

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055664	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2025
NAME OF PROVIDER OR SUPPLIER York Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call light (consists of a button that, when pressed, sends a signal to the nursing station or a centralized system, alerting healthcare providers that assistance is required in the patient's room) was within reach for Three out of eight sampled residents (Residents 66, 83, and 54).</p> <p>This deficient practice has the potential to delay care and services to the residents and preventing a timely response to care needs.</p> <p>Findings:</p> <p>1. A review of Resident 66 ' s admission record indicated the resident was originally admitted to the facility on [DATE], with diagnoses that included aphasia (loss of language) and dysphagia (difficulty with verbal communication) following cerebral infarction with hemiplegia(paralysis or weakness of one side of body) and hemiparesis (weakness or inability to move on one side of body) affecting right dominant side.</p> <p>A review of Resident 66 ' s Minimum Data Set (MDS, a resident assessment tool) dated 04/18/2025, indicated resident had moderate cognitive impairment (difficulty with short term memory, trouble making decisions, challenges with orientation), unclear speech (slurred or mumbled words), and has impairment on onside of his body (upper right extremity including shoulder, elbow, wrist, and hand).</p> <p>A review of Resident 66 ' s Care plan for At Risk for falls, dated 12/28/2024, indicated interventions to ensure Resident 66 ' s call light was within reach and to encourage the resident to use it for assistance as needed.</p> <p>A review of Resident 66 ' s Care plan for Potential for injury, initiated on 04/11/22025, indicated interventions to keep call light within reach.</p> <p>During a concurrent observation and interview on 05/13/2025 at 11:29AM, in Resident 66 ' s room, Resident 66 was observed lying in bed. The call light was observed not within Resident 66 ' s reach. Resident 66 stated only able to use his left hand and that he could not locate where the call light was placed.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 05/13/2025 at 11:45AM with licensed vocational nurse (LVN)3 in resident 66 ' s room, Resident 66 ' s call light was observed. Resident 66 ' s call light was positioned above the resident ' s head and not within Resident 66 ' s reach. LVN 3 stated Resident 66 ' s call light should be within reach of the resident and that when the call light was not within a resident ' s reach, and the resident required assistance, the resident could not call for assistance.</p> <p>2.A review of Resident 83 ' s admission record indicated the resident was originally admitted to the facility on [DATE], with diagnoses that included dysphagia (difficulty with verbal communication) and dependence on supplemental oxygen.</p> <p>A review of Resident 83 ' s MDS dated [DATE] indicated the resident has moderate cognitive impairment (difficulty with memory or recalling information and requires supervision or assistance with activities) requiring maximal assistance with ability to move from lying on the back to sitting on the side of the bed.</p> <p>A review of Resident 83 ' s Care plan for Activities of Daily Living (ADL basic skills necessary for individuals to independently care for themselves, such as eating, bathing, and mobility) self-care performance deficit, dated 05/19/2024, indicated intervention to encourage the resident to use call light to call for assistance.</p> <p>A review of Resident 83 ' s Care plan for Communication Problem, dated 8/14/2024, indicated to ensure and provide a safe environment which indicated interventions to place call light within reach.</p> <p>A review of Resident 83 ' s care plan for at Risk for Falls dated 12/09/2024, indicated the resident required a functional and reachable call light.</p> <p>During a concurrent observation and interview on 05/13/2025 at 2 PM in Resident 83 ' s room, Resident 83 ' s call light was observed. Resident 83 ' attempted to grab for the call light but could not reach for the call light.</p> <p>During a concurrent observation and interview on 5/13/2025 at 2 PM in Resident 83 ' s room, LVN 3 stated that Resident 83 ' s call light was not within the residents ' reach, and that Resident 83 could not reach her call light. LVN 3 stated that it was important for the call light to be within reach, and if the call light was not within reach the resident was unable to request assistance when needed.</p> <p>3. A review of Resident 54's admission Record indicated Resident 54 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), muscle weakness and history of falling</p> <p>A review of Resident 54 ' s History and Physical Examination (H&P), dated 9/24/2024, indicated Resident has the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 54's Minimum Data Set (MDS - a resident assessment tool), dated 3/22/2025, indicated Resident 54 required Setup and clean-up assistance (helper sets up and cleans up; resident completes activity) with eating, supervision or touching assistance (Helper provides verbal cues and or touching steadying) with personal hygiene and dressing, and partial/moderate assistance (helper does less than half the effort) with toileting and bathing.</p> <p>A review of Resident 54 ' s care plan (CP) for potential for injury related to the use of one half (&frac12;) side rail (a barrier attached to the side of a bed) for bed mobility, turning and repositioning, dated 9/23/2024, indicated intervention to keep call light within reach.</p> <p>A review of Resident 54 ' s care plan (CP) for an actual fall dated, 3/29/2025, indicated intervention for the use of bilateral floor mats and low bed.</p> <p>A review of the facility provided documents for falls, titled Fall Risk Evaluation dated 3/29/25 and 5/3/2025, indicated Resident 54 was at high risk for fall.</p> <p>During a concurrent observation and interview on 5/14/2025 at 8:18 AM with Resident 54 in Resident 54 ' s room, Resident 54 was observed sitting on his wheelchair to the left side of the bed, with a bedside table in front of him. Resident 54 ' s call light was placed to the right side of Resident 54 ' s bed. Resident 54 stated he cannot reach the call light, and he uses it if he needs assistance.</p> <p>During a concurrent observation and interview on 5/14/2025 at 8:20 AM with LVN (license Vocational Nurse) 8, in Resident 54 ' s room, licensed vocational nurse (LVN) 8 stated, Resident 54 ' s call light was not within Resident 54 ' s reach. LVN 8 stated, the policy of the facility for call lights was to ensure residents ' call light were within residents reach at all times in case of emergencies.</p> <p>During an interview on 5/14/2025 at 11:22 AM with the DON (Director of Nurses), DON stated, the facility ' s policy was to ensure residents call light was always within the residents ' reach. DON stated, a residents ' call light must be reachable so residents can call for assistance, especially during emergencies, and to prevent accidents, such as falls.</p> <p>A review of the facility ' s policy and procedure titled, Communication - Call system, revised on 01/01/2024, indicated that the purpose of the policy is to provide a mechanism for residents to promptly communicate with Nursing Staff. The policy specifies the facility will provide a call system to enable resident to alert the nursing staff from their rooms, toileting and bathing facilities. The policy ' s procedure indicated that call cords will be placed within reach of residents in their rooms. When a resident is out of bed, the call cord will be clipped to the bedspread in a manner that ensures it remains accessible to a wheelchair - bound resident.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a homelike environment for two of two sampled residents (Residents 89 and 32) by failing to ensure: Resident 89 was provided with a wall clock in the room, and Resident 32 ' s bedside table was in functional and working condition.</p> <p>These deficient practices had the potential to create an uncomfortable environment leading to Resident 89 verbalizing feelings of frustration and Resident 32 ' s personal items to be exposed.</p> <p>Findings:</p> <p>1. A review of Resident 89's admission Record indicated the facility admitted Resident 89 on 12/27/2024 with diagnoses that included hemiplegia (characterized by paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) affecting left non-dominant side, depression (a persistent feeling of sadness and a loss of interest or pleasure in activities, lasting for at least two weeks, that interferes with daily life) and anxiety disorder (A condition in which a person has excessive worry and feelings of fear, dread, and uneasiness).</p> <p>A review of Resident 89 ' s History and Physical (H&P), dated 3/18/2025, indicated Resident 89 was alert with normal affect.</p> <p>A review of Resident 89's Minimum Data Set (MDS - a resident assessment tool), dated 5/1/2025, indicated Resident 89 ' s cognitive status (ability to think and reason) was intact. The MDS indicated Resident 89 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating, and oral hygiene, supervision or touching assistance (Helper provides verbal cues and or touching steady) with dressing, partial/moderate assistance (helper does less than half the effort) with personal hygiene, and substantial/maximal assistance (helper does more than half the effort) with toileting and bathing.</p> <p>2. A review of Resident 32's admission Record, indicated the facility admitted Resident 32 on 1/7/2025 with diagnoses that included hemiplegia and hemiparesis affecting left non-dominant side, chronic kidney disease (when the kidneys have become damaged over time and have a hard time doing all their important jobs) and generalized muscle weakness.</p> <p>A review of Resident 89 ' s History and Physical (H&P), dated 1/10/2025, indicated Resident 89 was alert cooperative with the exam.</p> <p>A review of Resident 89's MDS dated [DATE], indicated Resident 89 ' s cognitive status moderately impaired. The MDS indicated Resident 89 required supervision or touching assistance (Helper provides verbal cues and or touching steady) with eating, partial/moderate assistance (helper does less than half the effort) with oral and personal hygiene, substantial/maximal assistance with dressing and toileting and dependent (helper does all the effort) with bathing.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 5/13/2025 at 10:05 AM with Resident 89 in Resident 89 ' s room, Resident 89 was observed in bed with the head of bed elevated and watching television. Resident 89 ' s room did not have a wall clock. Resident 89 stated, she did not know why her room did not have a wall clock. Resident 89 stated she did not know why she was not provided a wall clock, and that it was frustrating always asking facility staff for the time.</p> <p>During an interview on 5/13/2025 at 10:10 AM with licensed vocational nurse (LVN) 6 in Resident 89 ' s room, LVN 6 stated, Resident 89 should have been provided a wall clock in her room. LVN 6 stated, having a wall clock in Resident 89 ' s room assisted Resident 89 with orientation and may prevent frustration, and having a clock made the room more homelike.</p> <p>During a concurrent observation and interview on 5/13/2025 at 3:35 PM in Resident 32 ' s room, Resident 32 was in bed with head of bed elevated. Resident 32 ' s bedside table, located to the right side of Resident 32 ' s bed was broken. Resident 32 ' s personal items located inside the bedside table were exposed.