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	06/25/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its grievance process for one of three sampled residents (Resident 1) by failing to:Provide written notification of the grievance investigation results and actions taken.Ensure grievance reports were signed.Make the reports available to the resident or the resident's representative. These failures had the potential to result in delayed communication of grievance outcomes, prevent the resident or resident representative from determining whether concerns were adequately investigated and resolved, and impede the residents ability to exercise their right to appeal, request further review, or pursue additional actions regarding unresolved concerns and impact resident well-being. During a review of Resident 1' s Resident Face Sheet, the Resident Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior).During a review of Resident 1's History and Physical (H&P) dated 9/2/2025, the H&P indicated Residen1 had the capacity to understand or make decisions. During a review of Resident 1's Minimum Data set the (MDS- a resident assessment tool) dated 5/20/2026, the MDS indicated Resident 1's cognition (thought process) was moderately impaired. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for activities of daily living (ADL's- routine task/activities such as bathing, dressing, and toileting a person preforms daily to care for themselves).During an Interview with Resident 1's family member (FM) on 6/24/2026 at 11:30 a.m., the FM stated that multiple grievances were filed with the facility administration regarding medication administration, physician service, and patient care. The FM stated administration did not inform the family of the findings of the investigations, nor was the family provided with any of the actions that would be taken to correct any of the identified problems.During a concurrent interview and record review on 6/25/2026 at 12:30 p.m., with the Administrator, the following three Grievance/Complaint Reports for Resident 1 and the Grievance QA&A logs were reviewed: The Grievance/Complaint Report dated and received on 4/20/2026, indicated under Documentation of facility follow up the date to be resolved by: the area was blank.Under Resolution of Grievance/Complaint: was grievance resolved: the area was blankThe Grievance/Complaint Report indicated a 2nd grievance dated and received on 4/20/2026, indicated under Resolution of Grievance/Complaint: was grievance resolved: the area was blankThe Grievance/Complaint Report dated and received on 5/20/2026, indicated under Documentation of facility follow up: Date to be resolved by: the area was blank.Staff Signature and title was left blankUnder Resolution of Grievance/Complaint: was grievance resolved: identify method used to notify family: the area was blankThe Grievance QA & A logs for April, May, and June 2026, the column noting Administrators Signature was left blank for all eight grievances logged.Resolution of Grievance/Complaint was Grievance resolved: There was no check mark given for yes or no response.The Administrator stated she was aware the documents were incomplete and families were (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not notified of actions taken and resolutions and stated that failing to follow up on grievances could delay patient care resolutions and impact resident well-being. During a review of the facility's undated policy and procedure (P&P) titled, Grievances and Complaints, the P&P indicated, The administrator (Grievance Official) is responsible for the resolution of all grievances and complaints. All grievances and complaints are investigated, resolved, and documented. The resident or person filing the grievance or complaint on behalf of the resident will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. All reports must be signed and will be made available to resident or person acting on behalf of the resident.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of three sampled residents (Resident 1) who refused the covid vaccine and the facility failed to reassess the resident's vaccination status or offer vaccination again during a facility-wide COVID-19 outbreak.This failure had the potential to compromise the resident's health, safety and wellbeing. During a review of Resident 1' s Resident Face Sheet, the Resident Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior).During a review of Resident 1's History and Physical (H&P) dated 9/2/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Preventative Health Care note dated 9/4/2025, the documentation indicated that the resident's family refused the COVID-19 vaccine based on a conscientious objection (when a person declines to participate in a lawful process or procedure due to their personal beliefs, values, or moral concerns).During a review of Resident 1's Progress note dated 12/4/2025, the Progress note indicated, Spoke with resident and family regarding covid vaccine. Will follow up again when family members come into the facility.During a review of Resident 1's Progress Note dated 5/18/2026 at 3:30 p.m., the Progress Note indicated Resident 1 tested positive for Covid on 5/18/2026.During a review of Resident 1's Minimum Data set the (MDS- a resident assessment tool) dated 5/20/2026, the MDS indicated Resident 1's cognition (thought process) was moderately impaired. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for activities of daily living (ADL's- routine task/activities such as bathing, dressing, and toileting a person preforms daily to care for themselves).During a concurrent interview and record review on 6/25/2026 at 12:30 p.m., with the Infections Infection Preventionist (IP), Resident 1's plan of care was reviewed. There was no plan of care developed or implemented for Resident 1's refusal of the COVID -19 vaccine. The IP stated a plan of care for COVID-19 refusal should have been developed and implemented for Resident 1. The IP further stated that without the plan of care there was no process in place to monitor Resident1's risk for infection and the plan of care would have helped ensure the interdisciplinary team identified Resident 1's risk and implement appropriate infection prevention measures, particularly during a facility-wide COVID-19 outbreak.During a review of the facility's policy and procedure (P&P) titled, Comprehensive Plan of Care. dated 2/9/2026, the P&P indicated Each resident will have a comprehensive care plan developed that includes goals, measurable objectives, and timetables to meet their medical nursing needs. The comprehensive care plan must describe services that are provided to the resident to attain or maintain the residents highest practicable physical, mental and psychosocial well-being. The comprehensive care plan must address the residents individual needs, strengths and preferences reflective of current standards of professional practice and include interventions to prevent avoidable decline in function or functional level which reflect the company's efforts to provide alternative methods when a resident wishes to refuse certain treatments or services.

