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	12/05/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to:1. Maintain the COVID vaccination status for 19 employees.This deficient practice had to the potential to cause a delay in response in the event of an outbreak, since the unvaccinated staff cannot be easily identified.During a concurrent interview and record review on 12/4/2025 at 8:00 a.m. with the Infection Prevention Nurse (IPN), a binder titled Staff Vaccination 2025 was reviewed. The binder indicated 19 employees declined to receive a COVID vaccine. The IPN stated she cannot show documentation of what staff are vaccinated. The IPN stated she is supposed to offer the vaccine to all staff. The IPN further stated it is important to know who is or is not vaccinated in case there is an outbreak. It will be easier to track where the outbreak may have started if you know who is not vaccinated.During a review of the facility's policy and procedure (P&P) titled, COVID-19 Vaccination-Staff, (no date), the P&P indicated the infection preventionist maintains a tracking worksheet of staff members and their vaccination status.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to maintain a safe, clean, and sanitary environment when an air filter in the hallway for four of four sampled Residents (Residents 13, Resident 33, Resident 67, and Resident 99) was full of dust and gray, fuzzy substance accumulation.This deficient practice had the potential to exposing residents to an environment that was unclean, and negatively impacting residents' comfort, safety, and quality of life.Findings:a. During a review of Resident 13's admission Record (Face sheet), the admission Record indicated the facility admitted Resident 13 on 12/3/2024 with diagnoses including acute respiratory failure with hypoxia (a life-threatening condition where the lungs cannot get enough oxygen into the blood), shortness of breath, heat failure, and sepsis (a life-threatening blood infection).During a review of Resident 13's History and Physical (H&P) dated 1/15/2025, the H&P indicated the resident was alert, cooperative, had normal affect (a person shows a healthy, appropriate, and varied range of emotional expressions), and normal speech.During a review of Resident 13's MDS Minimum Data Set (MDS - a resident assessment tool) dated 9/1/2025, indicated Resident 13's cognitive function was intact (alert, oriented and able to recall information). During a concurrent observation and interview on 12/2/2025 at 11:02 a.m. outside Resident13's room, Resident 13 stated, Look at this air filter, it's so filthy. It's full of dust. During an interview on 12/4/2025 at 1:25 p.m. in Resident 13's room, Resident 13 stated, I don't feel good walking outside the hallways because the air quality is not good. There could be different air pathogens in the air. I have had multiple lung problems in the past. That is why I always have my doors closed, and have all staff wear mask when they come in my room.b. During a review of Resident 33's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 3/13/2025 with diagnoses including asthma (a lung disease that swells and narrows airways, causing symptoms like wheezing, coughing, chest tightness, and shortness of breath), acute respiratory failure with hypoxia (a life-threatening condition where the lungs cannot get enough oxygen into the blood), shortness of breath, and obesity (excessive fat in the body).During a review of Resident 33's History and Physical (H&P) dated 3/10/2025, the H&P indicated the resident was alert, oriented, mild dementia (a noticeable decline in memory or thinking skills), and can make own decisions.During a review of Resident 33's MDS Minimum Data Set (MDS - a resident assessment tool) dated 11/13/2025, indicated Resident 33's cognitive function was intact (alert, oriented and able to recall information). During an interview on 12/4/2025 at 1:27 p.m. in Resident 33's room, Resident 33 stated, It is important to have clean air filter, so lungs don't have difficulty breathing. I have asthma. I would feel horrible if the air filters were dirty because my asthma could get worse. c. During a review of Resident 67's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 6/27/2022 with diagnoses including acute respiratory disease (sudden lung issues, often causing cough, fever, and breathing trouble), hypertension ((HTN-high blood pressure), and acute kidney failure (a sudden, severe loss of kidney function where kidneys can't filter waste or fluids). During a review of Resident 67's History and Physical (H&P) dated 11/25/2025, the H&P indicated the resident was alert, oriented, and can make own decisions.During a review of Resident 67's MDS Minimum Data Set (MDS - a resident assessment tool) dated 9/27/2025, indicated Resident 67's cognitive function was intact (alert, oriented and able to recall information). During an interview on 12/4/2025 at 1:28 p.m. in Resident 67's room, Resident 67 stated, I have seen those air filters outside. Breathing clean air is important to keep germs away, helps our health. They should be cleaned out because if the dirt gets in the lungs, it will mess with my lungs.d. During a review of Resident 99's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 4/3/2025 with diagnoses including heart failure (the heart is unable to pump enough blood for the body's needs), pace-maker (a small, battery-powered device implanted under the skin that sends electrical signals to regulate the heart's rhythm), and (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	syncope (fainting, a brief, sudden loss of consciousness and posture due to a temporary decrease in blood flow and oxygen to the brain, often preceded by dizziness, nausea, or lightheadedness).During a review of Resident 99's History and Physical (H&P) dated 4/4/2025, the H&P indicated the resident was alert, oriented, but has fluctuating capacity to understand and make decisions.During a review of Resident 99's MDS Minimum Data Set (MDS - a resident assessment tool) dated 10/11/2025, indicated Resident 99's cognitive function was intact (alert, oriented and able to recall information). During an interview on 12/4/2025 at 1:20 p.m. in Resident 99's room, Resident 99 stated, Those white or black ones, that changes color. I don't like it if they are dirty. Clean air is important. I have a heart pacemaker. Dirty air filters can make me more sick.During an interview on 12/5/2025 at 10:10 a.m. with Housekeeping Supervisor (HS), the HS stated residents had the right to breathe clean air and have clean air filters to prevent them from getting sick from the air they breathe in. HS stated the filters needed to be changed twice monthly to keep filters in good condition. During a concurrent interview and record review on 12/5/2025 at 10:10 a.m. with HS, HS indicated that the facility's Cleaning Air Purifier Log from 5/3/2024 to 11/24/2025 indicated the air purifier filter was changed only once a month. During a review of the facility's Policy and Procedure (P&P), titled Maintaining a Clean Environment, undated, the P&P indicated, Items that collect dust or secretions may harbor microorganisms that can colonize and infect susceptible residents, or be inhaled by employees performing cleaning tasks. During a review of facility's policy and procedure (P&P), titled, The Quality of Life-Homelike Environment, dated 10/2017, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment. 1. Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Clean, sanitary and orderly environment;.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to:1. Ensure linen was folded using proper technique to prevent recontamination.This deficient practice put residents at risk of infection if they came in contact with the contaminated linen.2. Ensure the Laundry Aide did not pour a chemical into a new unlabeled/uncovered container in the laundry room.3. Ensure air purifier filter in the hallway was maintained in a clean condition for four of four sampled Residents (Residents 13, Resident 33, Resident 67, and Resident 99) when the air filter was full of dust and fuzzy, grey buildup accumulation.This deficient practice had the potential to increase the risk of airborne particle (tiny solid or liquid particles in the air) accumulation in the hallway, which could contribute to the spread of infection among residents.4. Ensure the ice machine in the kitchen was maintained in a clean and sanitary condition. This deficient practice had the potential to expose residents to contaminated ice, increasing the risk of foodborne illness. 