</p> <p>During an interview on 5/13/2025 at 3:40 PM with LVN 7, in Resident 32 ' s room, LVN 7 stated Resident 32 ' s bedside table was and should have been fixed right away. LVN 7 stated Resident 32 ' s personal belongings were exposed and that the broken bedside table in Resident 32 ' s room was not homelike. LVN 7 stated the Maintenance Supervisor (MS) would be notified right away.</p> <p>During an interview on 5/14/2025 at 11:10 AM with the MS, MS stated, everything in a resident ' s room should always be functioning and operable, and that he would continue to follow up with the nurses to ensure residents items were in good condition and not broken. MS stated facility staff were the one who informed the MS on items that required repairing or were missing.</p> <p>During an interview on 5/14/2025 at 11:17 AM with the DON (Director of Nurses), DON stated, it was the policy of the facility to ensure that all the rooms had a wall clock for residents ' orientation. The DON stated broken furniture or equipment such as Resident 32 ' s bedside table must be fixed right away to create a home like environment for the residents.</p> <p>A review of the facility ' s policy and procedure (P&P) titled, Maintenance Service, revised 1/1/2012, indicated; a) the maintenance department is responsible for always maintaining equipment ' s in a safe and operable manner, b) providing routinely scheduled maintenance service to all areas and other services that can become necessary or appropriate.</p> <p>A review of the facility ' s policy and procedure (P&P) titled, Residents Room and Environment, revised 1/1/2012 indicated the purpose was to provide residents with safe, clean, comfortable and homelike environment. The P&P indicated the facility staff will provide residents with a pleasant environment and person-centered care, and that the facility staff aim to create a personalize home like atmosphere.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a person-centered care plan (a treatment plan that focused on the needs and preferences of a resident or individual) for one of three sampled residents (Resident 94) Speech Therapy (ST, helped people who had trouble with speaking, understanding language, or swallowing).</p> <p>This deficient practice had the potential for a lack of individualized care and to affect the quality of services provided to Resident 94.</p> <p>Findings:</p> <p>A review of Resident 94 ' s admission Record (AR), indicated the resident was admitted to the facility on [DATE], with diagnoses that included encephalopathy (a disease, disorder, or damage that affected the brain ' s structure or function), muscle weakness (decrease in muscle strength), and abnormalities of gait and mobility (a change to your walking pattern).</p> <p>A review of Resident 94 ' s History and Physical (H&P) dated 4/1/2025, indicated the resident ' s neurological status alert and oriented times four (A&Ox4, someone who was alert and oriented to person, place, time, and event). The H&P indicated Resident 94 was able to answer questions appropriately.</p> <p>A review of Resident 94 ' s Physician ' s Order dated 4/1/2025 at 2:40 PM, indicated ST order for dysphagia (difficulty swallowing) and cognitive-communication deficits (having difficulty communicating because of problems with thinking and processing information, not just speaking or listening), six times for 27 days for cognitive training (a workout for your brain, designed to improve mental skills like attention, memory, and problem-solving), safe swallow strategies training, aspiration precautions (to prevent food, liquid, or saliva from going into your lungs instead of your stomach when you swallow), diet/liquids analysis/management, patient/caregiver education/training.</p> <p>A review of Resident 94 ' s ST Evaluation and Plan of Treatment dated 4/1/2025, indicated the goal for the resident was to improve cognition and tolerate the least restrictive diet and liquids without over signs or symptoms of aspiration. The ST Evaluation indicated Resident 94 had mild dysphagia and severe cognitive-communication deficits, decreased cognition, incomplete bolus formation (difficulty forming a cohesive, well-shaped ball of food and saliva [the bolus] in the mouth before swallowing), oral residue (having food or liquid left over in your mouth after you swallow), difficulty chewing the regular texture, decreased bolus preparation (the process of preparing food for swallowing was not happening properly), and manipulation and decreased lingual base retraction (pulling back part of your tongue towards the back of your throat, a crucial part of the swallowing process helping to push food down your throat and away from your airway).</p> <p>A review of Resident 94 ' s Comprehensive (complete) Care Plan for 4/1/2025, indicated there was no ST care plan initiated after Resident 94 ' s ST evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 94 ' s Minimum Data Set (MDS, a resident assessment tool) dated 4/7/2025, indicated the resident had severe cognitive impairment (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 94 had a manual wheelchair and required substantial/maximal assistance (helper did more than half the effort) from facility staff for toileting hygiene, showering, rolling to the left, rolling to the right, sitting to lying, and lying to sitting. The MDS indicated Resident 94 was dependent (helper did all of the effort) on facility staff for lower body dressing, sitting to stand, and chair/bed-to-chair transfers.</p> <p>During a concurrent interview and record review of Resident 94 ' s Comprehensive Care Plan on 5/15/2025 at 10:26 AM, the Minimum Data Set Coordinator (MDSC) stated the resident did not have a ST care plan but should have had one. The MDSC stated that without a care plan, the facility staff would not know the specific needs required for Resident 94 ' s dysphagia and Resident 94 could not receive the appropriate treatment further affecting resident ' s diet, chewing or swallowing depending on the needs.</p> <p>During a concurrent interview and record review of Resident 94 ' s Comprehensive Care Plan on 5/15/2025 at 3:45 PM, the Director of Nursing (DON) stated there should have been a care plan for the resident ' s ST Evaluation to guide the staff on how to care for the resident. The DON stated the Speech Therapist did an assessment, provided recommendations, and communicated with the staff to safely care for Resident 94. The DON stated if those recommendations were not listed, the resident could be at risk.</p> <p>During a concurrent interview and record review with the MDSC of the facility ' s policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning dated 9/7/2023, the P&P indicated The comprehensive care plan will also be reviewed and revised at the following times: onset of new problems; change of condition; in preparation for discharge; to address changes in behavior and care; and other times as appropriate or necessary. The MDSC stated the facility was not following the P&P but should have been. The MDSC stated if the P&P was not followed then the facility was not providing that direction which could affect the resident ' s quality of care and would not be resident centered.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan were revised for two of two sampled residents (Resident 1 and Resident 94) that included resident-specific interventions.</p> <p>This deficient practice had the potential to delay care and services that were specific to the residents ' needs.</p> <p>Findings:</p> <p>1. A review of Resident 1 ' s admission Record indicated the resident was initially admitted on [DATE], and readmitted on [DATE], with diagnoses that included dementia (a progressive state of decline in mental abilities), Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities), fractures, and muscle wasting (weakening, shrinking, and loss of muscle).</p> <p>A review of Resident 1 ' s History and Physical (H&P), dated 7/2/2024, indicated the resident had the capacity to understand and make decisions.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 4/2/2025, indicated the resident has severely impaired cognition (ability to process thoughts). The MDS also indicated the resident requires substantial assistance (helper does more than half the effort) on activities such as toileting, bathing, dressing, changing position from sitting to lying and lying to sitting on side of the bed. The MDS also indicated the resident is dependent (helper does all the effort on activities such as transferring from chair to chair or bed to chair. The MDS also indicated the resident was not assessed on activities such as sitting to stand due to medical condition or safety concerns. Further review of the MDS also indicated Resident 1 requires supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) to operate and move while on a manual wheelchair for at least 150 feet.</p> <p>A review of Resident 1 ' s Order Summary Report, dated 5/15/2025, included the following orders:</p> <p>a. Ordered on 12/2/2024, May have a bed alarm to remind resident not to get up unassisted. Charge nurse to monitor for proper placement and function. Every shift document Y if the alarm is in place and functioning properly, and N if not.</p> <p>b. Ordered on 12/2/2024, May have a wheelchair alarm to remind resident not to get up unassisted. Charge nurse to monitor for proper placement and function. Every shift.</p> <p>c. Ordered on 7/1/2024, May have bilateral landing pads due to risk of falls. Check for placement every shift.</p> <p>d. Ordered on 5/13/2025, May transfer via 911 due to [status post/after] fall for further evaluation 7 days bed hold.</p> <p>e. Ordered on 7/1/2024, Psychology/Psychiatrist consult, with follow-up treatment as indicated.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1 ' s Change in Condition Evaluation (CIC), dated 7/21/2024, timed at 10:49 PM, indicated Resident 1 was observed to be sitting up right at her bedside on top of the landing pad (a thin foam that is placed beside the bed as a cushion for when a resident falls).</p> <p>A review of Resident 1 ' s CIC, dated 5/2/2025, timed at 11:20 PM, indicated the resident had an unwitnessed fall. The CIC indicated facility staff heard an alarm coming from Resident 1 ' s room. The CIC indicated Resident 1 was seated on the floor next to Resident 1 ' s bed. The CIC indicated that the Resident 1 had facial redness and could not state why she was on the floor.</p> <p>A review of Resident 1 ' s Fall Risk Evaluation (FRE), dated 5/2/2025, timed at 11:17 PM, signed by the Assistant Director of Nursing (ADON) indicated the resident had a history of three (3) or more falls within the past 3 months. The FRE did not include any interventions under the section titled Risk for Falls.</p> <p>A review of Resident 1 ' s CIC, dated 5/13/2025, timed at 8:07 PM, indicated the resident had another fall. The CIC indicated the Resident 1 attempted to get up on her without calling for assistance, and staff were alerted after Resident 1 ' s wheelchair alarm was triggered. The CIC indicated facility staff found Resident 1 on the floor, grimacing and reaching towards her left hip. The CIC indicated Resident 1 had a discoloration to the top left of the head, and Resident 1 was transferred via 911 at 8:37 PM.</p> <p>A review of Resident 1 ' s care plan for impaired communication, initiated on 11/11/2023, revised on 10/08/2024, included interventions to evaluate the resident ' s ability to comprehend.</p> <p>A review of Resident 1 ' s care plan for actual fall on 5/2/2025 at 11:00 PM, initiated on 5/4/2025 and revised on 5/14/2025, indicated the resident also sustained an unwitnessed fall on 5/13/2025 at 8:07 PM. The care plan included the following interventions:</p> <ul style="list-style-type: none"> a. Monitor for hypoglycemia (low blood sugar levels) [related to] Insulin (injectable medication that is used to control the blood sugar) use. b. Monitor for hypoglycemia and bradycardia (low heart rate) [related to] Glimepiride (oral medication used to control the blood sugar) use. c. Monitor for dizziness, hypotension (low blood pressure), and bradycardia [related to] Amlodipine (oral medication used to control or lower the blood pressure) use. d. Hypotension can cause dizziness or blurry vision which may increase the risk of falling. Please monitor [blood pressure] as indicated. e. Low vitamin D level may cause muscle weakness. f. May have a bed alarm to remind resident not to get up unassisted. Charge nurse to monitor for proper placement and function, initiated on 5/4/2025 g. May have a wheelchair alarm to remind resident not to get up unassisted. Charge nurse to monitor for proper placement and function, initiated 5/4/2025 <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER York Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 6071 York Blvd. Los Angeles, CA 90042	
