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	12/31/2024

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** 50203 Based on observation, interview, and record review, the facility failed to prevent one of four sampled residents (Resident 2) from developing pressure injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence) by not providing the necessary treatment and services to prevent the formation of and promote healing of pressure injury in accordance with the facility's policy and procedure and physician's order. This failure resulted in Resident 2 developing Deep Tissue Injuries (damage to the soft tissue and skin caused by pressure or shear forces) to the left and right heels and had the potential for complications that included pain, infection, tissue necrosis, delayed wound healing, and reduced mobility. Findings: During a review of Resident 2 ' s Admission Record, the facility admitted Resident 2 on 5/27/2024 and readmitted Resident 2 on 11/23/2024 with diagnoses that included fracture of unspecified part of neck of left femur(broken upper leg), Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and protein-calorie malnutrition (an imbalance between nutrients the body needs to function and the nutrients it absorbed). During a review of Resident 2 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of a resident ' s health status), dated 11/23/2024, the H&P indicated Resident 2 did have the capacity to understand and make decisions. During a review of Resident 2 ' s Minimal Data Set (MDS, a resident assessment tool), dated 9/30/2024, the MDS indicated Resident 2 did not have any pressure injuries. During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 was cognitively (a person ' s mental process of thinking, learning, remembering, and using judgements) intact and required maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) and functional mobility (a person ' s ability to move safely and independently within their environment). The MDS indicated Resident 2 does not have any unhealed pressure injuries. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s Order Summary Report (instructions that communicated the medical care that the resident received while in the facility), an order, dated 11/23/2024, indicated Resident 2 had partial weight bearing status (a resident may only put a small amount of body weight on the injured leg). During a review of Resident 2 ' s Braden Scale - for Predicting Pressure Ulcer Risk Evaluation (Braden Scale, a scale used to assess a resident ' s risk of developing pressure injury by evaluating six factors: sensory perception, skin moisture, activity mobility, friction and shear, and nutritional status), dated 11/23/2024, the Braden Scale indicated Resident 2 was At risk for pressure ulcers. The Braden Scale indicated that Resident 2 ' s activity level was confined to bed, he occasionally made slight changes in his body ' s position, he ate over half of his meals, required minimum assistance with mobility. During a review of Resident 2 ' s Skin Check document, dated 11/23/2024, the new admit skin assessment indicated left lateral inguinal hernia, cyst to left side of scrotum, bilateral upper arm skin discoloration, and there was no documented evidence of pressure injuries. During a review of Resident 2 ' s Wound Assessment and Plan, dated 11/26/2024 [3 days after readmission], the document indicated Resident 2 did not have a pressure injury. During a review of Resident 2 ' s care plan, initiated on 11/27/2024 and revised on 12/13/2024, the care plan indicated Resident 2 had the potential for impaired skin integrity as evidence by the Braden Scale for Predicting Pressure Ulcers Risk. The care plan interventions initiated on 11/27/2024 included evaluating the Resident ' s skin integrity and provide skin care as needed. During a review of Resident 2 ' s Early Warning Tool, dated 12/9/2024, the Early Warning Tool indicated Resident 2 complained of pain on his bilateral heels and redness was noted on the left heel. The Tool indicated the charge nurse and treatment nurse was made aware. During a review of Resident 2 ' s eINTERACT Change in Condition Evaluation document, dated 12/9/2024, the document indicated Resident 2 complained of soreness to bilateral heels during routine physical therapy. The document indicated and skin assessment was done, and Resident 2 was noted with non-blanchable (a red area on the skin that did not turn white or fade in color when pressed) redness to bilateral heels. The document indicated, Physician 1 recommended to paint Resident 2 ' s bilateral heels with betadine (an antiseptic to disinfect wounds) and wrap with rolled gauze. During a review of Resident 2 ' s Skin Check document, dated 12/9/2024, indicated 3 skin assessments: a surgical incision to the left hip, a diabetic ulcer to the left heel that was 3 centimeters (cm, unit of measure) by 3 cm by 0 cm, and a diabetic ulcer to the right heel