1. During a concurrent observation and interview on 12/2/2025 at 2:48 p.m. with the Laundry Aide (LA) in the laundry room, the LA was observed folding sheets and allowing the sheets to drag on the floor during folding. The surveyor brought attention to the action, and the LA then took the dirty sheet and placed it on top the clean pile of linen. The LA could not explain what he did wrong or why it was harmful. During an interview on 12/2/2025 at 3:17 p.m. with the Housekeeping Supervisor (HS), the HS stated laundry should not touch the floor while it is being folded. The HS stated this contaminates the laundry and residents who come in contact with it can get sick. During a review of the facility's policy and procedure (P&P) titled, Laundry Handling Practices, (no date), the P&P indicated proper handling of linen will reduce the likelihood of recontamination. During a review of the Laundry Aide job description, dated January 2012, the job description indicated the Laundry Aide will provide laundry services to ensure a safe and sanitary environment for residents. 2. During a concurrent observation and interview on 12/2/2025 at 2:50 p.m. in the laundry room with the Laundry Aide (LA), an uncovered white plastic bucket containing a yellowish liquid was noted sitting on the floor in front of the washer. The bucket was not labeled. The LA stated the liquid in the bucket was bleach. The LA further stated he poured bleach from the original container into the white plastic bucket. The LA could not explain why this practice was not safe. During an interview on 12/2/2025 at 3:17 p.m. with the Housekeeping Supervisor (HS), the HS stated staff should never pour chemicals from one container into a new container. The HS stated, It's dangerous because someone else won't know what it is. During a review of the Material Safety Data Sheet ([MSDS]- a document that provides information about the hazards of a chemical, safe handling practices, and emergency procedures), dated January 2012, the MSDS indicated bleach should be stored in a closed container. During a review of the Laundry Aide job description, dated January 2012, the job description indicated the Laundry Aide will take appropriate actions to secure laundry chemicals. 3. During a review of Resident 13's admission Record, the admission Record indicated the facility admitted the resident on 12/3/2024 with diagnoses including acute respiratory failure with hypoxia (a life-threatening condition where the lungs can't get enough oxygen into the blood), shortness of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	breath, heat failure, and sepsis (a life-threatening blood infection). During a review of Resident 13's History and Physical (H&P) dated 1/15/2025, the H&P indicated the resident was alert, oriented, normal affect (a person shows a healthy, appropriate, and varied range of emotional expressions), and normal speech. During a review of Resident 33's admission Record, the admission Record indicated the facility admitted the resident on 3/13/2025 with diagnoses including asthma (a chronic lung disease that swells and narrows airways, causing symptoms like wheezing, coughing, chest tightness, and shortness of breath, acute respiratory failure with hypoxia (a life-threatening condition where the lungs can't get enough oxygen into the blood), shortness of breath, and obesity (having a excess body fat). During a review of Resident 33's H&P dated 3/10/2025, the H&P indicated the resident was alert, oriented, and can make own decisions. During a review of Resident 33's MDS Minimum Data Set (MDS – a resident assessment tool) dated 11/13/2025, indicated Resident 33's cognitive function was intact (alert, oriented and able to recall information). During a review of Resident 67's admission Record, the admission Record indicated the facility admitted the resident on 6/27/2022 with diagnoses including acute respiratory disease (sudden lung issues, often categorized as infections, causing cough, fever, and breathing trouble), hypertension ((HTN-high blood pressure), and acute kidney failure (a sudden, severe loss of kidney function where kidneys can't filter waste, fluids). During a review of Resident 67's H&P, dated 11/25/2025, the H&P indicated the resident was alert, oriented, and can make own decisions. During a review of Resident 99's admission Record, the admission Record indicated the facility admitted the resident on 4/3/2025 with diagnoses including heart failure(the heart can't pump enough blood for the body's needs, often due to damage from conditions like high blood pressure or heart attack, leading to fluid backup and symptoms like shortness of breath, fatigue, and swelling), pace-maker (a small, battery-powered device implanted under the skin that sends electrical signals to regulate the heart's rhythm), and syncope (fainting, a brief, sudden loss of consciousness and posture due to a temporary decrease in blood flow and oxygen to the brain, often preceded by dizziness, nausea, or lightheadedness). During a review of Resident 99's H&P, dated 4/4/2025, the H&P indicated the resident was alert, oriented, but has fluctuating capacity to understand and make decisions. During a concurrent observation, and interview on 12/2/2025 at 11:07 a.m. with the Infection Preventionist Nurse (IPN), The IPN stated the air filter was filled with dust and of poor quality. The IPN stated a dirty air filter could cause lung infections (infections that affect the lungs) and other respiratory diseases (any illness affecting the lungs) such as pneumonia (an infection/inflammation in the lungs), COVID-19 (an infectious lung disease caused by the SARS-CoV-2 virus), flu, and asthma, potentially leading to hospitalizations for residents. During an interview on 12/5/2025 at 2:10 p.m. with Registered Nurse Supervisor 1 (RNS 1), RNS 1 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated maintaining clean air filters was important to provide residents with clean air, improve their comfort, and prevent airborne illnesses. RNS 1 stated a dirty air filter might get contaminated with bacteria, which could then potentially spread to other residents, especially those with lung diseases. During a review of the facility's Policy and Procedure (P&P), titled Maintaining a Clean Environment, undated, the P&P indicated, Items that collect dust or secretions may harbor microorganisms that can colonize and infect susceptible residents, or be inhaled by employees performing cleaning tasks . 4. During a concurrent observation and interview on 12/2/2025 at 9:02 a.m. with Dietary Aid (DA) 1 in the kitchen, DA 1 stated the ice machine lid had brown, grey dusty particulate and the top of the ice chest had a green slimy film. DA 1 stated the ice machine was deep cleaned by the maintenance staff monthly. DA 1 stated cleaning the ice machine was important to ensure there was no buildup of any dirt and to provide safe consumable ice for the residents. DA 1 stated if the ice machine was not cleaned the residents may acquire illnesses from bacteria that was carried through the ice. During an interview on 12/3/2025 at 12:44 p.m. with the Dietary Supervisor (DS), the DS stated cleaning the ice machine monthly was important to prevent bacterial from building up that may be transferred to the ice. The DS stated if the ice machine was not cleaned, the residents would be exposed to water pathogens that may lead to illnesses and infections. During a review of the facility's monthly Ice Machine Cleaning Log, the Ice Machine Cleaning Log indicated the ice machine was not cleaned on 11/6/2025. During a review of the facility's policy and procedure (P&P) titled Cleaning & Maintaining Ice Machines undated, the P&P indicated .Cleaning. 2. Empty and disinfect the ice storage compartment prior to quarterly maintenance according to the steps shown below:.g. Clean the chest with disinfectant solution according to manufacturer's label directions.

