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 09/25/2024
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)
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** 46144 Based on interview and record review, the facility failed to ensure one out of four sampled residents (Resident 2) had a Care Plan (a documentation that outlines a patient's care and is created by a nurse as part of the nursing process) for physical aggression (behavior causing or threatening physical harm towards others). This deficient practice of not having a Care Plan for physical aggression had the potential for Resident 2 to be physical aggressive again. Findings: During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was initially admitted to the facility on [DATE]. Resident 2's diagnoses included schizophrenia (a serious mental illness that affects a person's thoughts feelings, and behaviors), bipolar disorder (a mental illness that causes extreme mood swings), major depressive disorder (a mental health disorder persistently sad mood or loss of interest in activities). During a review of Resident 2's History and Physical (H&P), dated 8/21/2024, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set ([MDS] a comprehensive assessment and care-screening tool), dated 9/11/2024 the MDS indicated, Resident 2 cognition (ability to learn, reason, remember, understand, and make decisions) was cognitively intact. Resident 2 activities of daily living ([ADL] activities related to personal care) required maximal assistance for dressing, dependent for toileting hygiene and showering. During an interview on 9/24/2024 at 4:15 p.m. with Licensed Vocational Nurse (LVN) 2, the LVN 2 stated Resident 2 did not have a Care Plan for physical aggression. LVN 2 stated it was important to develop a Care Plan for physical aggression. LVN 2 stated Care Plan for physical aggression would specifically set the goals and interventions Resident 2. LVN 2 stated after the develop of the Care Plan will continue to monitor to see if the interventions are working. LVN 2 stated if the interventions are not working; the interventions can be changed. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/24/2024 at 4:45 p.m. with Director of Nursing (DON), The DON stated Resident 2 did have a Care Plan for the physical aggression on 9/10/2024. The DON stated there should had been a Care Plan for Resident 2 with the focus on the physical altercation. The DON stated the interventions should have included Resident 2's whereabouts and the frequency (the number of times something should be completed) of his whereabouts. The DON stated it was important to have a Care Plan for physical aggression to prevent Resident 2 from doing it again. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, date unknown, the P&P indicated, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated, to incorporate identified problem areas and incorporate risk factors associated with identified problem. The P&P indicated, areas of concern that are identified during the resident assessment and address the underlying source of the problem area not just addressing only symptoms or triggers.

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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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on interview and record review the facility failed to ensure the physician order was followed for one out of four sampled Residents (Resident 1). This deficient practice of not following physician orders placed the Resident 1 at risk for continuing aggressive behavior after an altercation (a noisy argument or quarrel between people which could include fighting). Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included moderate intellectual disabilities (a level of intellectual disability that is characterized by an average mental age of six to nine years), osteomyelitis (inflammation or swelling that occurs in the bone), functional quadriplegia (a mental health disorder persistently sad mood or loss of interest in activities). During a review of Resident 1's History and Physical (H&P), dated 8/21/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a comprehensive assessment and care-screening tool), dated 7/30/2024 the MDS indicated, Resident 1 cognition (ability to learn, reason, remember, understand, and make decisions) was cognitively intact. Resident 1 was dependent on staff for toileting hygiene, showering, and dressing. During a review of Resident 1's physician orders titled, Order Summary Report, dated 9/10/2024, the Order Summary Report indicated to monitor resident for negative psychological impact due to recent altercation every shift. During a review of Resident 1's Medication Administration Record, dated 9/10/2024, the Medication Administration Record had no indication to monitor resident for negative psychological impact due to recent altercation every shift. During a concurrent interview and record review on 9/24/2024 at 4:30 p.m. with Licensed Vocational Nurse (LVN 2), Resident 1's physician orders titled, Order Summary Report, dated 9/10/2024 was reviewed. The Order Summary Report indicated, on 9/10/2024 Resident 1 was to be monitored for negative psychological impact due to recent altercation every shift. LVN 2 stated I reviewed the Medication Administration Report, and I did not see an order to monitor Resident 1's for psychological impact every shift. LVN 2 stated there is a physician order to monitor Resident 1 every shift on the Order Summary Report and did not notice it. LVN 2 stated the physician order was not being followed. LVN 2 stated the monitoring of the psychological impact was not being documented and the physician will have no knowledge if the orders are effective. LVN 2 stated without proper monitoring Resident 1's behavior could remain the same or get worse. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 9/24/2024 at 4:55 p.m. with Director of Nursing Resident 1's physician orders titled, Order Summary Report, dated 9/10/2024 was reviewed. The Order Summary Report indicated, on 9/10/2024 Resident 1 was to be monitored for negative psychological impact due to recent altercation every shift. The DON stated there is no documentation of Resident 1's psychological impact on the Medication Administration Record. The DON stated when the physician placed the order to monitor Resident 1 it should have been transcribed to the Medication Administration Record. The DON stated, If it's not documented it's not done. The DON stated Resident 1 was to be monitored for his behavior and the impact of that behavior. The DON stated we were to keep record of the impact of Resident 1's behavior on the Medication Administrator Record. The DON stated the impact of not keeping track Resident 1's behavior could affect the other Residents. During a review of the facility's policy and procedure (P&P) titled, Policy and Procedure on Physician Orders, date unknown, the P&P indicated, to ensure that all physician orders are executed accurately and timely by nursing staff in a skilled nursing facility, thereby promoting optimal patient care and safety. The P&P indicated, each nursing staff member must document the execution of orders in the patient's medical record, noting the date, time, and any relevant observations.