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>h. For no apparent acute injury, determine and address causative factors of the fall.</p> <p>A review of Resident 1 ' s care plan for an actual unwitnessed fall on 5/13/2025 at 8:07 PM, initiated on 5/13/2025, revised on 5/15/2025, indicated the resident had left hip pain and left scalp discoloration.</p> <p>A review of Resident 1 ' s care plan for impaired cognitive function or impaired thought processes, revised on 5/14/2025, indicated goals for the resident to maintain safety by the review date.</p> <p>A review of Resident 1 ' s care plan for safety, revised on 5/15/2025, indicated the resident had poor safety awareness related to impaired cognition and attempts to perform [activities of daily living] beyond physical ability. Resident self-propels in wheelchair. The care plan indicated the resident was at risk for falls, elopement, and injury. The care plan included interventions for facility staff to include strategies to reduce the risk of falls and injury. The care plan did not indicate specific strategies to reduce the risk for falls for Resident 1.</p> <p>A review of Resident 1 ' s care plan for falls, revised on 5/15/2025, indicated the resident was at risk for falls related to history of falls, dementia, Alzheimer ' s disease, poor safety awareness, and wheeling self around in the wheelchair.</p> <p>A review of Resident 1 ' s care plan for an actual unwitnessed fall on 5/13/2025 at 8:07 PM, initiated on 5/13/2025, revised on 5/15/2025, indicated the resident had left hip pain and left scalp discoloration.</p> <p>During a concurrent interview and record review on 5/16/2025 at 3:40 PM with Assistant Director of Nursing (ADON), Resident 1 ' s care plans were reviewed. ADON stated the interventions in the care plans were not person-centered since the care plan did not address Resident 1 ' s poor safety awareness. ADON stated interventions should include frequent visual checks on the resident.</p> <p>A review of the facility ' s Policy and Procedure (P&P) titled, Dementia Care, revised 10/2017, indicated the following regarding the care of a resident with a diagnosis of dementia:</p> <p>a. The resident ' s plan of care will reflect a baseline of common behaviors (target behaviors) exhibited by the resident, interventions and specific goals.</p> <p>b. Behavioral interventions are individualized approaches that are provided as part of a supportive physical and psychosocial environment, and are directed toward understanding, preventing and relieving, a resident ' s distress or to accommodate loss of abilities.</p> <p>c. The IDT will develop plans of care and interventions in an attempt to understand and address behaviors as a form of communication and modify the environment and daily routines to meet the resident ' s needs/preferences.</p> <p>d. Interventions will be assessed, including benefits and complications of interventions, in a timely manner.</p> <p>e. Interventions will be regularly monitored for efficacy, risks, and benefits.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility ' s P&P titled, Comprehensive Person-Centered Care Planning, effective 9/2023, indicated the following:</p> <p>a. The care plan should address resident-specific health and safety concerns to prevent decline or injury, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary.</p> <p>b. The care plan will be reviewed and revised to address changes in behavior and care.</p> <p>2. A review of Resident 94 ' s admission Record (AR) indicated the resident was admitted to the facility on [DATE], with diagnoses that included encephalopathy (a disease, disorder, or damage that affected the brain ' s structure or function), muscle weakness (decrease in muscle strength), and abnormalities of gait and mobility (a change to your walking pattern).</p> <p>A review of Resident 94 ' s History and Physical (H&P) dated 4/1/2025, indicated the resident ' s neurological status alert and oriented times four (A&Ox4, someone who was alert and oriented to person, place, time, and event). The H&P indicated Resident 94 was able to answer questions appropriately.</p> <p>A review of Resident 94 ' s Physician ' s Order dated 4/1/2025 at 10:02 AM, indicated PT services necessary for treatment diagnosis (other abnormalities of gait and mobility) to provide therapeutic exercise (a type of physical activity designed to help heal or improve physical functions), therapeutic activities (intentionally chosen tasks and exercises designed to improve physical, mental, and emotional well-being), neuromuscular re-education , gait training, and patient/caregiver education as necessary for five times per week for four weeks, one time only for 30 days.</p> <p>A review of Resident 94 ' s PT Evaluation and Plan of Treatment dated 4/1/2025 indicated the goal for Resident 94 was to reach optimal level (the best possible level or state of something, like performance) in order to be safely discharged home. The PT Evaluation indicated Resident 94 required skilled PT services to analyze gait pattern (the way someone walks), assess functional abilities, evaluate need for assistive device, improve dynamic balance (the ability to maintain your balance while you were moving or changing positions), increase coordination, increase lower extremity range of motion and strength and promote safety awareness. The PT Evaluation indicated that ambulation was not attempted due to medical conditions or safety concerns.</p> <p>A review of Resident 94 ' s PT Care Plan dated 4/1/2025, indicated Resident 94 had limited bilateral assisted range of motion (AROM, a type of exercise where you move a body part with some help), bilateral weakness, assistance with bed mobility and transfers, increase assistance with standing, inability to ambulate, and fall risk with cognitive impairment and unable to follow directions. The Care Plan goal indicated to improve bilateral AROM, increase bilateral strength, decrease assistance with bed mobility, transfers, standing, ability to ambulate, and reduce fall risk. The Care Plan goal was not updated with Resident 94 ' s current ambulation status and did not include a new goal.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 94 ' s Minimum Data Set (MDS, a resident assessment tool) dated 4/7/2025, indicated the resident had severe cognitive impairment (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 94 had a manual wheelchair and required substantial/maximal assistance (helper did more than half the effort) from facility staff for toileting hygiene, showering, rolling to the left, rolling to the right, sitting to lying, and lying to sitting. The MDS indicated Resident 94 was dependent (helper did all of the effort) on facility staff for lower body dressing, sitting to stand, and chair/bed-to-chair transfers.</p> <p>A review of Resident 94 ' s PT Therapy Progress Report dated 5/5/2025 to 5/11/2025, indicated the resident required partial/moderate assistance with ambulation and Resident 94 ' s gait distance was 100 feet (ft, unit of measurement) with a two-wheeled walker (a mobility aid with wheels on the front two legs and fixed, non-wheeled rear legs).</p> <p>During a concurrent interview and review of Resident 94 ' s Comprehensive Care Plan on 5/15/2025 at 10:43 AM, the MDS Coordinator (MDSC) stated the resident ' s PT Care Plan should have been updated since Resident 94 was ambulating. The MDSC stated the PT Care Plan should have been resident specific to indicate how far Resident 94 could ambulate, the schedule of ambulation, and a new goal for how much further rehabilitation (rehab, care that could help you get back, keep, or improve abilities that you need for daily life) would like Resident 94 to walk. The MDSC stated if the PT Care Plan was not updated the facility staff would not know if Resident 94 was improving or not.</p> <p>During a concurrent interview and record review of Resident 94 ' s Comprehensive Care Plan on 5/15/2025 at 3:45 PM, the Director of Nursing (DON) stated there should have been a care plan for the resident ' s ST to guide the staff on how to care for the resident. The DON stated the Speech Therapist did an assessment, provided recommendations, and communicated with the staff to safely care for Resident 94. The DON stated if those recommendations were not listed, the resident could be at risk.</p> <p>During a concurrent interview and record review with the MDSC of the facility ' s policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning dated 9/7/2023, the P&P indicated The comprehensive care plan will also be reviewed and revised at the following times: onset of new problems; change of condition; in preparation for discharge; to address changes in behavior and care; and other times as appropriate or necessary. The MDSC stated the facility was not following the P&P but should have been. The MDSC stated if the P&P was not followed then the facility was not providing that direction which could affect the resident ' s quality of care and would not be resident centered.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that the insulin order to manage the diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) of one of one sampled residents (Resident 79) was followed when Resident 79 ' s blood sugar was tested above 300 mg/dL, in accordance with the physician ' s order to notify the physician of the results.</p> <p>This deficient practice had the potential for facility staff to mismanage the Resident 79 ' s diabetes mellitus.</p> <p>Findings:</p> <p>During a review of Resident 79 ' s admission Record indicated the resident was admitted on [DATE] with diagnoses that included diabetes mellitus, sepsis (a life-threatening blood infection), and kidney failures (a condition in which the kidneys stop working and are not able to remove waste and extra water from the blood or keep body chemicals in balance).</p> <p>During a review of Resident 79 ' s care plan for diabetes mellitus, initiated on 3/4/2025, the care plan indicated the resident was at risk for complications of hypoglycemia and hyperglycemia. The care plan indicated interventions that included the following:</p> <ul style="list-style-type: none"> -Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. -Fasting Serum Blood Sugar as ordered by doctor. -Notify MD if [blood sugar] is [more than] 300. <p>During a review of the residents Order Summary, for May 2025, the Order Summary indicated a physician order dated 3/25/2025, for Resident 79 to receive Insulin Lispro Injection Solution 100 unit/mL (Insulin Lispro) Inject subcutaneously before meals and at bedtime for DM, notify MD (medical doctor) if [blood sugar] [is more than] 300.