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure two of five sampled residents (Resident 78 and Resident 98) was provided with goods and services when1.Resident 98 had notified staff he would like to retrieve his vehicle.2. Staff were standing over Resident 78 while assisting with eating lunch.These deficient practices of not providing goods and services for Resident 98 to escort him to retrieve his vehicle had the potential for him to feel unacknowledged of his needs and placed Resident 78 at increased risk for choking, aspiration, or inadequate monitoring of the resident's tolerance during meals.1.During a review of Resident 98's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 98 was initially admitted to the facility on [DATE]. Resident 98's diagnoses included respiratory failure (the lungs can't adequately oxygenate the blood or remove carbon dioxide), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and heart failure (the heart can't pump enough blood to meet the body's needs). During a review of Resident 98's History and Physical (H&P), dated 10/27/2025, the H&P indicated Resident 98 had the capacity to understand and make decisions. During a review of Resident 98's Minimum Data Set ([MDS] a resident assessment tool), dated 11/3/2025, the MDS indicated Resident 98's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 98 required partial/moderate assistance (helper does less than half the effort. Helper helps lifts, holds, or supports trunk or limbs) by staff for toileting hygiene, showering, and dressing. The MDS indicated Resident 98 had the ability to walk 50 feet and make two turns. During a review of Resident 98's, Progress Notes, dated 12/1/2025, the progress notes indicated Resident 98 had requested to go out on pass ([OOP] – temporary, authorized leave for activities such as going home and community participation) to retrieve his vehicle from the hospital parking lot. During an interview on 12/2/2025 at 10:55 a.m., with Resident 98, in Resident 98's room, Resident 98 stated he had requested to leave the facility to retrieve his vehicle from the hospital parking lot. Resident 98 stated the social worker had not followed up with him to retrieve his vehicle. During an interview on 12/3/2025 at 1:11 p.m., with Social Services Director (SSD), the SSD stated she was aware Resident 98 needed to go OOP and needed an escort to leave the facility to run his errands. SSD stated she had no documentation regarding Resident 98's concerns about going OOP. SSD stated she did not check nor follow-up with Resident 98 if he went OOP. SSD stated not following up with Resident 98 could make him feel upset. During an interview on 12/4/2025 at 9:08 a.m., with Registered Nurse (RN) 3, RN 3 stated when Resident 98 expressed he wanted to go out on pass, the facility could provide transportation with an escort. RN 3 stated she was aware Resident 98 wanted to retrieve his vehicle. RN 3 stated social services were to work with Resident 98 no later than the following day (12/2/2025) to check if this issue was resolved. RN 3 stated not following up with Resident 98 about his needs could make him feel his needs are not being acknowledged. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Resident Rights, unknown date, the P&P indicated the resident had the right to a dignified existence, self-determination, and communication with access to persons and services inside and outside the facility. 2. During a review of Resident 78's Face Sheet, the Face Sheet indicated the facility admitted Resident 78 on 9/4/2025 and was readmitted on [DATE] with diagnoses including encephalopathy (any disease or damage that changes how the brain works), pneumothorax (collapsed lung), urinary tract infection (UTI- an infection in the bladder/urinary tract), hyperlipidemia (excessive fat in the blood) and otalgia (ear pain or earache). During a review of Resident 78's History and Physical (H&P) dated 9/5/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 78's Minimum Data Set (MDS- a resident assessment tool) dated 10/27/2025, the MDS indicated the resident had intact cognition (ability to think, learn, understand and remember) and required dependent assistance (helper does all of the effort) with eating, oral and toileting hygiene, showering, upper and lower body dressing, and putting on and taking off footwear. During a concurrent observation and interview on 12/2/2025 at 12:59 p.m. with Certified Nursing Assistant (CNA) 1 in Resident's 78's room, CNA 1 was observed standing over the resident while feeding Resident 78. CNA 1 stated the importance of sitting down when feeding resident was to ensure the resident was safe, to prevent the resident from choking, and to engage with the resident so the resident does not feel rushed. CNA 1 stated if staff does not sit down when feeding the resident, there would be a potential for the resident to choke, cross contamination when reaching over the resident's tray, and the resident would feel like he or she was being rushed to finish his or her food. During an interview on 12/3/2025 at 12:57 p.m. with CNA 2, CNA 2 stated the importance of sitting down when feeding resident was to ensure the resident and staff were eye level to prevent choking and to engage with the resident so the resident feel like he or she was at home. CNA 2 stated if staff were not sitting down when feeding resident, the resident may choke and prevent cross contamination. During an interview on 12/3/2025 at 1:45 p.m. with Registered Nurse Supervisor (RNS) 2, RNS 2 stated the importance of sitting down when feeding resident was to ensure the safety of the resident and to engage in conversation with the resident to simulate a homelike environment. RNS 2 stated if staff was not seated while feeding the resident was the resident had the potential to choke, the resident will feel like he or she was being rushed, and cross contamination. During a review of the facility's Policy and Procedure (P&P) titled Resident Dining Program, undated, the P&P indicated . F. Staff Training All staff involved in food service will receive training during the orientation process and annually thereafter on: Proper food handling, Resident rights during meal service, Infection control during dining, Responding to choking or aspiration events.

