STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055608	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026

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 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 observation, interview, and record review, the facility failed to ensure the facility followed- up with the Medical Doctor (MD 1) of one of three residents (Resident 1), regarding the resident and Resident 1's Responsible Party's (RP 1) request to talk to MD 1.This failure violated Resident 1 and RP 1's right to communicate with and access to persons and services inside and outside the facility.Findings:During a review of Resident 1's admission Record, the admission record indicated Resident 1 was admitted on [DATE] with diagnoses including cognitive communication deficit (a difficulty communicating due to cognitive impairments), retention of urine (the inability to fully empty the bladder), and obstructive and reflux uropathy (a blockage in the urinary tract that prevents urine from flowing properly). The admission Record indicated Resident 1 had a responsible party, RP 1.During a review of Resident 1's History and Physical (H&P), dated 7/5/2025, the H&P indicated Resident 1 was capable of making medical decisions.During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 was able to understand and be understood and did not have disorganized thinking or acute mental status change. Resident 1 did not reject care. Resident 1 was dependent (helper does all the effort) on staff for toileting hygiene, bathing, and personal hygiene. Resident 1 had an indwelling catheter and was always incontinent of bowel movements. Resident 1 and her family were active participants in the assessment process.During a review of Resident 1's Nursing Progress Notes, dated 1/28/2026, the Progress Notes indicated MD 1 and Nurse Practitioner [unnamed] were notified about RP 1's request for communication regarding Resident 1's medical condition. The Progress Notes indicated the clinical team will follow up with RP 1.During an observation on 1/28/2026 at 1:25 p.m., at Nursing Station 1, RP 1 requested to speak with MD 1 directly. Registered Nurse (RN 1) informed RP 1 that she will notify MD 1 and ensure that MD 1 contacts RP 1.During an interview on 1/28/2026 at 1:40 p.m., with Resident 1, Resident 1 stated she would like to speak to MD 1. Resident 1 stated she made a request with RN 1 for MD 1 to call her [Resident 1] or RP 1 and was awaiting MD 1's call.During an interview on 2/2/2026 at 1:15 p.m. with MD 1, MD 1 stated he and his office were not contacted by the facility about RP 1's request to talk to MD 1. MD 1 stated he had not been notified about Resident 1 and RP 1's request for communication and information. MD 1 stated he had not spoken with RP 1 and would have promptly called RP 1 if the facility had contacted him. During a concurrent interview and record review on 2/2/2026 at 1:40 p.m., with RN 1, Resident 1's Progress Note, dated 1/28/2026, was reviewed. RN 1 stated the Progress Notes indicated she [RN 1] notified MD 1 about RP 1's request to speak with MD 1. RN 1 stated there was no indication staff had followed up with MD 1 about Resident 1 and RP 1's requests. RN 1 stated she did not know if MD 1 responded to RP 1's request or the nursing team received MD 1's response. RN 1 stated she did not have time to follow up with MD 1 about Resident 1 and RP 1's request. During a concurrent interview and record review on 2/2/2026 at 4:12 p.m., with NP 1, Resident 1's (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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NAME OF PROVIDER OR SUPPLIER Primrose Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 515 Centinela Ave. Inglewood, CA 90302	

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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	Physician Progress Notes, date 9/22/2025 and 10/6/2025, were reviewed. NP 1 stated she was not notified about RP 1's request to speak with MD 1. NP 1 stated she had never spoken with RP 1 on behalf of MD 1. During an interview on 2/11/2026 at 1:50 p.m. with the Director of Nursing (DON), Resident 1's Nursing Progress Notes from 1/28/2026 through 2/10/2026, were reviewed. The DON stated the nursing progress notes on 1/28/2026 indicated RN 1 notified MD 1 about RP 1's request for contact. The DON stated the nursing progress notes did not indicate any follow-up with MD 1 to ensure Resident 1 and RP 1's rights were upheld. The DON stated a licensed nurse should have called MD 1 within one day to ensure RP 1's request was honored. During a review of the facility's policy and procedure (P&P), titled Resident Rights, dated 04/2025, the P&P indicated residents have the right to communicate with and access people and services inside and outside the facility, be supported be the facility in exercising their rights, exercise their rights without interference, and participate in decision-making regarding their care.

