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	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrews	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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure fortified diets (meal plan that increases a resident's caloric intake by adding high calorie items) were prepared as prescribed by the physician for five of 10 sampled residents (Resident 16, Resident 21, Resident 42, Resident 46, and Resident 51).This deficient practice had the potential for the residents not to meeting their nutritional needs.Findings:During a review of Resident 16's admission Record, the admission Record indicated the facility admitted the resident on 11/20/2025 with diagnoses including sepsis (a severe body wide infection that can lead to organ failure), unspecified protein-calories malnutrition (not getting enough calories and protein, leading to weight loss and weakness), vitamin D deficiency (low vitamin D levels that can weaken bones).During a review of Resident 21's admission Record, the admission Record indicated the facility admitted the resident on 9/27/2021 with diagnoses including complete traumatic amputation of the two or more left lesser toes (surgical or injury related loss of toes), unspecified protein-calories malnutrition, iron deficiency anemia (low iron causing low red blood cell, tiredness and weakness), basal cell carcinoma of the skin (form of skin cancer). During a review of Resident 42's admission Record, the admission Record indicated the facility admitted the resident on 5/26/2022 with diagnoses including cachexia (severe weight loss and muscle wasting due to illness), unspecified protein-calorie malnutrition.During a review of Resident 46's admission Record, the admission Record indicated the facility admitted the resident on 2/26/2024 with diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (type of stroke where part of the brain is damaged because blood flow is blocked, causing brain tissue death) affecting left non-dominant side, unspecified protein-calorie malnutrition, adult failure to thrive (significant decline in weight, strength, and overall health).During a review of Resident 51's admission Record, the admission Record indicated the facility admitted the resident on 8/13/2020 with diagnoses including aphasia (difficulty speaking or understanding language) following unspecified cerebrovascular disease (problems with blood flow in the brain), chronic obstructive pulmonary disease (long term lung condition that makes breathing difficult), unspecified protein-calorie malnutrition. During an observation on 6/3 /2026 11:50 a.m., in the kitchen, Dietary Staff (DS) 1 was preparing lunch meals and did not add the addition of extra caloric fortification (increasing calorie intake by adding calorie dense items) to meal designated as fortified diet for Resident 16, Resident 21, Resident 42, and Resident 46, and Resident 5. The residents' dietary cards (reference card that lists a resident's physician ordered diet, texture, and nutritional requirements to guide staff during meal preparation) indicated fortified diet.During an interview on 6/3/2026 at 12:03 p.m., with DS 1, DS 1 stated fortified diet meant the residents require extra food. DS 1 stated for residents on regular fortified meals, fortification was completed by adding margarine to the bread portion. DS 1 stated that for minced and moist fortified meals, margarine was applied to the meat portion.During an observation on 6/3/2026 12:12 p.m., in the resident's room, Resident 42's meal tray was observed without additional fortification.During an observation on 6/3/2026 12:13 p.m., in the resident's room, Resident 46's meal tray was observed without additional fortification.During an observation on 6/3/2026 12:14 p.m., in (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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's room, Resident 51's meal tray was observed without additional fortification.During an observation on 6/3/2026 12:15 p.m., in the resident's room, Resident 21's meal tray was observed without additional fortification.During an observation on 6/3/2026 12:19 p.m., in the dining room, Resident 16's meal tray was observed without additional fortification.During an interview on 6/3 /2026 at 15:38 p.m., with the Registered Dietitian (RD), the RD stated fortified diets are intended to increase caloric intake by adding calorieˆdense items such as butter, margarine, gravy, increasing milk or providing shake quantities to at least 8 ounces The RD stated that failure to fortify a diet as ordered may result in a resident not receiving sufficient calories to meet their estimated nutritional needs.During a review of the facility's policy and procedure (P&P) titled, Fortified Diet Policy and Procedure, undated, the P&P indicated, Residents identify as nutritionally at risk, experiencing significant weight loss, inadequate oral intake, pressure injuries, malnutrition, or increased nutritional requirement shall receive a fortified diet as ordered by the physician and implemented under the direction of the Registered Dietitian (RD).

