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	09/06/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48481 Based on observation, interview, and record review, the facility failed to ensure one of seven sampled residents (Resident 2), who was assessed by the facility as a high risk for developing pressure ulcer (PU, a localized injury to the skin and/or underlying tissue usually over a bony prominence due to unrelieved prolong pressure in combination with shear) and was admitted without pressure ulcers received the necessary care and services to prevent PU as indicated in the facility's policy and procedure. Resident 2 was observed with Stage 2 PU (a partial-thickness skin loss that appears as an open sore or blister) in the sacrococcyx (tailbone) that was not previously assessed and identified by the facility. This deficient practice placed the resident and other potentially high risk residents for PU to be at risk of developing pressure ulcer that could result in delayed treatment, infection, discomfort, poor healing, and deterioration of PU. Findings: During a review of Resident 2's Admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (a chronic condition that results in increased blood sugar), chronic kidney disease (a long-term condition that occurs when the kidneys are damaged and can't filter blood properly), and muscle weakness (generalized). During a review of Resident 2's Minimal Data Set (MDS- a resident assessment and care planning tool) dated, 8/28/24, indicated Resident 2 had severe cognitive (ability to think and reason or thought process) impairment that required maximum assistance with turning and repositioning. The MDS indicated Resident 2 was at risk for developing PU and had zero PU, no other ulcers, wound or skin problems. During a review of Resident 2's Weekly Skin Check, dated 9/2/24, indicated Resident 2 was noted to have MASD (Moisture Associated Skin Damage, an inflammation of the skin caused by long-term exposure to moisture) to sacrococcyx area, and a history of pressure ulcer stage 3 (a wound that has full-thickness skin loss). The Weekly Skin Check indicated the resident will be assisted with turning and repositioning and will place and pillow to offload heals and PU from developing. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 9/5/24 at 2:15 pm, in Resident 2's room. Resident 2 was observed with a stage 2 PU on the sacrococcyx area measuring approximately one and a half centimeter in diameter. Resident 2 stated, I didn't know anything about the wound on my buttocks, I just felt they put something on my buttock. I didn't know I have a wound. I was never turned side to side by the staff, no one mentioned to me anything about skin care or bedsore (another name for pressure ulcer) prevention. During a concurrent observation of Resident 2's PU and concurrent interview on 9/5/24 at 2:15 pm with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, she did not know that Residents 2 has a PU on the sacrococcyx area. During an interview on 9/5/24 at 3:50 pm with Treatment Nurse (TXN) stated, Resident 2 returned to the facility from the hospital with MASD on the sacrococcyx area that was treated with Zinc Oxide (ointment used to treat pressure ulcers because of its anti-inflammatory and antimicrobial (against development of disease-causing agent). The TXN stated I assessed the resident's skin, it was red, non-blanchable (rash or skin that doesn't fade when pressure is applied), but the skin was not open yesterday The TXN stated, I haven't done skin treatment for the resident today, but I'll do it later. During a review of Resident 2's Weekly Skin Check, dated 9/5/24, indicated Resident 2 has Sacrococcyx (tailbone area) scars from previous wound developed outside of the facility and the skin was currently clear and intact. However, Resident 2 was observed by the surveyor on 9/5/24 at 2:15 pm with stage 2 PU on the sacrococcyx area that was not documented in Resident 2's clinical record. During a record review and concurrent interview on 9/6/24 at 9:25 am, pm with LVN 1 stated, there was no documented evidence Resident 2 was assessed for the stage 2 PU on the sacrococcyx area on 9/4/24 and 9/5/24. During an interview with the Director of Nursing (DON) on 9/6/24, the DON stated the CNAs reports to the charge nurses right away if there was any change of skin condition on the residents, including new pressure ulcer. DON stated the LVN was supposed to assess the skin condition and report to the Treatment Nurse (TXN), or Registered Nurses (RNs) immediately if there were new pressure ulcers so that the facility will start interventions to prevent the potential infection and the deterioration of the wound. DON stated the CNAs and the LVNs should not wait for the TXN to conduct skin assessment for the resident. DON stated the delay of treatment could lead to wound infection and deterioration. During a review of the facility's policy and procedure (P&P) titled, Pressure Injury Prevention dated 3/30/23, the P&P indicated that staff would observe and report any signs of potential or active pressure ulcer as appropriate. The facility will complete skin assessment upon admission, readmission, weekly, consecutive weeks after admission, quarterly and when there is a significant change in condition.