STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055526	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inglewood Health Care Center	100 S. Hillcrest Blvd Inglewood, CA 90301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview and record review, the facility failed to implement infection prevention and control practices during wound care, for 3 of five sampled residents (Residents 2, 3, and 4.) This deficient practice had the potential to cause wound infections and delay wound healing process. Findings: a). During an observation on 11/12/2024 at 9:30 a.m. with Licensed Vocational Nurses (LVN) 1 in Resident 2 ' s room, LVN 1 cleaned the bedside table and applied plastic cover. LVN 1 washed hands, applied gloves and removed soiled dressing from Resident 2 ' s right heel. LVN 1 applied new pair of gloves and cleansed the right heel wound with normal saline ([NS] a cleansing solution). LVN 1 applied new pair of gloves and applied collagenase santyl ointment (wound ointment to remove damaged tissue from chronic skin ulcers) and covered the wound with gauze. LVN 1 applied vitamin A&D ointment (moisturizer to treat or prevent dry, rough) to Resident 2 ' s left heel and applied Resident 2 ' s bilateral heel protector boots, that had dried flaky skin particles built up inside the boots. During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis that included cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and hypertension (HTN-high blood pressure). During a review of Resident 2 ' s Minimum Data Set ([MDS] a standardized care assessment and care screening tool), dated 7/4/2024, the MDS indicated Resident 2 was sometimes understood and able to sometimes be understand. The MDS indicated Resident 2 was dependent with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side). During a review of Resident 2 ' s Treatment Administration Record (TAR) dated 10/1/2024, the TAR indicated to cleanse Resident 2 ' s right heel unstageable pressure wound, with NS pat dry, apply santyl ointment then wrap it with gauze and secure with tape daily for 30 days. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b). During an observation on 11/12/2024 at 10:00 a.m. with LVN 1, in Resident 3 ' s room, LVN 1 prepared Resident 3 ' s wound care supplies on the bedside table. LVN 1 was observed washed her hands and applied gown, face shield and gloves for personal protective equipment ([PPE] protection equipment that includes face shields, gloves, goggles and glasses, gowns, head covers, masks, respirators, and shoe cover to protect against the transmission of germs through contact and droplet routes).LVN 1 removed Resident 3 ' s soiled dressing in the sacral area, removed gloves, washed hands, and went outside Resident 3 ' s room wearing the PPE and took wound care supplies from the treatment cart. LVN 1 returned to Resident 3 ' s room, applied gloves, cleansed Resident 3 ' s sacral wound with NS and applied collagenase santyl ointment to Resident 3 ' s sacral area wound and covered the wound with gauze. LVN 1 applied A&D ointment to bilateral feet and applied the heel protector boots. During a review of Resident 3 ' s Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] with a diagnosis that included cervical disc degeneration (discs in neck wear down), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and HTN. During a review of Resident 3 ' s history and physical (H&P) dated 11/4/2024, the H&P indicated Resident 3 did have the mental capacity to understand and make medical decisions. During a review of Resident 3 ' s MDS dated [DATE], the MDS indicated Resident 3 was able to be understood and be understand by others. The MDS indicated Resident 3 wasdependent with ADLs such as dressing, toilet use, personal hygiene, and transfer. During a review of Resident 3 ' s TAR dated 10/18/2024, the TAR indicated to cleanse Resident 3 ' s Stage 4 pressure ulcer (full thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle, bones) in the sacral area with NS, pat dry, apply santyl ointment and cover with gauze daily for 30 days. c). During an observation on 11/12/2024 at 10:45 a.m., in Resident 4 ' s room, with LVN 1, LVN 1 prepared Resident 4 ' s wound care supplies on the bedside table. LVN 1 washed hands, applied PPE and gloves and proceed to clean Resident 4 ' s sacral wound with NS. LVN 1 applied collagen powder (medical grade collagen supplements) to the sacral wound, then covered the wound with a gauze. LVN 1 removed gloves, washed his hands and went outside Resident 4 ' s room wearing PPEand took more supplies from the treatment cart. During a review of Resident 4 ' s Admission Record, the Admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4 ' s diagnosis included chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty in breathing), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), and HTN. During a review of Resident 4 ' s H&P dated 11/1/2024, the H&P indicated Resident 4 did not have the mental capacity to understand and make medical decisions. During a review of Resident 4 ' s MDS dated [DATE], the MDS indicated Resident 4 was rarely/never understood and rarely/never understand others. The MDS indicated Resident 4 was dependent with ADLs such as dressing, toilet use, personal hygiene, and transfer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4 ' s TAR dated 10/25/2024, the TAR indicated to irrigate Resident 4 ' s sacrococcyx stage 4 wound with NS, pat dry, sprinkle with collagen then cover with gauze daily for 30 days. During an interview on 11/12/2024 at 2:30 p.m., with LVN 1, LVN 1 stated prior to starting the wound care, the licensed nurse should gather wound dressing supplies and arrange on a clean table. LVN 1 stated, the licensed nurse should wash hands before applying new gloves and after removing dirty gloves. The LVN 1 stated the license nurses should wash hands before and after removing wound dressings and before applying ointment. The LVN 1 stated, if hand hygiene were not performed, bacteria present in the gloves could cause wound infections. During an interview on 11/12/2024 at 5:09 p.m. with the Director of Nursing (DON), the DON stated when LVN 1 performed wound care to Residents 2, 3, and 4, the LVN 1 should have washed hands every time gloves are changed. The DON stated nurses should follow that procedure for infection control and avoid cross contamination. The DON stated nurses need to prevent the wound to get worse and get contaminated with bacteria. During a review of the facility ' s policy and procedure (P&P) titled, Clean Dressing Change, dated 9/17/2024, the P&P indicated, to remove soiled dressing, wash hands, put on clean gloves, then clean the wound as ordered. During a review of the facility ' s P&P titled, Personal Protective Equipment Guidelines, dated 5/29/2024, the P&P indicated to wash hands after removal of gloves or other PPE. The P&P indicated to remove PPE before leaving the work area.