</p> <p>During a review of Resident 79 ' s History and Physical (H&P), dated 4/9/2025, does not indicate if the resident has the capacity to understand and make decisions. The H&P indicated the resident ' s chief complaints include diabetes mellitus.</p> <p>During a review of Resident 79 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 4/16/2025, indicated the resident has severely impaired cognition (ability to process thoughts). The MDS also indicated the resident has an active diagnosis of diabetes mellitus. The MDS also indicated that the resident receives insulin.</p> <p>During a review of the Resident 79 ' s Blood Sugar Summary from March to May 2025, the Summary included the following test results:</p> <ul style="list-style-type: none"> -On 4/17/2025 at 11:56 AM, 328 mg/dL. -On 4/17/2025 at 11:19 AM, 328 mg/dL. <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 5/14/2025 at 12:17 PM, 322 mg/dL.</p> <p>-On 5/14/2025 at 11:49 AM, 322 mg/dL.</p> <p>-On 5/5/2025 at 9:09 PM, 302 mg/dL.</p> <p>During a review of Resident 79 ' s entire medical records did not indicate documented evidence that the MD was informed when the resident ' s blood sugar was more than 300 mg/dL on 5/14/2025, 5/5/2025, and 4/17/2025.</p> <p>During an interview and concurrent record review on 5/15/2025 at 10:30 AM with Director of Nursing (DON), Resident 79 ' s medical records were reviewed. The DON stated the resident ' s blood sugar was more than 300 mg/dL on 5/14/2025, 5/5/2025, and 4/17/2025. The DON stated there was no documented evidence that licensed nurses informed the doctor regarding Resident 79 ' s blood sugar, as indicated in the physician ' s order. The DON stated the licensed nurses should inform the doctor because there could be a need to change the order to better manage the resident ' s blood sugar. The DON added mismanagement of the resident ' s DM could include conditions such as hyperglycemia episodes (high blood sugar).</p> <p>During an interview on 5/16/2025 at 1:45 PM with Licensed Vocational Nurse (LVN) 6, LVN 6 stated she made a mistake when she did not inform the doctor when Resident 79 ' s blood sugar was more than 300 mg/dL. LVN 6 stated if the doctor is not notified, the doctor would not be able to know if the resident requires a change in the dose of insulin required to manage the resident ' s blood sugar.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Diabetic Care, revised 1/1/2012, indicated the following:</p> <p>A licensed nurse will monitor the resident ' s blood glucose (blood sugar) per the [doctor ' s] order and will administer medication as indicated.</p> <p>The attending physician will write parameters for notification for blood sugar that is out of control, and the attending physician must be notified; unless otherwise noted on the physician ' s order.</p> <p>A licensed nurse will ensure that lab tests ordered by the attending physician are carried out and that abnormal tests are reported to the attending physician</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled residents (Resident 1), who was at risk for fall due to poor safety awareness and history of repeated falls was provided care and services to prevent recurrent falls in accordance with the facility's policy and procedures (P&P). The facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure a fall assessment and reassessment was conducted to identify the risk factors and cause of each fall, in accordance with the facility ' s Fall Management Program. 2. Ensure the care plan interventions were revised after each unwitnessed falls ([DATE], [DATE] and [DATE]) by addressing what caused the fall that included identifying the resident ' s behavior, poor safety awareness due to severe cognition impairment and inability to communicate as a result of dementia (a progressive state of decline in mental abilities), in accordance with the facility ' s P&P on Dementia Care. 3. Ensure to communicate to all facility staff Resident 1 ' s need for a person-centered observation or monitoring systems to address the identified risk factors for falls, in accordance with the facility P&P on Resident Safety. <p>As a result of these deficient practices, Resident 1, who had an unwitnessed fall with no injuries inside his room due to getting up unassisted on [DATE] and [DATE], sustained another unwitnessed fall on [DATE] at 8:07 PM.</p> <p>Resident 1 complained of left hip pain, head pain, bruising to the left forehead and was transferred to the General Acute Care Hospital (GACH) on [DATE] via 911 emergency services. The GACH indicated Resident 1 sustained a fracture (a break in the bone) to the left upper leg. The GACH record indicated Resident 1 underwent a left hip hemiarthroplasty (a surgical procedure that replaces or reconstructs a joint) on [DATE].</p> <p>Findings:</p> <p>During a review of Resident 1 ' s admission Record [AR], the AR indicated the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included dementia, Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities), fractures, and muscle wasting (weakening, shrinking, and loss of muscle).</p> <p>During a review of Resident 1 ' s History and Physical (H&P), dated [DATE], the H&P indicated the resident had the capacity to understand and make decisions.</p> <p>During a review of Resident 1 ' s care plan for impaired communication, initiated on [DATE], revised on [DATE], included interventions initiated on [DATE], to evaluate Resident 1 ' s ability to comprehend.</p> <p>During a review of Resident 1 ' s care plan for communication, initiated on [DATE], indicated the resident has communication problems related to her confusion, language barrier, and dementia.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s care plan for safety, initiated on [DATE], indicated the resident has poor safety awareness related to impaired cognition and attempts to perform [activities of daily living] beyond physical ability. Resident self-propels in wheelchair. The care plan added the resident is at risk for falls, elopement, and injury. The care plan included interventions for facility staff to include strategies to reduce the risk of falls and injury.</p> <p>During a review of Resident 1 ' s care plan for falls, initiated on [DATE], indicated the resident is at risk for falls related to history of falls, dementia, Alzheimer ' s disease, poor safety awareness, and wheeling self around in the wheelchair and a Fall Score of 15 (High Risk for Falls). The care plan included the following interventions initiated on [DATE]:</p> <ul style="list-style-type: none"> -Assist Resident with ambulation (walking) and transfers, utilizing therapy recommendations. -Determine Residents ability to transfer. -Evaluate fall risk of admission and [as needed]. -If fall occurs, alert provider. -If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol. -If resident is a fall risk, initiate fall risk precautions. <p>During a review of Resident 1 ' s Minimum Data Set (MDS &ndash; a federally mandated resident assessment tool), dated [DATE], the MDS indicated the resident had severely impaired cognition (the ability to process thoughts). The MDS indicated the resident requires substantial assistance (helper does more than half the effort) on activities such as toileting, bathing, dressing, changing position from sitting to lying and lying to sitting on side of the bed. The MDS also indicated the resident is dependent (helper does all the effort on activities such as transferring from chair to chair or bed to chair. The MDS also indicated the resident was not assessed on activities such as sitting to stand due to medical condition or safety concerns. Further review of the MDS also indicated Resident 1 requires supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) to operate and move while on a manual wheelchair for at least 150 feet. The MDS assessment did not indicate that the resident had any falls prior to MDS assessment, admission/readmission/entry/reentry from the facility.</p> <p>During a review of Resident 1 ' s Fall Risk Evaluation (FRE), dated [DATE], the FRE indicated the following information regarding Resident 1 ' s fall risks:</p> <ul style="list-style-type: none"> -Resident 1 had no falls in past 3 months. -Resident 1 had intermittent confusion. -Resident 1 was chairbound (state of being confined to a chair/wheelchair) and incontinent (does not have the ability to control over urination or defecation). -Resident 1 had 1 to 2 predisposing diseases. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident 1 had a change in condition in the last 14 days from the time of assessment.</p> <p>-Resident 1 was recently hospitalized from the time of assessment due to hypotension (low blood pressure) and bradycardia (slow heart rate).</p> <p>-Resident 1 was taking 1 to 2 medications at the time or within the last 7 days of assessment.</p> <p>-Resident 1 was at risk for falls.</p> <p>-Interventions included to assist resident with ambulation and transfers, determine resident ' s ability to transfer, evaluate fall risk on admission and [as needed], and if resident is a fall risk, initiate fall risk precautions.</p> <p>During a review of a physician order dated [DATE], indicated an order for Resident 1 to have bilateral landing pads (or floor mat, (a thin foam that is placed beside the bed as a cushion for when a resident falls) due to risk of falls. Check for placement every shift.</p> <p>During a review of Resident 1 ' s Change in Condition Evaluation (CIC), dated [DATE], timed at 10:49 PM, the CIC indicated Resident 1 was, observed to be sitting up right [at] her bedside atop the landing pad.</p> <p>During a review of a physician order dated [DATE] (five months after the [DATE] fall), indicated an order for Resident 1 to have a bed alarm to remind resident not to get up unassisted. The order further indicated for the charge nurse to monitor for proper placement and function. Every shift document Y if the alarm is in place and functioning properly, and N if not.</p> <p>During a review of a physician order dated [DATE] (five months after the [DATE] fall), indicated an order for Resident 1 to have a wheelchair alarm to remind resident not to get up unassisted. The order further indicated for the charge nurse to monitor for proper placement and function every shift.</p> <p>During a review of Resident 1 ' s Fall Risk Evaluation (FRE), dated [DATE], the FRE indicated the following information regarding Resident 1 ' s fall risks:</p> <ul style="list-style-type: none"> - Resident 1 had no falls in past 3 months. - Resident 1 was disoriented (confused) x 3 at all times. - Resident 1 was chairbound and incontinent. - Resident 1 had poor vision (with or without glasses). - Resident 1 had 1 to 2 predisposing diseases. - Resident 1 had balance problems while standing and walking. - Resident 1 requires the use of assistive devices such as a cane, wheelchair, or walker. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- Resident 1 was taking 3 to 4 medications at the time or within the last 7 days of assessment.</p> <p>During a review of Resident 1 ' s care plan for risk of falls, initiated on [DATE], revised on [DATE], the care plan indicated the resident is at risk for falls related to confusion, gait and balance problems, poor communication and comprehension, and unaware of safety needs. The care plan included the following interventions:</p> <p>May have a bed alarm to remind resident not to get up unassisted. Charge nurse to monitor for proper placement and function, initiated on [DATE] (two months after Fall Risk Evaluation on [DATE]).</p> <p>-May have a wheelchair alarm to remind resident not to get up unassisted. Charge nurse to monitor for proper placement and function, initiated on [DATE] (two months after Fall Risk Evaluation on [DATE]).</p> <p>Anticipate and meet the resident ' s needs.