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	06/04/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to implement its policy and procedure titled, Abuse Prevention and Management for one of three sampled residents (Resident 1) by, Failing to report to the State Agency (SA where state law provides for jurisdiction in long-term care facilities), ombudsman (advocates for residents of nursing homes, board and care homes and assisted living facilities) and local enforcement within 2 hours after Resident 1 reported an allegation of physical abuse to the facility. 2. Failing to thoroughly investigate, protect and prevent the possibilities of further abuse happening to Resident 1 and other residents in the facility. These deficient practices lead to Resident 1 feeling unsafe, frustrated for not being taken seriously. Potentially result in recurrences of abuse that could affect Resident 1 and other residents in the facility's health, mental and emotional wellbeing and safety.Findings: During a review of Resident 1's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including but not limited to hemiplegia (complete or partial paralysis) and hemiparesis (weakness or partial paralysis) following cerebral infarction (ischemic stroke - occurs when blood flow to an area of the brain is blocked or significantly reduced) affecting right dominant side, abnormalities of gait and mobility, and muscle weakness. During a review of Minimum Data Set (MDS, a resident assessment tool), dated 5/16/2026, indicated Resident 1's cognitive skills (ability to make daily decisions) was intact. The MDS indicated Resident 1 required setup and clean-up assistance (helper sets up and cleans up; resident completes activity) with eating, oral hygiene and toileting and partial/moderate assistance (helper does less than half the effort) with bathing dressing and personal hygiene. During a review of Resident 1's Progress Notes (PN) dated 5/22/2026 timed at 1:29 PM, the PN indicated approximately around 10:00 AM, Resident 1 reported to the Police Officers (PO), who came to see the Resident in the facility, Resident 1 complained that someone came to the room, went over his things and hit him in the head. During a review of Resident 1's PN dated 5/26/2026 timed at 10:30 AM, the PN indicated, Los Angeles Fire Department Captain (LAFD) called the facility stated that Resident 1 called and complaining of a man hitting him on the head. PN also indicated when Registered Nurse (RN) 3 ask Resident 1 which part of his head got hit and resident kept pointing to the left side of his aggressively. During a concurrent interview and record review on 6/3/2026 at 1:35 PM with the Director of Nurses (DON), email sent by the Administrator (ADM) to the Sales and Marketing Staff (SMS) dated 5/28/2026 timed at 4:41 PM was provided by the DON to the Surveyor was reviewed. The email indicated interviews conducted by the ADM regarding Resident 1's abuse allegations incident. The email indicated, on 5/22/2026, ADM's response to Resident 1's abuse allegation was by conducting an interview with Resident 1, and on 5/26/26, interviewed RN 3 there were no other actions, measures, and investigations carried out for Resident 1's abuse allegation. DON stated, the interviews of Resident 1 and RN 3 conducted by the ADM on 5/22/2026 and 5/26/2026 was not enough to be considered a thorough investigation. During a phone interview on 6/3/2026 at 12:30 PM with Resident 1, Resident 1 stated, although he does not remember who and when, he did report to everyone in the facility that someone hit him on the head. He did not think facility took his complaint seriously and it was not investigated, that made him very frustrated. During an interview on 6/4/2026 (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 8:30 AM with RN 2 (RN 2 worked on 5/22/2026 from 7 AM to 3 PM shift), RN 2 stated, on 5/22/2026, a PO came in around 10:00 AM and stated, Resident 1 complained that someone at night hit him on the head. RN 2 stated, he did tell ADM about the abuse allegation around 12:00 PM on 5/22/2026. RN 2 stated, since the ADM was the abuse coordinator he thought the abuse protocol would be initiated. RN 2 stated, he was not aware if it was reported to appropriate agencies and/or thoroughly investigated. RN 2 stated, the least the facility could have done was to report and thoroughly investigate any abuse allegation. During an interview on 6/4/2026 at 9:15 AM with RN 3 (RN worked on 5/26/2026 from 7 AM to 3 PM), RN 3 stated, on 5/26/2026 LAFD called around 10:30 AM stating, Resident 1 called them complaining someone hit him on the head. RN 3 stated, when she asks Resident 1 where he was hit Resident 1 pointed at the left side of the head. RN 3 stated, she did not see any abnormalities on Resident 1's head. RN 3 stated, she reported it to ADM right away because it was an allegation of abuse. RN 3 stated, abuse allegation needs to be thoroughly investigated, and needs to be reported to the Police Department, Ombudsman and CDPH immediately. RN 3 stated, she thought ADM followed the abuse process/protocol. RN 3 stated, as mandated reporter, she should have followed up with the ADM if the abuse protocol of investigating and reporting was initiated. During an interview on 6/4/2026 at 2:30 PM with the DON, DON stated, on 5/22/2026 and on 5/26/2026, Resident abuse allegation was reported to the ADM but was not thoroughly investigated and was not reported to the ombudsman and CDPH as per policy. DON stated, facility did not follow policy of Abuse by not reporting and not conducting a thorough investigation which potentially can result in recurrence of abuse allegations and that can affect Resident 1 and other residents in the facility. A review of the facility's policy and procedure (P&P) titled Abuse Prevention and Management dated 6/12/2024, indicated, a) allegation of abuse or reasonable suspicion of a crime are to be reported to the Administrator or designated representative, b) when the Administrator receives a report of an allegation of resident abuse, the Administrator or designated representative will initiate an investigation immediately, c) immediate actions include the Administrator or designated representative conducting the investigation will interview individuals who may have information relevant to the allegation, witnesses include but are not limited to the resident, witnesses to the incident, roommates, visitors, etc. and the Administrator or designated representative will notify law enforcement by telephone immediately but no longer than 2 hours, and send the written SOC 341 report to the ombudsman, law enforcement, and CDPH licensing and certification within (2) hours.