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	03/24/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report to the California Department of Public Health (CDPH), the verbal altercation (a noisy, angry dispute) on 2/3/2026, between the Social Services Director (SSD) and one of three residents' (Resident 1). This deficient practice delayed the investigation by the CDPH and placed Resident 1 at risk for verbal abuse.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included morbid (severe) obesity due to excess calories (chronic disease characterized by having excessive body fat that poses an immediate, serious risk to health, resulting from consistently consuming more energy than the body burns) and hypertension (high blood pressure). During a review of Resident 1's History and Physical (H&P) dated 8/20/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 3/4/2026, the MDS indicated Resident 1 was able to understand and be understood by others. Resident 1 was independent (Resident completes the activity by themself with no assistance from a helper) for eating and oral hygiene. Resident 1 required moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for toileting hygiene, shower/bathing self, and lower body dressing. Resident 1 required setup assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for upper body dressing, putting on/taking off footwear and personal hygiene. Resident 1 required supervision (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with rolling from left to right, from sitting to lying position, lying to sitting on side of the bed, sitting to stand, chair/bed to chair transfer, and was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity. Or tile assistance of 2 or more helpers is required for the resident to complete the activity.) for toilet transfer, tub/shower transfer. The MDS indicated Resident 1 required supervision for walking 10 feet, 50 feet and was dependent for walking 150 feet. During an interview on 3/19/2026 at 9:11 a.m., with RN 1, RN 1 stated Resident 1's FM 1 entered the facility without a facemask (mask, a personal protective equipment to protect against the transmission of germs) and went inside Resident 1's room. The SSD saw FM 1 and asked FM 1 to wear mask. RN 1 stated Resident 1 asked the SSD what the outbreak was and the SSD responded, not to worry about it because Resident 1 was leaving the facility. Resident 1 did not like the SSD's response and called the SSD a bitch (B.) while the SSD was stepping out the room. RN 1 stated the SSD raised her voice and asked Resident 1 why do I have to be a B ? RN 1 stated she got in between Resident 1 and SSD to calm the situation. RN 1 stated Resident 1 reported SSD's behavior was threatening and unprofessional towards her (Resident 1) and should not be in her room. During an interview on 3/20/2026 at 10:10 a.m., with RN 2, RN 2 stated she reported the 2/3/2026 incident (SSD and Resident 1's verbal altercation) to the ADM but did not know if the ADM reported the incident to the (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CDPH. During an interview on 3/24/2026 at 3:41 p.m., the ADM stated on 2/3/2026, Resident 1 or anyone in the facility did not report feelings of fear or threat and did not hear resident stating she was scared for her life. The ADM stated if there was a report, she would have reported the incident to the CDPH. The ADM stated if an abuse allegation was not reported, it could affect resident's' wellbeing, mental state and repetitive abuse if exposed to abuser. During a review of the facility's undated policy and procedure (P&P) titled, Abuse Prevention Program, the P&P indicated to report any allegations of abuse within timeframes as required by federal requirements. During a review of the facility's undated P&P titled, Abuse, Neglect & Exploitation Prohibition,, the P&P indicated the company should report all abuse allegations to the State agency as designated by state law. During a review of the State Operations Manual (a federal document issued by the Centers for Medicare & Medicaid Services [CMS] that provides guidelines and regulations for healthcare facilities participating in Medicare and Medicaid programs), Appendix PP, dated 7/23/2025, the Appendix PP indicated the facility must ensure that all alleged violations involving abuse or mistreatment should be reported to the State Survey Agency immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse. Report the results of all investigations to the State Survey Agency within 5 working days of the incident.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to investigate the Social Services Director (SSD) and one of three residents' (Resident 1) verbal altercation (a noisy, angry dispute) on 2/3/2026, as indicated in the facility's policy and procedure (P&P) titled Abuse Investigation & Reporting. This deficient practice placed Resident 1 at risk for verbal abuse (the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, within their hearing distance regardless of their age, ability to comprehend or disability) and psychosocial harm.Findings: 1). During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included morbid (severe) obesity due to excess calories (chronic disease characterized by having excessive body fat that poses an immediate, serious risk to health, resulting from consistently consuming more energy than the body burns) and hypertension (high blood pressure). During a review of Resident 1's History and Physical (H&P) dated 8/20/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 3/4/2026, the MDS indicated Resident 1 was able to understand and be understood by others. Resident 1 was independent (Resident completes the activity by themself with no assistance from a helper) for eating and oral hygiene. Resident 1 required moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for toileting hygiene, shower/bathing self, and lower body dressing. Resident 1 required setup assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for upper body dressing, putting on/taking off footwear and personal hygiene. Resident 1 