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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 observation, interview, and record review the facility failed to ensure one of five sampled residents (Resident 98) walking cane was located when Resident 98 notified Social Worker Director (SSD) the walking cane was missing.This deficient practice of not promptly resolving Resident 98's grievance of the missing walking cane had the potential for Resident 98 to feel the SSD did not want to help him replace the walking cane. During a review of Resident 98's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 98 was initially admitted to the facility on [DATE]. Resident 98's diagnoses included respiratory failure (the lungs can't adequately oxygenate the blood or remove carbon dioxide), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and heart failure (the heart can't pump enough blood to meet the body's needs). During a review of Resident 98's History and Physical (H&P), dated 10/27/2025, the H&P indicated, Resident 98 had the capacity to understand and make decisions. During a review of Resident 98's Minimum Data Set ([MDS] a resident assessment tool), dated 11/3/2025, the MDS indicated Resident 98's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 98 required partial/moderate assistance (helper does less than half the effort. Helper helps lifts, holds, or supports trunk or limbs) by staff for toileting hygiene, showering, and dressing. The MDS indicated Resident 98 had the ability to walk 50 feet and make two turns. During an interview on 12/2/2025 at 10:55 a.m., with Resident 98, in Resident 98 room, Resident 98 stated he was admitted on [DATE] and his walking cane was left on the gurney. Resident 98 stated he had notified the SSD of the missing cane, when he was admitted . Resident 98 stated the SSD did not have him file out a grievance for the missing cane. Resident 98 stated the SSD had not helped him recover his walking cane. Resident 98 stated SSD made him feel like SSD did not want to help him and it made him upset. During an interview on 12/3/2025 at 1:25 p.m., with SSD, the SSD stated she was aware Resident 98 had left the walking cane in the ambulance on 10/22/2025. The SSD stated it was important for Resident 98 to have his walking cane because it was his preference to have it. The SSD stated she had not documented the walking cane in her progress notes, nor had Resident 98 filed a grievance for the missing cane. The SSD stated this could make the resident feel that the staff does not care about his situation. During a concurrent interview and record review on 12/3/2025 at 1:42 p.m., with MDS Nurse, the MDS Nurse stated missing items the social services would be notified, and the resident can file a grievance about the missing item. The MDS Nurse stated Resident 98's walking cane should have been located or replaced immediately. The MDS Nurse stated Resident 98 not having his cane was hindering him from using it and may feel he is not being heard. During a review of the facility's policy and procedure (P&P) titled, Grievances and Complaints, unknown date, the P&P indicated the facility was to support each resident's right to voice grievances and to actively resolve the issue and communicate a resolution.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of five sampled residents (Resident 10) Minimum Data Set ([MDS] a resident assessment tool) was filled out accurately.This deficient practice of not accurately completing the MDS had the potential for Resident 10 goods and services not to be met while residing at the facility. During a review of Resident 10 's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 10 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 10's diagnoses included chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing), respiratory failure (when the body's respiratory system is unable to exchange oxygen and carbon dioxide properly), and heart failure (heart muscle can't pump enough blood to meet the body's needs). During a review of Resident 10's History and Physical (H&P), dated 7/4/2025, the H&P indicated, Resident 10 could not make medical decisions but was able to make needs known. During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10 had the ability to understand others. The MDS indicated Resident 10 required partial/moderate assistance (helper does less than half the effort for lifts, hold trunk, or limbs) by staff for toileting hygiene, showering, and dressing. The MDS indicated Resident 10 required respiratory treatment with oxygen therapy (providing a patient with supplemental oxygen, which is extra oxygen beyond what they can breathe from the air). During a review of facility's, Resident Census, dated 11/15/2025, the Resident Census indicated Resident 10 had returned to the facility on [DATE] from the hospital.During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10 was readmitted to the facility on [DATE]. During a concurrent interview and record review on 12/4/2025 at 2:14 p.m., with MDS Nurse, Resident 10's MDS indicated he was re-admitted to the facility on [DATE] was reviewed. The MDS Nurse stated Resident 10 was re-admitted on [DATE]. The MDS Nurse stated the MDS was not updated and completed within 14 days after being re-admitted . The MDS Nurse stated the MDS should be updated and accurate when Resident 10 returned to the facility. The MDS Nurse stated the MDS was not accurate which had the potential for Resident 10 to not receive proper care. The MDS Nurse stated this could lead to Resident 10's needs not being met. During a review of facility's policy and procedure (P&P) titled, Certifying Accuracy of the Resident Assessment, unknown date, the P&P indicated any person completion a portion of the MDS must sign and certify the accuracy of that portion of the assessment. The P&P indicated resident assessment coordinator was responsible for ensuring the MDS assessment had been completed for each resident.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR- a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) was completed for one of one resident (Resident 2).This failure had the potential to result in an inappropriate placement and delay in needed services for Resident 2.Findings:During a review of Resident 2's Face Sheet (admission Record), the Face Sheet indicated the facility admitted Resident 2 on 8/13/2025 and was readmitted on [DATE] with diagnoses psychosis (when a person has trouble telling the difference between what is real and what is not real not) due to substance or known physiological (normal, healthy functioning of a living body) condition.During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 8/19/2025, the MDS indicated Resident 2 was taking antipsychotic (a type of medicine used to treat symptoms of mental disorder) medication.During a review of Resident 2's History and Physical (H&P) dated 9/12/2025, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions.During a review of Resident 2's Prescription Order (Physician's Order), the Prescription Order indicated:a. aripiprazole (medication used to treat a variety of mental health conditions) tablet 5 milligram (mg, unit of weight) orally, once a day for psychosis manifested by visual hallucinations (a sensory experience involving sight, sound, smell, taste, or touch that a person believes to be real, but is not actually happening in reality), disorganized thinking ordered on 8/13/2025.b. aripiprazole tablet 5 mg oral once a day for psychosis manifested by visual hallucinations, disorganized thinking ordered on 9/17/2025.c. aripiprazole table 5 mg oral for psychosis manifested by (seeing things or hearing things that are not there), disorganized thinking (incoherent words that lack any meaningful connection) ordered on 10/5/2025.d. aripiprazole table 5 mg oral for psychosis manifested by (seeing things or hearing things that