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident representative was informed of the dysphagia (difficulty of swallowing) screening result for one of one sampled resident (Resident 54).This deficient practice violated the resident representative's right to be fully informed of Resident 54's plan of care and had the potential to result in a delay of care and services.Findings:During a review of Resident 54's admission Record, the admission Record indicated Resident 54 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 54's diagnoses included cerebrovascular accident ([CVA] - stroke, loss of blood flow to a part of the brain), dysphagia, and gastrostomy tube ([GT] - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) placement.During a review of Resident 54's Minimum Data Set (MDS, a resident assessment tool), dated 3/19/2026, the MDS indicated Resident 54's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never and rarely made decisions). The MDS indicated that Resident 54 was dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing. The MDS indicated Resident 54 had a feeding tube.During a review of Resident 54's Dysphagia Screening, dated 3/23/2026, the Dysphagia Screening indicated Resident 54 to continue nothing by mouth and not safe for oral intake at this time.During a review of Resident 54's History and Physical (H&P), dated 5/28/2026, the H&P indicated that Resident 54 did not have the capacity to understand and make decisions.During a telephone interview on 6/2/2026 at 4:43 p.m., with Resident 54's representative (RR 1), RR 1 stated he had made a request to facility staff several times for Resident 54 to have an oral diet, but nothing had been done. RR 1 stated no one told him if Resident 54 could swallow food and have an oral diet.During an interview on 6/3/2026 at 11:31 a.m., with Minimum Data Set Nurse 1 (MDSN 1), MDSN 1 stated the facility staff had an interdisciplinary team (IDT, team members from different disciplines who come together to discuss resident care) meeting with Resident 54's representative on 3/19/2026 and Resident 54's representative requested for Resident 54 to have an oral diet. MDSN 1 stated Resident 54 had a dysphagia screening completed on 3/23/2026 and it was determined that Resident 54 was not safe to have an oral diet. MDSN 1 stated the IDT was not able to inform Resident 54's representative regarding Resident 54's dysphagia screening result. MDSN 1 stated it is important to collaborate the resident's plan of care to his designated representative so they would be updated regarding the resident's condition.During an interview on 6/4/2026 at 9:42 a.m., with Registered Nurse 1 (RN 1), RN 1 stated it was a violation of resident rights by not informing the resident's designated representative about the outcome result of Resident 54's dysphagia screening.During a review of the facility's policy and procedure (P&P), titled Resident Rights, dated 2/2021, the P&P did not indicate the importance of informing resident's representative of resident medical condition, care planning and treatment.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two physical restraints weren't simultaneously used for one of eight sampled residents (Resident 35).This deficient practice resulted in the use of unnecessary restraints and restricted Resident 35's movement.Findings:During a review of Resident 35's admission Record, the admission Record indicated Resident 35 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 35's diagnoses included malignant neoplasm of the kidney (kidney cancer), type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysarthria (a motor speech disorder caused by brain or nerve damage that weakens or paralyzes the muscles used for speech) and anarthria (the complete loss of the motor ability to articulate speech).During a review of Resident 35's history and physical (H&P) form, dated 4/7/2026, the H&P indicated Resident 35 had fluctuating capacity to understand and make decisions.During a review of Resident 35's Minimum Data Set (MDS- a resident assessment tool), dated 4/13/2026, the MDS indicated Resident 35's cognitive (thinking) skills were severely impaired. The MDS also indicated Resident 35 required substantial assistance (helper does more than half the effort) from staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During an observation, on 6/2/2026 at 9:45 a.m., Resident 35 was observed with a soft mitten restraint on his right hand.During an observation, on 6/3/2026 at 9:30 a.m., Resident 35 was observed in the rehabilitation room exercising his legs with the soft mitten restraint on his right hand.During a record review of Resident 35's physician orders, dated 5/1/2026, the physician orders indicated Resident 35 had an abdominal binder for his gastronomy tube. The physician order, dated 6/1/2026, indicated to discontinue Resident 35's abdominal binder order. The physician order indicated Resident 35's right hand mitten was initiated on 5/3/2026. During a concurrent interview and record review, on 6/4/2026 at 12:29 p.m, with the Director of Nursing (DON), the DON stated the protocol for restraints was to begin with less restrictive measures such as distractions and allowing residents to express their feelings. The DON stated if the less restrictive measures were not effective then the doctor would be notified to obtain an order for physical restraints. The DON stated an abdominal binder was used for residents who try to remove their gastrostomy tube. The DON stated the soft hand mitten restraint was used to prevent pulling of tubes also. The DON stated Resident 35 had an abdominal binder from 5/1/2026 to 6/1/2026. The DON stated Resident 35's hand mitten was ordered on 5/3/2026. The DON stated the use of two restraints simultaneously on a resident was excessive. The DON stated the risk of using two restraints on a resident could result in the restriction of body movement.During a review of the facility's policy and procedures (P&P), titled Use of Restraints, dated 4/2017, the P&P indicated Restraints may only be used if and when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention AND a restraint is required to: treat the medical symptom; protect the resident's safety; and help the resident attain the highest level of his/her physical or psychological well-being.