STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055608	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Primrose Post-Acute	515 Centinela Ave. Inglewood, CA 90302

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to: 1. Implement its abuse prevention and reporting policy by failing to submit the results of the investigation of an allegation of financial abuse to the state agency (California Department of Public Health) within five working days of the incident for one of one sampled resident (Resident 52). This deficient practice delayed the investigation by the CDPH and placed Resident 52 at risk for further abuse. Findings: During a review of Resident 52's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 52 was admitted to the facility on [DATE]. Resident 52's diagnoses included dementia (a progressive state of decline in mental abilities), osteoarthritis (a progressive disorder of the joints, caused by gradual loss of cartilage) of knee, and acute kidney failure (a sudden and often temporary loss of the kidneys ability to function properly). During a review of Resident 52's History and Physical (H&P), dated 1/21/2025, the H&P 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 4/2/2025, the MDS indicated, Resident 52's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated, Resident 52 was totally dependent (helper does all of the effort) from staff with toileting hygiene, upper and lower body dressing, and personal hygiene. During a review of Resident 52's Progress Notes, dated 10/1/2024, the Progress Notes indicated, the Social Service Director (SSD) submitted a report of financial abuse to Adult Protective Services ([APS] - a government agency that investigates allegations of a vulnerable adult being or having been abused, neglected, or exploited by their caregivers). (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Report of Suspected Dependent Adult/Elder Abuse (SOC 341) faxed to CDPH on 5/21/2025 at 11:24 a.m. (approximately 7 months after the allegation was reported) indicated, the date and time of financial abuse incident occurred on 10/1/2024 at approximately 4:30 p.m. The SOC 341 indicated the SSD was suspicious of potential financial abuse of Resident 52 by her representative and reported the case to APS on 10/1/2024. During an interview on 5/21/2025 at 8:54 a.m., with the SSD, the SSD stated she filed the report of an allegation of financial abuse to APS on 10/1/2024 against Resident 52's representative. The SSD stated the allegation of financial abuse of Resident 52's funds by her representative was reported to the Director of Nursing (DON) but not to the CDPH, Ombudsman and law enforcement agency. The SSD stated she was a mandated reporter, and any allegation of abuse should be reported immediately or within 2 hours to the CDPH, Ombudsman, and law enforcement agency. The SSD stated the facility did not investigate the allegation of financial abuse. The SSD stated the facility should have submitted the final written investigation result to CDPH after 5 days so they would know the outcome of the findings conducted by the facility. During a concurrent interview and record review on 5/21/2025 at 9:17 a.m., with the DON, the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating, dated 4/2025, was reviewed. The P&P indicated, Folow-up report, within five business days of the incident, the Administrator will provide a follow-up investigation report. The follow-up investigation report will provide as much as information as possible at the time of submission of the report. The DON stated this was the facility's P&P when it comes to the 5-day follow-up investigation report that will be submitted to the CDPH.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record, the facility failed to ensure an accurate Minimum Data Set ([MDS] - a resident assessment tool) assessment was completed accurately for three of 17 sampled residents (Residents 13, 120, and 42) by failing to: 1. Ensure Resident 13's Gabapentin (medication used to treat seizure and nerve pain medication) was encoded as anticonvulsant medication under MDS section N (N0415 High-Risk Drug Classes). 2. Ensure Resident 120's Pressure Ulcer stage 2 ([PU] Partial-thickness loss of skin, presenting as a shallow open sore or wound) was encoded under MDS section M0300 (Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage) discharge assessment. 