was 3cm by 3cm by 0cm. During a review of Resident 2 ' s Wound Assessment Plan document, dated 12/10/2024, the Wound Assessment Plan indicated Resident 2 had a Deep Tissue Injury on his right heel. The document indicated Resident 2 ' s right heel wound measurements was 1.2 cm length x2.5 cm width. The document indicated Resident 2 had a Deep Tissue Injury on his left heel. The document indicated Resident 2 ' s left heel wound measurements was 1.7cm length x 3.1cm width. The document indicated Resident 2 ' s Treatment order was to cleanse the wound with sterile water, cover with dry clean dressing, hydrocolloid dressing (a dressing for wounds) change as needed, and to apply heel protectors (medical equipment used to minimize the risk of pressure damage to heels) every day and as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s SNF/NF to Hospital Transfer Form document, dated 12/10/2024, the document indicated Resident 2 was transferred to the General Acute Care Hospital (GACH) for an abnormal low hemoglobin (iron rich protein inside the red blood cells that carries oxygen from the lungs to the rest of the body; normal adult levels were 12 to 18 grams per deciliter [g/dL, unit of measure]) level of 6.4. During a review of Resident 2 ' s General Acute Care Hospital (GACH) 1 H&P, dated 12/11/2024, the H&P indicated Resident 2 had a stable deep tissue pressure injury to the left and right heel upon admission to the GACH. During a review of Resident 2 ' s care plans, revised on 12/12/2024, the care plans indicated Resident 2 had a deep tissue pressure injury to the left and right heel. The care plan interventions included monitoring resident ' s skin for worsening changes, elevating heels, applying heel protectors, and the physician ' s treatment to apply hydrocolloid dressing. During an interview on 12/31/2024 at 12:07PM with Treatment Nurse (TXN) 2, TXN 2 stated Resident 2 was admitted on [DATE] with a left hip incision and no wounds noted on Resident 2 ' s bilateral heels. TXN 2 stated, Resident 2 ' s bilateral heels deep pressure injury did not develop until 12/9/2024. TXN 2 stated, Resident 2 had Physical Therapy daily and would get up and walk. TXN 2 stated, on 12/9/2024, Resident 2 suddenly started to complain about pain to his bilateral heels. TXN 2 stated, the interventions for Resident 2 bilateral heels included apply heel protector, elevate heels with pillow, apply betadine, and wrap heels with rolled gauze. During an interview on 12/31/2024 at 2:50PM with the Director of Nursing (DON), the DON stated that a pressure ulcer or injury was an injury to the skin along boney prominences. The DON stated that pressure injuries may develop quickly, and the DON stated a Deep Tissue Injury was defined as a resident ' s skin was intact with some discoloration and bogginess to touch but unable to see the extent of the injury because the skin was still intact. The DON stated, on the Braden Scale, At Risk or moderate risk indicated a Resident who may have issues with mobility, repositioning, and required assistance. The DON stated, a resident has an existing problem that increased their risk for a pressure injury but at risk does not mean the resident has a pressure ulcer. The DON stated, the pressure injury prevention included frequent monitoring of resident ' s skin and reposition resident with peri-care every 2 hours and as needed. During an interview on 12/31/2024, at 4:30PM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated prior to a resident ' s transfer to GACH, a thorough head to toe assessment must be completed. LVN 3 stated, a head-to-toe assessment included a thorough skin assessment which required the licensed nurse to check the resident ' s back, trunk, and under all skin folds to see if there were any wounds present. LVN 3 stated, if there were any wounds present, it should be documented in the skin assessment section in the transfer form. During a review of facility ' s policy and procedures (P&P), titled skin integrity management, effective date 11/14/2024 with revision date 10/26/2023 indicated, the licensed nurse will complete skin assessment when there is change in skin integrity weekly. Notify physician, provide treatment ordered by physician, provide dietitian evaluation, and documented in the resident ' s medical record. During a review of the facility ' s P&P, Pressure Injury Prevention, dated 7/31/2024, revised on 6/27/2024, the P&P indicated, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complete skin risk evaluation upon admission/readmission, weekly , quarterly and when there is a significant change in condition. During a review of the facility ' s P&P, Pressure Injury Prevention, dated 7/31/2024, revised on 6/27/2024, the P&P indicated, implement interventions identified in the plan of care, staff will observe for any signs of potential or active pressure injury daily and weekly skin check will be completed and documented in the medical record.