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the use of lorazepam (brand name Ativan, a medication used to treat anxiety and aggressive behaviors) had an adequate indication for use for one of eight sampled residents (Resident 38).This deficient practice had the potential to result in the use of a chemical restraint which could cause oversedation for Resident 38.Findings:During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 38's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities) and liver cirrhosis (the permanent scarring of the liver caused by long-term, chronic disease or injury).During a review of Resident 38's Minimum Data Set (MDS- a resident assessment tool), dated 5/8/2026, the MDS indicated Resident 38's cognitive (thinking) skills were severely impaired. The MDS also indicated Resident 38 required substantial assistance (helper does more than half the effort) from staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a review of Resident 38's History and Physical (H&P), dated 5/28/2026, the H&P indicated Resident 38 did not have the capacity to understand and make decisions.During an observation, on 6/2/2026 at 10:32 a.m., Resident 38 was observed in bed, asleep.During an observation, on 6/3/2026 at 11:04 a.m., Resident 38 was observed in bed, asleepDuring an observation, on 6/3/2026 at 2:02 p.m., Resident 38 was observed still asleep in bed.During a record review of Resident 38's physician orders, on 6/4/2026 at 8:26 a.m., the physician orders indicated to administer Ativan 0.5 milligrams (mg, a unit of measurement) every 6 hours as needed (PRN) due to aggressive behavior toward staff and trying to pull out G-tube (gastrostomy tube- a soft plastic tube placed directly into the stomach through a small, surgical opening in the stomach). During a record review of March 2026 Medication Regimen Review (MRR) binder, on 6/4/2026 at 8:37 a.m., the MRR binder indicated to administer Ativan PRN (as needed): If resident is asking for it frequently then inform MD (medical doctor) and or psychiatrist if a routine order for Ativan is clinically indicated instead of renewing it frequently. The response to that recommendation indicated Will refer to psych. During a record review of Resident 38's May 2026 and June 2026 Medication Administration Record (MAR- a legal document that tracks medications given to a patient), the MAR indicated Resident 38 had received Ativan 0.5mg daily three times a day.During a record review, on 6/4/2026 at 9:02 a.m., there was no psychiatric consult found in Resident 38's chart.During a telephone interview, on 6/4/2026 at 9:17 a.m., with the Pharmacist Consultant (PC), the PC stated Resident 38 had been taking Ativan as needed since 2023. The PC stated he asked Resident 38's physician to consider switching the Ativan order from as needed to routine since the medication was being administered frequently. The PC stated the facility should have offered the least restrictive interventions before administering Ativan frequently such as obtaining and a psychiatric consultation. The PC stated the risk of administering Ativan frequently could result in placing a resident at risk for dependence on the medication, decreased respirations and sedation.During a concurrent interview and record review, on 6/4/2026 at 10:08 a.m., with the Director of Nursing (DON), the DON stated there was no psychiatric consult for Resident 38 due to Resident 38's son preference for Resident 38 to be seen at Kaiser Permanente. The DON stated Resident 38's son stated he would set the psychiatric consult appointment for Resident 38 and did not. The DON stated Resident 38 had an abdominal binder to protect Resident 38 from pulling out his gastronomy tube. The DON stated Resident 38's Ativan order should have been changed to a routine order instead of as needed since it was given frequently. The DON stated aggressive behaviors exhibited by Resident 38 included spitting and cursing at staff (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	members. The DON stated that administering Ativan three times a day as needed could be viewed as excessive. The DON stated the risk of administering Ativan frequently could result in serious side effects.During a review of the facility's undated policy and procedure (P&P), titled Chemical Restraints, the P&P indicated if antipsychotic medications were administered as PRN dosages repeatedly over several days, the Physician should discuss the situation with staff and evaluate the resident as needed to determine whether the use is appropriate and the symptoms are responding to the medication.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) was coded accurately for one of 23 sampled residents (Resident 47) by failing to ensure Resident 47's MDS, dated [DATE], reflected his serious mental illness (a health condition that affects a person's thinking, mood, behavior, or ability to relate to others).This deficient practice resulted in the transmission of inaccurate data to the Centers for Medicare and Medicaid Services (CMS) regarding Resident 47's health status and had the potential to negatively affect the plan of care and delivery of care and services for Resident 47. Findings:During a review of Resident 47's admission Record, the admission Record indicated Resident 47 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 47's diagnoses included personal history of other mental and behavioral disorders, hypertension (HTN, high blood pressure), and benign prostatic hyperplasia (BPH, enlarged prostate gland).During a review of Resident 47's a Preadmission Screening and Resident Review (PASARR) Level 1 Screening (a federally required preliminary screening for individuals seeking admission to a Medicaid-certified nursing facility), dated 10/16/2025, the PASARR Level 1 Screening indicated Resident 47 was diagnosed with a serious mental illness of schizophrenia (a mental illness that is characterized by disturbances in thought). The PASARR Level 1 indicated the case status was referred for PASARR Level II (a federally mandated, in-depth evaluation required for anyone applying to a Medicaid-certified nursing facility who screens positive for a suspected mental illness, intellectual disability, or related developmental condition).During a review of Resident 47's History and Physical, dated 5/23/2026, the H&P indicated Resident 47 did not have the capacity to understand and make decisions.During a concurrent interview and record review on 6/3/2026 at 11:12 a.m., with Minimum Data Set Nurse 1 (MDSN 1), Resident 47's MDS, dated [DATE], was reviewed. MDSN 1 stated Resident 47's MDS was completed inaccurately. MDSN 