STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055664	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
York Healthcare & Wellness Centre	6071 York Blvd. Los Angeles, CA 90042

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to ensure the resident received treatment and services in accordance with professional standards of practice and the facility's policy and procedures on Fall Management Program, revised 3/13/2021 and Completion & Correction, revised 1/1/2012 for one of two sampled residents (Resident 1) by failing to: 1. Ensure Resident 1 had appropriate footwear as indicated in the resident's care plan and on oxygen while ambulating as indicated in the physician's order, during the time of fall incident on 1/13/2024. 2. Perform neurological check monitoring immediately after the fall incident on 1/13/2024 as indicated in the facility's fall management protocol, to perform neurological checks at the ordered frequency every 15 minutes for one hour, then every 30 minutes for one hour, then every hour for 4 hours. 3. Ensure thorough assessment of Resident 1's Fall Risk Evaluation (FRV) on 11/26/2023, completion of post fall FRV and revision of care plan during the IDT (Interdisciplinary Team, a team of staff that review and develop the resident's plan of care) meeting with the resident on 1/13/2024. 4. Ensure accuracy of Resident 1's records documented related to the resident's fall on 1/13/2024. This failure resulted in Resident 1's transfer to the General Acute Care Hospital (GACH) after the fall incident on 1/13/2024 at 1 PM and had a potential to result in Resident 1's recurrent for falls. Findings: During a review of Resident 1's Admission Record, indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included protein-calories malnutrition ((inadequate intake of food as a source of protein, calories, and other essential nutrients), abnormality of gait (manner of walking or moving on foot) and mobility, muscle weakness, dependence on supplemental oxygen, anemia (lower than normal number of red blood cells in the blood stream). (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Fall Risk Evaluation, dated 11/26/2023, indicated Resident 1 was at high risk for falls due to balance problem while standing and walking, decreased muscular coordination, change in gait pattern when walking through doorway, and requires use of assistive devices. The record indicated interventions and clinical suggestions (Utilize personal/pressure sensor alarms; Rubber-soled shoes or nonskid slippers worn for ambulation; Utilize toileting program) that addressed risk for falls was left unchecked. During a review of Resident 1's Care Plan, dated 12/2/2023, indicated Resident 1 was at high risk for falls related to gait/balance problems and unaware of safety needs due to history of fall, stroke (damage to the brain from interruption of its blood supply), compression fracture (broken bone) lumbar vertebra (largest bones of the spine), the goals were that the resident would be free of falls, free of minor and serious injury with the interventions that included to anticipate and meet the resident's needs, ensure resident's call light within reach and prompt response to all request for assistance, ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheel chair, and follow facility fall protocol. The Care plan indicated, resident had an actual fall due to syncope ad hypotension on 1/13/2024 and the care plan was revised on 2/10/2024. During a review of Resident 1's Minimum Data Set (MDS, a comprehensive assessment and screening tool) dated 12/3/2024, indicated Resident 1's cognitive skills were severe impairment (difficulty with or unable to make decisions, learn, remember things), needed moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) in toileting hygiene (ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement) and walking 10 feet in a room/corridor/similar space. The MDS indicated toilet transfer (the ability to get on and off a toilet or commode) was not attempted for assessment due to medical condition or safety concern. The MDS indicated, Resident 1 was frequently incontinent (unable to control bladder to urine and bowel to have a bowel movement). The MDS indicated, Resident 1 had a history of fall with fracture within one month prior to initial admission to the facility on [DATE]. During a review of Resident 1's Order Summary Report, indicated, on 12/8/2023, Resident 1 had a physician order for oxygen at 2 litter per minutes via nasal cannula to keep oxygen saturation at or above 93% every shift. During a review of Resident 1's Change in Condition Evaluation (COC), dated 1/13/2024 at 1 PM, indicated Resident 1 had a change in condition related to abdominal pain, abnormal vital signs, falls, loss of consciousness, nausea/vomiting, uncontrolled pain, trauma (fall related or other), seems different than usual, talks/communicates less, new or worsening pain. The record indicated patient had alleged episode of syncope after self-transferring from raised toilet seat to wheelchair. B/P (blood pressure) showed 20 mmHg drop from supine to sitting, and patient c/o (complained of) 10/10 abdominal pain s/p (status post, meaning after) fall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same record review, the COC indicated CNA reported