are not there), disorganized thinking (incoherent words that lack any meaningful connection) ordered on 10/5/2025.During a review of Resident 2's Care Plan titled Resident with mental illness/psychosis diagnosis (DX) including: (X) Psychotic disorder, and (X) Other Psychotic manifestation initiated on 8/15/2025 with the goal to maximize the resident's functional potential and well-being, while minimizing the hazards associated with medication side effects. The care plan interventions included administer medication as ordered: aripiprazole tablet; 5 mg; amount 5 mg; oral Special Instructions: Psychosis manifested by (m/b) visual hallucinations, disorganized thinking. Once a day. Monitor possible signs and symptoms (s/s) of side effects and report to attending physician (AP).During a concurrent interview and record review on 12/4/2025 at 8:15 a.m. with the Minimum Data Set Nurse (MDS), the MDS stated Resident 2's PASRR was not completed upon admission. The MDS stated she was responsible for completing and following up the PASRR screening for Resident 2. The MDS stated completing a PASRR screening was to assess resident for mental or behavioral services the resident may need during his stay in the facility. The MDS stated if the PASRR screening was not completed upon admission, the resident may not receive the mental or behavioral treatment and services needed for his mental or behavioral diagnoses.During an interview on 12/4/2025 at 12:08 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated the MDS was responsible for conducting the PASRR screening upon admission of a resident. RNS 1 stated completing a PASRR screening was to identify resident's needs upon admission based on the resident's admission diagnoses so the resident can be referred to a care team that can better manage the resident's mental or behavioral condition. RNS 1 stated if the PASRR screening was not conducted there would be potential for delayed mental or behavioral treatment and services, and the safety of the resident was at risk.During a review of the facility's policy and procedures (P&P) titled Preadmission Screening and Resident Review (PASSR) undated, indicated PROCEDURE . 3. The facility's designated staff will review the PASSR from the acute hospital and determine if there is a required follow-up i.e., Level II referral, etc. Level I Screening The screening is submitted online by (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the hospital (or facility if not admitted from the acute hospital) and is a tool that helps identify possible SMI and/or ID/DD/RC.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure one of five sample residents (Resident 4) meal tray was properly set up with containers unopened and within reach for Resident 4 to eat breakfast. This deficient practice of not setting up Resident 4's meal tray had the potential for delay in Resident 4's ability to eat his food and placed him at risk for inadequate nutrition and compromised dignity. Findings:During a review of Resident 4's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 4 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 4's diagnoses contractures (painful, permanent tightening and shortening of muscles causing joints to become stiff and their lose their normal range of motion), protein-calorie malnutrition (a severe form of undernutrition from insufficient intake of protein and calories), and adult failure to thrive (progressive decline in older adults that are often manifested of underlying physical, mental, or psychosocial conditions). During a review of Resident 4's History and Physical (H&P), dated 11/16/2025, the H&P indicated, Resident 4 did not have capacity to make medical decisions due to cerebrovascular accident ([CVA]- a medical condition characterized by the sudden interruption of blood flow to the brain) causing impaired function. During a review of Resident 4's Minimum Data Set ([MDS] a resident assessment tool), dated 10/20/2025, the MDS indicated Resident 4's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 4 was dependent (helper does all the effort) on staff for toileting hygiene, showering, and dressing. The MDS indicated Resident 4 required supervision/touching assistance (helper assist as resident completes activity) while eating meals once the meal is placed before the resident. During an observation on 12/4/2025 at 8:00 a.m., in Resident 4's room, Resident 4 had a breakfast tray which was not positioned for him to reach nor were the food items in the containers opened for him to eat or drink.During a review of Resident 4's physician orders titled, Physician Order Report, dated 11/18/2023, the physician orders indicated diet was to be supervise resident at meals for set up and intermittently for safety.During an observation and interview on 12/4/2025 at 8:05 a.m., in Resident 4's room, Resident 4 had right hand contracture and had difficulty opening food items. Resident 4 could not remove the plastic from his drink or remove the cover of the oatmeal. Resident 4 stated the staff does this all the time. Resident 4 stated sometimes he does not eat his meals because it's too hard to open the containers and then the staff takes the food away. Resident 4 stated it makes him frustrated that he can't enjoy his meal because the staff does not assist with setting up the meal to eat. During a concurrent observation and interview on 12/4/2025 at 8:15 a.m., with Certified Nursing Assistant (CNA) 1, in Resident 4's room, Resident 4 had a breakfast tray which was not positioned for him to reach nor were the food items in the containers were opened for him to eat or drink. CNA 1 stated she was to set up the meal tray and position Resident 4 in an upright position to eat his food. CNA 1 stated Resident 4 had difficulty opening his food items and she should have opened them for him. CNA 1 stated not opening Resident 4's food items had the potential for his food to get cold, not opening the salt /pepper the food would lack flavor, and he may not eat his food.During a concurrent observation and interview on 12/4/2025 at 8:25 a.m. with Registered Nurse (RN) 3, in Resident 4's room, Resident 4 had a breakfast tray which was not positioned for him to reach nor were the food items in the containers open for him to eat or drink. RN 3 stated the protocol was the food items were to be opened and within reach of the resident. RN 3 stated Resident 4 had the right to have food items offered and have them readily available. RN 3 stated not having the food items within reach and open could make the resident feel that he was not acknowledged and potentially loos weight.During a review of facility's policy and procedure (P&P) titled, Quality of Life, date unknown, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	self-esteem. The P&P indicated Residents were to be always treated with dignity and respect. The P&P indicated standard of care that compromise dignity was prohibited. The P&P indicated staff were expected to promote dignity and assist residents.During a review of facility's P&P titled, Assisting the Resident to Eat, unknown date, the P&P indicated to assist the resident to eat. The P&P indicated remove food covers, prepare, and arrange the food for the resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure two of two residents (Resident 18 and Resident 52) was supervised by staff while smoking. This failure had the potential to result to resident injury.Findings: a. During a review of Resident 52's Face Sheet (admission Record), the Face Sheet indicated the facility admitted Resident 52 on 9/26/2025 with diagnoses including acute respiratory failure, systemic lupus erythematosus (lupus - an ongoing disease where the body's immune system gets confused and attacks its own healthy tissues and organs by mistake), obstructive and reflux uropathy (when urine flows backward from the bladder up toward the kidneys), acute