1 stated there should be a check marked on MDS Section A1510 (Level II PASRR Conditions) (A) Serious mental illness and there should be no check marked on (C) Other related conditions. MDSN 1 stated Resident 47 has a diagnosis of schizophrenia which is considered as serious mental illness. MDSN 1 stated it is important to have an accurate MDS assessment in order to reflect the actual condition of the resident. MDSN 1 stated Resident 47's inaccurate MDS assessment would result in inappropriate psychiatric intervention and delay of care and services.During a review of the facility's policy and procedure (P&P), titled Certifying Accuracy of the Resident Assessment, dated 11/2019, the P&P indicated, Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a quarterly IDT (Interdisciplinary Team- a group of people with different training and skills who work closely together to solve a complex problem or care for someone) meeting was conducted for one of eight sampled residents (Resident 12).This deficient practice resulted in staff not updating Resident 12's care plan.Findings:During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 12's diagnoses included metabolic encephalopathy (a temporary brain malfunction caused by a chemical imbalance in the body), type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic obstructive pulmonary disorder (COPD, a chronic lung disease causing difficulty in breathing) and acute kidney failure (the sudden loss of your kidneys' ability to filter waste products from your blood).During a review of Resident 12's Minimum Data Set (MDS- a resident assessment tool), dated 3/16/2026, the MDS indicated Resident 12's ability to make decisions regarding tasks of daily life was consistent and reasonable. The MDS indicated Resident 12 required substantial assistance (helper does more than half the effort) 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) and mobility.During a review of Resident 12's History and Physical (H&P), dated 5/28/2026, the H&P indicated Resident 12 had the capacity to understand and make decisions.During a review of Resident 12's Interdisciplinary Team meeting notes, dated 12/16/2025, the IDT notes showed an IDT meeting was conducted on 12/16/2025.During a review of Resident 12's IDT note, dated 5/27/2026, the note indicated the IDT meeting was conducted with Resident 12 on 5/27/2026.During a concurrent interview and record review, on 6/4/2026 at 12:33 p.m., with the Director of Nursing (DON), the DON stated IDT meetings were conducted quarterly (every three months). The DON stated the IDT committee consisted of the resident's physician, the facility's MDS nurse, Social Services Director/Assistant, DON, Registered Nurse, Dietary Services and Activities Director/Assistant, Certified Nurse Assistant, the resident and/or resident's responsible party. The DON stated Resident 12 had an IDT meeting on 12/16/2025 and again on 5/27/2026. The DON stated there was no IDT meeting conducted for Resident 12 for March 2026. The DON stated the IDT committee should have conducted a meeting for Resident 12. The DON stated the risk of not conducting IDT meetings quarterly as required could result in staff not being able to be updated or provide necessary needs for residents.During a review of the facility's policy and procedures, titled Care Planning- Interdisciplinary Team, dated 3/2022, the P&P indicated comprehensive, person-centered care plans were based on resident assessments and developed by an interdisciplinary team (IDT).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a referral for cardiology (medical specialty focused on the diagnosis, treatment, and prevention of diseases and disorders related to the heart and the cardiovascular system) was completed for one of one sampled resident (Resident 11).This deficient practice had the potential not to keep track of Resident 11's underlying heart disease that could result in the delay of necessary care and services.Findings:During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was admitted to the facility on [DATE]. Resident 11's diagnoses included chest pain, presence of cardiac pacemaker (medical device implanted to regulate heartbeats), and dementia (a progressive state of decline in mental abilities).During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool), dated 4/23/2026, the MDS indicated Resident 11 was independent (decisions consistent and reasonable) in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated Resident 11 required supervision (helper provides verbal cues or contact guard assistance as resident completes activity) from staff with toileting hygiene, upper and lower body dressing, and personal hygiene.During a review of Resident 11's Progress Notes, dated 5/18/2026, the Progress Notes indicated to refer Resident 11 to other cardiologist for continuation of care because Resident 11's previous cardiologist was not covered by his insurance.During a concurrent interview and record review on 6/3/2026 at 11:55 a.m., with the Minimum Data Set Nurse 1 (MDSN 1), Resident 11's Progress Notes, from 5/19/2026 to 6/3/2026, were reviewed. MDSN 1 stated there was no follow-up by the facility staff to refer Resident 11 to other cardiologist for continuation of care. MDSN 1 stated it is important for Resident 11 to have a follow-up with a cardiologist in order to monitor his pacemaker and if there are any treatment recommendation.During an interview on 6/3/2026 at 1:07 p.m., with Registered Nurse 1 (RN 1), RN 1 stated he informed the Administrator (ADM) to follow up with Resident 11's insurance to refer Resident 11 to a cardiologist. RN 1 stated it is important to refer Resident 11 to a cardiologist to ensure his pacemaker device was working properly and for continuous monitoring of his heart condition.During an interview on 6/3/2026 at 2:00 p.m., with the ADM, the ADM stated he called Resident 11's insurance to obtain authorization for a cardiology referral but it was denied. The ADM stated he could not provide any documentation or denial letter from Resident 11's insurance that the request for a cardiology referral was denied. The ADM stated until now Resident 11 has not been referred to the cardiologist.During a review of the facility's undated policy and procedure (P&P) titled, Pacemaker Standard of Care, the P&P indicated, Staff shall ensure that outside appointments for pacemaker checks, cardiology follow-up, or device interrogation are scheduled and completed as ordered.