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a readmission Interdisciplinary Team ([IDT] group of healthcare professionals, including physician, nurses, resident/ resident representative, working together to develop a plan of care for the residents) meeting, for one of four residents (Resident 1), and her Responsible Party (RP), to allow participation in planning resident's care.This failure resulted in the resident and her RP not aware of the plan of care, and the potential for lack of coordinated or inadequate care plan and lack of opportunities to improve care.Findings:During a review of Resident 1's admission Record, the admission record indicated Resident 1 was admitted on [DATE]. Resident 1's diagnoses included cognitive communication deficit (a difficulty communicating due to cognitive impairments), retention of urine (the inability to fully empty the bladder), and obstructive and reflux uropathy (a blockage in the urinary tract that prevents urine from flowing properly).During a review of Resident 1's History and Physical (H&P), dated 7/5/2025, the H&P indicated Resident 1 could make medical decisions.During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 7/9/2025, the MDS indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 was able to understand and be understood and did not have disorganized thinking or acute mental status change. The MDS indicated Resident 1 did not reject care. The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting hygiene, bathing, and personal hygiene. The MDS indicated Resident 1 had an indwelling catheter and was always incontinent of bowel movements. The MDS indicated Resident 1 and her family were active participants in the assessment process.During a review of Resident 1's Progress Notes, dated 9/15/2025, the Progress Notes indicated Resident 1 was admitted to the facility with a foley ([indwelling urinary] to drain urine) catheter.During a review of Resident 1's Progress Notes for the month of September 2025, there was no indication a readmission IDT meeting was planned or occurred. During a review of Resident 1's Progress Notes, dated 12/8/2025, the Progress Notes indicated Resident 1 was re-admitted to the facility from a hospitalization related to complications of a urinary tract infection (UTI- an infection in the bladder/urinary tract).During a review of Resident 1's census tab, the census tab indicated Resident 1 was readmitted on [DATE].During a review of Resident 1's Progress Notes for the month of December 2025, the Progress Notes indicated, on 12/31/2025, an invitation was sent to Resident 1, and her Responsible Party (RP) to an IDT meeting. The Progress Notes did not indicate a readmission IDT meeting was conducted in December 2025.During an interview on 1/28/2026 at 1:40 p.m. with Resident 1 and Resident 1's RP 1, Resident 1 stated she was hospitalized in September 2025 and December 2025. Resident 1 and RP 1 stated facility staff did not inform them about Resident 1's plan of care to prevent future hospitalizations and UTIs after Resident 1 was hospitalized in December 2025. Resident 1 and RP 1 stated they wanted to be involved in the care planning process.During an interview on 1/29/2026 at 10:30 a.m., with the Social Services Director (SSD), the SSD stated IDT meetings must occur for every readmission to the facility.During an interview on 2/2/2026 at 8:40 a.m., with the Licensed Vocational Nurse (LVN 9), LVN 9 stated IDT meetings must occur to review Resident 1's condition, plan care, and uphold Resident 1's right to be informed and involved in care planning. LVN 9 stated Resident 1 could experience more hospitalizations and UTIs if IDT meetings are not conducted after each readmission. LVN 9 stated that Resident 1 and her family had the potential to not know Resident 1's condition or be involved in care planning, causing a potential infringement on their rights.During an interview on 2/2/2026 at 3:30 p.m., with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Care Planning - Interdisciplinary Team, (continued on next page)

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	055608	A. Building B. Wing	02/11/2026

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 04/2025, was reviewed. The DON stated the P&P was not followed when an IDT meeting was not conducted when Resident 1 was readmitted to the facility. The DON stated Resident 1's and RP 1's rights were violated when the readmission IDT was not conducted to inform them about the plan of care and allow them to participate in care planning.During a concurrent interview and record review on 2/6/2026 at 3:30 p.m. with the SSD, Resident 1's Progress Notes dated 12/31/2025, the policy and procedure (P&P) titled Resident Rights, dated 04/2025, were reviewed. The SSD stated the P&P indicated that the resident and/or the resident's representative should be part of the IDT meetings. The IDT meetings should occur within one week of readmission to the facility to coordinate care, update interventions, and allow the resident and their representatives to participate in care planning. When Resident 1 was readmitted on [DATE] and 12/8/2025, she did not conduct an IDT meeting to inform and allow Resident 1 to participate in care planning. The SSD stated the IDT invitation provided to Resident 1 and her RP as indicated in the progress note dated 12/31/2025 was for the quarterly IDT in January 2026 and not the readmission IDT. The SSD stated Resident 1's hospitalization and care changes to prevent re-hospitalization were not reviewed in the quarterly IDT meetings.During a review of the facility's policy and procedures (P&P) titled Resident Rights, dated 04/2025, the P&P indicated residents has the right to be informed of, and participate in, their care planning and treatment.During a review of the facility's P&P titled Care Planning - Interdisciplinary Team, dated 04/2025, the P&P indicated the IDT included the resident and/or the resident's representative to the extent practicable. The P&P indicated if the resident or representative cannot participate, an explanation was documented in the medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement intervention in one of three residents' (Resident 1), care plan titled, Resident 1 has indwelling foley catheter (catheter that drains urine from bladder into a bag outside the body), which indicated to monitor and document Resident 1's urine output.This failure had the potential to delay identification of changes and signs of complications (low urine output, signs of urinary tract infections) in the resident's urinary status, causing delay in care and interventions, that can lead to serious infections and hospitalization.Findings:During a review of Resident 1's admission Record, the admission record indicated Resident 1 was admitted on [DATE] with diagnoses including cognitive communication deficit (a difficulty communicating due to cognitive impairments), retention of urine (the inability to fully empty the bladder), and obstructive and reflux uropathy (a blockage in the urinary tract that prevents urine from flowing properly). During a review of Resident 1's History and Physical (H&P), dated 7/5/2025, the H&P indicated Resident 1 was capable of making medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 7/9/2025, the MDS indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 was able to understand and be understood. The MDS indicated Resident 1 did not have disorganized thinking or acute mental status change. The MDS indicated Resident 1 did not reject care. The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting hygiene, bathing, and personal hygiene. The MDS indicated Resident 1 had an indwelling catheter and was always incontinent of bowel movements. The MDS indicated Resident 1 and her family were active participants in the assessment process. During a review of Resident 1's care plan titled Resident 1 has indwelling foley catheter, dated 7/16/2025, one of the interventions indicated nursing staff will monitor and document Resident 1's output. During a review of Resident 1's clinical records, the progress notes for 7/2025 to 9/2025, did not indicate Resident 1's urine outputs were monitored. During a review of Resident 1's Physician Order dated 10/20/2025, the order indicated to monitor intake and output every shift. The physician's order indicated Resident 1's total fluid output monitoring must be performed every shift, starting 10/20/2025. During a concurrent interview and record review on 2/2/2026 at 3:30 p.m. with the Director of Nurses (DON), Resident 1's active care plans dated 7/16/2025, MAR(s) for the months of 7/2025, 8/2025, 9/2025, and 10/2025 and Resident 1's Physician's Order dated 10/20/2025, were reviewed. The DON stated Resident 1's care plan intervention to monitor Resident 1's urine output was not implemented on 7/16/2025 and the physician was not called around 7/16/2025 when the interventions was placed to monitor the urine output. The DON stated Resident 1's MAR for 7/2025, 8/2025 and 9/2025 did not indicate the urine output was monitored. The DON stated the facility called the physician on 10/20/2025 to obtain an order to monitor the urine output that was started on 10/20/2025 (three months later). The DON stated standards in nursing care being Resident 1 with indwelling catheter was to include output measurement and recording. The DON stated not implementing care plan interventions from 7/16/2025 until 10/20/2025 placed Resident 1 at increased risk of urinary infection and catheter-related complications. During a review of the facility's P&P titled Care Plans, Comprehensive Person-Centered, dated 4/2025, the P&P indicated care plans described the services furnished to residents to attain or maintain the resident's highest practicable physical well-being.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet professional standards of quality, by failing to ensure Medical Doctor's (MD 1) progress notes on 9/22/2025 and 10/6/2025, for one of three residents (Resident 1), indicating a plan for urology consultation, were clarified, ordered and scheduled.This failure resulted in Resident 1 being not seen by a urologist timely and placed the resident at risk for delayed necessary interventions to provide quality care when needed.Findings: During a review of Resident 1's admission Record, the admission record indicated Resident 1 was admitted on [DATE] with diagnoses including cognitive communication deficit (a difficulty communicating due to cognitive impairments), retention of urine (the inability to fully empty the bladder), and obstructive and reflux uropathy (a blockage in the urinary tract that prevents urine from flowing properly). During a review of Resident 1's History and Physical (H&P), dated 7/5/2025, the H&P indicated Resident 1 could make medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 7/9/2025, the MDS indicated Resident 1 had moderate cognitive impairment. Resident 1 was able to understand and be understood and did not have disorganized thinking or acute mental status change. The MDS indicated Resident 1 did not reject care. Resident 1 was dependent (helper does all the effort) on staff for toileting hygiene, bathing, and personal hygiene. Resident 1 had an indwelling catheter and was always incontinent of bowel movements. The MDS indicated Resident 1 and her family were active participants in the assessment process. During a review of Resident 1's Physician (MD 1) Progress Notes, dated 9/22/2025 and 10/6/2025, MD 1 indicated a plan for a follow-up appointment with urology (the branch of medicine and physiology concerned with the function and disorders of the urinary system) for Resident 1's