kidney failure, and benign prostatic hyperplasia (enlarged prostate gland). During a review of Resident 52's History and Physical (H&P) dated 9/27/2025, indicated Resident 52 had the capacity to understand and make decisions. During a review of Resident 52's Minimum Data Set (MDS – a resident assessment tool) dated 10/27/2025, the MDS indicated Resident 52 had moderate cognitive (ability to think, learn, understand and remember) impairment and needed supervision or touching assistance (helper provides verbal cues or touching, steadying, or contact guard assistance as resident completes activity) and partial to moderate assistance with oral, toileting and personal hygiene, showering, upper and lower body dressing, and putting on or taking off footwear. During a review of Resident 52's Safe Smoking assessment dated [DATE], the Safe Smoking Assessment indicated Resident 52 was a safe smoker and needed supervision while smoking. During a concurrent observation and interview on 12/3/2025 at 8:35 a.m. with Resident 52 in the smoking patio, Resident 52 was smoking without staff supervision. Resident 52 stated staff was supposed to be present when residents were outside smoking. During an interview on 12/3/2025 at 12:52 p.m. with the Activities Assistant (AA), the AA stated residents must be supervised when smoking, this was to ensure the residents were safe from harm such as burning themselves or others. The AA stated if the residents were not supervised during smoking, there would be potential for injury such as burns. During an interview on 12/3/2025 at 1:17 p.m. with the Minimum Data Set Nurse (MDS), the MDS stated all residents who smoke must be supervised by staff. The MDS stated residents must be supervised by staff per facility policy to ensure the safety of the residents and staff in the facility. The MDS stated if residents did not have staff supervision there is a potential for injury such as burns. During an interview on 12/3/2025 at 2:00 p.m. with the Activities Director (AD), the AD stated residents who have signed the smoking contract must be accompanied by staff when smoking to ensure the safety of the residents and the whole facility. The AD stated if residents were not supervised while smoking, there would be a potential for the residents to burn themselves. During an interview on 12/5/2025 at 12:08 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the importance of staff supervision while residents smoke was to assist residents with putting on aprons or lighting cigarettes and to prevent injuries such as burns. The RNS 1 stated if residents smoked without staff supervision, there would be potential for residents to burn themselves. During a review of the facility's smoking program schedule, dated 12/2025, indicated designated smoking time, location, staff assigned (for supervision) Monday through Friday, and staff assigned (for supervision) weekends. During a review of the facility's policy and procedure (P&P) titled Smoking Policy undated, the P&P indicated . 1. All residents that desire to exercise the privilege to smoke will be assessed to determine their smoking safety awareness. (Attachment A) Until this assessment is complete, the patient will only be allowed to smoke under supervision. b. During a review of Resident 18's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 11/7/2024 with diagnoses including, acute respiratory failure with hypoxia (a life-threatening condition where the lungs can't get enough oxygen into the blood), and left femur fracture (serious break in the thigh bone). During a review of Resident 18's History and Physical (H&P) dated 11/8/2024, the H&P indicated the Resident was alert, oriented, and can make own decisions. During a review of Resident 18's MDS Minimum Data Set (MDS – a resident assessment tool) dated 11/16/2025, indicated Resident 18's cognitive function was intact (alert, oriented and able to recall information). During a concurrent observation and interview on 12/3/2025 at 11:20 a.m. with Resident 18 outside the designated smoking patio, Resident 18 was seated in a wheelchair alone with a loose tobacco at hand. Resident 18 stated the facility staff has seen him with his tobacco, he has been smoking without supervision and has been keeping his tobacco with him in his room since about 2 to 3 months ago. During an interview on 12/4/2025 at 12:11 p.m. with Minimum Data Set Nurse (MDS), the MDS stated residents were assessed for smoking evaluation upon admission. The MDS stated the Activity Director (AD) was responsible for supervising residents who smoke. The MDS stated if the AD or activity staff were unavailable, licensed nurses or registered nurses could also supervise the residents. The MDS supervising residents was important to prevent injury. The MDS stated Resident 18 was a smoker, and he needed supervision. Stated residents all need supervision even though they are independent. During a record review of Resident 18's Safe Smoking Assessment/Evaluation, dated 11/24/2025, the Smoking Assessment indicated the Interdisciplinary Team (IDT-a group of health care professionals with various areas of expertise who work together toward the goals of their residents) determined Resident 18 needed supervision while smoking.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure one of one resident's (Resident 8) oxygen tubing was labeled with the date the tubing was last changed. This failure had the potential for Resident 8 to receive oxygen through compromised oxygen tubing and increasing the risk of infection while receiving oxygen therapy.Findings:During a review of Resident 8's Face Sheet (admission Record), the Face Sheet indicated the facility admitted the Resident 8 on 9/22/2025 and was readmitted on [DATE] with diagnoses including metabolic encephalopathy (a brain problem where the brain has trouble working correctly because of a chemical imbalance in the body), anemia (a condition where the body does not have enough healthy red blood cells), and acute respiratory failure with hypoxia (a medical condition where the body's tissues and cells do not get enough oxygen to function correctly).During a review of Resident 8's History and Physical (H&P) dated 10/28/2025, the H&P indicated the resident does not have the capacity to understand and make decisions.During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool) dated 11/3/2025, the MDS indicated Resident 8 had severe cognitive (ability to think, understand, and learn) impairment, needed dependent assistance (helper does all of the effort to complete the activity) with eating, oral and personal hygiene, toileting, showering or bathing, upper and lower body dressing, and putting on or taking off footwear, and needed continuous oxygen therapy.During an observation on 12/2/2025 at 10:06 a.m. in Resident 8's room, Resident 8 was in bed awake, able to track movement with his eyes. Resident 8's was wearing splints (a supportive device that is custom fit to hold the hand in a good, open position to gently stretch tight tissues, prevent the tissues from getting stiffer, and maintain better movement) with a rolled towel on both left and right hands. Resident 8 was on 2 liters of oxygen per minute (L/min, rate of oxygen flow) through nasal cannula (a simple, flexible medical tube that delivers extra oxygen into a person's nose to help them breathe more easily). The nasal cannula was not labeled with the date when the nasal cannula last changed.During a concurrent observation and interview on 12/2/2025 at 12:25 p.m. with Licensed Vocational Nurse (LVN) 1 in Resident 8's room, LVN 1 stated Resident 8's nasal cannula was not labeled with the date when the nasal cannula was last changed, and the tubing should have been labeled. LVN 1 stated oxygen set up which included a set up bag, oxygen tubing, and pre-filled humidifier (a bottle that adds moisture) were changed weekly or as needed by the charge nurse(s) or restorative nursing assistant(s). LVN 1 stated placing a label with the last date changed on the oxygen tubing was important to inform staff whether the tubing needs to be replaced for the safety of the resident and as part of infection control. LVN 1 stated if the oxygen tubing was not labeled when it was last changed, the resident would be at risk for infection. During an interview on 12/2/2025 at 12:30 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated the charge nurse(s) and restorative nursing assistant(s) were responsible for changing the oxygen tubing and was changed weekly or as needed. RNS 1 stated the oxygen tubing needed a label to identify when the nasal cannula was last changed to ensure the oxygen tubing was free of defect and for the resident to receive the precise liters of oxygen as prescribed by the medical doctor (MD).During a review of the facility's policy and procedure (P&P) titled Cleaning Respiratory Equipment undated, indicated . Supplies 1. Replace masks and/or cannulas used by an individual resident within 7 days, and when obviously contaminated. 