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St Andrews	2300 W. Washington Blvd. Los Angeles, CA 90018

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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** Based on observation and interview, the facility failed to ensure a floor mat was placed by the bed as ordered for one of eight sampled residents (Resident 3).This deficient practice had the potential to result Resident 3 sustaining injuries during a fall.Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included lack of coordination, muscle weakness, dementia (a progressive state of decline in mental abilities) and Post-Traumatic Stress Disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event)During a review of Resident 3's history and physical (H&P) form, dated 2/12/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 4/10/2026, the MDS indicated Resident 3's cognition (ability to think and process) was intact. The MDS also indicated Resident 3 required supervision (helper provides verbal cues or touching or contact guard assistance as resident completes activity) from staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a review of Resident 3's fall risk care plan, titled Actual Fall- 2/8/2026 unwitnessed fall, sitting on floor, facing the cabinet, dated 2/8/2026, the care plan interventions indicated Low bed with landing pad due to history of fall every shift for Fall Prevention.During a concurrent observation and interview, on 6/4/2026 10:45 a.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 3 was on fall precautions. LVN 2 stated Resident 3 was ordered to have his bed in the lowest position and a floor mat placed on the left side of his bed to prevent falls. LVN 2 observed Resident 3's room and stated Resident 3's bed was not in the lowest bed position and there was no floor mat on the left side of his bed. LVN 2 stated the risk of having a resident's bed in a high position with no floor mat could result in a resident having a fall causing a fracture or worse.During a review of the facility's policy and procedures (P&P), titled Falls and Fall Risk-Managing, dated 3/2018, the P&P indicated the staff, with the input of the attending physician, would implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident who has a suprapubic catheter (a thin, flexible tube used to drain urine from the bladder) was changed monthly as per the physician's order for one of one sampled resident (Resident 9).This deficient practice had the potential to result in the recurrence of a urinary tract infection ([UTI] - an infection in the bladder/urinary tract) that could develop into urosepsis (a potentially life-threatening complication of urinary tract infection).Findings:During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 9's diagnoses included obstructive reflux uropathy (a condition where a blockage in the urinary tract stops urine from leaving the body, forcing it to flow backward into the kidneys), urinary retention (inability to completely empty your bladder), and dementia (a progressive state of decline in mental abilities).During a review of Resident 9's History and Physical (H&P), dated 1/12/2023, the H&P indicated Resident 9 can make needs known but could not make medical decisions.During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool), dated 3/5/2026, the MDS indicated Resident 9 was independent (decisions consistent and reasonable) in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated Resident 9 was independent (resident completes the activity with no assistance from a helper) on eating, oral hygiene, and personal hygiene. The MDS indicated Resident 9 has an indwelling catheter.During a review of Resident 9's physician order, dated 3/8/2026 the physician order indicated Resident 9 has an order to change suprapubic catheter monthly and as needed.During a review of Resident 9's care plan, titled Resident has suprapubic catheter, dated 3/12/2026, the care plan indicated a goal for the resident not to develop signs and symptoms of UTI, until the next review in 3 months. The care plan intervention included to change the suprapubic catheter as ordered.During an interview on 6/4/2026 at 8:44 a.m., with Treatment Nurse 1 (TN 1), TN 1 stated the last time Resident 9's suprapubic catheter was changed was March 2026 when Resident 9 was sent to the hospital. TN 1 stated Resident 9's suprapubic catheter was not changed for two months. TN 1 stated it was an oversight on her part by not scheduling to change Resident 9's suprapubic catheter monthly. TN 1 stated it is important to change the suprapubic catheter on a regular monthly schedule as ordered by the physician to prevent UTI, damage and accumulation of urine sediments (solid microscopic particles found in urine) in the tube. TN 1 stated a UTI could cause urosepsis and endanger Resident 9's health and safety that would require hospitalization.During an interview on 6/4/2026 at 9:32 a.m., with Registered Nurse 1 (RN 1), RN 1 stated it is important to change the suprapubic catheter regularly in order to prevent UTI and to maintain the patency of the tube.During a review of the facility's undated policy and procedure (P&P) titled, Suprapubic Catheter, the P&P indicated, Each resident with a suprapubic catheter shall receive care and monitoring in a manner that promotes dignity, comfort, infection prevention, urinary drainage, skin integrity, and the resident's highest practicable physical, mental, and psychosocial well-being. The P&P also indicated suprapubic catheter care shall be provided according to the physician orders, professional standards of practice, resident's condition, care plan, and facility infection control policies.