that she found the resident side lying on her right side on the floor with her pants down and emesis and stool noted beside her, emesis green in color and think in consistency. Resident was assessed BP 90/40, pulse 58, RR 20, T 97.8, pain 10/10 lower abdominal pain. Patient had episode of syncope due to orthostatic hypotension, patient complained of nausea, skin noted cold. Body assessment done, no bruising or bleeding, resident claimed she hit the back of her head when she attempted to independently self-transfer from the toilet to her wheelchair and allegedly fainted. Head was assessed, no injuries present, skin remains intact and free from discoloration. Neuro-check was provided and within normal limit to self and situation. A&O x 4. Resident stated she did not utilize call light when she attempted to transfer independently. MD was notified of new change in condition; new order noted and carried out. Resident was transferred via 911 to general hospital ER for further evaluation for abnormal vital signs secondary to episode of syncope orthostatic hypotension. POA was notified and verbalized understanding of fall. Nursing needs attended prior to transfer and left clean, dry, and free from odor. The COC indicated; the physician was notified on 1/13/2024 at [12 AM] with the recommendation to transfer to general acute hospital for fall secondary to episode of syncope orthostatic hypotension. During a review of Resident 1's Neurological Check List, dated 1/13/2024 at 2:30 PM (1 hour and 30 minutes from the time of fall incident at 1 PM), indicated, the form was incomplete with no licensed nurse signature and date. The Neurological Checklist indicated vital signs information and neurological assessment one time on 1/13/2024 timed at 12:50 AM. The Neurological Checklist did not indicate the signature and name/title of the licensed nurse who performed the Neurological Assessment. There were no other Neurological Assessments found preceding the indicated assessment as indicated in the facility's policy and procedures. During a review of Resident 1's SNF/NF to Hospital Transfer Form, undated, indicated, Resident was transferred to the GACH due to a fall happened on 1/13/2024. The record indicated Resident 1 was sent on 12/3/2023 (one month before the incident happened) at 4:10 AM and the report was given to receiving Registered Nurse on 1/12/2024 (one day before the incident happened) at 1:05 PM. The SNF/NF to Hospital Transfer Form dates and timeframes were inaccurate. During a review of Resident 1's GACH record titled Emergency Documentation, ED Note - Provider, dated 1/13/2024 timed at 3:30 PM, indicated, Resident 1 was admitted to the ED for a mechanical fall, Resident 1 reported that she was trying to transfer from toiler back to wheelchair, she as feeling weak and tried to sit down but wheelchair was not where she thought, hit her head, complains of left lateral head pain. During a review of Resident 1's Progress Notes, Type: IDT Progress Notes-Falls, dated 1/15/2024, indicated a late entry for the resident's fall on 1/13/2024. The record indicated root cause analysis was Resident has hypotension, resident fainted, unsteady with gait and transfer, desires for independence not asking for assistance, and the interventions were neuro check initiated, encourage resident to ask for assistance, transfer via 911 due to hypotension, resident will be re-assessed by rehab when back from the hospital. During a review of Resident 1's Post Fall Evaluation, dated 1/24/2024 (11 days after the fall), indicated Resident 1 had an unwitnessed fall on 1/13/2024 at 1 PM in her room while attempting to self-toilet and the primary physician was notified on 2/2/2024 for fall and notification of pain in the abdominal are. The record indicated, Resident 1 was found with bare feet (no shoes/socks or non-skid shoes or socks), and Resident 1 was not wearing oxygen as prescribed at the time of fall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Fall Risk Evaluation, dated 1/26/2024, indicated Resident was a low risk for fall. The record indicated questions 4 to 11 in History, Current Status, Predisposing Conditions, interventions and clinical suggestions that addressed risk for falls were left unchecked/not assessed. During a review of Resident 1's Care Plan, dated 1/27/2024 (14 days after Resident 1's actual fall on 1/13/2024), indicated Resident 1 had an actual fall with poor balance, unsteady gait and the interventions included, to monitor/document/report as needed for 72 hours to the physician for signs and symptoms of pain/bruises/change in mental status/new onset of confusion/sleepiness/inability to maintain posture/agitation. The care plan indicated the interventions included neuro-checks with no specific frequency noted. During an interview on 8/14/2024 at 1:30 PM with the Director of Nurses (DON), the DON stated, the Certified Nurse Assistant (CNA) 1, Registered Nurse (RN) 1, and the previous DON that handled Resident 1's fall incident on 1/13/2024 was no longer employed with the facility. During an interview on 8/14/2024 at 2 PM with CNA 2, CNA 2 stated, she was working on 1/13/2024 and was not taking care of Resident 1. CNA 2 stated, she could not recall if there was any fall or fall huddle on 1/13/2024. During an interview on 8/14/2024 at 2:15 PM with CNA 3, CNA 