2. When not in use, store masks and cannulas in a plastic bag labeled with the resident's name and date.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of five sampled residents (Resident 57) was monitored for pain. This deficient practice of not monitoring for pain had to potential for Resident 57 to have discomfort.During a review of Resident 57's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 57 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 57's diagnoses included conversion disorder with motor deficit (a condition where psychological distress manifests as real, physical systems affecting movement), headache (pain in the head), and encephalopathy (a general brain disorder from injury, disease toxins, or metabolic issues, causing altered brain function). During a review of Resident 57's History and Physical (H&P), dated 5/27/2025, the H&P indicated, Resident 57 did not have the capacity to understand and make decisions. During a review of Resident 57's Minimum Data Set ([MDS] a resident assessment tool), dated 11/1/2025, the MDS indicated Resident 57's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 57 required set-up or clean-up assistance (helper sets up or cleans up prior or following the activity) by staff for oral hygiene, toileting hygiene, and showering. The MDS indicated Resident 57 was on pain management regimen. During a review of Resident 57's physician orders titled, Physician Order Report, dated 2/20/2024, the physician order indicated for the staff to monitor pain every shift. During a review of Resident 57's electronic medication administration record ([eMAR]- digital system replacing paper charts to track medications), dated 11/19/2025, the eMAR indicated the night shift licensed nurse did not monitor Resident 57's pain. During an interview on 12/2/2025 at 11:37 a.m., in Resident 57's room, Resident 57 stated he had headaches, and the staff gives him pain medication, but it does not always work. Resident 57 stated after the headache he will still have a headache. During a concurrent interview and record review on 12/3/2025 at 4:08 p.m., with MDS Nurse, Resident 57's eMAR, dated 11/19/2025, was reviewed. The eMAR indicated the night shift licensed nurse did not monitor Resident 57's pain. The MDS Nurse stated the pain monitoring was not recorded during the night shift. The MDS Nurse stated, If it's not documented then it was not done. The MDS Nurse stated if the pain was not monitored then Resident 57 could potentially have discomfort. During a review of the facility's policy and procedure (P&P) titled, Pain Management, unknown date, the P&P indicated to identify residents experiencing pain and develop, implement, and evaluate care plans for the management of pain, monitor, and document the resident's response to pain management interventions. The P&P indicated licensed staff was to discuss, review, and document pain management interventions.

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	055526	A. Building B. Wing	12/05/2025

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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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure one of one resident (Resident 108) had a hemodialysis (HD - a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed) emergency kit (e-kit) at bedside.This failure had the potential to result in a delayed emergency interventions during a life-threatening dialysis complications.Findings:During a review of Resident 108's Face Sheet (admission Record), the Face Sheet indicated the facility admitted Resident 108 on 11/26/2025 with diagnoses including acute and chronic respiratory failure with hypoxia (a medical condition where the body's tissues and cells do not get enough oxygen to function correctly), dependence on renal dialysis (a medical treatment that takes over the job of cleaning the blood when a person's kidneys stop working properly), and myocardial infarction (heart attack).During a review of Resident 108's History and Physical (H&P) dated 11/29/2025, the H&P indicated Resident 108 had the capacity to understand and make decisions.During a concurrent observation and interview on 12/2/2025 at 10:42 a.m. in Resident 108's room, there was no hemodialysis emergency kit at bedside. Resident 108 was awake, alert, and oriented to name, date, place, and situation, and was sitting on the right side of the bed. Resident 108 stated she does not recall any emergency kits placed at her bedside. During a concurrent observation and interview on 12/2/2025 at 12:10 p.m. with Licensed Vocational Nurse (LVN) 2 in Resident 108's room, LVN 2 stated there was no HD e-kit at Resident 108's bedside. LVN 2 stated having a HD e-kit at the resident's bedside was important for emergency situations related to hemodialysis access malfunction such as excessive bleeding at the hemodialysis access site. LVN 2 stated if there was no HD e-kit at bedside there would be potential for the resident to bleed out.During a concurrent observation and interview on 12/2/2025 at 12:15 p.m. with Registered Nurse Supervisor (RNS) 1 in Resident 108's room, RNS 1 stated there was no HD e-kit at Resident 108's bedside. RNS 1 stated having a HD e-kit at the resident's bedside was important so the e-kit will be readily available in case of emergency related to the resident's hemodialysis access site. RNS 1 stated if there was no HD e-kit at beside the resident can bleed excessively which placed the resident at risk for harm or even death.During a review of the facility's Policy and Procedure (P&P) titled Emergency Hemodialysis Kit, undated, the P&P indicated . It is the policy of this facility to maintain a dedicated Emergency Hemodialysis Access Site Kit for all residents who receive off-site hemodialysis treatment. The kit must remain readily accessible to licensed nursing staff in the of: Accidental bleeding from an arteriovenous (AV) fistula or graft, Bleeding from a central venous catheter (CVC) hemodialysis access, Dislodgement of dressing, excessive oozing, or unexpected bleeding after return from dialysis, Unscheduled return to facility with post-dialysis complications.The Emergency Hemodialysis Access Kit must be stored in: Medication Carts (Primary Location), Resident's bedside.