</p> <p>During a review of Resident 1 ' s Fall Risk Evaluation (FRE), dated [DATE], timed at 4:11 PM, the FRE indicated the resident the following information regarding Resident 1 ' s fall risks:</p> <p>-Resident 1 had no falls in past 3 months.</p> <p>-Resident 1 was disoriented (confused) x 3 at all times.</p> <p>- Resident 1 was chairbound and incontinent.</p> <p>- Resident 1 had poor vision (with or without glasses).</p> <p>- Resident 1 had 1 to 2 predisposing diseases.</p> <p>- Resident 1 had balance problems while standing and walking.</p> <p>- Resident 1 requires the use of assistive devices such as a cane, wheelchair, or walker.</p> <p>- Resident 1 was taking 3 to 4 medications at the time or within the last 7 days of assessment.</p> <p>During a review of Resident 1 ' s CIC, dated [DATE], timed at 11:20 PM, the CIC indicated the resident had an unwitnessed fall. The CIC indicated facility staff, heard an alarm coming from [Resident 1 ' s room]. The CIC indicated the Resident 1 was sitting down on the floor next to her bed. The CIC added that the resident was unable to state what occurred, however, she was noted with facial redness.</p> <p>During a review of Resident 1 ' s Fall Risk Evaluation (FRE), dated [DATE], timed at 11:17 PM, signed by the Assistant Director of Nursing (ADON), the FRE indicated if the total score was 10 or greater, the resident is considered as high risk for potential falls, prevention protocol should be initiated immediately and documented on the care plan. The FRE indicated the following information regarding Resident 1 ' s fall risks:</p> <p>-Resident had a history of 3 or more falls in past 3 months.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident 1 was disoriented x 3 at all times.</p> <p>-Resident 1 was chairbound and incontinent.</p> <p>-Resident 1 had poor vision (with or without glasses).</p> <p>-Resident 1 had a change in condition in the last 14 days.</p> <p>-Resident 1 ' s gait (ability to walk) and balance were not assessed. The evaluation was blank.</p> <p>-Resident 1 was taking 3 to 4 medications at the time or within the last 7 days of assessment.</p> <p>The FRE did not include interventions on the FRE Sections for 5. Risk for Falls, to indicate if Resident 1 was at risk for falls and Clinical Suggestions</p> <p>During a review of Resident 1 ' s Post Fall Evaluation (PFE) dated [DATE], timed at 11:23 PM, the PFE indicated the resident had a fall on [DATE]. The PFE indicated the resident ' s Pre-Fall Score was 15 (High Risk) and the resident Post Fall Score was now a 17 (High Risk). The PFE indicated the resident did not sustain any injuries from this fall. The PFE indicated Resident 1 was unable to state what she was doing (prior to the fall).</p> <p>During a review of Resident 1 ' s IDT Progress Notes- Falls, dated [DATE], timed at 11:58 AM, the IDT note indicated on [DATE] at 11:00 PM, the nurse heard an alarm coming from Resident 1 ' s room. The notes indicated the nurse found Resident 1 sitting down on the floor next to the bed. The notes indicated the root cause of the fall was poor safety awareness, impaired cognition, and unsteady gait and transfer. The notes indicated interventions such as remind resident regarding safety precautions, bed and wheelchair alarm, bed on the lowest position, and floor mats.</p> <p>During a review of Resident 1 ' s CIC, dated [DATE], timed at 8:07 PM, indicated the resident had another fall. The CIC indicated the resident took self to room and attempted to be independent without calling for help. The CIC indicated the wheelchair alarm sounded and when staff responded, the resident was noted on the floor, reaching for left hip/facial grimacing. The CIC also indicated the resident had skin discoloration on left top of head. The CIC added the resident was transferred via 911 at 8:37 PM.</p> <p>During a review of a physician order dated [DATE], the order indicated May transfer [Resident 1] via 911 due to [status post/after] fall for further evaluation 7 days bed hold.</p> <p>During a review of Resident 1 ' s care plan for impaired cognitive function or impaired thought processes, initiated on [DATE], and revised on [DATE], the care plan included goals for the resident to maintain safety by the review date. The care plan indicated to cue, reorient, and supervise [Resident 1] as needed.</p> <p>During a review of Resident 1 ' s Actual Fall care plan that happened on [DATE] at 11 PM (night shift), the care plan developed on [DATE], indicated the resident sustained another unwitnessed fall on [DATE] at 8:07 PM (evening shift). The care plan included the following interventions with corresponding dates of initiation:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Monitor for hypoglycemia (low blood sugar levels) [related to] Insulin (injectable medication that is used to control the blood sugar) use, initiated on [DATE], revised on [DATE].</p> <p>-Monitor for hypoglycemia and bradycardia [related to] Glimepiride (oral medication used to control the blood sugar) use, initiated on [DATE], revised on [DATE].</p> <p>-Monitor for dizziness, hypotension, and bradycardia [related to] Amlodipine (oral medication used to control or lower the blood pressure) use, initiated on [DATE], revised on [DATE].</p> <p>-Hypotension can cause dizziness or blurry vision which may increase the risk of falling. Please monitor [blood pressure] as indicated, initiated on [DATE], revised on [DATE].</p> <p>-Low vitamin D level may cause muscle weakness, initiated on [DATE], revised on [DATE].</p> <p>-May have a bed alarm to remind resident not to get up unassisted. Charge nurse to monitor for proper placement and function, initiated on [DATE].</p> <p>-May have a wheelchair alarm to remind resident not to get up unassisted. Charge nurse to monitor for proper placement and function, initiated [DATE]</p> <p>-For no apparent acute injury, determine and address causative factors of the fall, initiated [DATE].</p> <p>During a review of the resident ' s entire care plans on [DATE] at 12:09 PM in the presence of Assistant Director of Nursing (ADON), the ADON stated the resident ' s care plans did not address Resident 1 ' s specific behavior and poor safety awareness/inability to communicate, which caused the multiple falls, but instead focused on the resident ' s medications. The ADON stated the care plans did not have updated interventions to address the resident ' s behavior and poor safety awareness after the fall happened again on [DATE], because the bed alarms and wheelchair alarms were ordered on [DATE] and, therefore, they were not new fall interventions. The ADON further stated frequent visual checks or close monitoring of Resident 1 or moving Resident 1 closer to the Nurse Station would have prevented the resident ' s fall with injury on [DATE].</p> <p>During a review of the resident ' s entire medical records on [DATE] at 12:09 PM in the presence of the Assistant Director of Nursing (ADON), the resident ' s medical records did not indicate documented evidence that the resident was assessed if the resident understood that the sound of the wheelchair alarm meant for the resident not to get up unassisted.</p> <p>During a review of the resident ' s entire medical record on [DATE] at 12:09 PM in the presence of the ADON, the resident ' s medical records did not indicate documented evidence that the resident was closely monitored prior to the fall on [DATE].</p> <p>During a review of Resident 1 ' s Trauma Surgery History and Physical (H&P) from the GACH, dated [DATE], timed at 11:12 PM, the GACH H&P indicated Resident 1 was brought into the GACH by emergency medical services (EMS 911). The GACH H&P indicated Resident 1 ' s chief complaint indicated left hip and head pain. The H&P indicated Resident 1 ' s left forehead showed bruising, and the left lower extremity was tender to palpation (touch) over the hip. The GACH H&P also indicated Resident 1 sustained a left hip fracture.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s GACH Orthopedic Surgery Consult note, dated [DATE], the note indicated the resident sustained a left displaced femoral neck (a part of the thigh bone) fracture after a fall. The note indicated the resident will have a plan for a left hemiarthroplasty.</p> <p>During a review of Resident 1 ' s GACH Advanced Care Planning Note, dated [DATE], the note indicated the resident underwent a left hip hemiarthroplasty on [DATE]. The notes also indicated Resident 1 has not had meaningful recovery.</p> <p>During a review of Resident 1 ' s GACH Advanced Care Planning Note, dated [DATE], the note indicated the resident ' s health status has declined both mentally and physically since [the resident ' s] [hospital] admission/surgery, despite full support. The note indicated Resident 1 ' s family member (FM) wishes to change [the resident ' s] code status (type of emergent treatment a person would or would not receive if their heart or breathing were to stop) to do not attempt resuscitation (DNR, medical order that directs healthcare providers not to perform cardiopulmonary resuscitation (CPR, an emergency lifesaving procedure when the heart stops beating).</p> <p>During a phone interview on [DATE] at 3:19 PM with Licensed Vocational Nurse (LVN) 5, LVN 5 stated that on [DATE], about 20 minutes prior to Resident 1 ' s fall, LVN 5 saw Resident 1 on her wheelchair in the hallway. LVN 5 stated she was called by Certified Nursing Assistant (CNA) 5 into Resident 1 ' s room. LVN 5 stated when she arrived inside Resident 1 ' s room, the wheelchair alarm was ringing and the resident was lying on the floor next to the wheelchair, on her left side. LVN 5 stated Resident 1 appeared to have pain in her head and the left side of her body. LVN 5 added when the resident was interviewed, the resident was not able to provide an answer as to what happened prior to the fall.</p> <p>During a phone interview on [DATE] at 9:48 AM with CNA 2, CNA 2 stated Resident 1 wheels herself around the facility. CNA 2 stated Resident 1 is able to stand up with staff assistance. CNA 2 further added when the wheelchair alarm sounds, it means the resident wants something. CNA did not state that the wheelchair alarm indicated the resident is trying to get up unassisted.</p> <p>During a phone interview on [DATE] at 10:23 AM with CNA 3, CNA 3 stated Resident 1 is confused and wheels self around the facility using her wheelchair. CNA 3 stated Resident 1 usually goes back to bed at around 7:00 PM to 8:00 PM every night.</p> <p>During the same phone interview on [DATE] at 10:27 AM with CNA 3, CNA 3 stated on [DATE] at 7:55 PM, he saw Resident 1 on the wheelchair in the hallway. CNA 3 stated he was tending to another resident when he heard an alarm ring at around 8:07 PM. CNA 3 stated he went to Resident 1 ' s room immediately, and he saw the resident lying on the floor next to the wheelchair. CNA 3 could not recall the exact time that he responded to Resident 1 ' s room. CNA 3 stated LVN 5, Treatment Nurse (TN) 1, and Registered Nurse (RNS) 2 responded when he called for help. CNA 3 added Resident 1 is not a resident that is on close monitoring by staff.</p> <p>During an interview and concurrent record review on [DATE] at 11:26 AM with TN 1, Resident 1 ' s entire medical records were reviewed. TN 1 stated Resident 1 is confused and does not follow commands. TN 1 stated Resident 1 ' s medical records did not indicate that the resident would be and was closely monitored by facility staff as an added intervention to prevent further falls, as indicated in the facility ' s P&P, titled Fall Management Program, residents may require more frequent observation of activities and whereabouts.