| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055526 | A. Building<br>B. Wing | 04/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Inglewood Health Care Center | 100 S. Hillcrest Blvd<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report the resident to resident allegations of abuse for the three (3) of 7 sampled residents, (Residents 1, 2 and 3), as indicated in its policy and procedure (P&P) titled, Abuse Prevention Program, when:1). On 3/31/2026, Resident 2 scratched Resident 1 while Resident 1 was entering the dining room. Resident 1 sustained wound on the chin measuring 1 X 0.2 (unit of measurement not indicated) and to the upper lip measuring 0.2 (unit of measurement not indicated) with minimal blood noted.2). On 3/10/2026, Resident 3 slapped Resident 2 who was sitting in a chair, in the hallway.3). On 3/10/2026, Resident 3 was hitting residents and staff.4). On 3/14/2026, Resident 3 swung purse at Resident 1.5). On 3/25/2026, Resident 3 hit Resident 1. This failure delayed the investigation by the California Department of Public Health (CDPH) and placed the affected residents and other residents at risk for further abuse causing residents humiliation and severe injuries, including hospitalizations.Findings: During a review of Resident 1's admission Record date 4/13/2026, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 1's diagnoses included pneumonia (lung infection), presence of cardiac pacemaker (a small, implanted device that regulates a slow heart rate by delivering electrical pulses, typically used to treat irregular heart rhythms or heart blocks), and a displaced intertrochanteric fracture (broken bone) of right femur (hip bone). During a review of Resident 1's Minimum Data Set (MDS-a resident assessment and care planning tool) dated 2/17/2026, the MDS indicated Resident 1 had clear speech, the ability to express ideas and wants, and understands. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) from staff with oral hygiene, lower body dressing and shower/bathe self. During a record review of Resident 1's Situation, Background, Assessment, Recommendation ([SBAR] a structured way to communicate to the care team about a resident's change in condition), dated 3/14/2026, the SBAR indicated Resident 1 stated a dementia (a progressive state of decline in mental abilities) resident (Resident 3) hit Resident 1 with a purse. During a record review of Resident 1's SBAR dated 3/25/2026, the SBAR indicated Resident 1 was hit by Resident 3. During a review of Resident 1's Interview Record, dated 3/25/2026, the interview record indicated Resident 1 (the interviewee) stated, (on unspecified date), Resident 3 hit Resident 1 on her back with her purse while Resident 1 was sitting in her wheelchair. During a review of Resident 1's SBAR dated 3/31/2026 at 3:55 p.m., the SBAR indicated Resident 2 scratched Resident 1's face, while Resident 2 was entering the dining room. Resident 1 sustained wound on the chin measuring 1 X 0.2 (unit of measurement not indicated) and to the upper lip measuring 0.2 (unit of measurement not indicated) with minimal blood noted. During a review of Resident 1's Interview Record, dated 3/31/2026, the interview record indicated Resident 1 stated she was going out of the dining room and the lady with long fingernails scratched her. During a concurrent observation and interview on 4/13/2026 at 11:30 a.m. with Resident 1, Resident 1 was observed with a red scratch on her chin. Resident 1 stated Resident 2 scratched her face with her long fingernails. Resident 1 stated the incident occurred on 3/31/2026 while she was trying to go into the activities room while Resident 2<br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | was coming out of the activities room. 2). During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted on [DATE] with diagnoses of schizophrenia (involves a range of problems that affects thinking, behavior, and emotions), unspecified dementia (when confusion or mild cognitive impairment can't be clearly diagnosed as a specific type of dementia) and hypertension (high blood pressure). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had clear speech, the ability to express ideas and wants, and understands. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) from staff with personal hygiene, lower body dressing and shower/bathe self. During a review of Resident 2's SBAR, dated 3/10/2026 at 3:13 p.m., the SBAR indicated Resident 3, who was in a wheelchair, passed by Resident 2 and slapped her, while she (Resident 2) was sitting in a chair, in the hallway, between rooms [ROOM NUMBERS]. During a review of Resident 2's Progress Notes dated 3/10/2026, at 4:02 p.m., the progress notes indicated Resident 2 was in the hallway sitting in a chair, reading a paper when Resident 3 passed by in her wheelchair and slapped Resident 2 on the right shoulder. During a review of Resident 2's SBAR, dated 3/31/2026 at 4:07 p.m., the SBAR indicated Resident 2 was noted with aggressive behavior towards another resident. Resident 2 scratched Resident 1 (site not specified) while exiting the activity room. 3). During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 3's diagnoses included vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), metabolic encephalopathy (is when the brain has trouble working because of a chemical, or metabolic, problem in the body) and urinary tract infection (UTI- an infection caused by bacteria entering the urinary system, typically the bladder and urethra leading to inflammation, pain, and a strong, persistent urge to urinate). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had clear speech, sometimes understood, and was able to understand sometimes. The MDS indicated Resident 3 required partial/moderate assistance from staff with personal hygiene, toileting hygiene, and lower body dressing. During a review of Resident 3's SBAR, dated 3/10/2026 at 3:50 p.m., the SBAR indicated Resident 3 was hitting residents and staff. During a review of Resident 3's SBAR, dated 3/14/2026 at 1:23 p.m., the SBAR indicated Resident 1 stated that she was hit (area not specified) by Resident 3 swinging purse at her (Resident 1). During a review of Resident 3's SBAR, dated 3/25/2026 at 4:14 p.m., the SBAR indicated Resident 3 was hitting staff and a resident. The SBAR indicated a staff (unidentified) had witnessed Resident 3 hit Resident 1. During a concurrent interview and record review on 4/13/2026 at 12:49 p.m. with the Registered Nurse (RN 1), the All Facilities Letter 24-09 ([AFL] a letter from the Center for Health Care Quality (CHCQ), Licensing and Certification (L&C) Program to health facilities that are licensed or certified by L&C with information that include changes in requirements in healthcare, enforcement, new technologies, scope of practice, or general information that affects the health facility), dated 2/28/2024, was reviewed. AFL 24-09 indicated facilities were required to provide written notice to the appropriate state agency for incidents resulting in physical harm immediately or as soon as possible, but not later than two hours after the incident occurred. RN 1 stated the incident on 3/31/2026 when Resident 2 scratched Resident 1 on the face sustaining injuries was not reported to the CDPH. RN 1 stated the incident should have been reported to the CDPH within 2 hours because Resident 1 sustained a scratch (injury). During a concurrent interview and record review on 4/13/2026 at 1:20 p.m., with the Administrator (ADM), the AFL 24-09 was reviewed. The ADM stated Resident 2 had dementia and the abuse incident was reported to the Ombudsman and the Police. The ADM stated Resident 1 sustained an injury (scratch) on her chin on 3/31/2026. The ADM stated the incident on 3/31/2026 was not reported to the CDPH within 2 hours, and the lack of reporting in a timely manner may cause psycho-social harm to the residents. During an interview on 4/15/2026 at 9:35 a.m. with the ADM, the ADM stated none of Resident 3's incidents (3/10/2026, when Resident 3 slapped Resident 2 who was sitting in a chair, in the hallway and when Resident 3 was hitting<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | residents and staff, on 3/14/2026 when Resident 3 swung purse at Resident 1 and on 3/25/2026, when Resident 3 hit Resident 1) were reported to the CDPH because of AFL 24-09. Resident 3 had dementia and the incidents were only reported to the Ombudsman and the Police, not CDPH. During a review of the AFL 24-09, dated 2/18/2024, the AFL indicated LTC facilities were informed about updates to the mandated reporter process for incidents of elder and dependent adult abuse. For incidents involving resident-on-resident abuse that did not result in bodily harm where the alleged abuser is a resident with dementia, facilities are required to notify the ombudsman and local law enforcement in writing within 24 hours. For incidents resulting in physical harm, facilities are required to notify local law enforcement immediately, but not later than 2 hours after the incident occurred. Facilities are required to provide written notice of the incident to the appropriate state agency. The AFL indicated facilities are responsible for following all applicable laws. The CDPH's failure to expressly notify facilities of statutory or regulatory requirements does not relieve facilities of their responsibility to comply with all laws and regulations. During a review of the State Operations Manual, Appendix PP dated 7/23/25, the SOM at F600 indicated that residents have the right to be free physical or mental abuse. The facility must provide a safe resident environment and protect residents from abuse. SOM at F609 indicated that the facility must develop and implement written policies and procedures that ensure reporting of crimes occurring in federally funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements:(B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.In response to allegations of abuse, the facility must ensure that all alleged violations involving abuse, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials including to the State Survey Agency in accordance with State law through established procedures. During a review of the facility's undated policy and procedure (P&P) titled, Abuse Prevention Program,, the P&P indicated residents have the right to be free from abuse. The P&P indicated, the administration will report any allegations of abuse within timeframes as required by federal requirements. |