3. Ensure Resident 42 had accurate documentation in the Minimum Data Set ([MDS]- a resident assessment tool) to reflect her use of Eliquis ([anti-coagulant]- medication used to thin the blood). These deficient practice resulted in incorrect data being transmitted to the Center for Medicare and Medicaid Services (CMS) and had the potential to negatively affect the plan of care and services for Residents 13, 120, and 42. Findings: 1. During a review of Resident 13's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 13 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 13's diagnoses included cerebrovascular accident ([CVA] - stroke, loss of blood flow to a part of the brain) with hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), congestive heart failure ([CHF] - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and hypertension ([HTN] - high blood pressure). During a review of Resident 13's History and Physical (H&P), dated 3/17/2025, the H&P indicated, Resident 13 did not have the capacity to make medical decision. During a review of Resident 13's MDS assessment, dated 4/11/2025, the MDS indicated, Resident 13's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated, Resident 13 was totally dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing. During a review of Resident 13's Order Summary Report (a document containing active orders), dated 5/20/2025 indicated, the physician placed a telephone order on 3/23/2025 for Resident 13 to start on Gabapentin and to give 200 milligrams ([mg) - metric unit of measurement, used for medication dosage and/or amount) three times a day for neuropathic pain (type of pain that can happen if your nervous system malfunctions or gets damaged). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/20/2025 at 1:57 p.m., with the Minimum Data Set Nurse (MDSN), Resident 13's MDS assessment, dated 4/11/2025, was reviewed. The MDSN stated Resident 13's MDS assessment was completed inaccurately. The MDSN stated there should be a check marked on section N0415 under anticonvulsant drug. The MDSN stated Gabapentin is classified as anticonvulsant drug. The MDSN stated coding of medication in the MDS assessment should be based on pharmacological classification of the medication not based on the reason it was prescribed. The MDSN stated inaccuracy of MDS assessment could affect the care and services and facility's interventions to residents. During a review of the facility's policy and procedure (P&P), titled Resident Assessments, dated 4/2025, the P&P indicated All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. 2. During a review of Resident 120's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 120 was admitted to the facility on [DATE]. Resident 120's diagnoses included , cerebrovascular accident ([CVA] - stroke, loss of blood flow to a part of the brain) with hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), left elbow contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 120's History and Physical (H&P), dated 11/16/2024, the H&P indicated, Resident 120 had the capacity to make medical decision. During a review of Resident 120's MDS Admission assessment, dated 11/19/2024, the MDS indicated, Resident 120's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated, Resident 120 was totally dependent (helper does all of the effort) from staff with oral hygiene, upper body and lower body dressing, and personal hygiene. During a review of Resident 120's Interventions to Reduce Acute Care Transfers ([eINTERACT] - a clinical support tool designed to help identify and manage changes in patient's condition, particularly in long-term care settings) Change in Condition Evaluation form, dated 1/7/2025, the eINTERACT indicated, Resident 120 had a PU Stage 2 on Sacrum (a triangular-shaped bone located at the base of the spine). During a concurrent interview and record review on 5/22/2025 at 10:44 a.m., with the MDSN, Resident 120's Discharge MDS assessment, dated 1/7/2025, was reviewed. The MDSN stated Resident 120's MDS Discharge MDS assessment was completed inaccurately. The MDSN stated Resident 120's Discharge MDS, Section M0300 (1. Number of Stage 2 Pressure Ulcers) should have been coded one (1) because resident was identified with one Stage 2 PU prior to discharge to acute hospital. The MDSN stated the Assessment Reference Date ([ARD] - the last day of the observation period used for gathering information in the MDS assessment process) for Section M (Skin Conditions) was 7 days. The MDSN stated she provided wrong information of Resident 120's assessment to the CMS. During a review of the facility's P&P, titled Resident Assessments, dated 4/2025, the P&P indicated All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48712 3. During a review of Resident 42's Admission Record, the Admission Record indicated Resident 42 was admitted to the facility on [DATE]. Resident 42's diagnoses included hypertension (HTN-high blood pressure), diabetes mellitus ((DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and hyperlipidemia (condition where there is high levels of fat in the blood). During a review of Resident 42's History