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on [DATE] at 11:50 AM with RNS 2, RNS 2 stated Resident 1 does not know how to follow directions because of confusion related to dementia. RNS 2 stated Resident 1 ' s use of the wheelchair alarm is not new, because it has been used previously, before Resident 1 ' s fall on [DATE]. RNS 2 stated Resident 1 ' s room was not in front of any of the Nurses ' Station for closer monitoring. RNS 2 further added Resident 1 is a high fall risk resident.</p> <p>During an interview and record review on [DATE] at 12:09 PM with the ADON, Resident 1 ' s medical records were reviewed. The ADON stated the bed and wheelchair alarm was ordered and placed for Resident 1 ' s use since 12/2024 (before [DATE] and [DATE] episodes of falls), to remind the resident not to get up unassisted. The ADON stated there was no documented evidence in the medical records that Resident 1 understood that the sound coming from the bed and wheelchair alarm meant to remind the resident not to get up by herself. The ADON stated the use of the wheelchair alarm did not work because Resident 1 fell on [DATE].</p> <p>During the same interview on [DATE] at 12:09 PM with the ADON, the ADON stated other interventions added in the Resident 1 ' s Actual Fall care plan initiated on [DATE] in response to the resident ' s fall on [DATE], that included monitoring for hypoglycemia, bradycardia, dizziness, and hypotension, were not adequate enough to prevent further falls because Resident 1 ' s fall was related to the resident ' s behavior of trying to get up unassisted. The ADON stated the resident ' s care plan should have included strategies to prevent falls such as frequent visual checks/monitoring and/or moving the resident closer to the Nurses ' Station would have been the appropriate interventions to prevent the resident from repeated falls. The ADON stated if Resident 1 ' s bed or wheelchair alarm was already ringing, it will already be too late, because that means Resident 1 was already trying to get up.</p> <p>During an interview on [DATE] at 1:10 PM with Director of Nursing (DON), the DON stated the cause of Resident 1 ' s fall on [DATE] was due to the resident ' s lack of safety awareness and getting up without staff assistance. The DON stated changing the resident ' s room to a room closer to the Nurses ' Station would be hard because of the resident ' s diagnosis of dementia. The DON stated that if the resident ' s room was changed to a room near the Nurses ' Station for closer monitoring, after the fall on [DATE], it could have changed the outcome of the resident ' s fall on [DATE], but stated he was not sure of what the outcome would be.</p> <p>During an interview and concurrent record review on [DATE] at 3:01 PM with the ADON, Resident 1 ' s entire medical records were reviewed that included the nurses' notes, care plans, IDT progress notes, CICs. The ADON stated Resident 1 ' s IDT Progress Notes- Falls, dated [DATE], documented at 11:58 AM, did not indicate that changing Resident 1 ' s room to a room closer to the station or frequent/closer staff monitoring was discussed. The ADON also stated there is no documented evidence that Resident 1 ' s roommates were interviewed regarding the fall on [DATE].</p> <p>During a review of the facility ' s P&P, titled Fall Management Program, revised [DATE], indicated the following:</p> <p>a. Interdisciplinary (IDT) and/or licensed nurse will develop a care plan according to the identified risk factors and root cause of the fall.</p> <p>b. The licensed nurse will evaluate the resident ' s response to the interventions on the weekly summary and update the resident ' s care plan as necessary.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>c. Residents may require more frequent observation of activities and whereabouts.</p> <p>d. Residents may require a structured environment or routine.</p> <p>During a review of the facility ' s P&P titled, Resident Safety, revised [DATE], indicated the following:</p> <p>a. The IDT will establish a person-centered observation or monitoring systems for the resident to address the identified risk factors identified.</p> <p>b. To observe the safety and wellbeing of the residents, a resident check will be made at least every two hours around the clock by nursing service personnel. The person-centered care plan may require more frequent safety checks.</p> <p>During a review of the facility ' s P&P titled, Dementia Care, revised 10/2017, indicated the following regarding the care of a resident with a diagnosis of dementia:</p> <p>a. The resident ' s plan of care will reflect a baseline of common behaviors (target behaviors) exhibited by the resident, interventions and specific goals.</p> <p>b. Behavioral interventions are individualized approaches that are provided as part of a supportive physical and psychosocial environment, and are directed toward understanding, preventing and relieving, a resident ' s distress or to accommodate loss of abilities.</p> <p>c. The IDT will develop plans of care and interventions in an attempt to understand and address behaviors as a form of communication and modify the environment and daily routines to meet the resident ' s needs/preferences.</p> <p>d. Interventions will be assessed, including benefits and complications of interventions, in a timely manner.</p> <p>e. Interventions will be regularly monitored for efficacy, risks, and benefits.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of eight sampled residents (Resident 84) who had a Foley catheter (a thin, flexible catheter used especially to drain urine from the bladder), received appropriate care when Resident 84 ' s Foley catheter was nonfunctioning and leaking.</p> <p>This deficient practice had the potential to result in an increased risk for urinary tract infection (UTI- an infection in any part of the urinary system), increased pain and discomfort for Resident 84.</p> <p>Findings:</p> <p>A review of Resident 84 ' s admission Record (AR) indicated Resident 84 was originally admitted to the facility on [DATE] with a diagnosis not limited to Retention of urine(a condition in which you are unable to empty all the urine from your bladder), and urinary tract infection with prostatic hyperplasia (Prostate gland enlargement).</p> <p>A review of Resident 84 ' s History and Physical (H&P), Dated 04/25/2025 indicated resident 84 was alert and had no apparent neurological disease.</p> <p>A review of Resident 84 ' s Minimum Data set (MDS &ndash; a resident assessment tool) dated 05/01/2025, indicated resident 84 is cognitively intact (ability to think and process information effectively without any significant limitations in their thinking skills or mental abilities). Further indicating Resident 84 is always incontinent (unable to control their bladder) and has an indwelling catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag).</p> <p>A review of Resident 84 ' s Care Plan for indwelling Catheter due to obstructive Uropathy (a condition in which the flow of urine is blocked) initiated on 08/07/2024, indicated interventions to monitor, record and report to the medical doctor (MD) for signs and symptoms of pain, burning, blood-tinged urine, cloudiness, and no urine output.</p> <p>A review of Resident 84 ' s Care Plan for at risk for urinary tract infection (UTI, an infection in any part of the urinary system) related to Benign prostatic hyperplasia (the prostate gland grows larger than normal) initiated on 02/19/2025, indicated interventions to evaluate for urinary complaints, incontinence and urine characteristics.</p> <p>A review of Resident 84 ' s Order summary dated 04/24/2025, indicated Foley catheter was to be changed as needed for leaking, occlusion, dislodgement, and excessive sedimentation.</p> <p>A review of Resident 84 ' s Order summary dated 04/24/ 2025, indicated to irrigate with 100 ml of normal saline if clogged and as needed for clogging and obstruction.</p> <p>A review of Resident 84 ' s Progress notes, dated 05/12/2025 at 7:53PM, indicated Resident 84 ' s Foley catheter was not working. The Progress Note did not indicate the MD was notified.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 84 ' s Care plan for UTI, dated 05/13/2025, did not indicate any goals or interventions to prevent or monitor for UTI.</p> <p>During a review of Resident 84 ' s Care plan for Antibiotics for Urinary tract infection, dated 5/14/2025, indicated Sulfamethoxazole & Trimethoprim (used to treat infections including urinary tract infection) 800; 160 milligrams (mg) was to be taken twice a day for five days for UTI.</p> <p>During an interview on 05/13/2025 at 10:02 AM with Resident 84, Resident 84 stated his Foley catheter was clogged, and that the urine was leaking out, around the urethra (the tube through which urine leaves the body). Resident 84 stated he had a towel close by since the Foley catheter had been leaking onto Resident 84 ' s bedding. Resident 84 stated the Foley catheter had been leaking since 5/12/25.</p> <p>During an interview on 05/13/2025 at 10:27AM with licensed vocational nurse (LVN) 1, LVN 1 stated Registered Nurse (RN) 1 informed LVN 1 on 5/13/25 at 7 AM about Resident 84 not having any urine output from the Foley catheter since 3 AM. LVN 1 stated attempting to flush Resident 84 ' s Foley catheter with RN 1, and still, Resident 84 did not have any output. LVN 1 stated Resident 84 ' s Foley catheter was not changed, even after identifying that the Resident 84 ' s Foley catheter was not working. LVN 1 stated Resident 84 ' s Foley Catheter should not be left in Resident 84 ' s since it was not working and could cause an infection or injury to Resident 84 ' s urethra. During an interview on 05/13/2025 at 4:20 PM with LVN 2, LVN 2 stated when a foley Catheter was not functioning the MD must be notified.</p> <p>During an interview on 05/13/2024 at 4:30 PM with Nurse Practitioner (NP), NP stated she had been notified the morning of 5/13/25 regarding Resident 84 experiencing issues with his Foley catheter. NP stated after assessing Resident 84, NP ordered the catheter to be discontinued and replaced due to leakage and no urine output and also ordered for a bladder scan. NP stated since Resident 84 was undergoing a procedure at the general acute care hospital (GACH) later that day, interventions for the non-functioning catheter could be addressed at the GACH.</p> <p>During a review of the facility ' s policy and procedure(P&P) titled, Catheter & Care of, dated 09/01/2014, the P&P indicated that the purpose of the policy is to relieve bladder distention, obtain urine specimens for diagnostic testing, and maintain consistent urinary drainage. The policy states that catheterization is to be performed under physician ' s order using sterile technique. Indwelling catheters are to be used only when medically indicated. The licensed nurse is responsible for notifying the physician if assessment indicates a need to discontinue catheter use. The discontinuation of the catheter must be ordered by a physician.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of six sampled residents (Resident 7) who received dialysis (a life-sustaining treatment for people whose kidneys were not functioning properly, replacing their filtering function) had a post-dialysis weight documented on 5/3/2025 and 5/10/2025.</p> <p>This deficient practice had the potential for unidentified complications after dialysis such as fluid shifts or significant weight loss.</p> <p>Findings:</p> <p>A review of Resident 7 ' s admission Record (AR),indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with diagnoses that included end stage renal disease (ESRD, the kidneys have failed and could no longer perform their essential functions, requiring dialysis or a kidney transplant to survive), arteriovenous fistula (AV fistula, an abnormal connection between an artery and a vein, bypassing the normal capillary network), and dependence on renal dialysis.