required supervision (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with rolling from left to right, from sitting to lying position, lying to sitting on side of the bed, sitting to stand, chair/bed to chair transfer, and was dependent (Helper does all the effort. Resident does none of the effort to complete the activity. Or tile assistance of 2 or more helpers is required for the resident to complete the activity.) for toilet transfer, tub/shower transfer. The MDS indicated Resident 1 required supervision for walking 10 feet, 50 feet and was dependent for walking 150 feet. During a review of Resident 1's Progress Notes dated 2/3/2026 at 4:16 p.m., the note indicated SSD asked Resident 1's Family Member (FM) 1 who entered Resident 1's room, to put on a face mask (mask, a personal protective equipment to protect against the transmission of germs). The progress note indicated Resident 1 asked SSD if there was an outbreak, but SSD stated she could not disclose the other residents' information. The note indicated Resident 1 was very upset and started yelling at the SSD for not disclosing the information. The note indicated as SSD was exiting Resident 1's room, the SSD overheard Resident 1 called her a bitch (B). The note indicated SSD walked back to Resident 1's room and kindly asked Resident 1 why she called her a bitch (B.). During a review of Resident 1's clinical records, Resident 1's clinical records had no documentation that an investigation was conducted regarding the SSD and Resident 1's verbal altercation on 2/3/2026. During an interview on 3/19/2026 at 12:23 p.m., Resident 1 stated she was afraid of SSD because she was trying to fight with her at the beginning of last month (February). Resident 1 stated, on 2/3/2026, RN 1 was in the room with her, Resident 1's FM 1 visited and entered the room without a mask. Resident 1 stated, the SSD entered her (Resident 1) room and told FM1 to wear a mask because of an outbreak. Resident 1 stated she asked the SSD what the type of the outbreak and the SSD responded, not to worry about it because she (Resident 1) was going to leave anyway. Resident 1 stated that the SSD was not supposed to enter her room because of the multiple incidents she had with her ([SSD] not specified). Resident 1 stated that was when she called the SSD a B. and the SSD did not like that. During an (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 3/20/2026 at 8:35 a.m., Resident 1 stated on 2/3/2026, when the incident with the SSD occurred, the SSD was waving her arms, yelling and asking why she (Resident 1) called her a B., tried to go back inside her room. Resident 1 stated she felt threatened when the SSD seemed like she wanted to fight with her (Resident 1). Resident 1 stated the SSD had no professionalism and no sense of respect to someone who was bedridden. During an interview on 3/24/2026 at 3:10 p.m., the Administrator (ADM) stated she have not conducted an investigation regarding the SSD and Resident 1's verbal altercation on 2/3/2026 because she discussed the incident with Resident 1 and Resident 1 agreed to put it as a grievance. During a review of the facility's undated policy and procedure (P&P) titled, Abuse Prevention Program, the P&P indicated to investigate any allegations of abuse within timeframes as required by federal requirements. During a review of the facility's undated P&P titled, Abuse, Neglect & Exploitation Prohibition, the P&P indicated the facility will conduct an investigation of any alleged abuse in accordance with state law. The company will investigate all patterns, trends or incidents that suggest the possible presence of abuse. During a review of the State Operations Manual (a federal document issued by the Centers for Medicare & Medicaid Services [CMS] that provides guidelines and regulations for healthcare facilities participating in Medicare and Medicaid programs), Appendix PP, dated 7/23/2025, the Appendix PP indicated, in response to allegations of abuse or mistreatment, the facility must have evidence that all alleged violations are thoroughly investigated and report the results of investigations to the State Survey Agency, within 5 working days of the incident.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Social Services Director (SSD) acted in accordance with the professional standards when interacting to one of three sampled residents, (Resident 1). This failure had the potential to affect the resident's psychosocial well-being, leading to emotional harm.Findings: 1). During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included morbid (severe) obesity due to excess calories (chronic disease characterized by having excessive body fat that poses an immediate, serious risk to health, resulting from consistently consuming more energy than the body burns) and hypertension (high blood pressure). During a review of Resident 1's History and Physical (H&P) dated 8/20/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 3/4/2026, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 was independent (Resident completes the activity by themself with no assistance from a helper) for eating and oral hygiene. MDS indicated Resident 1 required moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for toileting hygiene, shower/bathing self, and lower body dressing. MDS indicated Resident 1 required setup assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for upper body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 1 required supervision (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with rolling from left to right, from sitting to lying position, lying to sitting on side of the bed, sitting to stand, chair/bed to chair transfer, and was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity. Or tile assistance of 2 or more helpers is required for the resident to complete the activity.) for toilet transfer, tub/shower transfer. The MDS indicated Resident 1 required supervision for walking 10 feet, 50 feet and was dependent for walking 150 feet. During a review of Resident 1's Progress Notes dated 2/3/2026 at 4:16 p.m., the note