and Physical (H&P), dated 4/4/2025, the H&P indicated Resident 42 had the capacity for medical decision making. During a review of Resident 42's Minimum Data Set (MDS - a resident assessment tool), dated 4/8/2025, the MDS indicated Resident 42's cognition (ability to think and reason) was intact. Resident 42 was dependent on staff for toileting, showering, and dressing. The MDS indicated Resident 42 was not taking an anti-coagulant. During a review of Resident 42's Order Summary, dated 5/23/2025, the summary indicated on 4/2/2025 the physician entered an order to give Eliquis 5 mg (a unit of measure for medication) twice a day. During a review of Resident 42's care plan, dated 4/3/2025, the care plan indicated Resident 42 was at risk for bleeding due to her use of an anti-coagulant. During a concurrent interview and record review on 5/23/2025 at 8:53 a.m. with the Minimum Data Set Nurse (MDSN), Resident 42's MDS assessment was reviewed. The MDSN stated the assessment indicated Resident 42 is not on an anti-coagulant. The MDSN stated if the assessment is not completed accurately, it could affect what type of interventions are provided in the residents' care. MDS assessments are done to collect data about a residents' care to send to CMS so CMS can know what kind of residents are in the facility and what type of care the facility is providing. During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, dated April 2025, the P&P indicated information in the MDS assessment will consistently reflect information in the progress notes and plans of care.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure resident who was admitted to the facility with intact skin did not develop a pressure ulcer ([PU] - injury to skin and underlying tissue resulting from prolonged pressure on the skin or bony prominences) for one of four sampled residents (Resident 120) by failing to: 1. Ensure nursing staff implemented Resident 120's care plan titled Resident is at risk for skin breakdown to apply barrier cream and to check resident's skin daily. This deficient practice resulted in Resident 120 acquiring a PU stage 2 (Partial-thickness loss of skin, presenting as a shallow open sore or wound) on sacral (a triangular-shaped bone located at the base of the spine) area. Findings: During a review of Resident 120's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 120 was admitted to the facility on [DATE]. Resident 120's diagnoses included cerebrovascular accident ([CVA] - stroke, loss of blood flow to a part of the brain) with hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), left elbow contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 120's History and Physical (H&P), dated 11/16/2024, the H&P indicated, Resident 120 had the capacity to make medical decision. During a review of Resident 120's Minimum Data Set ([MDS] - a resident assessment tool) admission assessment, dated 11/19/2024, the MDS indicated, Resident 120's cognitive ability to think and reason) skills for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated, Resident 120 was totally dependent (helper does all of the effort) from staff with oral hygiene, upper body and lower body dressing, and personal hygiene. The MDS indicated Resident 120 did not have unhealed PU or injuries. During a review of Resident 120's Braden Scale (tool commonly used in healthcare to assess and document a resident's risk for developing pressure ulcers) form, dated 11/13/2024, the Braden scale indicated Resident 120 had slightly limited sensory perception (ability to respond meaningfully to pressure-related discomfort), was occasionally moist, bedfast (confined in bed), very limited mobility (ability to change and control body positions), adequate nutrition, and had a problem in friction and shear. The Braden scale indicated, Resident 120 had a score of 13 (at risk score of 15-18, moderate risk 13-14, high risk 10-12, and very high risk 9 or below), indicating Resident 120 was moderate risk for developing PU. During a review of Resident 120's Comprehensive Skin Evaluation/Assessment form, dated 11/14/2024, the Comprehensive Skin Evaluation/Assessment form indicated Resident 120 had no existing wounds or skin integrity concerns. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 120's Interventions to Reduce Acute Care Transfers ([eINTERACT] - a clinical support tool designed to help identify and manage changes in patient's condition, particularly in long-term care settings) Change in Condition Evaluation form, dated 1/7/2025, the eINTERACT indicated, Resident 120 had a PU Stage 2 on Sacrum. During an interview on 5/21/2025 at 1:40 p.m., with Treatment Nurse 1 (TN 1), TN 1 stated Resident 120 had no barrier cream applied to his body as skin maintenance to prevent resident from developing PU. TN 1 stated nursing staff would do a general skin inspection during residents scheduled shower or bed bath (a wash that you give to someone who cannot leave their bed). TN 1 stated the purpose of checking the skin condition of resident was to identify immediately the presence of PU in order to provide and implement wound care interventions. TN 1 stated Resident 120's PU stage II on sacrum was identified the day he was transferred to the hospital on 1/7/2025. During a concurrent interview and record review on 5/21/2025 at 2:40 p.m., with the Director of Nursing (DON), Resident 120's clinical records and care plan titled Resident at risk for skin breakdown related to bedbound and impaired circulation dated 11/14/2024, was reviewed. The care plan goal was to prevent or delay skin breakdown for Resident 120. The care plan interventions included to apply barrier cream and check resident skin during daily care provisions. The DON stated licensed nursing staff should have called Resident 120's physician to obtain an order for skin barrier since resident is at risk for development of PU. The DON stated barrier cream maintains skin integrity by protecting the skin from moisture and shear and could possibly prevent risk of skin breakdown for resident at risk for PU. The DON stated there was no documentation by nursing staff that Resident 120's skin was assessed daily during care. The DON stated facility staff did not follow and implement the care plan interventions to prevent Resident 120's from developing stage II PU. During a review of the facility's policy and procedure (P&P), titled Prevention of Pressure Injuries, dated 4/2025, the P&P indicated Inspect the skin on a daily basis when performing or assisting with personal care or ADL's and use a barrier product to protect skin from moisture.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to: 1. Ensur e an inventory of personal belongings was completed upon transfer to General Acute Care Hospital (GACH) for one of one sampled resident (Resident 120). This deficient practice had the potential for not having proper accountability of Resident 120's personal belongings. Findings: During a review of Resident 120's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 120 was admitted to the facility on [DATE]. Resident 120's diagnoses included , cerebrovascular accident ([CVA] - stroke, loss of blood flow to a part of the brain) with hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), left elbow contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 120's History and Physical (H&P), dated 11/16/2024, the H&P indicated, Resident 120 had the capacity to make medical decision. During a review of Resident 120's Minimum Data Set ([MDS] - a resident assessment tool) admission assessment, dated 11/19/2024, the MDS indicated, Resident 120's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated, Resident 120 was totally dependent (helper does all of the effort) from staff with oral hygiene, upper body and lower body dressing, and personal hygiene. During a review of Resident 120's Interventions to Reduce Acute Care Transfers ([eINTERACT] - a clinical support tool designed to help identify and manage changes in patient's condition, particularly in long-term care settings) Transfer form, dated 1/7/2025, the eINTERACT indicated, Resident 120 was transferred to GACH. During a concurrent interview and record review on 5/22/2025 at 10:26 a.m., with the Social Service Director (SSD), Resident 120's Inventory of Personal Effects form, was reviewed. The SSD stated Resident 120's Inventory of Personal Effects was not completed and signed by facility representative when Resident 120 was transferred to GACH on 1/7/2025. The SSD stated it was her responsibility to keep track and safeguard residents personal belongings. The SSD stated it was important to account residents personal items to prevent fraud and it is residents rights to protect their personal items by having an inventory. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/2025 at 10:00 a.m., with Registered Nurse 1 (RN 1), RN 1 stated the Inventory of Personal Effects of resident should be completed immediately at the time of transfer or discharge. RN 1 stated it was the responsibility of the SSD to keep resident personal belongings for safe keeping. RN 1 stated by not keeping residents personal belongings there would be a potential for loss and theft. During a review of the facility's policy and procedure (P&P), titled Personal Property, dated 4/2025, the P&P indicated The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary. During a review of facility's Social Service Director Job Description, the SSD Job Description indicated to assist in inventory and tracking patient belongings.