</p> <p>A review of Resident 7 ' s Dialysis Care Plan revised 4/26/2025, indicated a goal for the resident to have no complications from dialysis treatment and the resident ' s vascular access (gaining access to the bloodstream, typically through a vein, to administer fluids, medications, for blood draws or dialysis) site would have no signs and symptoms of infection every day. The Care Plan indicated interventions to monitor Resident 7 ' s AV access, instruct resident not to sleep on access site, and facility staff to document time, date, and the resident ' s general condition when taken to dialysis and when Resident 7 returns back to the facility.</p> <p>A review of Resident 7 ' s History and Physical, dated 5/1/2025, indicated the resident ' s neurological status had no focal deficits, the resident was alert and had no abnormality detected (NAD, neurological examination findings to indicate that the exam did not reveal any significant issues or abnormalities).</p> <p>A review of Resident 7 ' s Minimum Data Set (MDS, a resident assessment tool) dated 5/2/2025, indicated the resident ' s cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated Resident 1 ' s active diagnoses included ESRD, arteriovenous fistula, and dependence on renal dialysis. The MDS indicated special treatments, procedures, and programs Resident 1 received included dialysis.</p> <p>A review of Resident 7 ' s Pre-Dialysis Evaluation dated 5/3/2025 at 6:48 AM, indicated that the post-dialysis weight was blank.</p> <p>A review of Resident 7 ' s Pre-Dialysis Evaluation dated 5/10/2025 at 6:24 AM, indicated that the post-dialysis weight was blank.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER York Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 6071 York Blvd. Los Angeles, CA 90042	
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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/15/2025 at 11 AM, Restorative Nursing Aid (RNA) 1 stated when residents were receiving dialysis, all weights were obtained from the dialysis report and were never taken at the facility. RNA 1 stated Resident 7 was placed on weekly weights upon readmission to the facility from the General Acute Care Hospital (GACH), and the facility would only use the weights from the dialysis report.</p> <p>During a concurrent interview and record review of Resident 7 ' s Pre-Dialysis Evaluation on 5/15/2025 at 3:29 PM, the Director of Nursing (DON) stated the weights from dialysis were the most accurate since dialysis rids the resident ' s excess fluid. The DON stated the post-dialysis weight should have been documented on the Pre-Dialysis Evaluation and should not have been left blank. The DON stated that when Resident 7 returned to the facility the facility staff should have re-weighed the resident upon return to the facility. The DON stated if the facility staff did not re-weigh the resident, then Resident 1 ' s weight would have been missed and the facility staff would not have known if the resident had lost or gained any weight.</p> <p>During a concurrent interview and record review of Resident 7 ' s Pre-Dialysis Evaluation on 5/15/2025 at 4:30 PM, the Assistant Director of Nursing (ADON) stated dialysis residents were weighed at dialysis and the weights obtained from dialysis was inputted into the facility ' s Point Click Care (PCC, a software platform that helped healthcare providers manage various aspects of care, particularly for senior care settings like skilled nursing facilities). The ADON stated if the Pre-Dialysis Evaluation did not have the post-dialysis weight, facility staff should have called the dialysis center to request documentation of Resident 1 ' s post-dialysis weight. The ADON stated that knowing Resident 1 ' s post-dialysis weight was important to identify any fluid shift or significant weight loss.</p> <p>A review of the facility ' s policy and procedure (P&P) titled, Dialysis Management dated 3/27/2024, indicated A pre and post dialysis evaluation will be completed by the licensed nurse. The P&P indicated All documentation concerning dialysis services and care of the dialysis resident will be maintained in the resident ' s medical record. Dialysis Communication Record: The nursing staff will send a dialysis communication form to the dialysis center every time a resident is scheduled for off-site dialysis. The dialysis provider ' s nurse will be responsible for documentation of dialysis treatment and providing the resident ' s post dialysis weight.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of eight sampled residents (Resident 52), who was receiving Apixaban (anticoagulant medication used for the treatment of blood clots) was adequately monitored for signs and symptoms of bleeding.</p> <p>This deficient practice had the potential for Resident 52 to not be adequately monitored leading to the worsening of Resident 52 ' s health condition.Findings:</p> <p>A review of Resident 52 ' s admission Record indicated Resident 52 was admitted to the facility on [DATE], with a diagnosis that included Obstructive Pulmonary Embolism (a blood clot in the lung artery) and Atrial Fibrillation (an abnormal heartbeat).</p> <p>A review of Resident 52 ' s Minimum Data Set (MDS, a resident assessment tool), dated 04/22/2025, indicated Resident 52 was cognitively intact (mentally alert, oriented, and capable of thinking clearly and making decisions) but required moderate assistance (helper lifts, holds, or supports limbs) with tasks that include eating and oral hygiene (using utensils to bring food and / or liquids to the mouth and swallow food and/ or liquid once the meal is placed before the resident).</p> <p>A review of Resident 52 ' s Care Plan titled for Anticoagulant therapy, dated 05/07/2025, indicated resident would be free from adverse reactions (undesired effect of a drug) related to anticoagulant use. The Care Plan indicated to administer anticoagulant medications as ordered by the physician and to monitor for side effects and effectiveness every shift.</p> <p>A review of Resident 52 ' s Care Plan for anticoagulant therapy use, dated 05/05/2025, indicated Apixaban (oral tablet, 5mg) was a black box warning (alerts healthcare providers and patients about serious or life-threatening risk associated with a drug) medication.</p> <p>A review of Resident 52 ' s care plan for anticoagulant therapy use, dated 05/05/2025, indicated to monitor, document and report adverse reactions of anticoagulant therapy such as bruising and to preform daily skin inspection reporting abnormalities to the nurse.</p> <p>A review of Resident 52 ' s Order Summary dated 04/28/2025, indicated to observe for discolored urine, black tarry stools, sudden severe headache, nausea, vomiting, muscle joint pain, lethargy, bruising, sudden changes in mental status and or vital sign, shortness of breath, and nosebleed. The Order Summary indicated to monitor every shift for the use of Apixaban.</p> <p>A review of Resident 52 ' s Medication Administration Record (MAR) dated 04/ 28/2025 to 5/13/2025, indicated to observe for discolored urine, black tarry stools, sudden severe headache, nausea, vomiting, muscle joint pain, lethargy, bruising, sudden changes in mental status and or vital signs , shortness of breath, and nosebleed to be done every shift for the use of Apixaban. The MAR indicated if symptoms exist, document Y for yes or N for no. If yes, document the findings in the resident's progress notes or change of condition. The MAR indicated ' N was documented from 4/28/2025 to 5/13/2025.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/13/2025 at 12 PM with Resident 52, Resident 52 stated she was admitted to the facility approximately three weeks ago. Resident 52 stated she had bruising on her arms and believed the bruising was from the medication she was taking.</p> <p>During a concurrent interview and record review on 05/15/2025 at 12:03PM with Licensed Vocational Nurse (LVN) 4, Resident 52 ' s MAR, dated 04/28/2025 to 05/13/2025 was reviewed. The MAR indicated, from 04/28/2025 &ndash; 05/13/2025, for the day, evening, and night shift licensed nursing staff documented NO under observations of bruising for Resident 52. LVN 4 stated there was no documentation on the MAR to indicate resident had bruising from day, evening or night shift. LVN 4 stated she documented NO in the monitoring portion of the MAR and had only become aware of the bruising because Resident 52 ' s daughter had informed LVN 4 of Resident 52 ' s bruising. LVN 4 stated bleeding was an adverse symptom of blood thinners.</p> <p>During an interview on 05/15/2025 at 01:23 PM with Nurse Practitioner (NP), NP stated she was notified of Resident 52 ' s bruising and discoloration on both arms by LVN 4 on 5/13/2025. NP stated she had not notified the Medical Doctor (MD) since NP believed the discoloration was a side effect of the resident ' s medication and not urgent. NP stated Resident 52 ' s bruising was non-critical and that only when the MD was onsite was when the NP would notify the physician. NP stated she had conducted an assessment on Resident 52 but did not document the assessment of the bruising on Resident 52 ' s medical record.</p> <p>During an interview on 05/15/2025 at 1:32PM with Medical Director (MD), MD stated licensed nurse should follow MD orders to notify the MD when adverse signs or symptoms occur due to residents medications, and that physician orders must be carried out.</p> <p>During an interview on 05/15/2025 at 5 PM with Pharmacy Consultant (PC) stated Apixaban 5 milligrams twice a day was considered a high dose and required to be monitored every shift for adverse signs and symptoms PC stated anticoagulant therapy could result in bleeding and adverse outcomes such as Cerebral hemorrhage (brain bleed).</p> <p>A review of the facility ' s policy and procedure (P&P) titled, Adverse Drug Reactions, revision date 01/01/2012, the P&P indicated to monitor the resident ' s reaction to prescribed medications. If an adverse reaction is suspected, the first observed occurrence must be reported to the attending physician immediately. Any subsequent reactions are to be recorded in accordance with the physician ' s instructions. Documentation of the observed reaction, physician notification, and the physician ' s response must be completed in full by a licensed nurse. Monitoring of the resident during the episode should be carried out by the physicians ' orders, with all appropriate documentation entered into the resident ' s medical record. In addition, the pharmacist must be notified of adverse drug reactions experienced by the resident.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their infection control policy of two out of two sampled residents (Resident 25 and Resident 29) by failing to:</p> <ol style="list-style-type: none"> 1. Ensure Resident 25, who had a wound infection and used a peripheral inserted central catheter (PICC a long, thin tube that's inserted through a vein in the arm and passed through the larger veins near the heart) to receive antibiotics (medicines that fight bacterial infections in people) was provided care using enhanced barrier precaution (EBP) (taking extra steps to prevent the spread of serious infections, like using gowns and gloves) by Certified Nurse Assistant (CNA) 4 who failed to wear a gown. 2. Ensure a used glove was disposed of properly after each use and not placed on Resident 29 ' s blanket while Resident 29 laid in bed. <p>This deficient practice had the potential to transmit and spread infection (a process when a microorganism, such as bacteria, fungi, or a virus, enters a person's body and causes harm) and multidrug resistant organism (MDRO - is a germ that is resistant to many antibiotics) from resident to resident.