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of eight sampled residents (Resident 3) with Post Traumatic Stress Disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) received Trauma Informed Care (TIC- an intervention and approach that focuses on how trauma may affect an individual's life and his or her response to behavioral health).This deficient practice had the potential to result in the staff's inability to identify possible triggers that could result in re-traumatization (the reactivation of trauma symptoms via thoughts, memories, or feelings related to the past traumatic experience) for Resident 3.Findings:During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included lack of coordination, muscle weakness, dementia (a progressive state of decline in mental abilities) and Post-Traumatic Stress Disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event).During a review of Resident 3's initial Social Services assessment, dated 1/13/2026, the Social Services assessment indicated Resident 3 was a veteran who served in the Army.During a review of Resident 3's history and physical (H&P) form, dated 2/12/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 4/10/2026, the MDS indicated Resident 3's cognitive (thinking) skills were intact. The MDS also indicated Resident 3 required supervision from staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During an observation, on 6/4/2026 at 8:38 a.m., Resident 3 was observed in his room, talking to unseen people. Resident 3 stated, You don't even know what I've been through in my life!During an interview, on 6/5/2026 at 9:03 a.m., with Certified Nurse Assistant 2 (CNA 2), CNA 2 stated the definition of PTSD was a mental condition caused by a traumatic event that occurred in a resident's life. CNA 2 stated signs and symptoms of PTSD could be cursing, paranoia, striking out and having flashbacks of a traumatic event if triggered by certain events such as loud noise. CNA 2 stated he was aware Resident 3 had PTSD. CNA 2 stated he has observed Resident 3 attempting to lash out at staff. CNA 2 stated when Resident 3 lashed out, the staff attempted to calm Resident 3 down by distracting and redirecting him. CNA 2 stated he had not received in-services on how to provide care for residents with PTSD. CNA 2 stated the risk of not being in-serviced on how to care for residents with PTSD could result in staff not being able to provide care to a resident.During an interview, on 6/5/2026 at 9:30 a.m., with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated she did not know the definition of PTSD nor what the abbreviation meant. CNA 1 stated she was not aware of Resident 3's PTSD diagnosis. CNA 1 stated she did not recall if she received PTSD in-services. During a concurrent interview and record review, on 6/5/2026 at 10:05 a.m., with the Director of Staff Development (DSD), the DSD stated PTSD was a traumatic event that happens in someone's life causing a resident to have flashbacks. The DSD stated he was responsible for providing in-services to the facility's staff members. The DSD stated he did not conduct any in-services to the staff regarding PTSD from January 2025 to present. The DSD stated the risk of not providing PTSD in-services to staff and PTSD care services to a resident could result in not providing the necessary care needs and services that a resident may require.During a review of the document titled Facility Assessment, dated 1/20/2026, under Part 2: Services and Care We Offer Based on our Resident's Needs, the Facility Assessment indicated, Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairments, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities.During a review of the facility's undated policy and (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedures (P&P), titled Post-Traumatic Stress Disorder (PTSD) Resident Care Policy and Procedure the P&P indicated Staff shall receive education regarding trauma-informed care and PTSD management.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on observation, interview and records review, the facility failed to ensure one of four sampled residents (Resident 24) was free from unnecessary medications when:1. There were two physician orders for Acetaminophen ([Tylenol] used to relieve mild to moderate pain) with the same indication.2. Tramadol (prescription painkiller used to treat moderate to severe pain) was administered routinely without a clinical indication.This deficient practice had the potential to result in medication errors, overdose, and unnecessary use of opioid (prescription drugs used to treat moderate to severe pain and carry significant risks of addiction, dependence, and overdose.Findings:During a review of Resident 24's admission Record, the admission Record indicated the facility admitted the resident on 2/7/2025 with diagnoses including severe protein calorie malnutrition (body lacks both enough energy calories and protein), anxiety disorder (mental health condition characterized by excessive worry about everyday situations), and major depressive disorder ([MDD] - a mood disorder that cause a persistent feeling of sadness and loss of interest).During a review of Resident 24's Minimum Data Set (MDS, a resident screening tool), dated 4/8/2026 indicated Resident 24 was severely impaired with cognitive skills (ability to think and reason) for daily decision making and required extensive assistance with staff for her activities of daily living.During the review of Resident 24's Order Summary Report (a document containing active physician orders), dated 4/30/2026, indicated the following physician orders:1. Acetaminophen 325 milligrams (mg, a metric unit used for medication dosage) give 1 tablet by mouth every 4 hours as needed for mild pain. Order status: active dated 4/30/2026.2. Acetaminophen 325 mg, give 1 tablet by mouth every 4 hours as needed for mild pain. Order status: active dated 3/25/20263. Tramadol 50 mg PO (medication taken orally) three times daily for pain management dated 4/3/2026During an interview on 6/4 /2026 at 10:22 a.m., with Pharmacist Consultant (PC), the PC stated there should not be two active orders for the same medication, such as Tylenol 325 mg. PC stated the presence of duplicate orders poses a risk of administering a double dose to Resident 24, which could lead to potential harm or adverse effects. The PC stated medication orders for Tramadol must include a clearly defined pain scale (a communication tool used to measure the intensity of a person's pain) to prevent under or over medication. The PC stated that the Tramadol order written as one tablet by mouth three times daily for pain management lacked specificity and did not identify the medical condition being treated.During an interview on 6/4 /2026 at 12:20 p.m., with