indicated Social Services Director (SSD) had asked Resident 1's Family Member (FM) 1 to put on a mask as Resident 1's FM1 was entering Resident 1's room. The progress note indicated Resident 1 asked SSD if there was an outbreak, but SSD stated she could not disclose that information. The note indicated Resident 1 was very upset and started yelling at the SSD for not disclosing the information. The note indicated as SSD was exiting Resident 1's room, the SSD overheard Resident 1 called her a bitch (B). The note indicated SSD walked back to Resident 1's room and kindly asked Resident 1 why she called her a bitch (B.). During an interview on 3/19/2026 at 12:23 p.m., with Resident 1, Resident 1 stated she was afraid of SSD because she was trying to fight with her at the beginning of last month. Resident 1 stated, on 2/3/2026, RN 1 was in the room with her, a FM 1 who was visiting, entered Resident 1's room without a mask. Resident 1 stated, the SSD entered her (Resident 1) room and told FM1 to wear a mask because of an outbreak. Resident 1 stated she asked the SSD what the type of the outbreak and the SSD responded, not to worry about it because she (Resident 1) was going to leave anyway. Resident 1 stated that the SSD was not supposed to enter her room because of the multiple incidents she had with her ([SSD] not specified). Resident 1 stated that was when she called the SSD a B. and the SSD did not like that. During an interview on 3/20/2026 at 8:35 a.m., Resident 1 stated on 2/3/2026, when the incident with the SSD occurred, the SSD who was waving her arms, yelling and asking why she (Resident 1) called her a B., tried to go back inside her room. Resident 1 stated she felt threatened when the SSD seemed like she wanted to fight with her (Resident 1). Resident 1 stated the SSD had no professionalism and no sense of respect to someone who was bedridden. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/20/2026 at 9:11 a.m., with RN 1, RN 1 stated the facility had an Influenza A (a viral infection that attacks the respiratory system, including the nose, throat, and lungs) outbreak (a sudden increase in the occurrence of a disease that exceeds what is typically expected) and visitors were expected to mask up prior to entering the building. RN 1 stated Resident 1's FM1 had entered the facility without a mask, reason why the SSD entered Resident 1's room and asked FM1 to wear mask. RN1 stated when Resident 1 asked the SSD what type the outbreak was and the SSD responded, not to worry about it because Resident 1 was leaving the facility, Resident 1 did not like the SSD's statement. That was when Resident 1 called the SSD a B. as the SSD was stepping out the room. RN 1 stated the SSD raised her voice and asked Resident 1 why do I have to be a B ? RN 1 stated she got in between Resident 1 and SSD to calm down the situation. RN 1 stated Resident 1 reported to her (RN 1) that the SSD was not supposed to be in her room because SSD's behavior was threatening and unprofessional towards her (Resident 1). During an interview on 3/20/2026 at 12:05 p.m., with the SSD, the SSD stated she did not see the incident as a confrontation with Resident 1. The SSD stated when Resident 1?s FM1 entered the room without a mask, she followed FM1 and asked her to put on a mask. Resident 1 asked her what type of outbreak there was, and SSD responded to Resident 1 that she could not disclose the other residents' information. The SSD stated as she (SSD) was exiting the resident's room, she (SSD) heard Resident 1 yelling, calling her (SSD) a B. That was when she (SSD) walked back into the room and asked Resident 1 why she had to be a B. The SSD stated she was not trying to confront Resident 1; she was just asking Resident 1 why she (SSD) had to be a B . The SSD stated RN 1 was at the door and was not sure why RN 1 got in between them. It was not like she (SSD) was going at her (Resident 1), but when she realized Resident 1 was not calming down, she (SSD) stepped outside the resident's room. The SSD stated she went back to the room because she thought it was her job to calm Resident 1 down. The SSD stated she probably should not have gone back in the room and ask the resident why she called her a B , instead, she should have allowed RN 1 to deescalate (calm down) the situation. The SSD stated, prior to the incident, Resident 1 had asked her not to go into her room. The SSD stated she only went in Resident 1's room to talk to the FM1 to put on a mask. 2). During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses hypertension (high blood pressure) and dementia (general term for a decline in mental ability such as memory, thinking, or reasoning). During a review of Resident 2's H&P dated 1/12/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was able to understand and be understood by others. The MDS indicated Resident 2 was independent for eating. MDS indicated Resident 2 required setup assistance for oral hygiene. The MDS indicated Resident 2 required maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.) The MDS indicated Resident 2 required moderate assistance for shower/bathing self, and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 2 required supervision for upper body dressing. The MDS indicated Resident 2 required moderate assistance with rolling from left to right, from sitting to lying position, lying to sitting on side of the bed, sitting to stand, chair/bed to chair transfer, for walking 10 feet, and was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity. Or tile assistance of 2 or more helpers is required for the resident to complete the activity.) for toilet transfer, tub/shower transfer, walking 50 feet with two turns and walking 150 feet. During an interview on 3/20/2026 at 8:57 a.m., Resident 2 stated Resident 1 told her, that is why I don't like that B. (SSD) because she (SSD) would not tell me what type of outbreak there was in the facility. Resident 2 stated the SSD was already leaving the room when Resident 1 called her a bitch. The SSD walked back and yelled at Resident 1, stating why do I have to be a bitch?