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure three of three sampled Residents (Resident 7, Resident 48, and Resident 111) opened medication boxes and a medication bottle were labeled with the date opened.This failure had the potential to result in the use of medications past their stability period, reducing efficacy and compromising resident's health and safety.Findings:1. During a concurrent observation and interview on 12/3/2025 at 3:20 p.m. with the Infection Preventions Nurse (IPN), for medication cart 3 located in station 2, the following medications boxes were inside medication cart 3 without opened date labels: a. Lidocaine Patch (medication used for pain) and Albuterol Sulfate Inhalation (medication used to treat lung diseases) for Resident 48b. Lovenox injections (medication used to treat blood clots) for Resident 111During an interview on 12/3/2025 at 3:20 p.m. with IPN, the IPN stated it was important to have open date labels to know when medications expire. The IPN stated labeling medications with opened dates was important to prevent using them past their expiration, following manufacturer's guidelines, and possible adverse effects to residents increasing their risk for harm.2. During a concurrent observation and interview on 12/4/2025 at 12:25 p.m. with Licensed Vocational Nurse (LVN) 3 for medication cart 3 located in station 2, the following medication bottle was inside medication cart 3 without an opened date label:a. Levetiracetam (medication used to treat seizures) for Resident 7During a concurrent observation and interview on 12/4/2025 at 12:25 p.m. with LVN 3, LVN 3 stated opened medications must be labeled with the open date to track expiration, stability, and efficacy.During a review of the facility's policy and procedure (P&P) titled, Medication Storage, Storage of Medication, undated, did not indicate procedure(s) for placing open date labels on newly opened medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure chocolate frosting, flour, and starch stored in the kitchen were not expired.This failure had the potential to result in unsafe food preparation practices and increased risk of residents consuming foods made with expired ingredients, leading to decreased food quality or foodborne illness.Findings:During an observation on 12/2/2025 at 8:55 a.m. in the kitchen food storage room, chocolate frosting in a plastic tub was observed with an expiry date on 11/19/2025, starch stored in a grey circular bin with lid had an expiry date on 11/24/2025, and flour in a grey circular bin with lid had an expiry date on 11/24/2025.During an interview on 12/2/2025 at 8:57 a.m. with Dietary Aid (DA) 1, DA 1 stated the chocolate frosting, starch, and flour were expired and expired foods in storage must be thrown away as it may be used for foods served to the residents. DA 1 stated the residents may get severely sick from eating foods that were made with expired ingredients.During an interview on 12/3/2025 at 12:44 p.m. with Dietary Supervisor (DS), the DS stated expired food must be thrown away as soon as the food expires to prevent staff from using expired ingredients. The DS stated if foods were made with expired ingredients there would be a potential for the residents to experience signs and symptoms of food-borne illnesses that may lead to more complicated health issues.During a of the facility's Policy and Procedure (P&P) titled Food Storage Principles, undated, indicated .PROCEDURE.3. Label each package, box, can, etc. with the expiration date, date of receipt, or when the item was stored after preparation. a. Discard foods that have exceeded their expiration date.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain a television in a safe and operating condition for one of 42 resident rooms' (room [ROOM NUMBER]B), when an uncovered and unsecured cable electrical wire was hanging underneath the television and not having a system in place to timely take care of equipment repairs.This deficiency had the potential to cause injury from electrical hazards.Findings:During an observation on 12/4/2025 at 1:28 p.m. in room [ROOM NUMBER]B, a wall-mounted television had an uncovered wire hanging from the cable at the bottom of the television.During a concurrent observation, and interview on 12/5/2025 at 10:27 a.m. in room [ROOM NUMBER]B, the Housekeeping Supervisor (HS) stated the television cable wire was exposed and should not be exposed because the wires could be dangerous to the residents. During a concurrent interview and record review on 12/5/2025 at 10:35 a.m., the HS indicated the facility's Preventative Maintenance Monthly Checklist, dated 2025, did not include logs for tracking the televisions individually in each resident's room.During a record review of the maintenance log, dated 5/17/25, the maintenance log indicated a complaint about a tv wall cable faulty and sparkling lights from naked area. During a review of facility's policy and procedure (P&P), titled, Preventative Maintenance Program, undated, indicated A basic preventative maintenance program results in cleaner, safer, and more efficient operation with fewer deficiencies and emergency repairs.A company-wide system to communicate issues or items that need attention, repair, or replacement.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of five sampled residents (Resident 23) the licensed staff had turned off the oxygen when Resident 23 was not in the room and not in use. This deficient practice of not turning off the oxygen while the resident was not in the room had the potential for hazardous conditions.During a review of Resident 23's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 23 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 23's diagnoses included chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing), respiratory failure (when the body's respiratory system is unable to exchange oxygen and carbon dioxide properly), and dementia (a progressive state of decline in mental abilities). During a review of Resident 23's History and Physical (H&P), dated 8/13/2025, the H&P indicated, Resident 23 had limited capacity to understand and make decisions. During a review of Resident 23's Minimum Data Set ([MDS] a resident assessment tool), dated 11/1/2025, the MDS indicated Resident 23's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 23 required substantial/maximal assistance (helper does more than half the effort for lifts, hold trunk, or limbs) by staff for toileting hygiene, showering, and dressing. The MDS indicated Resident 23 required respiratory treatment with oxygen therapy (providing a patient with supplemental oxygen, which is extra oxygen beyond what they can breathe from the air). During an observation on 12/2/2025 at 10:44 a.m., in Resident 23's room, Resident 23's oxygen concentrator (a medical device that provides concentrated oxygen to people with breathing problems) was on and set at two liters ([l]-a metric unit of capacity) with a nasal cannula attached and Resident 23 was not in the room. During a concurrent observation and interview on 12/2/2025 at 11:16 a.m., in Resident 23's room, with Registered Nurse (RN) 1, Resident 23's oxygen concentrator was on and set at two liters with a nasal cannula attached and Resident 23 was not in the room. RN 1 stated the oxygen concentrator should be off when the resident was not in the room. RN 1 stated leaving the oxygen on was a fire hazard and had placed the residents endangered.During an interview on 12/3/2025 at 11:24 a.m., with Certified Nursing Assistant (CNA) 3, CNA 3 stated when the resident was no longer in the room, he was to report to the licensed nurse to turn off the oxygen. CNA 3 stated it was dangerous to leave the oxygen unattended because it is flammable and could create a fire. During a concurrent interview and record review on 12/4/2025 at 4:16 p.m., with the Director of Staff Development (DSD), the DSD stated the protocol was to turn off the oxygen when the resident was no longer in the room. The DSD stated oxygen was a medication and the licensed staff were to turn off the oxygen when Resident 23 was not in the room. The DSD stated there was no policy and procedure (P&P) regarding oxygen safety and no staff training regarding oxygen safety. During a review of facility's policy and procedures (P&P) there were no P&P on oxygen safety regarding turning off oxygen while residents were not in their rooms.