Registered Nurse (RN) 1, RN 1 stated RN 1 stated it was the RN's responsibility to check with the attending physician to determine which medication orders should continue to ensure they accurately reflect the resident's needs. RN 1 stated having two active orders for Acetaminophen 325 mg for Resident 24 can create confusion for staff responsible for medication administration and increase the risk of an overdose due to duplicate dosing for the resident. RN 1 stated there was no current clinical need for the medication and it should not be administered on a routine basis. RN 1 stated continue to give Tramadol creates an unnecessary risk for adverse opioid effects and potential dependency.During an interview on 6/4/2026 at 1:40 p.m., with Resident 24, Resident 24 stated she does not have any pain currently, and she experienced no pain this week.During an interview on 6/04 /2026 at 1:43 p.m., with Certified Nurse Assistant (CNA) 4, CNA 4 stated she was responsible for taking care of Resident 24. CNA 4 stated Resident 24 did not report having pain.During a concurrent interview and record review on 6/4 /2026 at 1:43 p.m., with the Director of Nursing (DON), Resident 24's Medication Administration Record ([MAR] - a daily documentation record used by licensed nurse to document medications and treatments given to a resident) from 4/1/2026 to 5/31/2026, were reviewed. The DON stated Resident 24 had duplicate active orders for Acetaminophen 325 mg, ordered every four hours as needed for mild pain. The DON stated that duplicate orders place the resident at risk for receiving both doses, which could lead to an accidental overdose. The DON stated Tramadol should be used only for pain management, and long term use of Tramadol, may result in dependency or addiction for (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident. DON stated none of the resident's diagnoses indicated a need for routine Tramadol administration and should be discontinued because the resident no longer had a clinical condition requiring ongoing opioid therapy.During a review of the facility's policy and procedure (P&P) titled, Pain and Pain Assessment, undated, the P&P indicated, The pharmacist, physician/provider nursing staff, and interdisciplinary team shall review pain medication use as appropriate, including effectiveness, side effect, duplicated therapy, continue need, and possible dose adjustment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure an unopened Gabapentin (an anticonvulsant drug used primarily to treat nerve pain and seizure) oral solution was stored inside the medication room refrigerator for one of one sampled resident (Resident 35).This deficient practice had the potential for the loss of efficacy of the Gabapentin oral solution that would cause ineffective pain management of Resident 35.Findings:During a review of Resident 35's admission Record, the admission Record indicated Resident 35 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 35's diagnoses included neuralgia (sharp and burning nerve pain), malignant neoplasm of the kidney (kidney cancer), Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and gastrostomy tube placement (GT, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems).During a review of Resident 35's History and Physical (H&P), dated 4/7/2025, the H&P indicated Resident 35 had altered mental status to understand and make decisions.During a review of Resident 35's Minimum Data Set (MDS, a resident assessment tool), dated 4/13/2026, the MDS indicated Resident 35's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 35 was dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing.During a review of Resident 35's physician order, dated 5/1/2026, the physician order indicated to administer Gabapentin oral solution 100 milligrams (mg, unit of measurement) via GT three times a day (9:00 a.m., 1:00 p.m., 5:00 p.m.) for neuropathic pain.During a concurrent observation and interview on 6/3/2026 at 10:14 a.m., with Registered Nurse 1 (RN 1), at medication room storage 1, 1 bottle of unopened Gabapentin oral solution for Resident 35 was found in a box, stored at room temperature. RN 1 stated Resident 35's bottle of unopened Gabapentin oral solution had a sticker indicated Refrigerate. RN 1 stated Resident 35's bottle of unopened Gabapentin oral solution was received on 6/2/2026. RN 1 stated the facility did not follow the manufacturer's recommendation to refrigerate the Gabapentin oral solution. RN 1 stated the Gabapentin oral solution should be stored in the refrigerator to maintain the potency, strength, and effectiveness of the medication.During a review of online.[NAME].com (web portal for clinical drug information and medication decision-support tool), medication guide for the literature of Gabapentin oral solution, indicated to store the Gabapentin oral solution in the refrigerator between 36 to 46 degrees Fahrenheit.During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, dated 11/2020, the P&P indicated, medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurse's station or other secured location.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview, and record review, the facility failed to ensure one of one resident's (Resident 15) dislikes on the dietary card reflected the resident's preference.This deficient practice had the potential to result in dissatisfaction with meals leading to decreased intake and weight loss.Findings:During an observation in the kitchen on 6/3/2026 at 12:00 p.m., Resident 15's plastic dietary card indicated dislikes included rice. The resident's lunch tray was observed including chicken, bread, green vegetables and rice.During an interview with Resident 15 on 6/3/2026 at 12:05 p.m., Resident 15 stated that his lunch appeared fine, but he does not dislike rice. During an interview with Dietetic Services Supervisor (DSS) on 6/3/2026 at 12:15 p.m., the DSS stated he was responsible for updating dietary cards per physician orders and resident preferences. The DSS stated Resident 15's dietary card was not updated. The DSS stated that discrepancies in dietary cards may result in residents receiving meals inconsistent with physician orders and/or individual preferences. The DSS stated that disregarding residents' food preferences and inaccurate labels may cause them to refuse meals and face health complications like weight loss.During a review of facility's Policy and Procedures (P&P) titled Food Preference dated 2018, P&P indicated Food preferences will be adhered to within reason.Assessment must be completed within 7 days of admission by the FNS (Food and Nutrition Services) Director. Updating food preferences will be done as resident's need change and/or during the quarterly review.