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	04/03/2025

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 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** 48219 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1), having a history of dementia (a Condition of brain that makes it hard for a person to make decisions , and think clearly), requiring 1:1 supervision (one staff member is assigned to stay with and closely monitor one specific person at all times) for safety was not left unsupervised by Licensed Vocational Nurse (LVN) 2. This deficient practice resulted in Resident 1 sustaining a fall on 3/13/2025, requiring transfer to the acute hospital for evaluation and had the potential for serious physical injury. Findings: During a review of Resident 1 ' s Admission Record, (AR), the AR indicated Resident 1 was originally admitted on [DATE] with diagnoses including dementia (a Condition of brain that makes it hard for a person to make decisions , and think clearly), disorders of bone density and structure (fragile bones, more likely to break) and history of falling. During a review of Resident 1 ' s History and Physical (H&P) dated 3/14/2024, the H&P indicated Resident1 was somnolent (very drowsy or sleepy, not fully awake) but arousable (can be woken up) during Neurological assessment. During a review of Resident 1 ' s Minimum Data Set (MDS - Standardized assessment and care screening tool) dated 03/19/2025, the MDS indicated the resident had severe cognitive impairment (the person has difficulty with memory or understanding) and was dependent required two-person assistance for toilet transfers and sit to stand positions. During a review of Resident 1 ' s care plan titled Communication / comprehension dated 02/06/2025, the care plan indicated Resident 1 was unaware of safety needs. The care plan intervention included Resident 1 may have a 1:1 sitter due to poor safety awareness, getting up unassisted with poor balance and gait. During a review of Resident 1 ' s care plan titled [Resident 1] has a activities of daily living self-care performance deficit related to limited mobility dated 12/4/2024 with intervention stating resident is not able to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed and will need 1 person assistance. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s care plan titled [Resident 1] has an ADL self - care performance deficit related to limited mobility dated 12/04/2024, the care plan indicated interventions for Resident 1 to have a 1:1 sitter. During a review of Resident 1 ' s care plan titled [Resident 1] is dependent on staff for meeting emotional , intellectual, physical , and social needs, enjoys religious programs and music dated 12/11/2024, the care plan indicated Resident 1 needs 1:1 at bedside/in- room visits and activities if unable to attend out of room events. During a Review of Resident 1 ' s Progress notes titled Post fall evaluation dated 3/13/2025, the care plan indicated the resident ' s fall was unwitnessed and occurred in the bathroom while the resident was attempting to self- toilet. The notes indicated that the resident was disoriented and had a known tendency to attempt getting out of bed without assistance. At the time of the incident, Resident 1 had an assigned 1:1 sitter, who was reportedly on a bathroom break. During the sitter ' s absence, Resident 1 got out of bed , ambulated independently to the restroom, and later reported that she fell . According to the author of the note, Resident 1 did not sustain any injuries but was transferred to the General Acute Care Hospital (GACH) emergency room . During a review of Resident 1 ' s Telephone Order dated 02/07/2025, the Order indicated Resident 1 may have 1:1 sitter due to poor safety awareness, getting up unassisted with poor balance and gait. Every shift. During an interview on 4/3/2025, at 9:41AM with LVN1, LVN 1 stated Resident 1 has been observed attempting to stand and walk independently, despite having an unsteady gait and being too weak to stand without assistance. LVN 1 stated Resident 1 frequently attempts to stand without assistance, and that the staff is aware of this behavior. LVN 1 stated interventions are currently in place, including a wheelchair alarm, fall mat, and one -to-one sitter, to ensure resident safety and prevent falls. During an interview on 4/3/2025, at 9:50 AM with Certified Nursing Assistant (CNA1) stated Resident 1 is oriented but experiences periods of confusion. CNA 1 stated that the resident is frequently restless, trying to get out of bed and out of her chair. CNA1 stated that bed and chair alarms are in place for the resident ' s safety and added, We are always watching her, and that is why she has a one -to one sitter. CNA 1 stated Resident 1 consistently tries to get up on her own, and as a result, requires someone to be present with her at all times. During a concurrent interview and record review on 4/3/2025 at 10:12AM with Director of Nursing (DON) the physician ' s order dated 03/27/205, was reviewed. The order indicated that Resident 1 may have a one-to-one sitter in place due to poor balance and unsteady gait. The DON stated he is familiar with the resident and described her as a very active person with a history of falls and fractures. The DON stated that resident 1 frequently attempts to stand up and get out of bed, grabbing nearby surfaces, and taking small, unsteady steps. The DON stated at the time of the fall, the 1:1 sitter requested to use the restroom and notified the charge nurse, who then assumed responsibility for monitoring the resident. The Charge nurse reported checking on the resident, and confirmed she was in bed with alarms activated, and then stepped away to assist another resident with a procedure. During this time, Resident 1 got out of bed unassisted and was found on the bathroom floor. DON went on to state Resident 1 lacks mental capacity (ability) to use the call light, and following incident was transferred via 911 to an acute care hospital due to complaints of head pain after reportedly hitting her head during the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/3/2025 at 10:20AM with Director of Staff Development (DSD) stated the caregivers assigned to residents are not certified nursing assistants, but they are permanent staff members employed by the facility. The DSD explained that these caregivers receive dementia care training and participate in hand - in- hand training programs. The DSD stated that if a caregiver who is supervising a resident need to take a break or use the restroom, the charge nurse is responsible for covering their break. The DSD also stated that the person assuming coverage should not leave the resident alone, and once they take over supervision, they are responsible for the resident ' s safety. Furthermore, DSD said residents requiring constant supervision should never be left unattended, because of the significant risk for falls. During an interview on 4/3/2024 at 11:09AM with LVN 2 stated the caregiver assigned to Resident 1 needed to use the restroom and was called in to supervise the resident. LVN 2 stated after checking Resident 1 and saw that everything was in place and Resident 1 was fine at that time. LVN 2 stated that she was called away to perform a breathing treatment for another resident, and left Resident 1 unattended in the restroom. Upon returning and opening the restroom door, LVN 2 stated Resident 1 was found on the floor, in a sitting position. LVN 2 stated there was no visible bleeding, but Resident 1 complained of a headache. After the incident, Resident 1 was transferred to the hospital for further evaluation. LVN 2 stated The reason we don ' t leave a resident who is on 1:1 supervision is because they can fall and injure themselves. During a review of the facility ' s policy and procedure titled Resident safety, with a revision date of 04/15/2021, indicated its purpose was to provide a safe and hazard free environment. Procedure will include a risk evaluation and a resident centered care plan to be developed to mitigate safety risk factors. Resident will be checked a minimum of every two hours around the clock and may be care planned to require more frequent safety checks , modifying the frequency as necessary.