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 25 ' s admission Record (AR), indicated Resident 25 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses included hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (disrupted blood flow to the brain) affecting the left side of the body, diabetes (blood sugar, is too high), and osteomyelitis (bone infection) of right ankle and foot. <p>A review of Resident 25 ' s History and Physical Examination (H&P), dated 4/23/2025, indicated Resident 25 had no focal deficits, alert.</p> <p>A review of Resident 25 ' s Minimum Data Set (MDS-a resident assessment tool) dated 12/3/2024, the MDS indicated Resident 25 ' s cognitive status (the mental process of thinking and understanding) was intact. MDS indicated Resident 25 was dependent on eating, toileting, bathing, personal hygiene and dressing.</p> <p>A review of Resident 25 ' s care plan (CP) for Resident 25 on Enhance Barrier Precautions related to indwelling medical device (PICC line right upper arm), and surgical wound, right 2nd toe amputation dated 4/23/2025, indicated the goal was to reduce the risk of MDRO transmission through the next review date (8/11/2025). The CP indicated interventions to implement EBP to prevent the spread of infections and to perform hand hygiene and don (put on) PPE before beginning resident high contact care activities.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 5/13/2025 at 12:44 PM in the facility ' s hallway in front of Resident 25 ' s room, a signage was placed by the door that indicated Resident 25 was on EBP and providers and staff must wear gloves and a gown for high contact care (activities include, but are not limited to dressing, bathing/showering, transferring, changing linens, changing briefs or assisting with toileting, device care or use, Wound care (chronic wounds rather than skin tears and abrasions) and physical and occupational therapy). CNA 4 was observed talking to Resident 25 and moving up and down next to Resident 25 ' s bed.</p> <p>During a concurrent observation and interview on 5/13/2025 at 12:50 PM with Resident 25 and CNA 4, in Resident 25 ' s room, CNA 4 opened Resident 25 ' s privacy curtain and was observed not wearing a gown and holding a clear plastic bag with a used resident gown and towel. Resident 25 nodded when asked if CNA 4 groomed her and changed her clothes. CNA 4 stated, she groomed Resident 25, changed her clothes and repositioned her. CNA 4 stated, she knew she was supposed to wear PPE which included a gown when taking care of Resident 25 because Resident 25 was on EBP but stated she forgot. CNA 4 stated that using PPE for Resident 25, who ' s on EBP, would help prevent the spread of infections.</p> <p>During an interview on 5/13/2025 at 1 PM with Assistant Director of Nurses (ADON) in Resident 25 ' s room. ADON stated, Resident 25 was on EBP because of her wound infection to her second toe to the right foot and since Resident 25 ' s right arm had a PICC line, which was used for antibiotic administration. ADON stated, staff should wear PPE when providing close contact care to Resident 25, to protect Resident 25 and other residents in the facility from infections.</p> <p>A review of Resident 25 ' s facility document titled Order Summary Report (OSR), dated 5/14/2025, indicated to administer Ceftriaxone (medication to treat bacterial infection) sodium injection 2 grams (a unit of weight) intravenously (a method of putting fluids, including drugs, into the bloodstream) daily for osteomyelitis, and to administer Doxycycline Hyclate (medication to treat bacterial infection) 100 mg 1 tablet by mouth every 12 hours for diabetic foot infection.</p> <p>During an interview on 5/14/2025 at 9:38 AM with Infection Preventionist Nurse (IPN), IPN stated EBP was utilized for residents who had risk of transmission or acquisition of MDRO ' s which included Resident 25, due to her unhealed wound and the current use of a PICC line. IPN stated, staff were required to use PPEs which included wearing a gown when changing and dressing a Resident. IPN stated, not adhering to EBP policy, such as using a gown during close contact care with Resident 25, had the potential to transmit bacteria, virus and MDRO ' s and cause infection to Resident 25 and other residents in the facility.</p> <p>During an interview on 5/14/2025 at 11:29 AM with the DON (Director of Nurses), DON stated Resident 25 was currently on antibiotics due to the infection to her second toe of the, and since Resident 25 had a PICC line to administer antibiotics for osteomyelitis. DON stated it was important to utilize EBP for Resident 25 due to her wound infection and has a PICC line usage, which placed Resident 25 at risk to acquire and/or spread bacteria, virus and/or MDRO ' s in the facility. DON stated PPEs should always be used for Residents on EBP, due to the potential for acquiring and spreading of infections to Resident 25 and other residents in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility ' s policy and procedure (P&P) titled, Enhanced Barrier Precautions, revised 5/28/2024 indicated; a) purpose is to reduce the risk of transmission of epidemiologically (the study of the determinants, occurrence, and distribution of health and disease in a defined population) important microorganisms by direct or indirect contact, b) MDR ' s transmission is common in long term care (LTC) facilities contributing to substantial resident morbidity and mortality, and many residents in nursing homes are at increases risk of becoming colonized and developing infections with MDRO ' s, c) resident whom EBP is indicated, EBP is employed when performing high contact resident care that includes dressing, providing hygiene and device care such as central line, and d) to facilitate compliance with EBP, gowns and gloves are donned before each high contact task.</p> <p>A review of the facility ' s policy and procedure (P&P) titled, Infection Control & ndash; Policies and Procedures, revised 1/1/2012 indicated; a) policies and procedure are intended, b) prevent, detect, investigate, infections in the facility.</p> <p>2. A review of Resident 29 ' s admission Record indicated the resident was admitted on [DATE] with diagnoses that included metabolic encephalopathy (an alteration in consciousness caused due to brain dysfunction), muscle weakness, and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).</p> <p>A review of Resident 29 ' s History and Physical (H&P),indicated the resident did not have the capacity to understand and make decisions.</p> <p>A review of Resident 29 ' s Minimum Data Set (MDS - a resident assessment tool), dated 4/8/2025, indicated the resident has severe cognitive impairment. The MDS also indicated the resident required substantial assistance (helper does more than half the effort) on activities such as oral hygiene, toileting, bathing, and dressing, and in mobility such as rolling left and right, sitting to lying, and transferring from chair to chair.</p> <p>During an observation on 5/14/2025 at 9:00 AM inside Resident 27 ' s room, Resident 27 was observed lying in bed and a used glove was placed on top of Resident 27 ' s blanket toward the foot of the bed.</p> <p>During a concurrent observation and interview on 5/14/2025 at 9:05 AM inside Resident 27 ' s room with Restorative Nursing Assistant (RNA) 1, RNA 1 stated there was a used glove on top of Resident 27 ' s blanket. RNA 1 stated the glove appeared used since the glove was inside out. RNA 1 stated used gloves should always be thrown in the trash bin.</p> <p>During an interview on 5/14/2025 at 9:33 AM with Infection Preventionist Nurse (IPN), IPN stated used gloves were considered dirty and that used gloves could harbor infectious material and cause infections.</p> <p>During an interview on 5/15/2025 at 10:35 AM with Director of Nursing (DON), DON stated disposing of gloves was a basic infection prevention practice, and that used gloves need to be disposed into the trash. DON stated used gloves could be soiled with infectious material and was a transmission for infection from resident to resident and could potentially lead to an outbreak (two or more linked cases of the same illness).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility ' s Policy and Procedure (P&P) titled, Personal Protective Equipment, revised 1/1/2012, indicated protective equipment are to be used whenever there is touching blood, body fluids, secretions, excretions, mucous membranes, and/or non-intact skin. The P&P also indicated gloves are only used once and are discarded into the appropriate receptacle located in the room.</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>Based on observation, interview and record review, the facility failed to ensure the room space were at a minimum of 80 square feet (Sq. Ft.- a unit of measurement) for two out of 42 residents rooms (Rooms A & B). The two resident rooms consisted of two beds each room. Room A was occupied by Resident 65. This deficient practice had the potential to negatively impact the quality-of-care and the ability of the nursing care to safely provide care and privacy to the residents.</p> <p>Findings:</p> <p>During an interview with the Administrator (ADM) on 5/13/2025 at 9:34 AM, the ADM stated Room A and B do not have the required 80 square feet per resident. The ADM added the facility would like to continue to apply for the room waiver for the 2 rooms.</p> <p>During a review of the facility ' s Client Accommodation Analysis (CAA), dated 5/13/2025, indicated Room A and B each have 2 beds. The CAA indicated both rooms have a floor area of 156 square feet, which is equal to 78 square feet per resident.</p> <p>During a review of the Facility's Client Accommodations Analysis form date 5/13/2025, indicated the facility had two rooms that measured less than the required 80 square footages per resident in multiple bedrooms. A review of the facility's request for the room waiver dated 5/16/2025 indicated the variance will not compromise the health, welfare, and safety of the residents. The following resident bedrooms were:</p> <p>Room #</p> <p># of beds</p> <p># of residents</p> <p>Sq. Ft</p> <p>Sq. Ft. per resident</p> <p>Room A</p> <p>2 beds</p> <p>1 residents</p> <p>156</p> <p>78</p> <p>Room B</p> <p>2 beds</p> <p>(continued on next page)</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>1 residents</p> <p>156</p> <p>78</p> <p>During a concurrent observation and interview on 5/15/2025 at 11:19 AM with the Maintenance Supervisor (MS), Rooms A and B were measured. The MS stated both rooms currently have two residents each. The MS stated the rooms measured below the 80 square feet per resident requirement.</p> <p>During an observation and interview on 5/15/2025 at 11:25 AM inside Room A, Resident 65 stated the room has enough space to go around. The resident stated staff do not have any difficulties in providing care because of the space.</p> <p>During an interview on 5/15/2025 at 11:39 AM with Licensed Vocational Nurse (LVN) 6, LVN 6 stated the residents in Room A and B have enough space to move around. Per LVN 6, staff are able to provide care with no issues in the 2 rooms.</p> <p>During the recertification survey from 5/13/2025 to 5/16/2025, the rooms were observed and no issues were identified due to the room size.</p> <p>During a review of the facility ' s Room Waiver Request letter, dated 5/16/2025, indicated Room A and B are below the required 80 square feet per resident in a multiple resident room. The letter also indicated the rooms do not adversely affect the residents ' health and safety.</p> <p>The California Department of Public Health (CDPH) recommends continuation of the facility ' s room waiver.</p>