3 stated, she was working on 1/13/2024 from 7 AM to 3:30 PM and was not taking care of the resident. CNA 3 stated she could not recall any fall incident happened in the facility and if she attended any fall huddle during her shift. CNA 3 stated, she had taken care of Resident 1 prior to her fall. CNA 3 stated, Resident 1 always called for help when she needed to go to the bathroom. During an interview on 8/14/2024 at 2:30 PM with MDS Nurse, the MDS Nurse stated, she could not recall if the Resident 1 had any falls in January 2024. During an interview on 8/14/2024 at 3 PM with the Medical Record (MR), the MR stated, she could not find any neurological check records for Resident 1 on 1/13/2024. The MR stated there was only one neuro-check on file on 1/13/2024 at 2:30 PM that was not completed. During a concurrent record review and interview on 8/14/2024 at 3:50 PM with the DON, Resident 1's Fall Risk Evaluation, dated 11/26/2024 and 1/26/2024 was reviewed. The DON stated the evaluation was not thoroughly assessed. The DON stated, it should be completed, and all questions should be answered for appropriate interventions and recommendations. During a concurrent record review and interview on 8/14/2024 at 4 PM with the DON, Resident 1's Neurological Check List, dated 1/13/2024 was reviewed, the DON stated, the form was incomplete. The DON stated, per facility protocol, when a resident had a fall, the resident would be under monitoring for 72 hours, and neurological check supposed to be done every 15 minutes for one hour, every 30 minutes for another one hour, every hour for 4 hours after that. The DON stated, based on the record, the neurological check was initiated on 1/13/2024 at 2:30 PM and was not completed because the resident was already picked up by ambulance to the general acute hospital for higher level of care at 2:30 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 8/14/2024 at 4:30 PM with the DON, Resident 1's Progress Notes, Type: IDT Progress Notes-Falls, dated 1/15/2024 and Resident 1's Care plan, since admission on 11/26/2023 were reviewed. The DON stated, based on the record, the IDT meeting was done on 1/13/2024 just prior to Resident 1 was transferred to GACH. The DON stated, per facility protocol, when conducting IDT meeting fall, the facility's staffs who presented during the meeting would go over the existing care plan to determine why the current interventions were not working and they would revise the care plan so it could best adhere to the resident's specific needs. The DON stated the actual fall care plan was created on 1/27/2024 (14 days after the resident's actual fall on 1/13/2024), and the care plan for high risk of fall dated on 12/2/2023 was revised on 2/10/2024 (28 days after the resident's actual fall on 1/13/2024). During a concurrent record review and interview on 8/14/2024 at 5 PM with the DON, Resident's electronic medical records since admission on 11/26/2023 was reviewed. The DON stated, Resident 1's SNF/NF to Hospital Transfer Form was documented with the transfer date of 12/3/2023, which was incorrect because the incident happened on 1/13/2024. The DON stated, Resident 1's COC, dated 1/13/2024 with indication that the physician was notified on 1/13/2024 at midnight was incorrect because the physician should be notified at the time of the event, which should be 1 PM. The DON stated RN 1 and the previous DON did not document the incident correctly. During an interview on 8/14/2024 at 5:20 PM with the DON, the DON stated, based on incomplete fall risk assessment, late care plan revision, and inaccurate documentation, Resident 1 could potentially have a risk for a recurrent fall. During a review of the facility's policy and procedure (P&P) titled, Fall Management Program, revised 3/13/2021, the P&P indicated the following information: -A licensed nurse will conduct a new fall risk evaluation quarterly, annually, upon identification of a signification change of condition, port fall and as needed. -The IDT will initiate, review and update the Resident's fall risk status and care plan at the following intervals: on admission, quarterly, annually, upon identification of a significant change of condition, post fall and as needed. -For an unwitnessed fall or a witnessed fall with suspected or known head injury, the licensed nurse will complete neurological checks for 72 hours following the fall incident: perform neurological checks at the ordered frequency every 15 minutes for one hour, then every 30 minutes for one hour, then every hour for 4 hours. -The Residents' care plans will be updated with the IDT's recommendations. During a review of the facility's P&P titled, Completion and Correction, revised 1/1/2012, the P&P indicated the following: -Entries will be recorded promptly as the events or observations occur. -Entries will be complete, legible, descriptive and accurate. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Entries will include date: month, day, year and time; signature and professional designation (e.g. MD, RN, LVN) -Documentation content included: date, time, method of admission, transfer or discharge; each time a physician is notified via phone or in person regarding the resident's condition, date and time noting physician orders -An event is never to be documented before it occurs.