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to properly store, label and monitor food items for use when: Ravioli was kept in the freezer beyond use by date of 6/1/2026.Tamales was taken out of its original packaging and placed in a zip lock bag without use by date label.These deficient practices had the potential to place residents at risk for foodborne illness (an illness caused by food contaminated with bacteria, viruses, and other toxins).Findings:1.During an observation on 6/2/20206 at 8:19 a.m., reach-in freezer (Freezer 1) contained frozen ravioli stored in a zip lock bag labeled use by: 6/1/2026.During an interview on 6/2/26 at 2:37 p.m. with Dietary Service Supervisor (DSS), the DSS stated all food items removed from the original container must be labeled with use by date. The DSS stated the use by date was the last day residents can consume food items and food past the use by date was expired and must be discarded. The DSS stated consuming expired foods had the potential to cause residents to have stomach ache and illness. During an interview on 6/3/26 at 3:46 p.m. with Registered Dietician (RD), the RD stated that the use by date was the expiration date of stored food. The RD stated all foods taken out of original package must be labeled with use by date and food items that were not labeled must be thrown away to prevent residents from consuming potentially expired foods and develop any food borne illness. During a review of Policy and Procedures (P&P) titled Storage of Food and Supplies dated 2017, P&P indicated Food and supplies will be stored properly and in a safe manner.No food will be kept longer than the expiration date on the product.2.During an observation on 6/2/26 at 8:19 a.m., reach-in freezer (Freezer 1) contained individually wrapped tamales in a zip lock container without use by date label.During an interview on 6/2/26 2:37 with Dietary Service Supervisor (DSS), the DSS stated that tamales in the zip lock container without expiration label was considered expired and must be discarded. The DSS stated expired food had the potential to cause illness in residents.During an interview on 6/4/26 at 12:04 p.m. with Infection Preventionist (IP), the IP stated monthly checks were performed on food supply expiration dates, expired items were removed and the DSS was notified. The IP stated residents will be at risk for food borne illness and infection if expired food items were consumed.During a review of Policy and Procedures (P&P) dated 2018, P&P indicated Food and supplies will be stored properly and in a safe manner.labels should be visible.All food will be dated - month, day, year.

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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)
F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Arbitration Agreement form (a legally binding contract where parties agree to resolve future disputes through a private, out-of-court arbitration process instead of suing in a traditional courtroom) was not signed by one of eight residents, (Resident 1), who had a responsible party (the individual designated to pay a patient's medical bills, manage their care decisions, or supervise daily support services), had cognitive impairment, did not have the capacity to understand and make decisions and who was legally blind (a government classification for significant vision impairment used to determine eligibility for disability benefits, tax exemptions, and rehabilitation services).This deficient practice had the potential that Resident 1 did not understand what he was signing and resulted in the arbitration agreement not explained to the resident's responsible party.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE]. Resident 1's diagnoses included legal blindness, chronic kidney disease (a condition in which the kidneys are damaged and can't filter blood as well as they should), benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland) and hypertension (high blood pressure). Resident 1 had a Family Member as the responsible party. Resident 1 was not self-responsible (the state of being responsible, answerable, or accountable for something within one's power, control, or management).During a review of Resident 1's History and Physical (H&P) dated 2/27/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 3/18/2026, the MDS indicated Resident 1's cognitive (thinking) skills were moderately impaired. Resident 1 was dependent on staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a record review of Resident 1's Arbitration agreement form, dated 7/9/2024, the Arbitration agreement form indicated Resident 1 signed the form.During interview on 6/4/2026 at 2:54 p.m., with the admission Coordinator (AC), the AC stated she was responsible for explaining the Arbitration Agreement form to the residents and/or responsible parties. The AC stated if a resident was not self-responsible, then the Arbitration Agreement form should have been reviewed and signed by the resident's responsible party. Resident 1's responsible party should have signed the Arbitration Agreement form. The AC stated the risk of having Resident 1, who was not self-responsible, signed the Arbitration Agreement form could result in the Family Member taking legal action against the facility. The AC stated residents had the right to rescind an Arbitration form within 30 days. During a review of the facility's policy and procedure (P&P) titled Arbitration Agreement and Policy and Procedures, undated, the P&P indicated that the arbitration offered to residents or their responsible parties should be explained in a language and manner they understand and provide opportunities for questions. The resident or legal representative may accept or decline the agreement.