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	10/28/2024

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 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** 48219 Based on observation, interview, and record review, the facility failed to ensure the residents had the right to participate in self-care as indicated in the resident's care plan titled ADL (activities of daily living) self - care promoting independence and autonomy for one of three sampled residents (Resident 1). This deficient practice violated the residents ' rights to participate in his or her own care and had the potential to create emotional distress leading to loss of autonomy. Findings: A review of the admission record indicated Resident 1 was initially admitted on [DATE], with a primary diagnosis of Metabolic encephalopathy (a change in consciousness that can cause confusion, memory loss, and loss of consciousness). A review of the History and Physical report completed on July 20, 2024, indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 1 ' s Minimum Set Data (MDS - a federally mandated resident assessment tool) dated October 17, 2024, indicated resident had a BIMs (brief interview for mental status) score of 15 indicating residents ' cognition (thinking) is intact. A review of Resident 1 Care - Plan titled Activities of daily living dated July 20, 2024, indicated the resident was to be encouraged to participate to the fullest extent possible with interaction including bathing/showering, dressing, skin inspection and activities of daily living. During an interview on 10/25/2024 at 4:28 PM with Resident 1, Resident 1 stated two Certified Nursing Assistants [CNA 1 and 2] denied him the opportunity to engage in his own self-care by refusing to allow him to participate in doing of his own personal hygiene. Resident 1 stated that during the time CNAs 1 and 2was assisting him, his arm had been grabbed and twisted during the care leaving the resident feeling embarrassed and angry as if his independence had been taken from him. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/28/2024, at 10:45 AM with Social Service Director (SSD), the SSD stated during herinterview with Resident 1, the resident stated the CNAs assigned to him were insisting that they would clean Resident 1, even after Resident 1 made it known that he wished to clean himself. The SSD stated it was important to allow residents to participate in their care in order to promote independence. During an interview on 10/28/2024, at 11 AM with CNA1, CNA1 stated he Resident 1, You are clean, We cleaned you already. CNA1 stated Resident 1 became frustrated and angry, insisting he wanted to clean himself. CNA 1 stated while repositioning Resident1, he pulled his arm back from CNA 1and yelled No! During an interview on 10/28/2024 at 12:53 PM with Resident 1, Resident 1 stated he wanted to ensure his cleanliness, but the CNAs 1 and 2 were doing everything they could to stop him from trying to clean himself and in doing so twisted his arm. Resident 1 stated the CNA ' s kept saying loudly Your clean, your clean. Resident 1 stated he felt controlled and stated he was not allowed to clean himself. A review of the facility's policy and procedure titled Residents Rights with a revision date of January 1,2012, indicated Residents of skilled nursing facilities have a number of rights under state and federal law. The Facility will promote and protect those rights. Residents ' have freedom of choice, as much as possible, about how they wish to live their everyday lives and receive care. A review of the facility's policy and procedure titled Resident Rights - Quality of Life with a revision date of March , 2017, indicated Reach resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person -centered manner, as well as those that support the resident in attaining or maintaining his/ her highest practicable well - being.