required supervision/touch assistance from staff to bring food and/or liquid to his mouth. During an observation on 8/27/2024 at 10:57 AM, at Resident 2 ' s bedside, observed a pile of four (4) pills of various colors on Resident 2 ' s bedside table next to his water pitcher and a cup of water. The surveyor took a photo of the medications and exited the room. During a concurrent observation and interview on 8/27/2024 at 11:15 AM, with Licensed Vocational Nurse (LVN) 1, LVN 1 observed the photo taken of the pills on Resident 2 ' s bedside table. LVN 1 stated the photo demonstrated a pile of medications Resident 2 refused to take when offered that morning. LVN 1 stated she left the medications on Resident 2 ' s bedside table for him to take later. LVN 1 could not state what all four pills were, but stated two of the pills were to treat Resident 2 ' s heart conditions. LVN 1 stated the medications for Resident 2 ' s heart conditions required Resident 2 ' s blood pressure and heart rate to be within a certain range. LVN 1 stated she documented the medications as administered on Resident 2 ' s electronic medication administration record (EMAR) without ensuring Resident 2 had taken the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/27/2024 at 2:27 PM, with the Director of Nursing (DON), the facility ' s undated policy and procedure (P&P) titled Medication Administration, General was reviewed. The DON stated the P&P indicated the licensed nurse was not supposed to leave medications at the bedside for the resident to take later. The DON stated that leaving the medication at the bedside created the risk for another resident to accidentally take the medication. The DON also stated that medications that require the blood pressure and/or heart rate to be within a certain range need to be administered at the time the vitals were taken to ensure the administration was safe. The DON stated the medications should not be documented as administered unless witnessed as taken by the resident. During a review of the facility ' s undated P&P titled Medication Administration, General, the P&P indicated the licensed was never supposed to leave medication with the resident to take later, and indicated the licensed nurse was supposed to always observe the resident swallowing the medication prior to documenting the medication as administered. The P&P also indicated the licensed nurse was supposed to initial each medication on the EMAR as it was administered to the resident, and refusals of a medication were supposed to be documented promptly.