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	02/25/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Nurse Practitioner's (NP) verbal order of Tamiflu (medication to treat the Influenza [viral infection that attacks the respiratory system, including the nose, throat, and lungs]) for one of three residents (Resident 1), was transcribed to a telephone order form, the Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) and notify the pharmacy, as indicated in the facility's policy and procedure titled Physician Orders.This failure resulted in Resident 1 missing two doses of Tamiflu on 2/2/2026 and 2/3/2026.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted on [DATE]. Resident 1's diagnoses included heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), stage four chronic kidney disease (severe kidney impairment), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). The admission record indicated Resident 1 was self-responsible. During a review of Resident 1's History and Physical (H&P), dated 9/25/2025, the H&P indicated Resident 1 had the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/5/2026, the MDS indicated Resident 1 was cognitively intact and did not reject evaluation or care. During a review of Resident 1's Influenza Antigen Test (a test to detect flu) Result Form, dated 2/2/2026 12:00 p.m., indicated a positive result for influenza. During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 2/2/2026, the SBAR indicated Resident 1 tested positive for Influenza A. Resident 1 vomited, had an episode of coughing, and had a body temperature of 103?farenheit (unit of measurement of temperature). During a review of Resident 1's Physician Progress Note, dated 2/10/2026, the note indicated the resident's Medical Doctor (MD 1) ordered Tamiflu for influenza. During a review of Resident 1's Physician Orders, for the month of 2/2026, did not indicate Tamiflu. During a review of Resident 1's MAR for the month of 2/2026, the MAR did not indicate Tamiflu was administered. During a concurrent interview and record review on 2/24/2026 at 10:21 a.m., with the Infection Preventionist (IP), Resident 1's Influenza Antigen Test Result Form dated 2/2/2026, Resident 1's SBAR dated 2/2/2026, Resident 1's Physician Orders dated 2/2/2026, were reviewed. The IP stated the SBAR indicated Resident 1 had fever, cough, and vomiting which were symptoms of influenza. The IP stated on 2/2/2026, around 12:00 p.m., NP 1 was notified of Resident 1's positive influenza test result and verbally ordered Tamiflu 75 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) twice per day for five days. The IP stated she forgot to carry out the order and did not notify the pharmacy. The IP stated Resident 1's Tamiflu order was submitted 2/3/2026 at 4:00 p.m. Resident 1 missed two doses of Tamiflu on 2/2/2026 (evening) and on 2/3/2026 (morning). During a concurrent (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview and record review on 2/24/2026 at 3:45 p.m., with Registered Nurse (RN 1), Resident 1's Physician Orders, dated 2/2/2026, and Resident 1's MAR, for the month of 2/2026, were reviewed. RN 1 stated Resident 1's Physician Orders and MAR for the month of 2/2026 did not indicate an order for Tamiflu. During an interview on 2/25/2026 at 12:05 p.m., with NP 1, NP 1 stated on 2/2/2026, the Tamiflu 75 milligrams (mg) was ordered for Resident 1 to treat Influenza A, minimize the impact of the virus, decrease severity of symptoms and decrease the length of illness. NP 1 stated the nurses did not notify him (NP 1) that Resident 1 did not receive the Tamiflu. During a review of the facility's undated P&P titled Physician Orders, the P&P indicated when receiving an order (telephone or verbal), repeat the order to clarify and ensure all necessary informations are received. The licensed nurse will transcribe all components of the order onto a telephone order form, record the time, date and signs the order. Transcribe the written order and document the word noted next to the order along with the licensed nurse's signature, title and date. After noting the order, the receiving licensed nurse transcribes in permanent ink on the MAR and notify the pharmacy of the new order.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report Influenza A (viral infection that attacks the respiratory system, including the nose, throat, and lungs) outbreak on 2/2/2026, for two of eight residents (Residents 1 and 8), to the California Department of Public Health (CDPH) within 24 hours, as indicated in the facility's policy and procedure (P&P) titled Unusual Occurrence Reporting. This failure resulted in delayed investigation by the CDPH.Findings: 1). During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted on [DATE]. Resident 1's diagnoses included heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), stage four chronic kidney disease (severe kidney impairment), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). The admission record indicated Resident 1 was self-responsible. During a review of Resident 1's History and Physical (H&P), dated 9/25/2025, the H&P indicated Resident 1 had the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/5/2026, the MDS indicated Resident 1 was cognitively intact and did not reject evaluation or care. During a review of Resident 1's Influenza (Flu) Antigen Test (a test to detect flu) Result Form, dated 2/2/2026 12:00 p.m., indicated a positive result for influenza. 2). During a review of Resident 8's admission Record, the admission Record indicated Resident 1 was admitted on [DATE] with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertensive heart disease (a heart disorder which causes the heart to not pump the blood efficiently), and pleural effusion (abnormal build-up of fluid in the space between the lungs and chest wall).During a review of Resident 8's H&P, dated 7/31/2025, the H&P indicated Resident 8 was capable to understand and make decisions. During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 had moderate cognitive impairment. During a review of Resident 8's Influenza Antigen Test Result Form, dated 2/2/2026 at 12:00 p.m., the result indicated Resident 8's influenza test was positive. During a concurrent interview and record review on 2/24/2026 at 9:40 a.m., with the Infection Preventionist (IP), Resident 1 and 8's Influenza Antigen Test Result Form, dated 2/2/2026, the Los Angeles County Department of Public Health (LAC DPH) Influenza and other Respiratory Virus Diseases Outbreak Toolkit, dated 12/2025, and the facility's undated P&P titled Unusual Occurrence Reporting, were reviewed. The IP stated the LAC DPH indicated two or more laboratory confirmed influenza cases identified within 72 hours of each other are considered an outbreak and must be reported. Resident 1 and Resident 8's positive test results for influenza on 2/2/2026 at 12:00 p.m., were two confirmed cases (an outbreak) not reported to CDPH. The influenza outbreak should have been reported to the CDPH within 24 hours, on 2/3/2026 at 12:00 p.m. The IP stated the influenza is a communicable respiratory disease and should have been reported to the state agency as indicated in the P&P titled Unusual Occurrence Reporting. During an interview on 2/25/2026 at 1:00 p.m., with the Administrator (Admin), the Admin stated the facility did not report the outbreak within 24 hours of the second positive influenza test result. The Admin stated the IP was responsible for reporting the outbreak to the CDPH. During a review of Los Angeles County Department of Public Health Influenza and other Respiratory Virus Diseases Outbreak Toolkit, dated 12/2025, the toolkit indicated two or greater laboratory confirmed influenza cases identified within 72 hours of each other are considered an outbreak. The toolkit indicated any sudden increases in acute respiratory illness cases, such as influenza, over the normal background rate must be reported. During a review of the facility's undated P&P titled Unusual Occurrence Reporting, the P&P indicated the facility will report an epidemic outbreak of any disease, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prevalence of communicable disease, via telephone to appropriate agencies as required by current law and/or regulations within 24-hours of such incident. During a review of the facility's undated Job Description titled Infection Preventionist, the job description indicated the IP must implement, coordinate, and direct the facility's infection prevention and control program in accordance with regulations. The IP will report all reportable diseases to the state health department.