urinary retention. During a review of Resident 1's Nursing Progress Notes for the month of 9/2025 and 10/2025, the progress notes did not indicate the facility clarified with the physician's progress notes or coordinate follow-up appointments with Urology. During a review of Resident 1's Physician Orders, dated 1/27/2025, the orders indicated a urology consultation was ordered for Resident 1 due to diagnoses including obstructive and reflux uropathy and foley catheter dependence. During an interview on 2/2/2026 at 1:15 p.m., with MD 1, MD 1 stated he was unsure if a urologist had been consulted for Resident 1. During a concurrent interview and record review on 2/2/2026 at 4:12 p.m., with Nurse Practitioner (NP 1), Resident 1's Physician Progress Notes, dated 9/22/2025 and 10/6/2025, were reviewed. NP 1 stated consultation with a urologist was standard practice due to Resident 1's obstructive uropathy, chronic indwelling urinary catheter, and history of multiple urinary tract infections (UTI- an infection in the bladder/urinary tract). NP 1 stated Resident 1's medical history and chronic indwelling urinary catheter put Resident 1 at high risk of UTIs, sepsis, and hospitalization. NP 1 stated she never reviewed urology notes or recommendations and did not know if the urology appointments listed on Resident 1's physician progress notes were carried out. NP 1 stated Resident 1 required a consultation with a urologist to assess Resident 1 and provide recommendations for Resident 1's plan of care. During interview on 2/9/2026 at 9:25 a.m., with Registered Nurse (RN) 2, RN 2 stated licensed nurses are responsible for reviewing physician's progress notes, clarify, and carry out planned interventions. RN 2 stated the licensed nurses should have spoken with the physician to clarify if the physician wanted to order a urology appointment. RN 2 stated not following up with the physician could have resulted in Resident 1 not receiving physician-directed care. During a concurrent interview and record review on 2/10/2026 at 1:50 p.m. with the Director of Nursing (DON), Resident 1's Physician Progress Notes dated 9/22/2025 and 10/6/2025, Resident 1's Nursing Progress Notes for the months of September and October 2025, and Nursing Progress Notes from (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/28/2026 through 2/10/2026 were reviewed. The DON stated the physician progress notes on 9/22/2025 and 10/6/2025 indicated a plan for a urology follow-up appointments. The DON stated the progress notes did not indicate documentations that the licensed nurses clarified and followed up with Resident 1's physician about the 9/22/2025 and 10/6/2025 planned urology follow-up appointment. The DON stated the urology follow-up appointment and consultation was recently ordered and scheduled for 1/2026. The DON stated this placed Resident 1 at risk for more UTIs and possible hospitalizations.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an accurate documentation for one of three residents (Resident 1), when the Interdisciplinary Team ([IDT] group of healthcare professionals, including physician, nurses, resident/ resident representative, working together to develop a plan of care for the residents) meeting was rescheduled. This failure resulted in Resident 1's medical record being inaccurate and incomplete.Findings: During a review of Resident 1's admission Record, the admission record indicated Resident 1 was admitted on [DATE] with diagnoses including cognitive communication deficit (a difficulty communicating due to cognitive impairments). During a review of Resident 1's History and Physical (H&P), dated 7/5/2025, the H&P indicated Resident 1 could make medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/8/2026, the MDS indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 was able to understand and be understood. Resident 1 did not have disorganized thinking or acute mental status change. The MDS indicated Resident 1 did not reject care. Resident 1 was dependent (helper does all the effort) on staff for toileting hygiene, bathing, and personal hygiene. Resident 1 had an indwelling catheter (catheter drains urine from bladder into a bag outside the body) and was always incontinent of bowel movements. The MDS indicated Resident 1 and her family were active participants in the assessment process. During a review of Resident 1's Progress Notes for the month of 1/2026, the Progress Notes did not indicate Resident 1's IDT meeting was delayed, rescheduled, or cancelled in 1/2026.During an interview on 1/28/2026 at 9:10 a.m. with Resident 1, Resident 1 stated she wanted herself (Resident 1) and Responsible Party (RP) 1 to be informed and involved in IDT meetings and care planning decisions. During an interview on 1/29/2026 at 10:30 a.m., with the Social Services Director (SSD), the SSD stated IDT meetings must occur for every readmission to the facility. During a concurrent interview and record review on 2/6/2026 at 3:30 p.m. with the Social Services Director (SSD), Resident 1's 12/2025 and 1/2026 Progress Notes, were reviewed. The SSD stated Resident 1's IDT meeting was rescheduled three times in 1/2026 due to Resident 1 and RP 1's requests but was not documented in Resident 1's progress notes. The SSD stated that when an IDT meeting is being scheduled or rescheduled, it should have been documented in the resident's clinical records to maintain accuracy. The documentation should include new scheduled date, reasons why the schedule was changed, and if the IDT were informed of the changes. During an interview on 2/11/2026 at 1:50 p.m., with the Director of Nursing (DON), the DON stated Resident 1's medical record was incomplete when the SSD did not document in Resident 1's progress notes when the IDT was cancelled and rescheduled and if the care team were made aware of the changes.