STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2026
NAME OF PROVIDER OR SUPPLIER Inglewood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 observation, interview and record review, the facility failed to meet professional standards of quality for 2 of 6 sampled residents, Resident 1 and Resident 5, by failing to ensure:1). Scheduled medications were administered in a timely manner in accordance to their physician's order.2). Medications were not left at Resident 1's bedside.3). The medication nurse administered and observe Resident 1 swallowed her medications.These failures had the potential to decrease the drug's therapeutic levels when given late, the potential for Resident 1 not taking her scheduled medications and for other residents to take Resident 1's medications out from her bedside and drink it, causing harm and severe drug interactions.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and re-admitted to the facility on [DATE]. Resident 1's diagnoses included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), acute kidney failure (a sudden and often reversible reduction in kidney function) and encephalopathy (a brain disorder). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/10/2026, the MDS indicated Resident 1 had clear speech and had the ability to express ideas and wants, and was able to understand. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half) with toileting, shower/bathe, and personal hygiene. During a review of the document titled Disciplinary Action Record, charge nurse Disciplinary Action Notice, dated 4/20/2026, the disciplinary action notice indicated the employee left Resident 1's 9 a.m. medications at the bedside without confirming/observing if Resident 1 had taken the medications. Resident 1's family member found the medications (no time indicated). The Disciplinary Action Notice indicated that leaving Resident 1's medication at her bedside threatened the resident's safety, enabled hoarding of medications and viewed as negligence and failure to follow the standards of care. During a review of Resident 1's Medications Administration History for 4/2026, the administration history indicated the following:1). Amlodipine 10 mg tablet oral medicine for high blood pressure) scheduled at 9 a.m., were charted late (late, beyond one [1] hour after scheduled time) on 4/2/2026, 4/3/2026, 4/8/2026, 4/9/2026, 4/12/2026, 4/14/2026, 4/15/2026 and 4/20/2026.2). Aspirin 81 mg chewable tablet (for stroke prophylaxis), scheduled at 9 a.m., were charted late on 4/2/2026 to 4/3/2026, 4/8/2026, 4/9/2026 and 4/12/2026 3). Buspirone 5 mg tablet (for anxiety), scheduled at 9 a.m. and 5 p.m., were charted late from 4/2/2026 to 4/13/2026, 4/16/2026 to 4/21/2026. 4). Gabapentin 100 mg capsule oral-three times a day (for restless leg syndrome), scheduled at 9 a.m., 1 p.m. and 5 p.m., were charted late from 4/2/2026 to 4/13/2026, 4/16/2026 to 4/21/2026. 5). Quetiapine 25 mg three times a day (for schizoaffective disorder manifested by hearing or seeing things that are not there), scheduled at 9am, 1pm and 5 pm, were charted late from 4/2/2026 to 4/13/2026, 4/16/2026 to 4/21/2026. During an interview on 4/27/2026 at 1:35 p.m., with the License Vocational Nurse (CN 1), the CN 1 stated on 4/20/2026 9 a.m., he left Resident 1's medications at the bedside when the resident asked him to leave it. The CN 1 stated he documented that Resident 1's medications were given on time, but the medications were taken late, between 11 a.m. to 12 noon. The charge nurse stated leaving the medications at the bedside and failure to administer 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2026

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

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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	medications and observe the resident swallow the medications may lead to another resident taking the medications. The medications may get lost and adverse reactions may occur. 2). During a review of Resident 5's admission Record, undated, the admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and re-admitted to the facility on [DATE]. Resident 5's diagnoses included toxic encephalopathy, hypertension (high blood pressure), and gastrostomy status (the presence of a gastrostomy tube, a feeding tube inserted directly into the stomach through the abdominal wall). During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 has clear speech, difficulty communicating some words or finishing thoughts but is able if prompted or given time, and usually understands. The MDS indicated Resident 5 required setup or clean-up assistance (helper sets up or clean-up) with toileting, personal hygiene and eating. During a review of Resident 5's Physician Order Report, dated 4/1/2026 through 4/22/2026, the physician order report indicated to administer aspirin tablet 81 mg via gastric tube (GT, a tube surgically inserted into the stomach for nutrition and medication administration) for Cerebrovascular Accident (CVA, stroke) prevention once a day at 9 a.m. The order indicated to crush the medications as needed, and docusate sodium (for bowel management) 100 mg via GT once a day at 9 a.m. During a concurrent observation and interview on 4/21/2026 at 11:40 a.m., with Licensed Vocational Nurse (LVN 1), at Resident 5's bedside, LVN 1 was observed administering the resident's 9 a.m. medications (aspirin 81 mg tablet, scheduled at 9 a.m. and docusate sodium 100 mg scheduled at 9 a.m.) at 11:40 a.m. LVN 1 stated the medications were administered late because he was assisting other residents. During a review of Resident 5's Medication Administration History, dated 4/1/2026 through 4/28/2026, the administration history indicated the following:1). On 4/21/2026, aspirin 81 mg tablet, scheduled at 9 a.m., was charted late.2). On 4/21/2026, docusate sodium 100 mg scheduled at 9 a.m., was charted late. During a review of the facility's policy and procedure (P&P) titled, Oral Medication Administration, undated, the P&P indicated oral medications should be administered in an accurate, safe and timely manner. The P&P indicated to verify that medications were actually taken.