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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 provide treatment, care, and documentation in accordance with accepted professional standards of practice for one of three sampled residents (Resident 1) by failing to:1.Respond to a Certified Nursing Assistant's (CNA's) written report of a change in condition for Resident 1, communicated through the facility's Stop and Watch process (a process whereby CNAs alert licensed staff via a form in writing of a resident's change in condition).Specifically, the Licensed Vocational Nurse (LVN) did not utilize the facility's Stop and Watch communication tool after it was presented by the CNA, delaying appropriate nursing evaluation of the reported change in condition.2.Ensure accurate and timely nursing documentation when the Licensed Vocational Nurse (LVN) inaccurately documented that Resident 1 had two sacral wounds on 5/20/2026 leaving the inaccurate documentation in Resident 1's medical record for 34 days.These failures were not consistent with accepted standards of nursing practice and had the potential to delay recognition, assessment, communication, and treatment of changes in the resident's condition. 1. During a review of Resident 1' s Resident Face Sheet, the Resident Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior).During a review of Resident 1's History and Physical (H&P) dated 9/2/2025, the H&P indicated Resident 1 had the capacity to understand or make decisions. During a review of Resident 1's Minimum Data set the (MDS- a resident assessment tool) dated 5/20/2026, the MDS indicated Resident 1's cognition (thought process) was moderately impaired. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for activities of daily living (ADL's- routine task/activities such as bathing, dressing, and toileting a person preforms daily to care for themselves).During an interview on 6/24/2026 at 2:00 p.m., with CNA 1, CNA 1 stated she completed a STOP and WATCH for Resident 1 on 5/20/2026 at 2:00 p.m., noting Resident 1 had a change in condition, Resident 1 was more drowsy than usual, had a rash on the face and had an open wound on the bottom. CNA 1 stated she attempted to give the STOP and WATCH form to the LVN 2 who was the Charge Nurse, but the Charge Nurse refused to take it stating she was not taking the form because it was after 2:00 p.m.During a concurrent interview and record review on 6/24/2026 at 3:00 p.m., with the Director of Staff Development (DSD), Resident 1's Stop and Watch form dated 5/20/26 at 2:00 p.m., was reviewed. The form was incomplete with areas left undocumented, with lines indicating reported to, nurse's name, date but the time were blank. The DSD stated the form is still not filled out or signed by the charge nurse and it should have been completed by the charge nurse. The DSD stated LVN 2 not accepting or completing the Stop and Watch form is against policy and could have placed Resident 1 at risk for delayed needed care. During a review of the facility's policy and procedure (P&P) titled, General Documentation Guideline/Utilization of Forms Certified Nurse Assistant dated 7/17/2025, the P&P indicated, for any changes in condition identified while caring for or observing a resident, the CNA may utilize the stop and watch form. The CNA will circle the change and notify the licensed nurse. The white original copy is given to the licensed nurse to address the change identified and the yellow copy is given to the director of staff development licensed nurse designee for follow up.2. During a review of Resident 1's Resident Progress Notes dated 5/20/2026 at 4:11 p.m., the Resident Progress Note indicated, At approximately 2:30 PM the resident was noted with low O2 saturation, drowsiness, and two sacral wounds. During resident care wounds were assessed and documented per facility protocol.During a review of Resident 1's Resident Progress Notes on 6/24/2026 at 8:00 a.m., the Resident Progress Notes dated 5/20/2026 was edited on 6/22/2026 at 5:08 p.m., the Resident Progress Notes indicated Skin excoriation caused by friction on sacrum noted (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scattered small red spot on face noted during patient care.During an interview on 6/24/2026 at 10:30 a.m., with Licensed Nurse (LVN) 2, LVN 2 stated the Resident Progress note was changed on 6/22/2026, 33 days after Resident 1 was discharged from the facility. LVN 2 stated an error was made within the documentation and it was later corrected on 6/22/26.During an interview with the Director of Nursing (DON) on 6/24/2026 at 11:00 a.m., the DON stated the charting policy for documentation for corrections should be followed to prevent errors and ensure that patient medical records are accurate. During a review of the facility's undated P&P titled, Charting, the P&P indicated If necessary to change or add information to a resident's medical record it shall be completed by means of an addendum by using the next available line to enter the current date and time, and write clarification or addendum to state the reason and refer back to the entry being amended.